Guide to Funding Resources for Assistive Technology in Delaware

Delaware Assistive Technology Initiative
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About This Guide

The *Guide to Funding Resources for Assistive Technology* was developed to enhance the efficiency and effectiveness of the AT acquisition process. By consolidating information about AT funding mechanisms, it becomes a handy desktop reference for those trying to navigating the often complex funding channels to secure payment for AT devices and services.

The *Guide* describes the most significant AT funding sources, their eligibility criteria, and the conditions under which they pay for equipment and services. Strategies for approaching and interacting with each agency or program have also been included. The *Guide* is partly a compilation of information gathered directly from the organizations represented, but it is also a "cookbook" of AT funding methods and approaches. Legal references have been included where local policies are new or still under development.

Note that information provided herein has no effect of law or regulation, and in no way constitutes an official notification of benefits. Anyone who would like to offer comments or request additional information is encouraged to complete the **Feedback & Information Request form,** located at the end of this document.

Acknowledgements

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The Delaware Division of Developmental Disabilities Services

The Delaware Division for the Visually Impaired

The Delaware Medical Assistance Program (Delaware Medicaid)

Community Legal Aid Society, Inc. and its Disabilities Law Program

The Delaware Division of Vocational Rehabilitation

The Delaware Insurance Department

The Easter Seal Society of Delaware and Maryland's Eastern Shore

The Social Security Administration

The Centers for Medicare and Medicaid Services

Assistive Technology Funding Overview

What is Assistive Technology?

Assistive technology (AT), which includes both devices and services, is a powerful means of enabling people with disabilities to participate and to achieve independence at work, school, at home, and at play. AT goes by different names under a variety of laws, policies, and regulations. For example, in the Rehabilitation Act amendments of 1998 (Public Law 105-220), AT is called rehabilitation technology. In insurance circles, it is termed durable medical equipment (DME), and is called Home Medical Equipment (HME) by some DME suppliers. Many commonly used 'low tech' devices, as well as more sophisticated environmental controls, may be called aids for daily living. All may be considered AT. In the Assistive Technology Act of 1998, Congress defined an AT device as

"...any item, piece of equipment or product system, whether acquired off the shelf, modified or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities" [29 U.S.C. 3002, Section 3 (a)(3)].

Put simply, AT might include any item that would enable a person to function better or more easily than he/she could without that item. It could be as simple as a piece of foam rubber taped to a pencil to make it easier to hold, or as sophisticated as a computer with Braille output, or a motorized wheelchair. The legal definition of AT service is

"...any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device."

According to the AT Act, these services include:

Evaluation of AT needs, including a functional evaluation of the impact of the provision of appropriate AT devices and services in an individual's customary environment

Purchasing, leasing, or otherwise providing for the acquisition of AT devices and services

Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing AT devices

Coordinating and using other therapies, interventions, or services with AT services

Training or providing technical assistance to individuals with disabilities, family members, guardians, advocates, and authorized representatives of an individual with disabilities

Training or providing technical assistance to professionals, employers, or other individuals who provide services to or are otherwise substantially involved in the major life functions of individuals with disabilities.

Getting the Right Assistive Technology

The issue of device selection is of critical importance—both in terms of funding and in terms of its benefit to the user. The first and single most important step in obtaining AT is the completion of a thorough evaluation and assessment of the person's needs. Of course, evaluations should be done by appropriately trained/certified professionals. For instance, a person with a communication deficit might consult a speech/language pathologist (SLP). Someone who has problems with mobility might need to be evaluated by a physical or occupational therapist. Sometimes a team of clinicians needs to be involved in the decision-making process. In all cases, a person's needs have to be identified before an appropriate device or device system can be selected. Also, the information obtained during the evaluation is often the key to accessing funding for AT. Nearly all funding sources require some form of documentation of an individual's need for AT before they approve payment. For funding purposes, the most effective documentation will include an equipment justification that: a) addresses the individual's functional needs relative to the person's disabilities; and b) is based on evaluation(s) performed by one or more qualified professionals.

Funding "Rules of Thumb" for Consumers

No matter what AT funding source you pursue, the following tips will save you a lot of time and help increase your likelihood of success.

1. Do Not Give Up! Persevere!
2. Get your AT needs properly evaluated and documented. Most AT funding sources require documented proof of your need for the equipment or services you are requesting. An appropriately certified professional such as a doctor or therapist, or sometimes a team of professionals, may do this. The evaluation process itself will help determine which particular device(s) and services are right for you.
3. Keep accurate records. Write down any disability-related services you receive. Remember to note the location, the date, and the reason for the service. You may be asked to recall or access this information several months (or even years) afterward. Keep copies of all documents related to your disability, such as prescriptions, reports of evaluations, receipts for treatments/medications, and expenses you incur that are in any way associated with your disability. Such documents may enable you to be reimbursed for equipment/services or to purchase them through Social Security Administration work incentive programs.
4. Be prepared to work. Accept responsibility for locating and/or working with your AT funding source. Do not assume it is someone else's job or expect that service providers will automatically understand your needs. You know your situation best; that makes you your own best advocate.
5. Keep asking questions until you understand what is expected of you and what you can expect from others. Make notes before and after the call. Gaining access to funding can sometimes be a complex process, and understanding the system

greatly enhances your likelihood of success…so be determined when seeking information. If you don't quite get it, don't be ashamed to say, "I don't understand—please explain again more simply...more slowly." Most service representatives respond positively to such requests. If not, simply ask politely for someone who will. Along similar lines, precise communication is crucial. Formulate your questions before you make the call and write them down. Leave space for responses and write them in during the discussion. Even when you've carefully worded your question, it is still possible that the service representative may misunderstand. Try asking the same question another way, perhaps in simpler terms.

6. Be patient and be persistent. There is no one best approach that fits every situation. The solution may involve trying several options, or combining two or more to produce the desired outcome. Keep trying, be creative, and most of all, don't give up. In many cases, particularly with insurance, negative decisions can be reversed by appeal. Simply regard the denial as a "request for additional information."
7. Take a firm approach, but always be polite. Remember that agency and service representatives are people too. Treat them with the same dignity and respect that you expect from them even when they fail to assist you properly. You'll get more cooperation (and better service) that way.
8. Final Rule—Don't Forget Rule #1.

Key Terms and Acronyms

Approved/authorized provider is a health care provider or AT supplier that has contracted with a health insurance company to provide services or equipment to its members.

Assignment is a signed authorization by the insured for the insurance company to pay the cost of equipment or services directly to the health care provider or equipment vendor. Assignment is particularly important when requesting funding for technology through Medicare since it is a cost reimbursement program.

Assistive technology (AT) is any device or service that is used or will assist a person with a disability to increase, maintain, or improve his/her functional capabilities. AT devices can be acquired commercially, modified, or customized. They range from simple devices like adapted eating utensils and page magnifiers to high tech devices like voice output communication devices and power wheelchairs. AT is sometimes known as durable medical equipment (DME), home medical equipment (HME), rehabilitation technology, or prosthetic devices.

Caps typically refer to annual or other limits on the frequency or dollar amount of a covered benefit.

Certificate of coverage is a document that lists the benefit that will be covered under a health insurance plan, including exclusions and limits on coverage.

Certificate of Medical Necessity (CMN) is a form required by Medicare, and sometimes by Medicaid, authorizing the use of certain DME prescribed by a physician. The CMN is completed by the physician.

Co-payment is an amount the insured must pay out-of-pocket for a specified service at the time the service is provided.

Coordination of benefits applies when a person may be insured by more than one health insurance company. In such cases, payments from the insurance companies are coordinated so that payments do not exceed the actual cost of the service or equipment.

Covered expenses refers to the type and amount of medical expenses incurred by the insured that entitle him/her to payment of benefits under a health insurance policy.

Deductible is a flat amount that the insured must pay before the health insurance plan will make any payments. The deductible amount can change each year.

Fee-for-service plans are health insurance policies under which the insurance company pays for each service as it is provided, after receiving a claim form and a bill, according to a set fee schedule.

Managed Care Organization (MCO) is an organization consisting of hospitals, doctors, and other health care providers that provides health care services to the insured for a fixed prepaid amount without regard to the frequency or extent of services provided to any one person. An MCO is also known as a Health Maintenance Organization (HMO).

Medical necessity is the standard used by health insurance companies to decide whether an insured person is entitled to certain benefits. The definition of medical necessity varies depending upon the health insurance plan.

Medicare-approved amount is the fee that Medicare decides is reasonable for a covered medical service. This is the amount that Medicare will reimburse the supplier or the insured for a service or equipment.

Out-of-pocket maximum is the maximum amount that the insured has to pay each year in co-payments and deductibles.

Participating providers are physicians and other health care providers who contract with health insurance companies and agree to accept the plan's allowable charge as full payment. An MCO or HMO may employ their own staff physicians and other health care providers.

Payment cascade is a model that illustrates the order in which multiple payment sources must be accessed.

Payor of first resort refers to the public or private health insurance carrier that has the primary responsibility to fund a particular medical service or item of AT.

Payor of last resort refers to the public or private health insurance carrier that has the responsibility to fund a particular medical service or item of AT only when all other applicable funding sources have been exhausted.

Premium is the monthly or other periodic payment an insured must make to a health insurance company for coverage.

Prior authorization refers to the requirement that approval from the insurance company is secured in advance of equipment or services being provided. The criteria for prior authorization vary depending upon the terms of the particular health insurance policy.

Rider is an addition or an amendment to an insurance policy.

Public and Private Insurance

I. Insurance Basics

Private insurance is any health insurance policy purchased by an employer or by an individual from a private insurance company.

Public insurance is an insurance plan or policy that is subsidized by federal or state funds (Medicaid, Medicare). To be eligible for these plans an individual must meet one or more qualifying criteria involving age, income level, and health status.

Throughout this section, we will be discussing both public and private insurances. Insurance coverage goes by different names: we will refer to private insurance as an insurance policy. Medicaid coverage is dictated by a State Plan, and Medicare coverage is determined by national Medicare Policy. For simplicity in this section, we will refer to all three as a “policy.”

Individuals may be covered by a single insurance policy or by multiple policies. While there is considerable variability among what health insurance companies and state and federal plans cover with regard to AT, keep these general considerations in mind when dealing with public and private insurance.

Private insurance is often overlooked when efforts are made to obtain AT for persons with disabilities. If one has private insurance, Medicare and Medicaid consider that insurance to be the "payor of first resort," and will not consider funding requests until an individual's private insurance has denied all or part of the claim. There are three main questions when one looks to any insurance to fund AT:

Is the child or adult with disabilities covered by the policy?

Is the AT being sought covered by the policy?

Is the AT medically necessary?

1. Know the Policy

Know the type of policy. For example, in a fee-for-service plan, the provider submits a bill to the payer after the service or equipment is provided. In the case of managed care plans, decisions about paying for services or equipment are generally made before the service or equipment is provided.

Remember that AT is referred to in some insurance policies by other names, such as durable medical equipment (DME), home medical equipment, rehabilitation technology, orthopedic appliances, medical supplies, vision services and equipment, or prosthetic devices. Stay alert to any policy changes that might improve coverage.

Read the insurance policy, certificate of coverage and accompanying documents carefully so that you understand the policy's definitions, covered benefits, exclusions, deductibles, caps, etc. Make sure you obtain the actual contract and

not just a handbook or summary. DME is usually not available in a "basic" plan but rather in a "major medical" plan, which is often a rider to a basic plan. Be aware not only of exclusions for certain types of DME but also of clauses that limit the dollar amount of funding for a particular item.

Be aware that an AT device can sometimes be provided as part of therapy services even if not explicitly listed as a covered AT device. For example, one might be able to obtain an augmentative and alternative communication (AAC) device as a component of covered speech and language therapy services.

2. Know the Process for Obtaining AT

Health insurance will pay for AT if it meets that insurance policy's particular definition of AT (by whatever name it's known) and if the request meets that policy's criteria for "medical necessity." The definition of "medical necessity" generally means that: (a) the device is prescribed by a physician; (b) it is used to restore or approximate normal function of a missing, malformed, or malfunctioning body part; (c) the device is directly related to a diagnosed medical condition; and (d) the device is expected to improve the user's ability to function. Keep in mind that this is how medical necessity is generally defined; consult the insurance policy for specific guidelines.

Most health insurance policies require prior approval for AT. Look to the insurance policy's benefits booklet for a description of the required procedure.

Follow the policy's process for acquiring AT. In addition to the doctor's prescription, this may include supporting documentation from other health care providers and therapists (speech/language, occupational, physical) regarding "medical necessity" and the expected benefits from the AT device or service. Refer to—and even incorporate—the language stated in the policy when writing supporting letters.

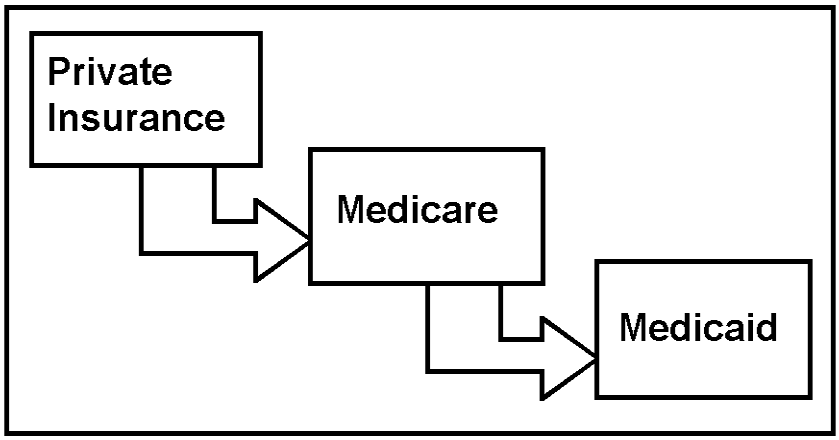
Understand the method of payment accepted by the AT supplier.

Find out whether the AT supplier will file the claims paperwork to request payment or whether that will be the responsibility of the insured party or a service provider.

3. Coordinate Insurance and Other Benefits

Identify all potential payment sources for which an individual is eligible before applying to any. Make sure you understand whether there is an order in which the sources must be tapped. For example, one must always exhaust private insurance payment options before applying for Medicare or Medicaid payment, and Medicaid will require someone dually eligible for Medicare and Medicaid to make application to Medicare first.

Medicaid is considered "payor of last resort" in most cases. The exception to this rule is when the device and/or service is both medically and educationally necessary for a child. In such cases, Medicaid functions as the "payor of first resort."



If you anticipate combining resources from several payors to fund devices and services, you will need to make sure that all of the payors include your selected service providers/equipment vendors among their authorized providers. It is not unusual for a private insurance company to exclude a provider that Medicaid includes on its list of approved providers. If you fail to consider this in advance, you can find yourself being denied access to a service or device simply because you started the process with a provider that was not enrolled with (authorized by) all insurance plans.

4. Appeal Denials

Unfortunately, denials are often the rule rather than the exception when it comes to seeking payment for AT. Consider the denial to be a request for more information. Do not assume that the insurance plan properly interpreted its own eligibility and coverage rules. Review the relevant language of these rules yourself.

Insurance providers are required to provide a written notice of denial. Once you have a written denial on an Explanation of Benefits (EOB) or other form, check your policy coverage guidelines for information about appeal procedures. Take advantage of any opportunity to discuss the decision by phone with the insurance provider.

Follow the appeal procedures, paying careful attention to time limits. Supply any additional evidence from your physician or others that will support your claim. Be prepared to argue, if appropriate, that the AT device is a necessary part of some therapy services or that it fits the policy's covered equipment definition even if not explicitly listed as covered equipment.

II. Medicaid of Delaware

www.dmap.state.de.us

Medicaid Program Overview: The Federal Entitlement

Medicaid is a medical assistance insurance program authorized under federal law in Title XIX of the Social Security Act of 1965. It is an income or "means" tested program, so eligibility always depends in some way on a person's income and resource level. Each state has the option to participate. Once a state decides to participate, it must submit a State Plan to the Federal Government. The State Plan is a contract that the state makes with the federal government. This plan describes how the state intends to follow the rules and how medical assistance program services will be administered locally. Then, the federal government pays a percentage of the cost for the medical assistance services the state provides. The federal share may vary anywhere from 50 percent to approximately 75 percent. In Delaware, the federal match is 50 percent. In addition to mandatory services that a state must cover, a state may also elect to cover optional groups and services.

Delaware Medicaid covers certain AT devices—the Medicaid term is durable medical equipment (DME)—and AT-related services when they are:

Medically necessary

Covered under the state plan

Prescribed by a physician.

NOTE: The state plan requirement has one exception. It is called the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, and involves the 0 to 21 age group (see the Medicaid for Children segment on page 47).

Medicaid Eligibility Criteria

As state medical assistance programs go, Delaware Medicaid is very consumer-friendly. In fact, there are times when the agency will provide or pay for certain services (such as Medicare insurance premiums) when the person has no actual Medicaid coverage. So the best approach is this: even when eligibility seems unlikely, check with your local Medicaid unit office about what services may be available to you.

In Delaware, income level formulas and other program eligibility criteria are very complex; they differ with each program category (and subcategory). The following sections offer a basic overview of the two main eligibility categories: Poverty Level-Related Groups, and SSI-Related Groups. Each of these has several subcategories; some examples are mentioned below.

Poverty Level-Related Groups

In order to qualify for Medicaid benefits in this category, a person's income must be below a certain level, usually expressed as a percentage of the federal poverty level. First, the 2004 federal poverty levels expressed in terms of annual income are:

$9,310 for a single person

$12,490 for a family of 2

$15,670 for a family of 3

$18,850 for a family of 4

$22,030 for a family of 5

Generally, add approximately $3,000 for each additional person.[1]

Several subgroups are included in the poverty-level category, and the required family income cut-off is different for each subgroup. For example:

Pregnant women and infants under the age of one may have family income up to 200 percent of the poverty level.

Children up to age six qualify at or below 133 percent of the poverty level.

Children up to age 19 qualify at or below 100 percent of the poverty level.

Uninsured adults in the expanded population qualify at or below 100 percent of the poverty level.

Families eligible for Transitional Medicaid qualify at or below 185 percent of the poverty level.

The Poverty-Related category also includes Medicare-related groups such as:

Qualified Medicare Beneficiaries (QMBs) for whom, under certain circumstances, Medicaid will pay Medicare Part B premiums, co-insurance and deductible amounts. QMB's must have income at 100 percent of the poverty level or less.

Qualified Disabled Working Individuals (QDWIs) - These are working people with disabilities who lost Medicare benefits because their incomes exceeded a specified cut-off.

Specified Low Income Medicare Beneficiaries (SLIMBs) - These individuals are at or below 120 percent of the poverty level, and are not eligible for any regular Medicaid services, but Medicaid will pay their Medicare Part B premiums (but not co-payments or deductibles).

SSI-Related Groups

Any individual age 65 or over or who is blind or otherwise permanently disabled may be eligible for Supplemental Security Income (SSI). In the state of Delaware, such persons are eligible for Medicaid automatically. Here again though, there are SSI-related groups whose members may not be receiving SSI benefits, but who are eligible for Medicaid. For example, a 1981 amendment to the Social Security Act [Section 1619(b)] allows some workers with severe disabilities to keep their Medicaid coverage in spite of their loss of SSI benefits

[1] This poverty level information was published on the U.S. Department of Health and Human Services' Website, http://aspe.hhs.gov/poverty/04computations.shtml.

due to employment. There are also instances when certain types of income can be excluded from the Medicaid eligibility determination, so the eligibility picture may not be what it seems. Never assume. Always ask.

Again, the best way to ascertain your eligibility for Medicaid services is to check with your local unit office.

Traditional Fee-For-Service Medicaid

The Delaware Medical Assistance Program (DMAP) is the official name of our state Medicaid program. DMAP operates out of Delaware's Department of Health & Social Services (DHSS) and administers the traditional Medicaid system. Under that system, the state directly reimburses Medicaid-authorized providers for covered services. This traditional Medicaid program applies today to only a small percentage of Medicaid recipients in Delaware:

- those in Long Term Care institutions (e.g., nursing homes, ICF/MR, ICFs/IMD)
- dual Medicaid/Medicare recipients
- those who require for their care a physician specialist who is not associated with any available managed care plan
- those eligible for one of the five Home and Community Based Services (HCBS) Medicaid waivers.

Contact information for fee-for-service Medicaid is:

Delaware Medicaid Office

Lewis Building, Division of Social Services, DHSS Campus
P.O. Box 906, 1901 N. DuPont Highway
New Castle, DE 19720
(302) 255-9500 or (800) 372-2022 (voice)
(302) 577-4150 (TTY)

Medicaid Waivers

The Medicaid Waiver system allows states to request "waivers" of federal Medicaid requirements for certain target populations. These groups are comprised of those who would otherwise require an institutional level of care but, with medical and support services, are able to remain in their own homes or other community setting. Those covered by one of the Home and Community Based Services (HCBS) Waiver programs are often able to obtain services, including DME, that are not available either to other fee-for-service members or to MCO members.

In addition to the Medicaid institutional criteria, those applying for services under a HCBS waiver must have incomes at or below 250 percent of the 2004 SSI level of $564 monthly income and must have less than $2,000 in resources. Those covered by waivers are eligible for services in addition to those already covered

under the State Plan. The contacts for determining waiver eligibility are detailed below.

1. Mental Retardation/Developmental Disability Waiver

DDDS has a waiver for individuals with mental retardation/developmental disabilities receiving residential services from the Division. Services included in the waiver are case management, respite care, residential services, day habilitation services, prevocational services, supported employment services, adult day health services, transportation, clinical support, and environmental adaptations and modifications. The Division's waiver was renewed in 2004 to 2009. For more information, call the Division of Developmental Disabilities Services (DDDS) at (302) 744-9600 or the Delaware Helpline at (800) 464-4357 (in-state), (800) 273-9500 (out-of-state) or visit the Division's Website http://www.state.de.us/dhss/ddds/index.html.

2. Elderly and Disabled Waiver

Those covered by this Waiver are eligible for case management, homemaker services, medical and social day care, respite care, orthotics and prosthetics (including hearing aids), and participation in the emergency response system.

For more information, call the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) in New Castle County at (302) 453-3820, in Kent and Sussex Counties at (302) 422-1386, or at the Delaware Helpline.

3. AIDS/HIV Waiver

Those covered by this Waiver are eligible for case management, homemaker services, respite care, mental health services, and supplemental nutrition.

For more information, call the Division of Social Services (Medicaid) at (302) 255-9625.

4. Assisted Living Waiver

Those covered by this Waiver are eligible for personal services/assistance with activities of daily living (e.g., bathing, dressing, eating, and bathing), nursing services, meal services, and social/emotional services.

For more information, call DSAAPD at (302) 255-9390 or (800) 223-9074.

5. Acquired Brain Injury (ABI) Waiver

This waiver is currently under development. Eligible persons are those between 18 and 64 years of age who have a primary or secondary diagnosis of acquired brain injury. Those persons with either a traumatic or a non-traumatic brain injury will be covered under this Waiver. Among those services being considered

for inclusion are case management, personal care services, respite care, adult day health, habilitation, environmental accessibility, specialized medical equipment and supplies, adult residential care, and assisted living and cognitive/behavior services.

Call Linda Heller of DSAAPD at (302) 255-9370.

The Delaware Medicaid Managed Care Program (MCO)

Since 1996, DMAP has provided services to most of its beneficiaries through a Medicaid managed care (HMO-type) health insurance program called the Diamond State Health Plan (DSHP). Currently, two managed care organizations (MCO), First State Health Plan and Diamond State Partners, are employed by the State/DMAP to provide Medicaid managed care services throughout the state. First State Health Plan, which is owned by Christiana Care, receives State funding for each recipient, establish its own network of authorized providers, and makes approval or denial decisions on services covered by the DSHP. Diamond State Partners is a relatively new MCO administered by DMAP. Contact is as follows:

First State Health Plan
11 Read's Way, New Castle, DE 19720
Customer Service: (302) 327-7600 or (800) 362-4214 (voice)
(302) 327-7699 or (800) 855-1155 (TDD)
Client Advocate: (800) 362-4214 or (302) 327-7630
Administration: (800) 362-4214

Diamond State Health Plan
1901 N. DuPont Highway, P.O. Box 906, Lewis Building, New Castle, DE 19720
Provider Relations Unit: (302) 454-7154 or (800) 999-3371
Member Service: (800) 390-6093

Each MCO has customer service and/or case management staff who will answer questions and issue replacement health insurance cards, and Client Advocates with whom to discuss disputes about equipment/service eligibility. However, outreach to members and information on program enrollment options may also be handled through yet another of Medicaid's service contractors called a Health Benefits Manager (HBM). Electronic Data Systems (EDS) is Delaware's current provider of HBM services. EDS can explain plans and enroll beneficiaries in them as well as teach beneficiaries how to use managed care. EDS also enrolls providers and members, helps members find physicians, and processes claims for equipment and services.

The phone number for EDS is (800) 996-9969. Their TTY number is (800) 232-5470.

Careful selection of an MCO is important, not only because one's primary care physician must be a member of the MCO, but also because the benefits package

offered by an MCO is not compatible with certain types of needs. An MCO, for example, may offer services beyond those required by the Medicaid contract. Prospective applicants should request information from the MCO and/or EDS prior to enrollment to review its plan. Once a person enrolls with a MCO, s/he is generally required to stay for at least one year. The State Medicaid office may make an exception if the member presents good reasons to justify the request for a change of MCO.

An MCO may request that the State disenroll or terminate a member from the plan for “good cause." However, before doing so, the MCO is required to attempt to resolve the problem with the member. An example of circumstances leading to disenrollment would be if a member habitually uses emergency room services instead of going to an MCO-authorized facility. If disenrolled, the person is not permitted to leave the DSHP program, but would be enrolled in another MCO.

Obtaining Equipment and/or Related Services

The Importance of Medical Necessity

Medicaid will purchase or rent various types of assistive devices for Medicaid beneficiaries if they are considered medically necessary. The first and most important step in developing an effective medical necessity justification for AT/DME is the completion of a thorough evaluation and assessment of the person's needs by an appropriately certified health care professional. Once a person's needs have been identified, the correct device or device system can be selected. The question of whether a given device is covered by Medicaid depends on the applicant's Medicaid eligibility status (eligibility criteria are outlined later in this section), and whether the item may be deemed medically necessary.

In order for an AT funding request to be successful, the following conditions must be met:

The person's diagnosis must be consistent with the use of the requested AT

The AT must be reasonable and necessary to maintain the person in the home

A physician must prescribe the AT

An enrolled AT provider must supply the item.

Delaware Medicaid's Definition of Medical Necessity

The State Plan, which governs both fee-for-service Medicaid as well as Medicaid MCO plans, defines medical necessity as essential medical care or services "prescribed by the beneficiary's primary physician care manager and delivered by or through authorized and qualified providers" that will meet **all** of the following criteria:

Be directly related to the diagnosed medical condition or the effects of the condition on the beneficiary (the physical or mental functional deficits that characterize the beneficiary's condition), and be provided to the beneficiary only;

Be appropriate and effective to the comprehensive profile (e.g., needs, aptitudes, abilities, and environment) of the beneficiary and the beneficiary's family;

Be primarily directed to treat the diagnosed medical condition or the effects of the condition on the beneficiary, in all settings for normal activities of daily living, but will not be solely for the convenience of the beneficiary, the beneficiary's family, or the beneficiary's provider;

Be timely, considering the nature and current state of the beneficiary's diagnosed condition and its effects, and will be expected to achieve the intended outcomes in a reasonable time;

Be the least costly, appropriate, available health service alternative, and will represent an effective and appropriate use of program funds;

Be the most appropriate care or service that can be safely and effectively provided to the beneficiary, and will not duplicate other services provided to the beneficiary;

Be sufficient in amount, scope and duration to reasonably achieve its purpose;

Be recognized as either the treatment of choice (that is, according to the prevailing community or statewide standard) or common medical practice by the practitioner's peer group, or the functional equivalent of other care and services that are commonly provided; be rendered in response to a life threatening condition or pain, or to treat an injury, illness, or other diagnosed condition, or to treat the effects of a diagnosed condition that has resulted in or could result in a physical or mental limitation, including loss of physical or mental functionality or developmental delay.

In addition, the device/service must be reasonably determined to address **at least one** of the following goals:

diagnose, cure, correct, or ameliorate defects and physical and mental illnesses and diagnosed conditions or the effects of such conditions; or

prevent the worsening of conditions or effects of conditions that endanger life or cause pain, or result in illness or infirmity, or have caused or threaten to cause a physical or mental dysfunction, impairment, disability, or developmental delay; or

effectively reduce the level of direct medical supervision required or reduce the level of medical care or services received in an institutional setting or other Medicaid program; or

restore or improve physical or mental functionality, including developmental functioning, lost or delayed as the result of an illness, injury, or other diagnosed condition or the effects of the illness, injury or condition; or

Provide assistance in gaining access to needed medical, social, educational and other services required to diagnose, treat, or support a diagnosed condition or the effects of the condition.

Further, the medical necessity definition requires that a covered device or service should enable the beneficiary to attain or retain independence, self-care, dignity,

self-determination, personal safety, and integration into all natural family, community, and facility environments and activities.

Letter of Medical Necessity - Essential Elements

The State Medicaid Office will give individual consideration to any request for DME that is accompanied by a Letter of Medical Necessity (LMN). The LMN should address, but not be limited to, the following, as appropriate:

- Description of the client (name, age, residence, caretaker, occupation, measurements of height, weight, ideal body weight, etc.)
- List of all relevant diagnoses
- Description of the effects of the diagnoses on the functionality of the person in areas such as activities of daily living, positioning, ambulation, transfer, respiratory system, communication, range of motion, muscle strength, continence, nutrition, pressure relief, etc.
- Explanation of what is currently being done and why this is not appropriate or effective. Is there similar equipment in the home?
- Description of trial use with device
- Clear statement of expected therapeutic value of the requested item. How will this device/service improve functionality?
- Explanation of why the item needs to be replaced. Why can it not be repaired or modified?
- Discussion of any alternative related service that has been tried and failed and/or was considered inappropriate.
- Physician's treatment plan (medical, pharmacy, surgical, special therapies, nursing care, other durable medical equipment, school services, etc.)
- Consideration for supportive documentation from another specialist and/or therapist that could help explain or describe the medical need. If so, this may also be submitted with a physician's LMN.
- Address any specific policy coverage criteria.

See Appendix A for sample Letters of Medical Necessity.

Prescription & Claim Submission

Currently, Medicaid will only pay for equipment if a physician prescribes it. The usual procedure for those enrolled in the fee-for-service plan is as follows:

- The patient is evaluated by a clinician (doctor or therapist) who identifies the patient's medical need for a given device.
- The patient receives a prescription (Rx) from the doctor for the necessary equipment. Certain equipment may require a specialist's Rx. For instance, under Delaware Medicaid regulations, only a neurologist, physiatrist, orthopedist, rheumatologist, or cardiac specialist may prescribe a motorized wheelchair.

Medicare has similar requirements. However, there is an exception: Medicaid may approve DME prescribed by non-specialty physicians who routinely work with rehabilitation agencies to develop and monitor plans of care for physical rehabilitation and who have backgrounds or expertise in rehabilitative medicine.

The patient takes the Rx to an equipment supplier. The supplier must be enrolled with Delaware Medicaid as a DME provider in order to bill and receive payment from DE Medicaid. In Delaware, the supplier may deliver the prescribed equipment anytime after receiving the Rx as long as the item is clearly defined in the DME provider manual and is known by the supplier to be a covered device/service.

Durable Medical Equipment

Assistive devices may be purchased with Medicaid funds if they are medically necessary, can be considered durable medical equipment (DME), and are covered under Title XIX and the State Plan.[2] The federal government defines DME as that which:

Can withstand repeated use

Is customarily used for a medical purpose

Is generally not useful to a person in the absence of an illness, injury, or disability

Is needed to maintain the person in his or her home.

The beneficiary owns DME purchased with Medicaid funds. The DMAP and each of its MCOs have policies that describe their DME-related procedures as well as examples of items generally covered and not covered. The policies are generally similar but some features of each are described below.

DMAP considers that presumptively medical DME, and therefore covered items, include hospital beds, wheelchairs, respirators, crutches, nebulizers, etc. It excludes coverage for DME that is "not primarily medical in nature." This includes physical fitness equipment, air conditioners, room heaters, humidifiers attached to home heating systems, and generally aids for daily living (ADL) and environmental control units (ECU).[3] DMAP also does not cover home or vehicle modifications.

<u>DMAP DME Access for Fee-For-Service and Diamond State Partners Members</u>

The decision as to whether to approve DME for fee-for-service and Diamond State Partners members is made by a DME Review Team. As previously stated, the DME Review Team has expressed its willingness to review any request for DME,

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[2] A device does not have to be included in the State Plan to be covered under the children's (EPSDT) program.

[3] However, since Medicaid considers requests on a case-by-case basis, do not assume an ADL or ECU will not be covered. An example of where a device might be covered as "medically necessary" is when an ECU is part of a covered item such as an AAC device.

supported by an LMN, on a case-by-case basis. DMAP, as well as the MCOs, strongly prefer that the LMN and any supporting documentation be submitted as one package.

However, the fact that a health care practitioner may order or recommend a type of item does not by itself make it a covered service. DMAP defines "supplies" as "disposable items that are used...to carry out the written plan of care of a licensed medical practitioner." A DME provider is not permitted to dispense more than a one-month quantity of supplies. This policy also provides that "supplies and equipment may not be dispensed and billed to the DMAP when the primary use is intended for a setting other than the client's home." DMAP will not reimburse a DME supplier for a duplicate item to be used in other settings (e.g., nursing homes, inpatient and outpatient hospitals, or physician/practitioner's offices).

What is important to remember is that if the device can be prescribed, and can restore or improve function that is absent due to a medically diagnosed condition, Delaware Medicaid programs may permit purchase, lease, or rental of the device. However, even if some non-medical equipment may have some distant medically related use, the item will not be covered because its primary and customary use is not medical. It is also important to remember that there must be prior authorization for equipment purchases and some equipment requires a physician's LMN.

DME Access for First State Health Plan Members

The First State Health Plan requires prior authorization for all AT purchases. In order to receive prior authorization, you must have a physician's prescription, an authorization request form, and an LMN. The case manager at the MCO will review the prescription and the LMN prior to giving authorization.

An MCO maintains a list of its own preferred/contracted equipment suppliers. The MCO will only furnish equipment through suppliers with whom they have agreements. However, in cases of "unusual" equipment claims, an MCO may be willing to recruit other suppliers of such equipment if the device is judged to be a covered item. Regulations issued by the Department of Health and Social Services (DHSS), effective January 10, 2002, mandate MCO referral 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. The regulations also require MCOs to cover nonparticipating providers if there are an insufficient number of network providers within a reasonable geographic distance.

An MCO is required to cover all the equipment and services covered by the DMAP fee-for-service plan, although the MCO is permitted to exceed DMAP's coverage and offer broader coverage.

First State's policy defines DME as "those items and related services which are customarily provided and used for medical purposes, in order to improve, support or maintain the health and functional capabilities of an individual." Examples of DME include, but are not limited to, wheelchairs, prosthetics, AAC devices, ambulatory assistance devices (e.g., canes, walkers, etc.), bath chairs, cushions/mattresses, and nebulizers. First State does not cover home or vehicle modifications and it offers limited coverage of ADL and ECU devices. The procedure for obtaining DME is as follows:

The primary care or other physician sends a prescription and a detailed LMN (including the diagnosis, prognosis, pertinent history and physical exam) supporting the "medical necessity" finding to the First State Case Management Department. The LMN must include information from the physician or an appropriate sub-specialist with expertise in the proper application and use of the specific DME requested.

The physician must also submit a prescription for the DME to a participating vendor.

The vendor submits a DME Authorization Form to the Case Manager. In some cases, items may be approved without further investigation. First State may contact non-participating vendors if the DME is not stocked by participating vendors.

The Case Manager reviews the documentation in support of the request, including the prescription, evaluation, CMN, and LMN prior to giving authorization.

In cases in which "medical necessity is questionable or approval is otherwise uncertain," the request is referred to the Medical Director for consideration using DMAP's definition of "medical necessity."

First State notifies DME vendors within three business days—or within 24 hours in urgent cases—of approval or denial. In cases where successive orders are placed for the same item, First State may authorize "home care-takers" to contact the vendors to "expedite re-supply of discardable items or those which can not be reused."

Members are informed in writing of a denial and their appeal rights.

Obtaining Orthotics and Prosthetics

First State has a separate policy for requests for orthotics and prosthetics. The process is as follows:

The primary care physician (PCP), physiatrist, or other specialist determines if the member requires an orthotic or prosthetic. If so, a prescription is sent to a participating vendor. A full evaluation by a physical therapist or occupational therapist is required for approval of devices applicable to extremities unless the PCP's report has sufficient detail. Certain prosthetics (breast, ocular) require a LMN from the PCP or specialist. First State covers dental orthotics as well as orthotics/prosthetics that allow individuals to function more effectively in vocational settings and in performing activities of daily living.

The vendor contacts First State Case Management or the Pre-certification Department via fax, using a standard DME authorization form.

The Case Manager, Pre-certification Nurse, and First State physician make a medical necessity determination and notify the vendor and member of the approval or denial.

If the participating vendor does not stock the required equipment, the Case Manager or Pre-certification Nurse may negotiate a purchase with a non-participating provider.

In situations in which DME is rented, those costs are applied to the purchase price. However, First State will not cover rental costs in excess of the purchase price. The vendor has the responsibility for all maintenance and replacement parts on rented items.

Funding of Specific AT Categories

Aids for Daily Living (ADL) - This category includes devices and adaptations to increase participation or independence in activities such as eating, dressing, grooming, and toileting, as well as routine tasks such as getting out of bed, cooking, and doing laundry. Medicaid generally does not fund ADL. However, because Medicaid considers requests on a case-by-case basis, it may be possible to get funding if one can satisfy the detailed "medical necessity" test and overcome Medicaid's position that an ADL does not meet the definition of DME ("generally not useful to a person in the absence of an illness, injury or disability").

Switches and Environmental Control Units (ECU)- These are controls or systems that enable people without mobility or sufficient dexterity or cognition to control household devices and appliances (radio, television, lights) or to make other changes in their immediate environment. As with ADL, Medicaid generally does not fund ECUs. However, ECU devices may be covered if they are built into covered devices such as AAC systems.

Assistive Listening Devices - This category includes equipment that amplifies auditory signals (e.g., hearing aids, personal listening devices) and devices that alert a person to sounds in the environment (e.g., flashing light for doorbell, vibrating pager that alerts a caregiver to a baby's cry). Once again, though Medicaid covers hearing evaluations, it does not generally cover devices in this category.

Aids for Low Vision - These include devices that increase contrast or enlarge images, or substitute tactile or auditory signals for visual ones. Examples are writing templates, talking watches and calculators, Braille, large print, magnifiers, the use of tape recorded materials, and auditory signage. Medicaid does not cover items in this category.

Augmentative and Alternative Communication (AAC) - This category includes equipment and services that enhance face-to-face communication: devices or systems that supplement or replace natural speech, ranging from language

boards to speech amplifiers to computer-based systems with voice output; telecommunications (text telephones, speaker phones, voice activation and automatic dialing that enhances telephone access by people with physical limitations); and writing aids (devices or systems that support written communication, ranging from adaptations to writing utensils to alternate ways of generating written communication such as voice dictation). Medicaid provides very good funding for AAC devices. Please review the process set forth by Medicaid (see page 33) as well as a copy of Delaware Medicaid's AAC policy (see Appendix B).

Computer Access - This category includes items that enhance access to computers in variety of ways to both facilitate input (adapted keyboards, keyguards, voice dictation, word prediction) and enhance output (screen readers, enlarged font, tactile displays). Medicaid will only fund computers when an important use of the computer is as the beneficiary's communication device.

Seating, Positioning, and Mobility - This category includes devices that support or improve mobility and the equipment used to customize mobility alternatives for use by a particular individual. Medicaid does fund these services and has set up a detailed process (see page 41). Seating and positioning devices and systems improve body stability, trunk/head support and upright posture, and reduce pressure on skin surfaces (cushions, lumbar supports) for those using wheelchairs and other seating systems. Power mobility options include three or four wheeled vehicles or chairs, usually powered by battery, for independent personal mobility. Movement may involve movement in space, such as stand and/or tilt features, as well as movement over distances. Manual mobility involves wheeled chairs or beds for personal mobility. Finally, this category includes mobility aids such as walkers and canes.

Home Modifications and Vehicle Modifications - This category includes modifications to residences and vehicles that help a person to live as independently and productively as possible. Medicaid does not cover funding for these modifications.

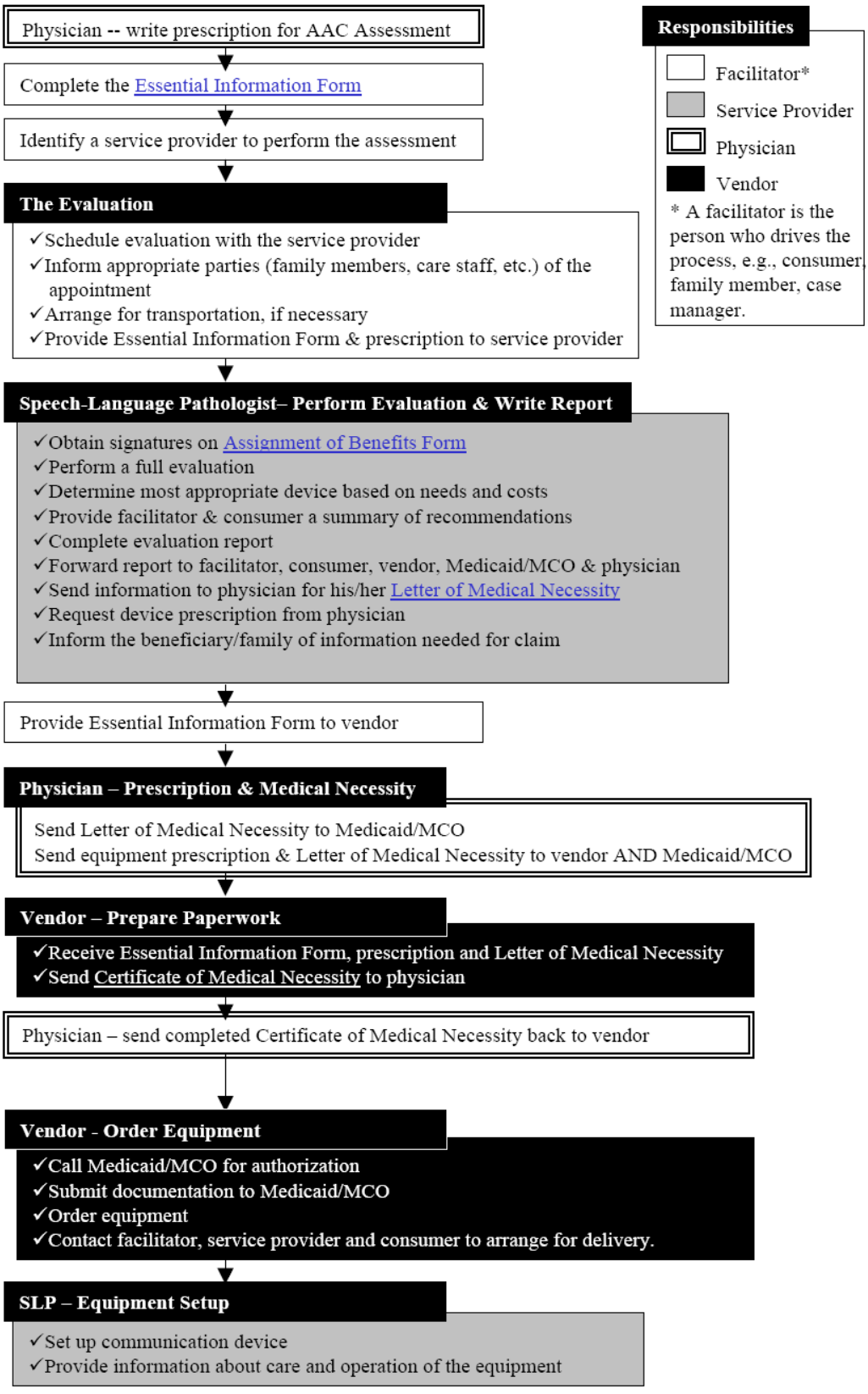
Orthotics and Prosthetics - Orthotic items are used for correction or prevention of physical deformities throughout the body. Prosthetic items replace all or part of the function of a body part. Medicaid covers orthotics and prosthetics. However, when there is a request to cover a prosthetic device, the DME Review Team will look at whether there is duplication. For example, Medicaid is not likely to pay for a prosthetic limb for an amputee who uses a wheelchair unless the beneficiary can show an attempt to eliminate reliance on the wheelchair through the use of a prosthetic leg.

Accessing AAC Devices Through Medicaid

AAC Device Purchase

The following chart outlines the process for obtaining AAC devices that are medically necessary under the Delaware Medical Assistance Program (Medicaid). Underlined items can be found in the appendices at the end of this document. The steps progress in a sequence from the time an AT need is identified to when the equipment is provided. This is a process that involves many team members. Their roles and responsibilities are outlined in the pages following the chart.

Obtaining AAC Devices - Medicaid



Roles and Responsibilities of Team Members

Facilitator*

*The facilitator is the person who drives the process. The person could be the consumer, a family member, a case manager, etc.

Completes the Essential Information Form (see Appendix C). Detailed instructions for completing this form are included. You will need:

Consumer identification information

Consumer support/contact information

Insurance information

Physician information

A prescription.

Identifies the service provider options based on who is a Medicaid provider, who provides services to the MCO(s) and what providers deliver the type of service needed. The AT Provider section at www.dati.org may assist you with this process.

Calls the service provider and schedules the evaluation, providing all of the information outlined on the Essential Information Form as well as the specific reason for the evaluation. The facilitator will need to know:

Whether the individual had an AAC system at one time or currently uses an AAC device.

If the consumer currently has an AAC system, who provided the device? With the manufacturer and the serial number (which is on the device), the manufacturer will be able to identify how and when the device was provided. It is important to take the device to the evaluation (even if the device is not working).

Once an appointment is scheduled, informs the appropriate parties (family members, care staff, etc.) of the appointment. The facilitator and a primary caregiver should attend and participate in the evaluation.

Arranges for transportation to the evaluation, if necessary.

Secures a copy of the LMN from the vendor, signifying that the claim submission process for the AT device has been completed. If a copy of the LMN is not received within 30 days of the evaluation, contact the vendor.

If there has been no action on the claim after 30 days of the submission of the LMN, contacts the appropriate Medicaid office:

DME Review Team

(302) 255-9500 or (800) 372-2022

First State Health Plan /Christiana Care

(302) 302 327-7600 (voice)

(302) 302-327-7699 (TDD)

Diamond State Partners

(800) 390-6093

Service Provider

Verifies insurance information provided on the Essential Information Form and schedules the appointment.

Reviews the intake information and obtains signatures on the assignment of benefits form on the day of the evaluation. Examples are available for review (see Appendix D).

Requests a copy of the prescription (Rx) for the evaluation from the facilitator. Without an Rx, the service may not be provided.

Completes the evaluation with input from the facilitator, the consumer, and the caregiver(s).

Provides the facilitator and the caregiver/consumer with a summary of the recommendations. Recommendations should include information about:

The specific type of equipment and component(s) needed

Estimated date of delivery

Training that is needed once the equipment is obtained.

Completes an evaluation report and sends a copy to the facilitator, the physician, the vendor, and the consumer/caregiver.

Sends information to the physician to support formulation of the LMN.

Contacts the consumer/facilitator to schedule an appointment when the equipment is ready to be delivered.

Sets up the new equipment per the specifications outlined in the assessment.

Provides information about the care and the operation of the equipment as well as warranties, repairs, and follow up upon delivery.

Vendor

The AAC vendor, in most cases, is the manufacturer and is not directly involved in the assessment process. The AAC manufacturers have funding specialists who will submit the documentation and claim to Medicare, Medicaid, or any other private insurance company. The vendor should:

Be enrolled as a medical equipment provider with Delaware's Medicaid Program. If the consumer is covered under an MCO, the vendor must be a participating provider with that MCO.

Submit the documentation related to the medical claim for the equipment to the insurance company.

Receive a copy of the Essential Information Form.

Call Medicaid/MCO for authorization once equipment is recommended.

Contact the physician to request the LMN if it has not been received.

Submit all paperwork to Medicaid/MCO.

Order the equipment.

Contact the facilitator, the service provider, the caregiver/consumer when the equipment is ready to be delivered.

Physician

Provides a prescription for the evaluation, equipment, and/or services needed.

Provides LMN to vendor based on results of the evaluation.

Completes the Medicaid CMN (see Appendix E) at such times that repairs/modifications are needed.

AAC Device Repair

You do not need a therapist to handle the repairs of a communication system. The manufacturer is your best resource when a device is not working. The manufacturer's "tech support" system is set up for your use and is user friendly. Prepare to call the manufacturer by having the device at hand. Identify the make, model, and serial number (look on the underside of the device for this information). Complete the following steps to gain assistance from the manufacturer:

Call the Technical support department or customer service to get information about getting the device repaired. Many companies prefer to do some troubleshooting on the phone before recommending that the device be returned to the manufacturer.

Refer to the AAC Companies Guide (see Appendix F) for telephone numbers, web site information and hours of operation.

Follow the manufacturers' directions for troubleshooting and identifying the problem with the device.

Does the device need to be returned to the manufacturer?

Do you have a return authorization number?

Does the manufacturer have specific instructions for returning the device to them?

Complete the Request for Repair form (see Appendix G).

The facilitator determines the source of funds for the costs of the repair.

If the communication device user has Delaware Medicaid, the costs of most repairs are covered by Medicaid as long as the following criteria are met:

CMN is completed and signed by the physician.

The manufacturer is enrolled as a Delaware Medicaid Provider.

A licensed SLP has verified that the device being repaired continues to be an appropriate device for the user.

If the cost of the repair is under $300, the manufacturer will proceed with repair upon receipt of a CMN.

If cost of the repair is more than $300, Delaware's Medicaid fee-for-service will require:

Authorization

A CMN signed by the physician

A letter from the SLP indicating that the device is in need of repair and that it is appropriate to repair the device since the user continues to use the system as a primary means of communication.

If the repair is not covered by Medicaid, a source of funds to cover the costs of the repair must be procured.

If the manufacturer is not an enrolled provider with Delaware Medicaid, the repair may be facilitated through a DME provider who is enrolled. Refer to Appendix F for assistance with this.

Repairing AAC Devices - Medicaid

Do not return the device to the manufacturer until you have completed the following steps!

Call the Manufacturer

- ✓Identify the make, model and serial number of the device.
- ✓Have the device with you.
- ✓Call the manufacturer's technical support or customer service number.
- ✓Work with the manufacturer to determine if device needs to be returned.

If device needs to be sent away for repairs…

Information FROM the Manufacturer

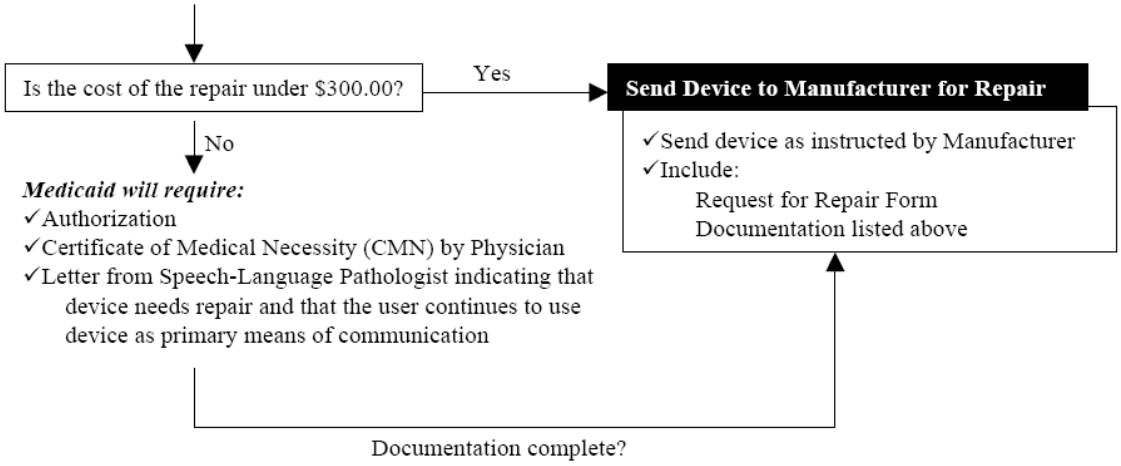
- ✓Return Authorization Number
- ✓Instructions for returning the device

Collect Documentation to send TO the Manufacturer

- ✓Copy of the Essential Information Form
- ✓Copy of the AAC Request for Repair Form (keep a copy for your records)

Coverage dependent on:

- ✓Certificate of Medical Necessity sent to vendor by Physician
- ✓Documentation that current device is still appropriate
- ✓Manufacturer is enrolled as a DE Provider or repair can be facilitated through a DME vendor who is enrolled



Check the Guide to Funding Resources for Assistive Technology in Delaware for special notes concerning:

- ✓Exceptions to payment procedures required by specific manufacturers
- ✓Repair or replacement of batteries
- ✓Rental devices during repair periods

Information About Specific Manufacturers

Before Dynavox will repair a device, the company must receive the LMN as well as the prescription. If the repair costs are over $300, Dynavox requires the CMN as well. The company must then submit the request to Medicaid before the repaired device is returned to the consumer. If the repair costs are less than $300, the LMN and prescription are still required, however, Dynavox is able to proceed with the repair without prior authorization. Without prior approval, Dynavox will not proceed with a repair to a First State Health Plan member's device no matter what the cost of the repair.

Prentke Romich Company will proceed with the repair if the costs are under $300, if Medicaid purchased the device, and if there is no Medicare or private insurance present. If the repair costs more than $300, this manufacturer requires:

A CMN signed and dated by physician.

Prescription from the physician

Letter of recommendation from the SLP.

Once funding is identified and obtained for the repairs, the device is repaired and returned to the user.

If the manufacturer or manufacturer's designee for the repair concludes that the device is not able to be repaired, written notice will be provided to the user or the person acting on the user's behalf that a replacement device is needed, which requires prior authorization.

Repair/Replacement of AAC Device Batteries

When the manufacturer identifies the device battery as the malfunctioning or nonfunctioning part, the following procedure will be followed:

Repair or replacement of the AAC device battery will be performed, and the device returned to the user or to the person acting on the user's behalf, as soon as possible.

Repair of the battery will occur independent of the $300 approval and the replacement of the battery will occur without the need for prior approval.

To have the battery replaced, follow the steps outlined in the AAC Device Repair section (see page 37).

Rental of AAC Device During Assessment, Repair and/or Replacement Period

The manufacturer is authorized to provide the user, on a rental basis, an AAC device during the assessment, repair and/or replacement period. The rental period is authorized to continue without regard to the need for prior approval for the repair and/or replacement of the user's device. *Rental of the AAC device is not limited to devices for which Medicaid was the original payment source*.

Note: Equipment will not be purchased or rented for use in nursing homes or health care facilities such as, but not limited to, SNF, sub-acute and acute rehabilitation, hospitals, inpatient or outpatient treatment facilities.

Exceptions may be made for specialized DME equipment on a case by case basis.

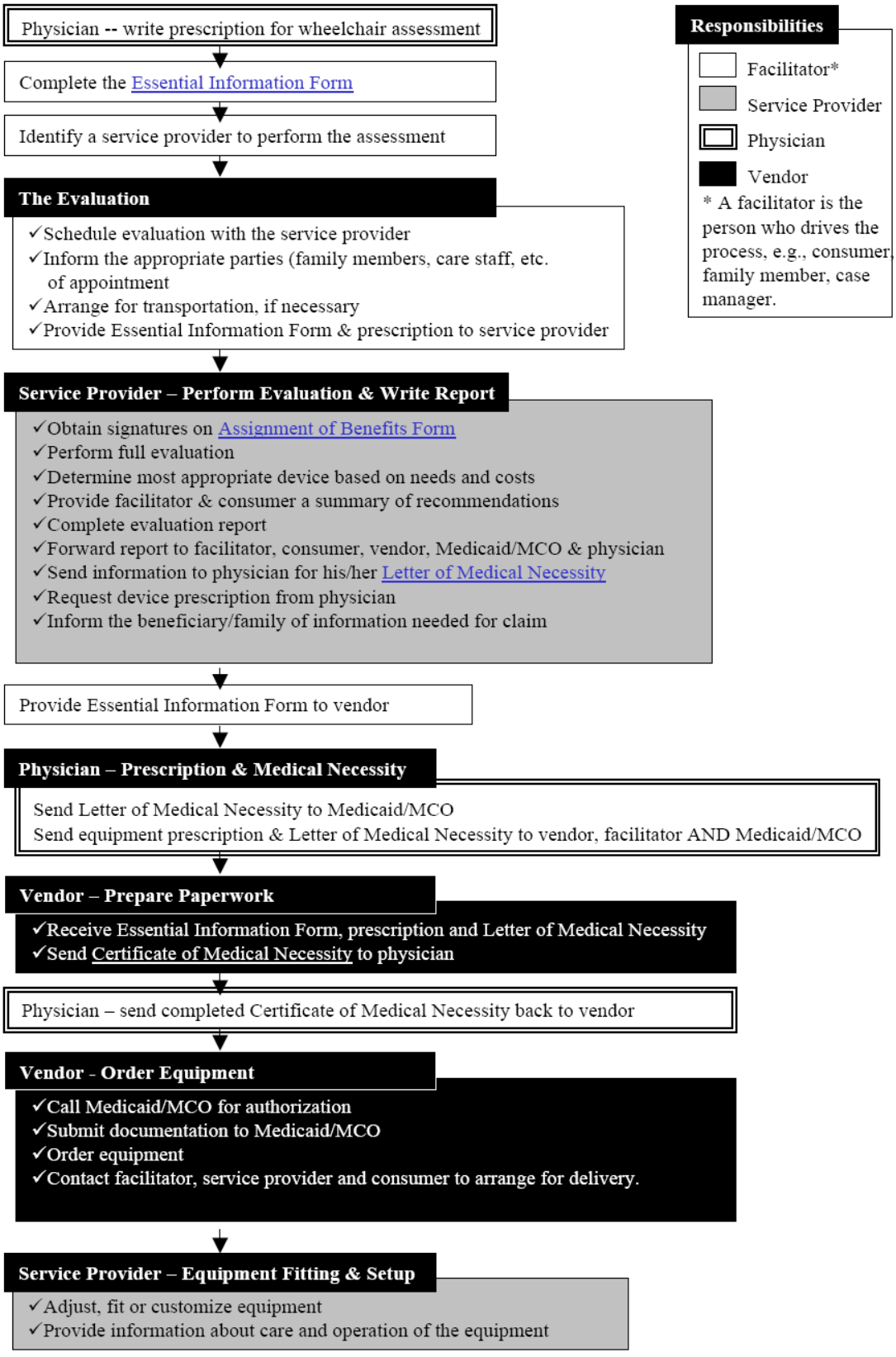
Accessing Wheelchairs Through Medicaid[4]

Wheelchair Purchase

The following chart outlines the process for obtaining wheelchairs under the Delaware Medical Assistance Program (Medicaid). Underlined items can be found in the appendices at the end of this document. The steps progress in a sequence from the time an AT need is identified to when the equipment is provided. This is a process that involves many team members. Their roles and responsibilities are outlined after the chart.

[4] Remember to first try to access AT through private insurance if the beneficiary has that type of insurance.

Obtaining Wheelchairs - Medicaid



Roles and Responsibilities of Team Members

Facilitator*

*The facilitator is the person who drives the process. The person could be the consumer, a family member, a case manager, etc.

The facilitator must first determine whether the AT is likely to meet the definition of medical necessity. If it does, and if the individual has a current Medicaid number, then the next step is to determine whether the consumer is covered under the traditional Medicaid fee for service plan or through a Medicaid MCO.

Completes the Essential Information Form (see Appendix C). Detailed instructions for completing this form are included. You will need:

Consumer identification information

Consumer support/contact information

Insurance information

Physician information

A prescription.

Identifies the service provider options based on who is a Medicaid provider, who provides services to the MCO (s) and what providers deliver the type of service needed. The AT Provider Section of the Website may assist you with this process.

Calls the service provider and schedules the evaluation, providing all of the information outlined on the Essential Information Form as well as the specific reason for the evaluation.

Once an appointment is scheduled, informs the appropriate parties (family members, care staff, etc.) of the appointment. Key informants (such as a primary caregiver or case manager) should attend and participate in the evaluation.

Arranges for transportation to the evaluation, if necessary.

Secures a copy of the LMN from the vendor, signifying that the claim submission process for the AT device has been completed.

If a copy of the LMN is not received within 30 days of the evaluation, contacts the vendor.

If there has been no action on the claim after 30 days of the submission of the LMN, contacts the appropriate Medicaid office:

DME Review Team

(302) 255-9500 or 800-372-2022

First State Health Plan /Christiana Care

(302) 302-327-7600 (voice); (302) 302-327-7699 (TDD)

Diamond State Partners

(800) 390-6093

Service Provider

Verifies insurance information provided on the Essential Information Form and schedules the appointment.

Reviews the intake information and obtains signatures on the assignment of benefits form on the day of the evaluation (see Appendix D).

Requests a copy of the prescription (Rx) for the evaluation from the facilitator. Without an Rx, the service will not be provided.

Completes the evaluation with input from the facilitator, the consumer, and the caregiver(s).

Provides the facilitator and the caregiver/consumer with a summary of the recommendations. Recommendations should include information about the specific type of equipment and component(s) needed, the estimated date of delivery, and training that is needed once the equipment is obtained.

Completes an evaluation report and sends a copy to the facilitator, the physician, the vendor, and the consumer/caregiver.

Sends information to the physician to support formulation of the LMN.

Contacts the consumer/facilitator to schedule an appointment when the equipment is ready to be delivered.

Adjusts or "fits" the new equipment per the specifications outlined in the assessment.

Provides information about the care and the operation of the equipment as well as warranties, repairs, and follow up upon delivery.

Vendor

The vendor is a member of the assessment team and is responsible for submitting the documentation related to the medical claim for the equipment to the insurance company. The vendor should be enrolled as a DME provider with Delaware's Medicaid Program. If the consumer is covered under an MCO, the vendor must be a participating provider with that MCO.

Receives a copy of the Essential Information Form.

Calls Medicaid/MCO for authorization once equipment is recommended.

Contacts the physician to request the LMN if it has not been received.

Submits all paperwork to Medicaid/MCO.

Orders the equipment.

Contacts the facilitator, the service provider, and the caregiver/consumer when the equipment is ready to be delivered.

Physician

Provides a prescription for the evaluation, equipment and/or services needed.

Provides LMN to vendor based on results of the evaluation.

Completes the Medicaid CMN at such times that repairs/modifications are needed (see Appendix E).

Wheelchair Repairs

These procedures may vary somewhat when specialized equipment is being prescribed. Equipment that is not generally covered by Medicaid may be covered through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for children 0-21 years of age. The Medicaid-preferred prescription process for this program is described under Medicaid for Children (see page 47).

Equipment prescribed by primary care physicians is provided through the managed care facilities with which they are affiliated. Again, the equipment supplier must be one of the MCO's preferred providers. While there are similarities regarding the insurer's relationship with the equipment supplier, the process of obtaining equipment may be quite different from the traditional approach described above. However, the general rules about obtaining a professional evaluation prior to selection of equipment, documentation of medical need, and the physician's prescription still apply.

The procedures differ for traditional Medicaid "fee for service" and Medicaid Managed care plans. Determine which Medicaid plan the user is covered under. Contact the vendor to assist with the repair.

Fee-For-Service Medicaid

Repairs under $300 do not require a pre-authorization.

Contact the vendors and they will provide the labor and parts needed to complete the repair.

Repairs over $300 require a pre-authorization. In order to get a pre-authorization, a CMN must be completed. The CMN includes following information:

Patient's name and identification number

Diagnosis

Dates of services

Service codes

Supplies/equipment provided

Doctor’s signature.

An LMN is required from the physician.

Medicaid MCO

The vendor must get prior authorization from the MCO for the repair. To get a pre-authorization, one must have a prescription and an LMN. The case manager at the MCO reviews these documents prior to approving pre-authorizations.

FYI...An Important Note for Health Care Professionals and Their Patients

Prescriptions for routine types of medical equipment, such as walkers and standard manual wheelchairs, may not require special letters or involved documentation. When the need is for more unusual or complex equipment such as motorized wheelchairs with custom seating or electronic communication devices, more detailed technical information (and a special type of teamwork) is required. We know that Medicaid will only purchase equipment if a physician prescribes it. Yet, oftentimes the doctor is much less familiar with the technology's benefits than the therapist or rehabilitation engineer who has recommended the device, or even family members who have witnessed its effectiveness in various environments. Consequently, a team approach is strongly recommended. For instance, the doctor should consult with the patient and/or family members, the professional(s) recommending the equipment (e.g., therapists, rehabilitation engineers, or other clinical diagnosticians), and the intended equipment supplier as well. The result will be a more comprehensive assessment of the patient's needs leading to an appropriate prescription. Claims are processed most efficiently when the doctor incorporates all relevant information into a single document of medical necessity for the prescribed equipment, and forwards the document to the supplier to be written onto or attached to the CMN. In any case, it is important to remain focused on the purpose of documentation. Ideally, it should paint a clear picture of the patient's condition and functional level, and how these things related to medical need for the prescribed equipment.

Medicaid for Children - The EPSDT Program

EPSDT is Medicaid's Early and Periodic Screening, Diagnosis, and Treatment program for individuals 0 to 21 years of age. It is the most comprehensive health care insurance available today. Under this program, Medicaid must provide any type of AT, related service, or treatment if:

It is shown to be medically necessary for a Medicaid beneficiary in this age group

It is the least costly and most appropriate alternative available

It is a federally approved item or service.

This is true regardless of whether the device or service is included in the Delaware Medicaid State Plan. For example, hearing aids are covered for those between the ages of 0-21, but not for those ages 21 and over. Specialized equipment that is not generally covered by Medicaid may be covered through the EPSDT program but, as mentioned earlier, the process may need to be handled a bit differently from that of standard DME claims.

Under the traditional Medicaid fee-for-service program, the physician prescribing the specialized item(s) is required to submit a letter to Medicaid's Medical Review Team. The letter must document the patient's diagnosed medical condition and how the prescribed item(s) will benefit the patient medically. If the physician's recommendation is approved for coverage through the EPSDT program, a letter will be forwarded to the physician with instructions to give a copy of the approval letter along with the prescription to the recipient's parent or guardian. The parent/guardian should present the prescription and approval letter to an enrolled DME supplier. The supplier may then order and provide the specialized equipment when presented with the approval letter and prescription. A CMN, signed by the physician, must be submitted to Medicaid along with the approval letter so an authorization can be assigned for billing purposes.

EPSDT & Managed Care

Again, the approach changes significantly under managed care. The process of obtaining equipment through a MCO may be much simpler, at least in theory. The nature and complexity of the process is determined by the internal policies of the particular MCO to which an individual belongs. Generally, a member-physician (or MCO approved-physician) must prescribe the equipment, and a MCO preferred provider must supply it upon approval.

The Right to Appeal

Any Delaware Medicaid applicant or recipient who is dissatisfied with a Medical Assistance Program decision about program eligibility or service eligibility, or who has experienced undue delay in action, may appeal that decision. An MCO member has the option of challenging the action through the MCO's internal appeal process as well as through the State Fair Hearing system.

State Fair Hearing Appeal System

Those members covered by traditional fee-for-service Medicaid have the right to request a State Fair Hearing. The request must be submitted in writing within 90 days of the disputed action or decision. Prior to the hearing, the member has the right "to examine all documents and records to be used by State agency or its agent at the hearing and to examine the claimant's case records." There is no charge to the member for copies of documents. The contact information is:

Delaware Health and Social Services—Medicaid

1901 N. Dupont Highway
P.O. Box 906
New Castle, DE 19720
(302) 255-9500
(800) 372-2022

In response to any correctly submitted Fair Hearing request, Medicaid staff must complete a summary of the factual and legal reasons for the action/decision being appealed, and submit that summary to an impartial Fair Hearing officer within five working days of the request. The officer must in turn mail a copy of the summary to the person requesting the appeal.

The agency must notify the applicant/recipient in writing about the date, time, and location of the hearing no less than 10 days before it is to take place. At the hearing, the applicant/recipient has the right to examine case records and relevant agency documents, present and cross-examine witnesses, and present arguments. The member bears the burden of proof in cases where there is an initial denial of eligibility or where there is a request for services. The State (or MCO) bears the burden of proof in cases involving termination of eligibility or terminations/reductions of services. The hearing officer must notify the applicant/recipient in writing of the decision, and must provide information about eligibility for judicial review if applicable.

If the Hearing Officer denies the member's appeal, the member has the right to appeal that decision within 30 days to the Delaware Superior Court.

Medicaid Managed Care & Appeals

For Medicaid beneficiaries served by an MCO, the complaint/appeal process usually starts with the MCO. The beneficiary may want to try to resolve a dispute with an MCO decision through that MCO's review/appeal process before taking further steps. The Health Benefits Manager (HBM) as well as the MCO's Client Advocate may help access this process. DMAP also monitors MCO operations and may assist the member.

In addition, the United States Supreme Court recently upheld a lower court's ruling that patients have the right to seek an independent review of denials of care by their MCOs.

Diamond State Partners

Complaints and appeals for Diamond State Partner members are handled identically to the process used for those persons in fee-for-service Medicaid.

First State Health Plan

First State has an informal complaint process. If a member's call to First State does not yield the desired result, the next step is to file a Formal Grievance. Formal Grievances need to be in writing and must be sent to First State within 90 days of the problem. Their Member Service Department, at (302) 327-7600 or (800) 362-4214, offers to assist those having trouble writing their grievance. A Formal Grievance should include the following:

A description of the problem

What the member did about the problem before filing the grievance

How the member wants the problem to be settled

Notification to First State if the member wants to attend and participate in the Grievance Meeting

Identification of any representative(s) who will attend the Grievance Meeting with the member or the member's request that a First State employee represent him/her.

The Grievance Committee meets within 30 days after receiving the Grievance. Members will be notified of the meeting date 10 days before it takes place. A decision is made within 30 days after the Grievance Committee meeting.[5] If the member is dissatisfied with the decision, s/he can pursue the appeal through the State Fair Hearing system within 90 days of the Grievance Committee decision.[6]

DHSS regulations require a uniform appeal procedure in cases of MCO decisions involving medical necessity. Essentially, these regulations call for a three stage appeal process:

Stage 1 - an internal review by the carrier

Stage 2 - a subsequent internal carrier review involving at least two physicians or other health care professionals who had no role in the matter

Stage 3 - an External Review under the DHSS Independent Health Care Appeals Program.

These regulations also establish timeframes for the various appeals and other procedural safeguards.

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[5] Under new federal regulations effective June 14, 2002, an expedited appeal (where a delay could seriously jeopardize the person's life or health) must be decided within three working days.

[6] Of course, MCO members have the same appeal rights to Delaware Superior Court as do fee-for-service members.

Medicaid County Offices

New Castle County:

Service Areas & Alphabetical References: 19720, 19801, 19804
Office Location: DHSS Campus, 1901 N. DuPont Hwy., New Castle, DE 19720
(302) 577-4448

Service Areas & Alphabetical References: 19703, 19707, 19710, 19732, 19735, 19736, 19802, 19803, 19805, 19806, 19807, 19809, 19810, 19899
Office Location: Northeast State Service Center, 1624 Jessup Street, Wilmington, DE 19802
(302) 577-3630

Service Areas & Alphabetical References: 19701, 19702, 19706, 19708, 19709, 19711, 19712, 19713, 19714, 19730, 19731, 19733, 19734, 19808 and all NC County long term care applications
Office Location: Robscott Building, 153 Chestnut Hill Road, Newark, DE 19713
(302) 368-6610

Kent County:

Service Areas & Alphabetical References: Dover service area with last names beginning with A-D and all of Milford service area[7]
Office Location: 32 Loockerman Square, Suite 106, Dover, DE 19901
(302) 739-6924

Service Areas & Alphabetical References: Dover service area with last names beginning with E-Z
Office Location: Williams State Service Center, 805 River Road, Dover, DE 19901
(302) 739-3716

Service Areas & Alphabetical References: All Long Term Care applications for both Kent & Sussex
Office Location: Milford State Service Center, 11-13 Church Avenue, Milford, DE 19963
(302) 422-1555

[7] The Dover Service Area includes: Camden-Wyoming, Cheswold, Clayton, Dover, Felton, Hartly, Kenton, Little Creek, Magnolia, Marydel, Smyrna, Viola, and Woodside. The Milford Service Area includes: Bowers Beach, Ellendale, Farmington, Frederica, Greenwood (Kent County side), Harrington, Houston, Lincoln, Little Heaven, and Milford (Kent County side).

Sussex County:

Service Areas & Alphabetical References: 19931, 19933, 19940, 19941, 19950, 19956, 19960, 19963, 19966, 19973
Office Location: Georgetown State Service Center, 546 S. Bedford Street, Georgetown, DE 19947
(302) 856-5501

Service Areas & Alphabetical References: 19930, 19939, 19944, 19945, 19947, 19951, 19958, 19966, 19968, 19969, 19970, 19971, 19975
Office Location: Georgetown State Service Center, 546 S. Bedford Street, Georgetown, DE 19947
(302) 856-5349

III. Medicare

www.medicare.gov/

The Medi**care** program was authorized under Title XVIII of the Social Security Act of 1965. It is often confused with the Medi**caid** Program (Title XIX) because their names are so similar. While they have a few points in common, the two programs are actually very different. For example, the federal government (Centers for Medicare & Medicaid Services or "CMS") administers Medicare, and the rules are the same for every state in the nation. This is not true of Medicaid. Also, Medicare requires co-payments and annual deductibles; Medicaid does not. While Medicare eligibility is based on age, disability, and work history, Medicaid generally does not consider work history. Instead, Medicaid looks to either poverty level or SSI related groups (those over 65, blind persons, and those permanently disabled) in determining eligibility. Medicare, on the other hand, does not consider income in determining eligibility. Some persons are dually eligible for Medicare and Medicaid.

Medicare is another major funding source for AT, which in the language of both the Medicare and Medicaid systems is called durable medical equipment (DME).

Eligibility

Medicare is a health insurance program for:

Individuals who are age 65 or over

People of all ages who are permanently and totally disabled[8]

People with end stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

Contact Information

In the case of those enrolled in the original Medicare plan (approximately 90 percent of all Medicare beneficiaries), Medicare DME claims are being administered by DME Regional Carriers (DMERCs). The carrier for the region to which Delaware belongs (Region A) is Health Now of New York, Inc. Contact information for questions about bills for DME and a list of approved DME suppliers is as follows:

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[8] The definition of disability is stated in the Social Security Act as the inability to engage in any substantial gainful activity by reason of any medically determined physical or mental impairment which can be expected to result in death, or has lasted or can be expected to last for a continuous period of not less than 12 months, or blindness (20/200 or less in better eye)[Sec. 216(i)1]. Also, the claimant must have been receiving Social Security Disability benefits for at least 24 months before s/he may qualify for Medicare disability insurance. An exception to this 24 month rule has been made for persons under age 65 with Amyotrophic Lateral Sclerosis (ALS/Lou Gehrig's disease). These persons can receive Medicare coverage during the first month in which they receive Social Security Disability benefits.

DMERC Region A

(800) 842-2052 (voice), (800) 842-9519 (TTY)

Provider Relations:

(866) 419-9458

Consumer Inquiries:

(800) 842-2052

Questions about Part B bills, services, and fraud and abuse for Region A are directed to a separate carrier, Trailblazer Health Enterprises. Contact information for Trailblazer is as follows:

(800) 444-4606 (voice), (800) 516-6684 (TTY), www.trailblazerhealth.com/

Questions regarding Medicare eligibility may be directed to the Social Security Administration office in the consumer's county of residence.

New Castle:
92 Reads Way
New Castle, DE 19720
(302) 323-0304 (voice)

Kent:
300 South New St.
Dover, DE 19901
(302) 674-5162 (voice)

Sussex:
600 N. DuPont Hwy.
Georgetown, DE 19947
(302) 856-9620 (voice)

A general phone number for Medicare is (800) 633-4227.

Individuals using telecommunication devices for the deaf/text telephones may call (800) 325-0778

Coverage

Medicare offers two types of coverage: Parts A & B.

Part A: Institutional health care coverage - This is essentially hospitalization insurance. However, Part A covers some DME (e.g., wheelchairs, oxygen, walkers) as Home Health Care. Part A coverage is mandatory for all Medicare beneficiaries. There is no premium for most beneficiaries.

Part B: Optional medical insurance - This is the type of coverage that pays for most DME as well as some of the services not covered by Part A, such as some physical and occupational therapy. If you are eligible for premium-free Part

A, you are automatically eligible for Part B. Part B is voluntary and it has the following costs:[9]

A monthly premium ($66.60 in 2004). All Medicare beneficiaries, regardless of which type plan covers them, must pay this premium.

An annual deductible ($100 in 2004)

20% co-insurance - 20% of the Medicare approved amount for a device or service after the deductible is paid.[10], [11]

Some individuals with low incomes may qualify for both Medicaid and Medicare benefits. When there is dual coverage, the Medicaid program may pay Medicare premiums, deductibles and co-payments, and for some services not covered by Medicare as well (Refer to Poverty Level-Related Groups on page 21).

Health Plan Options

Medicare offers several options for health care coverage from which beneficiaries may select. The two general categories of plans are:

Original Medicare Plan - this is sometimes called fee-for-service which means that beneficiaries are usually charged a fee for each health care service or supply they receive. The federal government manages this plan and members have the flexibility to go any doctor, specialist, or hospital that accepts Medicare.

Medicare+Choice - these plans provide health care under contract to Medicare, which pays a set amount of money to these plans each month for beneficiaries' health care. Medicare+Choice beneficiaries are supposed to receive the same services under Parts A and B as those covered under the Original Medicare Plan.

There are two types of Medicare+Choice plans:

Managed care plans (MCOs), which are like health maintenance organizations (HMOs). In order to be eligible to join an MCO, one cannot be diagnosed with permanent kidney failure and must have Part B coverage. With the MCO type of plan, beneficiaries usually must see a doctor or specialist who belongs to that plan. One generally needs a referral from a primary care doctor before visiting a specialist. Some MCO plans have a more costly, point-of-service option which allows a beneficiary to go to a doctor or specialist who is not part of the plan.

Private fee-for-service plans. With these plans, Medicare pays a certain amount each month to a private insurance company, which then provides health care

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[9] Under some circumstances, these costs may be covered by Medicaid or other insurers.

[10] Co-insurance may be paid by another insurer or waived if the beneficiary can document financial hardship, but the supplier must always bill for the 20 percent co-payment balance that Medicare does not cover.

[11] Medicare+Choice members are not necessarily subject to the $100 deductible and 20 percent co-insurance requirements. Instead, those plans are allowed by Medicare to charge members up to $105 monthly in cost sharing.

coverage to Medicare enrollees who join this plan. The insurer and the insurance company pay a fee for each visit to a doctor and each service. The private company, rather than the Medicare program, decides how much it and the beneficiary will pay as well as what services the beneficiary will receive. With a private fee-for-service plan, beneficiaries can choose any doctor or specialist who accepts the plan's payment.

The open enrollment period for **Medicare+Choice** is November of each year. Questions about this should be directed to the Centers for Medicare & Medicaid Services at (800) 633-4227.

In Delaware, there is one MCO, **Coventry Health Care**, which offers coverage under **Medicare+Choice**. As of 2004, the MCO is being referred to as Medicare Advantage. Those who subscribe to the **Medicare Advantage** plan pay $90 each month in addition to the $66.60 Part B premium. Like Original Medicare Plan members, Coventry members pay 20 percent of the cost for each Medicare approved service. Contact information is as follows:

Coventry Health Care of Delaware, Inc.

Plan name - Advantra
(888) 781-9411 (voice)
(800) 735-2966 (TTY/TDD)
www.chcde.com/

In Delaware, there is one private fee-for-service plan, administered by Sterling Life Insurance Company. Those enrolled under this plan pay $78 each month in addition to the $66.60 Part B premium. Beneficiaries who fail to notify Sterling of a DME purchase over $750 will have to pay 70 percent of the billed charges. Otherwise, beneficiaries pay 50 percent of the cost for each Medicare approved DME item.

Contact information is as follows:

Sterling Life Insurance Company

Sterling Option I
(888) 858-8572 (voice)
(800) 858-8567 (TTY/TDD)
www.sterlingplans.com/nonenrollee/states/delaware/delaware.html

Medical Necessity

Like Medicaid, Medicare will purchase various types of assistive devices if a Medicare provider supplies them and the items are considered medically necessary. Medically necessary services and supplies must be:

Prescribed by a physician, consistent with standards of good medical practice in the local community

Proper and needed for the diagnosis, direct care, and treatment of a medical condition

Expected to provide therapeutic benefits

Not mainly for the convenience of beneficiary or doctor.

Durable Medical Equipment (DME)

Medicare will usually pay for an assistive device if it can be considered durable medical equipment (DME) and is covered under Title XVIII. The federal government usually defines durable medical equipment as:

That which can withstand repeated use

Is customarily used for a medical purpose

Is generally not useful to a person in the absence of an illness, injury, or disability

Is necessary for use in the home.

Medicare-covered DME has several other important characteristics. The following are some examples:

Most commonly used home medical equipment such as wheelchairs, ambulatory aids, hospital beds, heating and decubitus pads, and seat lift chair mechanisms[12] each have their own coverage criteria. Equipment suppliers are the best sources of this information and most will provide it upon request.

Each service or piece of DME that Medicare routinely covers has a special HCFA Common Procedure Coding System (HCPCS) code. It is beyond the scope of this guide to list them here, but each DME supplier that accepts Medicare assignment has a Medicare Provider Manual that lists these codes.

Certain equipment that is not customarily purchased by Medicare may in fact be covered when the prescribing physician can provide a very strong, reasonable medical justification for that device. In fact, this is true of just about all insurance carriers when the policy covers DME. For example, a person with asthma typically would not use a power wheelchair. Under certain conditions, however, such a device may be medically necessary for an individual with a very severe form of this condition. It would fall to the physician to provide a compelling justification for the use of AT in atypical situations.

The Payment Process

Medicare assigns an allowable charge or amount to devices and services based on the lower of:

The fee schedule amount

Actual charge.

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[12] Currently, Medicare covers 80 percent of the allowable charge for the lift mechanism part of this device, but not the furniture (lounge chair) portion which contains the mechanism.

Medicare then pays 80 percent of the allowable charge and the consumer's private resources or other insurance must pick up the remaining 20 percent.

Medicare pays for the "least costly alternative." A device may have special features that make it more convenient for the user, but also more costly. When the additional device features are not related to the user's medical condition, Medicare's allowable price level is likely to be the cost of the standard, less expensive item. If the standard item is not desirable, it is possible to combine Medicare funds with other resources to obtain the higher-priced product.

Funding of Specific AT Categories

Aids for Daily Living (ADL) - Medicare does not generally fund ADL devices because they do not meet the "primarily medical" test.

Switches and Environmental Control Units (ECU) - Medicare generally does not fund ECU devices for the same reason it does not fund ADL devices. However, Medicare has funding codes for these devices so if there is very strong evidence that a particular ECU device is "primarily medical," it may be worth trying to get it funded through Medicare.

Assistive Listening Devices - Medicare does not fund Assistive Listening Devices.

Aids for Low Vision - Medicare does not cover Aids for Low Vision such as magnifiers, CCTVs, and screen enlargement software.

Augmentative and Alternative Communication (AAC) - Medicare covers AAC devices as "speech generating devices" (SGD). This wording emphasizes that Medicare's coverage is not as broad as Medicaid's since it is limited to devices that generate speech. (A description of Medicare’s process is available on page 58.)

Computer Access - Medicare will fund only computers and personal digital assistants that are "dedicated SGDs" (that is, they run AAC software exclusively).

Seating, Positioning, and Mobility - Medicare covers wheelchairs, scooters, walkers, and other AT devices in this category. (A description of Medicare’s process is available on page 68.)

Home Modifications and Vehicle Modifications - Medicare does not fund home and vehicle modifications.

Orthotics and Prosthetics - Medicare provides funding for orthotics and prosthetics. Medicare makes a distinction between "orthotics" and "durable medical equipment." Examples of orthotics and prosthetics are artificial limbs and eyes, breast prostheses, corrective lenses after cataract surgery, and leg, arm, and neck braces.

Equipment Prescription, Justification & Claim Submission[13]

Medicare will only pay for equipment if a physician prescribes it,[14] the beneficiary has Medicare Part B coverage, and the needed AT is consistent with Medicare's definition of DME.

Accessing AAC Devices Through Medicare

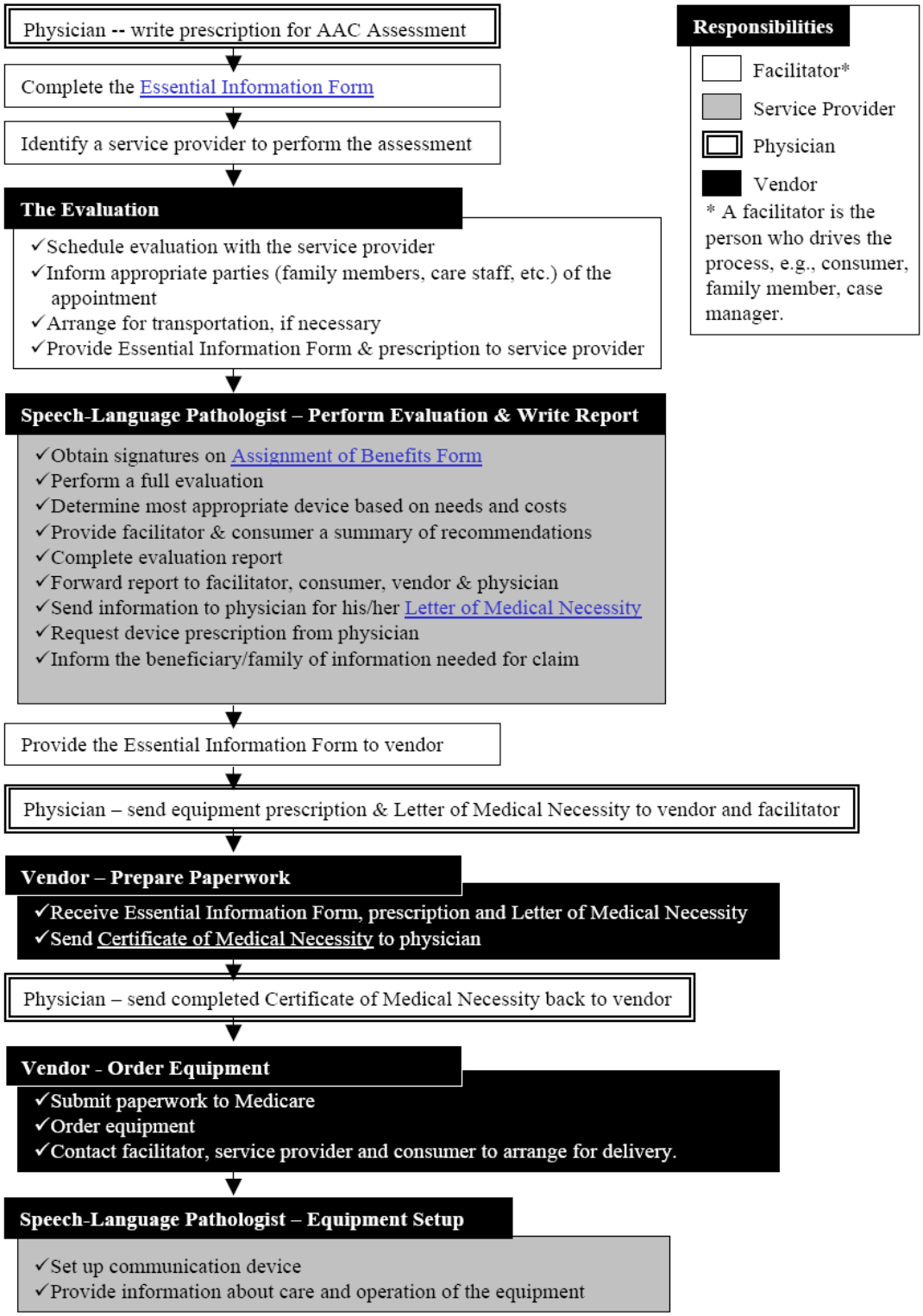
AAC Device Purchase

The following chart outlines the process for obtaining AAC devices that are medically necessary under Medicare. Underlined items can be found in the appendices at the end of this guide. The steps progress in a sequence from the time an AT need is identified to when the equipment is provided. This is a process that involves many team members. Their roles and responsibilities are outlined in the following chart.

[13] Remember to first try to access AT through private insurance if the person with disabilities has that type of insurance.

[14] Certain equipment may require a specialist's prescription. For instance, under Medicare regulations, only a neurologist, physiatrist, orthopedist, or cardiac specialist may prescribe a motorized wheelchair.

Obtaining Speech Generating Devices - Medicare



Medicare refers to augmentative communication devices as speech generating devices. A speech generating device must be medically necessary and must meet all the following criteria:

Prior to receiving a speech generating device the patient must have a formal evaluation of cognitive and communication abilities by SLP. The formal elements of the evaluation must include, at a minimum, the following elements:

Current communication impairment, including type, severity, language skills, cognitive ability, and anticipated course of impairment;

Assessment of whether the individual's daily communication needs could be met using any other natural modes of communication;

Rationale for selection of a specific device and any accessories;

Demonstration that the patient possesses a treatment plan that includes a training schedule for the selected device;

The cognitive and physical abilities to effectively use the selected device and any accessories to communicate;

For a subsequent upgrade to a previously issued SGD, information regarding the functional benefit to the patient of the upgrade compared to the initially provided speech generating device.

The patient's medical condition is one resulting in a severe expressive speech impairment.

The patient's speaking needs cannot be met using natural communication methods.

Other forms of treatment have been considered and ruled out.

The patient's speech impairment will benefit from the device ordered.

Copies of the written evaluation and recommendation from the SLP have been forwarded to the patient's treating physician prior to ordering the device.

The SLP performing the patient evaluation may not be an employee of or have a financial relationship with the supplier of the speech-generating device.

Laptop computers, desktop computers, PDAs (personal digital assistants) and other devices that are not dedicated speech generating devices are not covered because they do not meet the definition of DME.

Computer based and PDA-based AAC devices/speech-generating devices are only covered when they have been modified to run AAC software exclusively.

Accessories are covered if the medical necessity for each accessory is clearly documented in the formal evaluation by the SLP.

Roles and Responsibilities of Team Members

Facilitator*

*The facilitator is the person who drives the process. The person could be the consumer, a family member, a case manager, etc.

- Completes the Essential Information Form (see Appendix C). Detailed instructions for completing this form are included. The facilitator will need:
  - Consumer identification information
  - Consumer support/contact information
  - Insurance information
  - Physician information
  - A prescription (the service requested is Augmentative/Alternative Communication Assessment).
- Identifies the service provider options based on the following criteria:
  - Medicare provider
  - Provides services to the relevant MCO(s)
  - Delivers the type of service needed. The AT Provider section of the Website may assist the facilitator with this process.
- Calls the service provider and schedules the evaluation, providing all of the information outlined on the Essential Information Form as well as the specific reason for the evaluation. The facilitator will need to know:
  - Whether the individual had an AAC system at one time or currently uses an AAC device.
  - If the consumer currently has an AAC system, who provided the device? With the manufacturer and the serial number (which is on the device), the manufacturer will be able to identify how and when the device was provided. It is important to take the device to the evaluation (even if the device is not working.)
- Once an appointment is scheduled, informs the appropriate parties (family members, care staff, etc.) of the appointment. Key informants (such as a primary caregiver or case manager) should attend and participate in the evaluation.
- Arranges for transportation to the evaluation, if necessary.
- During the intake process, the consumer will be asked to provide written permission on a form that indicates that the service provider may bill Medicare and accept the assignment of benefits.
- Since Medicare covers 80 percent of the costs of the allowable service, the consumer and/or a secondary payor (Medicaid, other insurance, state agency) will be responsible for the remaining 20 percent. The facilitator may need to make arrangements for this payment if the consumer does not have Medicaid as a secondary insurance.
- Secures a copy of the LMN from the vendor, signifying that the claim submission process for the AT device has been completed. If a copy of the LMN is not received within 30 days of the evaluation, contacts the vendor.
- If there has been no action on the claim after 30 days of the submission of the LMN, contacts the Medicare Intermediary office.

Service Provider

Verifies insurance information provided on the Essential Information Form and schedules the appointment.

Reviews the intake information and obtains signatures on the assignment of benefits form on the day of the evaluation.

Requests a copy of the prescription (Rx) for the evaluation from the facilitator. Without an Rx, the service may not be provided.

Completes the evaluation with input from the facilitator, the consumer, and the caregiver(s).

Provides the facilitator and the caregiver/consumer with a summary of the recommendations. Recommendations should include the following information:

The specific type of equipment and component(s) needed

Estimated date of delivery

Training that is needed once the equipment is obtained.

Completes an evaluation report and sends a copy to the facilitator, the physician, the vendor, and the consumer/caregiver.

Sends information to the physician to support formulation of the LMN.

Sets up the communication device per the specifications outlined in the assessment.

Provides information about the care and the operation of the equipment as well as warranties, repairs, and follow up upon delivery.

More About the SLP's Role

The SLP is the key person in the Medicare claims process related to AAC devices. Medicare guidance related to AAC devices is unique because it designates a non-physician, the SLP, as the primary determiner of a beneficiary's medical need. For everything else Medicare covers, the beneficiary's doctor holds responsibility. There are four specific steps the SLP must complete as part of the Medicare claims process:

Complete an assessment for an AAC service pursuant to the DMERC Regional Medical Review Policy (RMRP) outline. A protocol has been developed to help SLPs conduct a complete assessment and prepare a complete application report consistent with Medicare's requirements. It is posted at www.aac-rerc.com/archive_aac-rerc/pages/MCsite/MCAppProtocol.html.

As part of the evaluation process, the SLP will determine the most appropriate device that will meet the beneficiary's daily communication needs, as well as determine the beneficiary's need for AAC software and/or accessories.

The SLP also must determine whether the beneficiary can obtain the most appropriate device, which requires consideration of the following points:

Does Medicare cover the device or is it currently excluded from coverage?

If covered, will the manufacturer/vendor accept assignment for the device?

If not covered, or no assignment will be taken, can the beneficiary afford the full purchase price of the device? (If not, the SLP will need to consider an alternative device.)

Complete a written report and supporting information pursuant to the DMERC RMRP outline. The protocol posted at www.aac-rerc.com/archive_aac-rerc/pages/MCsite/MCAppProtocol.html is intended to help ensure this report is complete. As part of the report, the SLP should address AAC accessories that are needed in addition to the need for the device.

Forward the report to the beneficiary's treating doctor along with a request for a prescription containing the information on the Essential Information Form. The physician must include the statement that each of these items is reasonable and necessary for the treatment of the patient's expressive communication diagnosis (dysarthria, aphasia, aphonia) and is necessary to achieve the functional communication goals stated for the patient in the SLP's treatment plan.

Inform the beneficiary and his/her family of the information that must be assembled to support a claim, including the assessment report, prescription, and co-payment or full payment amount.

Important Consideration: Medicare coverage of SLP services extends to reimbursement for the AAC evaluation. However, not all SLPs will qualify as Medicare SLP service providers. An evaluation and report recommending an AAC device, AAC software and/or accessories can support a Medicare claim for these items of equipment even if the SLP is not a Medicare provider him/herself. In this circumstance, the device can be reimbursed but the SLP will not be reimbursed for his/her evaluation. The SLP's duty in making an AAC device recommendation is to identify the most appropriate device that meets the individual's daily communication needs, which may or may not be the most technically advanced device. Medicare makes this duty more of a challenge because its guidance currently excludes some of the AAC devices that produce synthesized speech output. For this reason, additional consideration must be given to whether the device is affordable. A manufacturer/supplier is unlikely to accept assignment of benefits for a non-covered device, so the beneficiary will be required to pay its full catalogue or retail price. That requirement may make the device unaffordable, and the SLP cannot meet his or her obligations to a Medicare beneficiary by recommending a device that the beneficiary will not be able to acquire. If the device is not covered and not affordable, the SLP and family may chose to identify another device to meet the person's daily communication needs. The goal should be to recommend the best match between the client's communication needs and an appropriate AAC device, which may include consideration of the coverage status of the device in some cases.

Vendor

The AAC vendor, in most cases, is the manufacturer and is not directly involved in the assessment process. The AAC manufacturers have funding specialists who will submit the documentation and claim to Medicare, Medicaid, or any other private insurance company. The vendor should:

Be enrolled as a DME provider with Medicare. If the consumer is also covered under an MCO, the vendor must be a participating provider with that MCO.

Receive a copy of the Essential Information Form.

Contact the physician to request the LMN and CMN if it has not been received.

Submit all paperwork to Medicare.

Order the equipment.

Contact the facilitator, the service provider, and the caregiver/consumer when the equipment is ready to be delivered.

Note: The AAC manufacturer typically functions as the vendor. There are instances, however, in which the manufacturer is not an enrolled provider. In these cases the facilitator will have to use a DME vendor who will work with the manufacturer in supplying the equipment needed.

Physician

Provides a prescription for the evaluation, equipment, and/or services needed.

Provides LMN to vendor based on results of the evaluation.

Completes the Medicare CMN (see Appendix H) for new devices and at such times that repairs/modifications are needed.

More about the Physician's Role

The physician is a necessary part of the Medicare claims process. No Medicare payment will be made for an AAC device, AAC software, or accessory without a physician's prescription. Thus, if a Medicare beneficiary has multiple physicians, any one can sign the prescription. It is expected that the doctor will base the prescription on the SLP report. The SLP report that is prepared following the evaluation should be submitted to the doctor for review. It is recommended that the doctor be asked to prepare the prescription with information verifying:

The physical or communication diagnosis

That the doctor referred the consumer for SLP evaluation (if that occurred)

That the doctor reviewed the SLP report

That the doctor concurs with the recommendation of the SLP and prescribes EACH item—device, switches, software, etc.—that is recommended; and that each of the these items is reasonable and necessary for the treatment of the patient's expressive communication diagnosis (dysarthria, apraxia, aphasia, aphonia), and that each item is necessary to achieve the functional communication goals stated in the SLP's treatment plan.

AAC Rental

Medicare will provide reimbursement for the rental of AAC devices. Device rentals will be subject to the same documentation requirements as device purchases, requiring provision of the SLP's evaluation report and the physician's prescription.

Medicare will provide reimbursement for the rental equipment based on the code in which the device "fits." Medicare's fee schedule for rental represents the full amount of Medicare reimbursement, either to the beneficiary if assignment is not accepted or to the supplier/manufacturer if assignment is taken. If assignment is taken, the beneficiary or supplemental insurance will have to meet the 20 percent co-payment amount.

AAC Device Repair

Medicare will cover the AAC device and accessory repairs—both parts and labor—for devices and accessories that are beyond their warranty periods.

Medicare assumes that DME will have a useful life of five years. This means that Medicare will not replace items of DME within a five-year span, except when a substitution request is based on change of beneficiary condition. The impacts of this practice are significant:

Medicare apparently will not replace a non-repairable device if it is within its five year expected life span.

While a denial of a replacement device in this circumstance is appealable, it is unlikely a manufacturer/vendor will accept assignment for a replacement device within the five-year period. For this reason, the consumer must be able to afford a replacement device, and then pursue an appeal.

If the consumer cannot afford a replacement device, they may ask the SLP and/or a facilitator for help. This may include identifying another device that is affordable (even if it is not able to meet all of the person's needs) or identifying sources of financial loans, device loans, used devices, or other funding sources. The goal, of course, is to ensure that the beneficiary is not without functional communication for the duration of the five-year period.

To prevent this situation from occurring, beneficiaries should be told of this risk during the discussions about the device selection, and should be encouraged to purchase supplemental insurance that will cover replacement if the device becomes non-repairable and Medicare refuses to replace the device.

Procedures for AAC repairs

When a device is not working properly, complete the following steps to gain assistance from the manufacturer. Do not return the device to the manufacturer until you have completed the following steps. Most of the communication device manufacturers have an 800 number, which can be found in the user's manual and/or on the device. A table of AAC product companies and their contact information is available (see Appendix F).

Call the Technical Support or Customer Service departments to get information about getting the device repaired. Many companies will attempt to do some troubleshooting over the phone. (Before calling the manufacturer have the device at hand.)

Identify the make, model and serial number of the device.

Does the device need to be returned to the manufacturer?

Do you have a return authorization number?

Complete the AAC Request for Repair form (see Appendix G).

Follow the manufacturer's specific instructions for returning the device.

The device will be repaired once the following documentation is in place and the 20 percent balance is provided to the manufacturer.

Collect the following documents:

An original Rx from the doctor (not a fax) prescribing the repair of the device.

A letter from a licensed SLP stating the need for the repair

An assignment of benefits form signed by the beneficiary or his legal guardian

Copy of the Medicare card and a copy of any other insurance cards

Copy of the Essential Information Form.

Determine if Medicare purchased the device. If not, then documentation is needed to justify the device according to Medicare standards.

Determine how the 20 percent co-payment will be handled (e.g., Medicaid, end-user).

If Medicaid is the secondary insurance, the vendor must get pre-authorization from Medicaid for the 20 percent co-payment.

If there isn't a secondary insurance the 20 percent is collected up front and the facilitator may need to help in this process.

Determine if the manufacturer will accept the assignment of benefits for the repair. If not, arrange for payment for the repair.

(FYI: Zygo expects payment up front for the repair from the consumer but will submit a claim to Medicare on behalf of the consumer and Medicare pays the consumer.)

Once the manufacturer receives the device and has all of the completed documentation and payer information/payment, the device will be repaired and returned to the consumer.

Repairing Speech Generating Devices - Medicare

Do not return the device to the manufacturer until you have completed the following steps!

Call the Manufacturer

- ✓Identify the make, model and serial number of the device.
- ✓Have the device with you.
- ✓Call the manufacturer's technical support or customer service number.
- ✓Work with the manufacturer to determine if device needs to be returned.

If device needs to be sent away for repairs…

Information FROM the Manufacturer

- ✓Return Authorization Number
- ✓Instructions for returning the device

Collect Documentation to send TO the Manufacturer

- ✓Original Prescription from the Physician for the repair
- ✓Letter from a licensed Speech-Language Pathologist stating the need for the repair
- ✓Assignment of Benefits Form signed by beneficiary or legal guardian
- ✓Copy of the Medicare card and any other insurance cards
- ✓Copy of the Essential Information Form
- ✓Copy of the AAC Request for Repair Form (keep a copy for your records)

Plan for Payment

- ✓If Medicare did not purchase the device, complete documentation to justify device according to Medicare standards
- ✓Determine how 20% co-payment will be handled (e.g., Medicaid, end-user)
- ✓Determine if the manufacturer will accept assignment of benefits for the repair

Send Device to Manufacturer for Repair

- ✓Send device as instructed by Manufacturer
- ✓Include: Request for Repair Form
  20% co-payment
  Documentation listed above (e.g., prescription, copy of Medicare card)

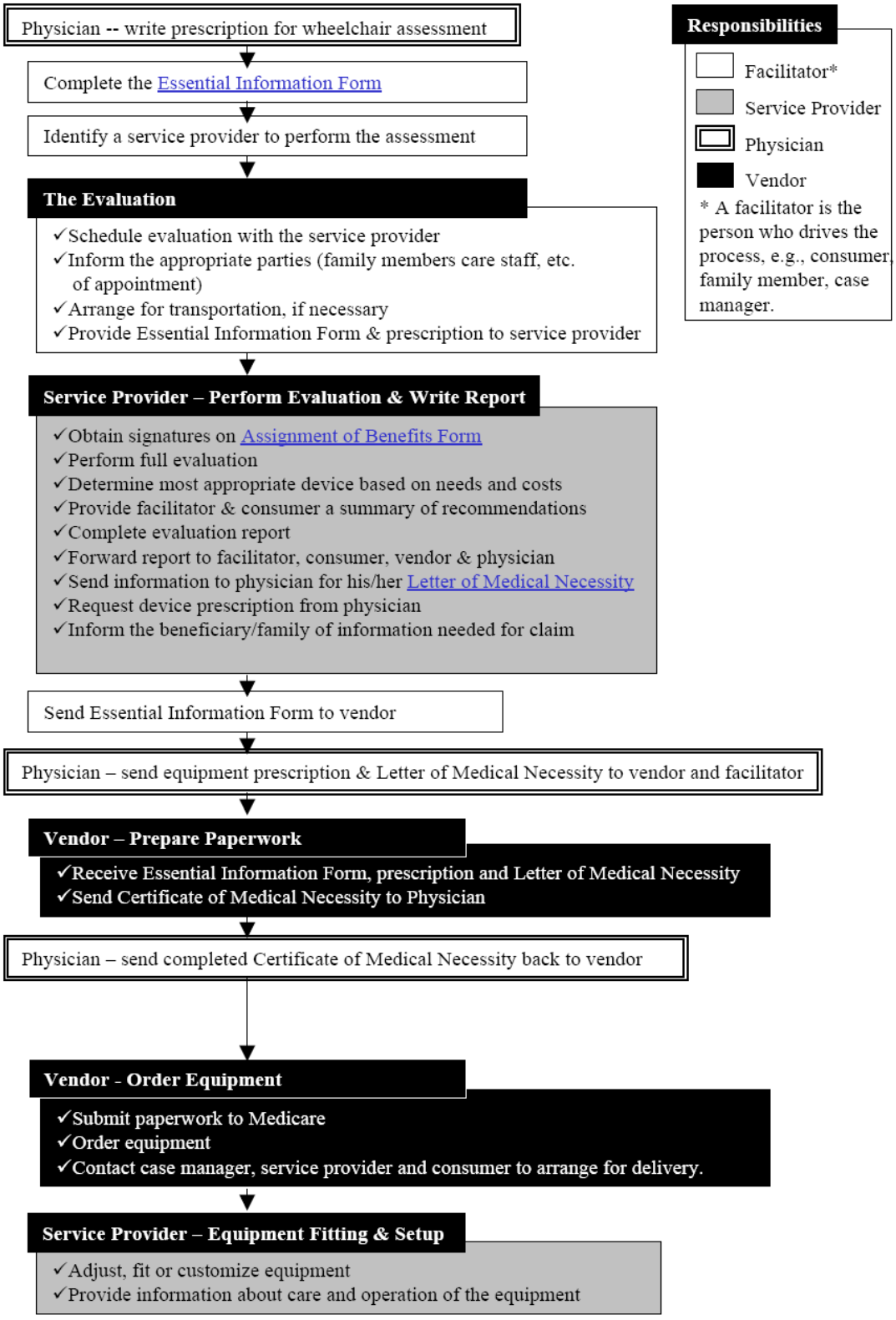
Vendor will: ***Get pre-authorization from Medicaid, if necessary (for example, when Medicaid is covering the co-payment)***
Repair device
Return device to consumer

Accessing Wheelchairs Through Medicare

Wheelchair Purchase

The following chart outlines the process for obtaining wheelchairs through Medicare. Underlined items can be found in the appendices at the end of this document. The steps progress in a sequence from the time the AT need is identified to when the equipment is provided. This is a process that involves many team members. Their roles and responsibilities are outlined following the chart.

Obtaining Wheelchairs - Medicare



Roles and Responsibilities of Team Members

Facilitator*

*The facilitator is the person who drives the process. The person could be the consumer, a family member, a case manager, etc.

Completes the Essential Information Form (see Appendix C). Detailed instructions for completing this form are included. You will need:

Consumer identification information

Consumer support/contact information

Insurance information

Physician information

A prescription

Identifies the service provider options based on the following criteria:

Medicare provider

Provides services to the relevant MCO(s)

Delivers the type of service needed.

If the consumer is currently using a wheelchair, identifies the vendor who provided the current wheelchair. The vendor will provide important information as to whether the wheelchair had been rented or purchased through Medicare. If the chair had been rented, it belongs to the vendor who provided the chair. If the chair had been purchased, you may select another vendor for the new chair, or rely on the service provider to determine the vendor.

Calls the service provider and schedules the evaluation, providing all of the information outlined on the Essential Information Form as well as the specific reason for the evaluation.

Once an appointment is scheduled, informs the appropriate parties (family members, care staff, etc.) of the appointment. Key informants (such as a primary caregiver or case manager) must attend and participate in the evaluation.

Arranges for transportation to the evaluation, if necessary.

During the intake process, the consumer will be asked to provide written permission allowing the service provider to bill Medicare and accept the assignment of benefits.

Since Medicare covers 80 percent of the costs of the allowable service, the consumer and/or a secondary payor (Medicaid, other insurance, state agency) will be responsible for the remaining 20 percent balance. If the consumer has Medicaid coverage, the vendor will get the relevant information from the Essential Information Form. If the consumer does not have Medicaid as a secondary insurance, other arrangements for the 20 percent will need to be made. The facilitator will need to make arrangements for this payment if the consumer does not have Medicaid as a secondary insurance.

Secures a copy of the LMN from the vendor, signifying that the claim submission process for the AT device has been completed. If a copy of the LMN is not received within 30 days of the evaluation, contacts the vendor.

If there has been no action on the claim after 30 days of the submission of the LMN, contacts the appropriate Medicare Intermediary office.

Service Provider

Verifies insurance information provided on the Essential Information Form and schedules the appointment.

Reviews the intake information and obtains signatures on the assignment of benefits form on the day of the evaluation.

Requests a copy of the prescription (Rx) for the evaluation from the facilitator, consumer or physician. Without an Rx, the service (PT, OT, SP) will not be provided.

Completes the evaluation with input from the facilitator, the consumer, and the caregiver(s).

Provides the facilitator and the caregiver/consumer with a summary of the recommendations. Recommendations should include the following:

The specific type of equipment and component(s) needed

Estimated date of delivery

Training that is needed once the equipment is obtained.

Completes an evaluation report and sends a copy to the facilitator, the physician, the vendor, and the consumer/caregiver.

Sends information to the physician to support formulation of the LMN.

Contacts the consumer/facilitator to schedule an appointment when the equipment is ready to be delivered.

Adjusts, "fits," or customizes the new equipment per the specifications outlined in the assessment.

Provides information about the care and the operation of the equipment as well as warranties, repairs, and follow up upon delivery.

Vendor

The vendor is a member of the assessment team and is responsible for submitting the documentation related to the medical claim for the equipment to the insurance company. The vendor must be enrolled as a DME provider with Medicare and, if the consumer is covered under an MCO, the vendor must be a participating provider with that MCO.

Receives a copy of the Essential Information Form.

Contacts the physician to request the LMN if it has not been received.

Completes the appropriate CMN and obtains the appropriate signatures.

Submits all paperwork to Medicare and Medicaid (if the consumer is using Medicaid to pay for the 20 percent co-payment).

Orders the equipment.

Contacts the facilitator, the service provider, and the caregiver/consumer when the equipment is ready to be delivered.

Physician

Provides a prescription for the evaluation, equipment, and/or services needed.

Provides LMN to vendor based on results of the evaluation.

Completes the CMN for wheelchairs, power-operated vehicles, scooters and all augmentative communication systems (see Appendix I). CMNs are also required at such times that repairs/modifications are needed.

Wheelchair Repairs

The process for managing and processing the repairs to a wheelchair depends on whether the wheelchair was purchased or rented through Medicare. Do not assume that the wheelchair was purchased until you have contacted the vendor who provided the chair.

Repairs to a Rented Wheelchair

Repairs are covered under Medicare only when the wheelchair is rented through Medicare. The rental payment to the vendor includes repairs and maintenance to the frame of the wheelchair. Wear and tear on removable parts is not usually covered under the rental agreement. The facilitator must work with the vendor who provided the wheelchair in order to have the repairs covered under the Medicare rental agreement.

In addition to the information on the Essential Information Form, the facilitator must provide information about the make, model, and serial number of the wheelchair.

Some repairs will require a prescription and some require a CMN. The vendor will be able to provide guidance about what will be needed.

When a prescription is needed it should include:

The consumer's diagnosis that necessitates wheelchair use

A projection of the timeframe in which the person will need to use the wheelchair

The person's height and weight

The doctor's name, address, UPIN number, and Medicare number.

Repairs to a Purchased Wheelchair

When a wheelchair has been purchased through Medicare, repairs that are needed to the chair are not covered under Medicare. All repairs are "unassigned," meaning that the patient will be billed for the repairs.

To arrange for repairs to a wheelchair, contact the vendor and provide the same information that is outlined on the Essential Information Form.

Identify the source of funds to be used for the repairs.

Need for Additional Wheelchair Components

If the need for the component can be justified as medically necessary, then the process is the same as the one used for an evaluation.

Medicaid as Secondary Insurance

If the vendor does not have accurate Medicaid information, the consumer will be responsible for the costs of the repairs.

Fee-for-Service Medicaid

Repairs under $300 do not require a pre-authorization. Vendors can be contacted and they will provide the labor and parts needed to complete the repair.

Repairs over $300 require a pre-authorization. In order to get a pre-authorization; a CMN must be completed. The CMN includes the patient's name, identification number, diagnosis, dates of service, service codes, supplies/equipment provided, and physician's signature.

The request goes to Medicaid where the information is reviewed and the claim is either approved or denied.

Doctors have to write the LMN (no therapist involved in the process.)

Medicaid MCO

When an individual has a Medicaid MCO as a secondary insurance, the vendor must get prior authorization from the MCO for the repair. To get a pre-authorization you must have a prescription and an LMN. The case manager at the insurance company reviews the Rx and the LMN and provides pre-authorization.

Denials/Appeals

Wheelchair vendors do not get involved in denials or appeals for repairs. The consumer will need assistance with the appeal process from the facilitator.

Access to Prosthetics and Orthotics Through Medicare

Funding requests for orthotics or prosthetics will always need a physician's prescription. A substantial majority of vendors will accept "assignment" for these devices. The orthotics coverage, insofar as braces are concerned, is limited to

leg, arm, back and neck braces. Orthopedic shoes are excluded from coverage. There is no similar limitation concerning prostheses.

Medicare uses what is known as an "L-Code" system in conjunction with Level II or "K-Modifiers" for billing these devices. Essentially, these "K-Modifiers" (K0 to K4) measure the patient's rehabilitation potential as determined by the prosthetist and physician. Those with a higher K level, such as K4, have better ambulation ability or potential and will be able to access a greater range of prosthetic components.

Medicare DME Changes

Beginning in October 2001, Medicare instituted an Advanced Determination of Medicare Coverage (ADMC) for customized wheelchairs. The ADMC is basically a prior authorization, which gives vendors advance notice as to whether Medicare will cover the cost of these devices. Medicare may expand the ADMC process in the future to other types of DME.

Medicare has a policy regarding the Advance Beneficiary Notice (ABN). The ABN is a written notice that a health care providers or DME suppliers must give to a beneficiary before providing any service or item that they think Medicare will not pay for. The ABN lists the services and items not covered and the reason why Medicare will not pay. The beneficiary then has the option to pursue purchase of the non-covered item/service with personal funds or other insurance. By signing the ABN, the consumer commits to payment for the non-covered items.

Medicare now covers treatment for persons with Alzheimer's disease.

The Appeal Procedure for Medicare Part B Claims

Original Medicare Plan

A Medicare beneficiary or service provider who does not agree with a Medicare carrier's decision has a right to appeal that decision. If Medicare denies an equipment claim or fails to reimburse the correct dollar amount, the equipment supplier who accepted assignment will usually attempt an appeal. If not, the beneficiary may wish to do so with assistance from DATI, other agencies, and/or the prescribing physician. Regardless of who takes the lead, the procedure is pretty much the same.

Request for Review of Initial Determination

Under Part B Medicare, either the beneficiary or the supplier must file a request for review in writing within six months of the time the initial decision was made. This is a paper review. Information about where to send the request, the deadline date for appeal, and the reason for denial all appear on the consumer's Explanation of Medicare Benefits (EOMB) form. The Medicare Summary Notice, or MSN, is replacing the EOMB notice. However, some Medicare carriers have not yet phased in this change.

Valid claims may be denied for several reasons, and the reason appearing on the EOMB/MSN will not always provide a clear explanation. Statements frequently used include "not medically necessary" or "not prescribed by a physician." A denial under medical necessity could mean any one of several things. It could mean that one of the criteria check-offs on the CMN was left blank, or that a HCPCS code was missing or incorrect. It could also mean that more information about the patient's condition is needed. The "not prescribed" reason can appear if the doctor fails to date his/her signature or omits the UPIN number. It is usually helpful to get an additional letter of support from the prescribing physician if a claim is denied as "not medically necessary." Ideally, this letter would contain additional evidence of the patient's medical/functional need for the prescribed equipment. Also, equipment dealers are usually very good at detecting what is missing from the CMN and will often assist the doctor with addressing specific points of Medicare coverage criteria. Consumers, their physicians, and DME suppliers are also welcome to contact the DATI for assistance. Appeals are usually very successful. Many denials are reversed on appeal.

Request for Fair Hearing (Carrier Hearing)

If the review decision is unsatisfactory and the disputed amount is $100 or more, the consumer[15] or service provider may submit a Request for Fair Hearing. This is also known as a Carrier Hearing. Again, the request must be in writing, and must be postmarked within six months of the review decision. Equipment denials that reach this level are often disputes about the medical necessity of the prescribed device(s). A supplementary letter of support from the prescribing physician is essential at this stage. Again, doctors are encouraged to tap the equipment suppliers or the DATI for hints about how to make their additional documentation speak directly to the denial issues and Medicare coverage criteria. Even the most compelling argument will be ineffective if it does not address the specific reason for denial.

Request for Administrative Law Judge (ALJ) Hearing

If the fair hearing does not yield satisfactory results, and the amount in dispute is $500 or more ($100 or more for denials of home health benefits), the consumer or service provider may file a request for a hearing before an ALJ. This request must be filed within 60 days of the fair hearing review. The beneficiary can testify, bring witnesses and additional evidence, and present arguments to support his/her claim.

[15] Disputed claims can be combined to add up to the required amount for the appropriate appeal level (Fair Hearing, ALJ, or Federal Court).

Departmental Appeals Board Review

A beneficiary who receives an unfavorable decision from the ALJ has 60 days to request a review by the Departmental Appeals Board. As at the ALJ hearing, the beneficiary may submit additional evidence and make additional legal arguments. The Appeals Board's function is to consider whether the ALJ misinterpreted the law or facts.

Federal Court

Those cases that are not resolved at earlier levels may be appealed to Federal Court if the disputed amount is $1,000 or more. Consumers who wish to appeal to Federal Court may consider contacting the Community Legal Aid Society, Inc. (CLASI) office in their county for possible assistance.

The following table summarizes the Medicare appeal process, time limits, and procedures.

Medicare Appeals: Part B Coverage Determinations

Step	Time Limits	Reviewing Agency	Procedures & Rights	Notes
Initial Determination	If request not acted upon within 60 days after carrier receives it, delay constitutes an appealable denial	Carrier issues Medicare Summary Notice (MSN)	Beneficiary has right to appeal if: - carrier pays less than expected - carrier denies coverage - new information is available to support claim - error in processing original claim. Provider may also file an appeal.	The appeal process can continue from the review stage up through later stages to federal court when the amount in controversy meets certain requirements
Request for Review of Initial Determination	Must file CMS Form 1984 within six months of initial determination	Carrier employee other than person who made initial determination	Beneficiary may submit additional evidence. Paper review only.	Review decisions often contain a more complete explanation of reasons for denial
Fair Hearing (Carrier Hearing)	Must request within six months of receiving review decisions	Hearing officer paid by carrier conducts hearing	Amount in controversy must be at least $100. Hearing procedure is informal. Hearing officer has no subpoena power. Hearing officer must follow CMS manual guidelines.	Beneficiary may aggregate claims to meet the $100 jurisdictional requirement. Carriers must complete 90% of Part B hearings within 120 days of request. Carriers must also provide hearing if request for payment was not acted upon with reasonable promptness.
Administrative Hearing (ALJ)	N/A	Social Security Administration ALJ conducts hearing	Amount in controversy must be at least $500 ($100 if the case involves denial of home health benefits)	Beneficiary may aggregate claims to meet the $500 jurisdictional requirement for ALJ hearing.
Departmental Appeals Board Review	Must request within 60 days of ALJ hearing decision	N/A	Paper review only. Beneficiary may submit additional evidence and legal arguments.	
Judicial Review	Complaint must be filed within 60 days of Appeals Board decision	U.S. Federal District Court	Amount in controversy must be at least $1,000. All rights available to litigants in civil cases in Federal District Court.	

Medicare+Choice Appeals

Appeals of carrier determination under Medicare+Choice plans involve a number of steps. Beginning January 1, 2004, beneficiaries under Medicare+Choice plans will have the right to a “fast-track” appeals process involving independent doctors reviewing the case. These are sometimes called Part C Appeals. The early stages of this process are handled internally by the carrier (MCO or private fee-for-service plan) before being sent to an outside contractor, the Center for Health Dispute Resolution (CHDR), which is retained by CMS. The stages include:

Organization Determination

The Organization Determination is the initial decision made by the MCO (carrier) that sponsors the health plan in which a member is enrolled when a complaint about a service or payment decision is filed. The MCO must make its determination within 14 days after the date it receives the member's request. This process is expedited in cases of medical urgency, based upon certain criteria (e.g., doctor requests expedited consideration, or MCO agrees that the standard time frame could seriously jeopardize the life or health of the member or their ability to regain maximum function). In these matters, each stage of the appeal must be resolved within 72 hours.

Request for Reconsideration

If dissatisfied with the Organization Determination, the member can request that a different decision maker at the carrier consider the appeal. This request must be made within 60 days of the Organization Determination. This review is done strictly on the information in the files. The MCO has 30 days to reconsider its determination, or 72 hours in expedited cases.

Independent External Review Organization (by CHDR)

If the decision upon a Request for Reconsideration is unfavorable to the member, the case is automatically sent to an Independent External Review Organization. The Center for Health Dispute Resolution (CHDR) currently is that organization. The file sent to CHDR contains the MCO's written justification for its decision. The member is notified of this development by a letter from the carrier as well as by a letter from CHDR advising the member of the right to submit any additional information relevant to the appeal. If the appeal involves a question of "medical necessity," it is also reviewed by a physician. The CHDR is not under any statutory or regulatory time limit, but it tries to make its decisions within 60 days, and within 10 days in expedited cases.

ALJ Hearing

The next step in the appeals process is an ALJ hearing, mirroring the rights and procedures at an ALJ Hearing on the fee-for-service side. This request must be made within 60 days of the ALJ decision. One difference, however, is that the amount in controversy need only be $100, not $500 as in fee-for-service appeals.

Departmental Appeals Board Review

Again, as on the fee-for-service side, the member may request a hearing before the Departmental Appeals Board if dissatisfied with the ALJ's decision. The time limit is again 60 days.

Federal District Court

An appeal of the Departmental Appeals Board decision can be brought to Federal District Court by either the member or the MCO within 60 days if the amount in controversy is at least $1,000.

Private Insurance

Private insurance is often overlooked when efforts are made to obtain AT for persons with disabilities. If one has private insurance, Medicare and Medicaid consider that insurance to be the "payor of first resort" and will not consider funding requests until an individual's private insurance carrier has denied all or part of the claim. It is in your interest, therefore, to be knowledgeable about your private insurance coverage and rights.

There are a number of informative online publications concerning private health insurance. A good, practical two-part article on private insurance and AT was published by the National Assistive Technology Advocacy Project's *AT Advocate* newsletter. The first article entitled "Will the Insurance Policy Pay for AT?" appeared in the February/March 1998 issue (www.nls.org/av/av-0398.htm#will). The second installment of the article entitled "Is the Assistive Technology Device in Question Covered by the Policy?" was published in the April/May 1998 issue (www.nls.org/av/av-0598.htm#policy).

The Henry J. Kaiser Family Foundation published an article entitled "How Private Insurance Works: A Primer" in April 2002 (http://www.kff.org/insurance/2255-index.cfm). This article provides more technical information regarding private insurance and AT.

Delaware Insurance Department

(302) 739-6775
(800) 282-8611
http://www.state.de.us/inscom

The Delaware Insurance Department produces a number of guides and publications for consumers on many topics. This Department regulates insurance companies licensed in Delaware and its Consumer Services Division has programs to resolve disputes with insurance companies. Their action kit "Resolving Health Care Insurance Disputes", an online complaint form, as well as a printable complaint form are excellent facilitators for resolving private insurance issues. The Department may assist in cases where there are slow payments or where a consumer believes a claim was unfairly denied. However, the Department's arbitration program exempts cases where there is a dispute over "medical necessity". The Department's website contains a long list of their publications on health insurance.

Individual Health Plans

Aetna U.S. Healthcare has begun covering speech generating devices (SGD) in a manner identical to Medicare's coverage. However, unlike Medicare, which considers SGDs as a form of DME, Aetna defines them as prosthetics. Aetna's policy requires that the member have a formal evaluation of cognitive and language abilities by an American Speech and Hearing Association (ASHA)

certified speech-language pathologist (SLP). A copy of the SLP's written evaluation and recommendation must be forwarded to the patient's treating physician.

Aetna will cover SGDs even if the plan excludes "communication aids" because SGDs are considered a true prosthetic replacing speech. Voice prosthetics, including voice amplifiers, are covered under a separate benefit.

Vocational Rehabilitation & Independent Living Programs

www.delawareworks.com/dvr/welcome.shtml

State vocational rehabilitation agencies are a major funding source of AT for working-age individuals with disabilities. In 1986, a definition of what was called "rehabilitation engineering technology" was added to the Rehabilitation Act. When the Act was amended again in 1992, not only did Congress include four new technology-related state plan requirements in the law, but it also made clear that rehabilitation engineering technology includes AT. The two terms are used here interchangeably.

Eligibility Criteria

In order to be eligible for Vocational Rehabilitation services, the applicant must:

Have a significant disability that has been a barrier to employment

Be willing to pursue vocational goals and employment

Be a working age adult (in Delaware, age 16 or older).

Special Notes

Under the Rehabilitation Act Amendments of 1992 (Public Law 102-569), state rehabilitation agencies must presume that a person with a disability is able to work regardless of the severity of disability, unless the counselor can clearly demonstrate otherwise. In other words, P.L. 102-569 makes it unlawful for state vocational rehabilitation (VR) agencies to determine automatically that a person is "unemployable" due to the presence of a disability. The VR counselor must exhaust all options, including AT interventions, before denying eligibility on the basis of a person's inability to work.

The same law contains a provision that prevents the VR agency from imposing undue delays in the provision of rehabilitation technology by making it exempt from the agency's customary "comparable services and benefits" restriction. For example, when VR counselors consider how most VR services are to be financed, they must exhaust all other possible funding options (comparable benefits) before deciding to pay with VR funds. This search for comparable services can be very time consuming and, in the past, has often caused long delays in service delivery. Fortunately, the comparable benefits and services rule does not apply to AT.

Obtaining Equipment and/or Related Services

Depending on the applicant's background and resources, a counselor is assigned to assist in determining which services may be needed. Next, the client's needs must be evaluated and an Individual Plan of Employment (IPE) is developed. The

IPE was formerly known as an Individualized Written Rehabilitation Plan (IWRP). The IPE should include any needed service (such as physical therapy or occupational therapy evaluations) and special equipment identified during the evaluation.

Once a person is considered eligible for VR services and needs an AT device in order to meet work-related goals, the equipment and related services should be written into the client's IPE. The DVR then provides or arranges for the client to obtain the necessary equipment and services.

DVR has specific guidelines in the case of certain types of AT, such as home modifications, vehicle modifications, and hearing aids. DVR will pay for home and vehicle modifications if they are in the IPE and if they will help promote or advance progress toward an employment goal. In the case of vehicle modifications, the agency will condition eligibility based upon certain factors such as the age of the vehicle, mileage, and its condition.

Contact Information

Division of Vocational Rehabilitation office locations and telephone numbers are as follows:

Central Office
4225 North Market Street
P.O. Box 9969
Wilmington, DE 19809-0969
(302) 761-8275 (voice)
(302) 761-8296 (TDD)

Churchmans Center Office
908 Churchmans Road Extension, Suite 1
Churchmans Center
New Castle, DE 19720
(302) 326-8930

Odessa Professional Park
Appoquinimink Service Center
122 Silver Lake
Middletown, DE 19709
(302) 378-5779 (voice & TDD)

Wilmington Office
4425 North Market Street
P.O. Box 9969
Wilmington, DE 19809-0969
(302) 761-8300 (voice & TDD)

Carroll's Plaza, Suite 105
1114 South DuPont Highway
Dover, DE 19901
(302) 739-5478 (voice & TDD)

Polly Drummond Office Park
Building 1, Suite 1301
Newark, DE 19711
(302) 368-6570 (voice)
(302) 368-6980 (TDD)

Georgetown Office
204-A North Race Street
Georgetown, DE 19947
(302) 856-5730 (voice & TDD)

Vocational Rehabilitation and Independent Living programs can also be accessed through the Delaware Helpline at (800) 464-4357.

Client Assistance Program

The Client Assistance Program (CAP) is a consumer-based organization funded by United Cerebral Palsy (UCP) of Delaware to advocate for AT for persons with disabilities. The DVR and its Independent Living program refer clients to the CAP. In addition to advocacy, the CAP provides information and referral services. Anyone who has difficulty receiving rehabilitation services or has a complaint about how such services have been provided can contact the CAP. The contact information for each county office is as follows:

New Castle County CAP
(302) 764-2400 (voice)
(302) 764-8708 (TDD)

Kent/Sussex County CAP
(800) 640-9336
(302) 698-9336
(302) 698-9338 (fax)

Worksite Evaluations/Accommodations

Depending on the complexity of the situation, the VR counselor may either perform a worksite evaluation, or authorize the appropriate allied health professional(s) or contractor(s) to do so. All such services should be provided at no cost to the client. If adaptive equipment is required, it is written into the IPE, and the counselor pursues the most appropriate and timely purchasing option.

An employer, for example, may be legally responsible for purchasing the equipment as a reasonable accommodation under Title I of the Americans with Disabilities Act (ADA).

Supported Employment Services Program

The DVR has a Supported Employment (SE) program, which trains persons with severe disabilities such as mental retardation, mental illness, and traumatic brain injury to find and retain employment, with the assistance of job coaches, in an integrated work setting. These services are time-limited, with a maximum of 18 months after placement in a job. If a client needs a relatively simple AT device for an activity of daily living (e.g., oversized alarm clock), the SE program may provide this directly to the client. Otherwise, the SE counselors try to obtain the AT from other sources.

Anyone interested in SE services should contact Mike McGarrity at (302) 761-8275.

Delaware Office for the Deaf and Hard of Hearing

The Delaware Office for the Deaf and Hard of Hearing (DODHH) is located within DVR. DODHH provides information and referral as well as some advocacy services for its clients. There are no income eligibility standards, nor do clients have to be otherwise eligible for DVR services to benefit from DODHH's assistance. It also trains persons in the use of TTY, relay services, and related services.

Anyone interested in DODHH services should contact Loretta Sarro at (302) 761-8275 or lsarro@dvr.state.de.us.

Other Options to Consider

Despite AT's exemption from comparable benefits requirements, it is sometimes better for the client to obtain equipment such as seating, positioning, and mobility devices through other programs such as Medicaid or private insurance. The VR counselor may recommend and then help the client access these other AT funding sources, some of which are described later.

Medically Necessary Equipment and Services

Public or private insurance can be an alternate source of AT funding. In most cases, a doctor's prescription will be required. In all cases, the needs and abilities of the potential AT user should be assessed by the necessary professional(s) to determine an appropriate match of user needs with device features. If the counselor suspects that the equipment may be medically necessary, the case is forwarded to DVR's Medical Consultant, a doctor. The equipment is written into the IPE when the counselor receives a prescription.

Workers Compensation

Employers are required by law to provide this type of coverage. If a person's disability is due to a work-related illness or injury, workers compensation is another possible AT funding source. (See the section on workers compensation on page 125 for more details.)

Social Security-Related Work Incentive Programs

Recipients of Supplemental Security Income (SSI) can set funds aside to pay for AT needed for work in a way that will not count against income eligibility for SSI. This can be done under what is called a Plan to Achieve Self Support (PASS). A similar program exists for SSI recipients who are blind. That particular program allows for more liberal financial set-asides called Blind Work Expenses (BWEs).

Working people with disabilities can receive Social Security Disability Insurance (SSDI) checks if their income falls below a certain level (called the SGA, or Substantial Gainful Activity, level). No SSDI cash benefits are awarded when income exceeds SGA. However, the cost of many services and types of equipment can be can be treated as a slightly different kind of set-aside from income that can contribute significantly to keeping reported income below the SGA level. When applied, these costs are called Impairment-Related Work Expenses (IWRE) under both SSI and SSDI programs. IRWEs can include the costs of medical services, assistive devices, transportation, home modifications, and more. Such expenses can be deducted from income to reduce it to below the SGA level such that the recipient remains eligible for SSDI cash benefits while actual earnings may be above the SGA level. Funds from the SSDI benefit can be diverted to the purchase of equipment. In some instances, like during the trial work period (TWP), it is possible to use an IRWE to purchase equipment and increase net income in the process.

As a result of recent federal legislation, Delaware is now a "Ticket to Work" state. The Social Security Administration began distributing "tickets" to all SSI and SSDI recipients in Delaware in February 2002. These "tickets" can be used to obtain vocational rehabilitation services and employment services, including AT, from an approved provider of the recipient's choice. The "Ticket to Work" is a voluntary program. As a result of this legislation, clients are no longer required to accept vocational rehabilitation services. (A more detailed description of this program appears in the Social Security Program section on page 94.)

Independent Living Services

The Independent Living (IL) Program is administered in Delaware by the DVR**. However, eligibility for IL services is not dependent upon employment.**

The IL Program was established under Title VII of the 1978 Rehabilitation Act Amendments (P.L. 95-602). Parts B and C of the law authorize funds for independent living services. Part B, administered by the Delaware Division of

Vocational Rehabilitation, can be a significant AT funding source for adults with disabilities.

Individuals become clients of the IL program if they meet the following eligibility standards:

- Are a Delaware resident aged 16 or older
- Have a significant disability
- Meet a financial needs test (Recipients of Social Security's SSI and SSDI benefits automatically meet this test)
- Seek to live more independently.

An Independent Living Plan (ILP) is developed which describes client needs. As the IL program's intent is to help people with disabilities function as independently as possible in their daily lives, AT can be a part of the ILP if it helps satisfy the goal of the ILP. Where needed, the IL program will pay for such things as Aids for Daily Living (ADL), Environmental Control Units (ECU), Augmentative and Alternative Communication (AAC), and other devices that Medicaid or other insurers will not provide. There is no cap or maximum on the amount of assistance under the IL program. IL will also fund home and vehicle modifications. Typically, the home modification projects are ramps, accessible bathrooms, wider doors, and installation of lifts. These services do not include building a new structure or addition. Home modifications cannot begin until IL reviews the applicant's medical records and a contractor from their approved list is available. With regard to vehicle modifications, IL will consider the age of the vehicle, condition, and the number of miles on it. Due to the demand for services, at times there may be a waiting period before needed AT is provided.

With regard to hearing aids, IL may be able to assist with a purchase under certain conditions. IL will only purchase devices for those with significant hearing loss in the conversational speech range. A licensed audiologist must recommend the specific device. IL will only pay for a hearing aid once in a client's lifetime, and will not cover device repair.

Anyone interested in the IL program should contact DVR's office in the Middletown Service Center at (302) 378-5779.

Independent Living Part C funds are currently dedicated to advocacy, independent living skill training, peer counseling, and information and referral. They are not currently being utilized for AT purchase, but might be considered by the administering agencies in the context of cost-sharing strategies. In Delaware, Independent Resources, Inc. (IRI) and the Freedom Center operate these types of programs using Part C funds. In addition to the above mandated areas of assistance, IRI has initiated programs to help deaf and hearing impaired clients and those with mental illness.

The contact numbers for IRI are as follows:

New Castle County
(302) 765-0191 (voice)
(302) 764-0194 (TTY)

Kent County
(302) 735-4599 (voice)
(302) 735-5629 (TTY)

Sussex County
(302) 854-9330 (voice)
(302) 854-9340 (TTY)

The contact numbers for the Freedom Center are (302) 376-4399 and (886) 687-7444 (toll free).

Social Security Programs

www.ssa.gov/

The Federal Social Security Act (Public Law 74-2710) was passed in 1935, establishing retirement benefits for older individuals. Income supplements and disability-related benefits were attached to the law in subsequent years. Today, there are three basic types of Social Security benefits:

Retirement Benefits (usually called "social security")

Social Security Disability Insurance (SSDI) - added to the law in 1954 as Title II

Supplemental Security Income (SSI) - added to the law in 1974 as Title XVI.

Social Security benefits provide limited monthly income from the federal government. The Social Security Administration (SSA) does not pay for AT directly, but entry into the system is an important first step in being able to access devices and services through other related programs. For example, in Delaware, anyone receiving SSI benefits is automatically eligible for Medicaid, and Medicaid pays for many AT devices as durable medical equipment. (Refer to the Medicaid section on page 20 for more details.) Note, however, that while a person may be eligible for certain programs, enrollment is not automatic. It is necessary to submit an application in order to receive benefits. Once an adult begins receiving Social Security benefits, AT may also be accessed through Social Security Work Incentive programs. Those programs are discussed later in this section. Proceeds from Social Security retirement benefits can also be applied to the purchase of AT devices for the beneficiary or that person's family members with disabilities.

Contact Information

Call the Social Security Administration's national toll-free number, (800) 772-1213, to find out how to apply. Questions regarding eligibility for Social Security benefits may be directed to the Social Security Administration office in the consumer's county of residence. The locations and telephone numbers of the county offices are:

New Castle:
920 W. Basin Road
New Castle, DE 19720
(302) 323-0304 (voice)

Kent:
300 South New St.
Dover, DE 19901
(302) 674-5162 (voice)

Sussex:
Suite 202, Professional Park
Georgetown, DE 19947
(302) 856-9620 (voice)

People using telecommunication devices for the deaf/text telephones may call:

(800) 325-0778 (weekdays 7 a.m.-7 p.m.)

Eligibility for Retirement Benefits - Self and/or Family

Social Security Retirement Benefits can be a source of AT funding for both the retiree and some members of that person's family. The retiree may utilize both financial and insurance benefit components. That person's family members who qualify can receive up to one half the amount of the retiree's full benefit (up to a certain overall family limit) without affecting the retiree's benefit amount. Family members who qualify include:

Spouse age 62 or over

Spouse of any age who is taking care of the retiree's child who is under age 16 or has a disability

Former spouse, age 62 or over, if the marriage lasted for 10 or more years and the former spouse remains unmarried

Children, stepchildren, adopted children, and sometimes grandchildren up to age 18 (age 18-19 if they are full-time students through grade 12)

Children over age 18 who have disabilities that occurred prior to age 22. This category is an important one for certain adults with disabilities. These individuals are qualified to receive benefits under their parents' earning records.

SSDI (Title II) Eligibility

Title II (the term the Social Security Administration uses for SSDI) is an insurance program that provides monthly cash benefits to those who are eligible. SSDI is not short-term or partial disability payment; rather, it is designed for those whose disability is expected to be long-term. Only people with one or more disabilities qualify, and the following additional requirements must be met:

The disability must prevent the person from earning above a certain income level called the Substantial Gainful Activity (SGA) level. A person with a disability who earns below the SGA level is eligible for SSDI benefits. While the SGA levels are likely to increase in future years, the 2004 levels are as follows:

$810 average gross income per month for persons with disabilities other than blindness

$1,350 average gross monthly income for people who are blind

SGA for self-employed individuals with disabilities is measured in hours rather than average monthly income.

The person (or his/her deceased spouse or parent) must have achieved insured status by having paid into the Social Security system. Typically, such payments need to be for at least half of the quarters in the 10 years preceding the onset of the disability.[16] Most employers pay automatically when federal taxes, sometimes called FICA taxes, are deducted from payroll.

Certain family members of a person who is receiving SSDI also qualify for benefits; the same ones identified above in the retirement benefit category are included.

In addition, some family members of deceased wage earners are entitled to benefits called "survivors' benefits."

The disabled son or daughter of a deceased worker may receive benefits indefinitely (or until the condition goes away) if: the adult child is unmarried, s/he was dependent on the parent, and the onset of the disability occurred prior to age 22. Those who are not disabled can receive similar benefits up to age 18. The deceased family member simply must have paid federal income taxes for the required number of years.

The disabled surviving spouse (or ex-spouse if the marriage lasted 10 or more years) qualifies if:

The surviving person is age 50 or above (one who is not disabled must be age 60 or above).

The disability of the surviving spouse started before the original beneficiary died, or within seven years after death.

The surviving spouse caring for the deceased's children who receive benefit payments becomes disabled before those payments end (for example, when the child turns 18) or within seven years after they end.

There is a five month waiting period for receipt of SSDI benefits after the person becomes disabled.

Disability Insurance Benefits

Only persons with disabilities who have received SSDI cash benefits for 24 months may be eligible for the medical insurance portion of SSDI, which is actually disability-related Medicare. The exception to this rule is that persons under age 65 with Amyotrophic Lateral Sclerosis (ALS/ Lou Gehrig's disease) can receive Medicare coverage during the first month in which they receive SSDI benefits.

[16] Workers disabled before age 31 are not held to this standard. The minimum requirement is 1.5 years work in the 39 months before onset of the disability.

SSI (Title XVI) Eligibility

SSI is a small monthly income supplement for qualified people with disabilities of all ages and for anyone who is age 65 or older. In contrast to SSDI, Title XVI eligibility depends on a person's income and resources. SSI, unlike SSDI, does not require a work history. The picture is a bit complex because some income and resources are counted in eligibility determinations while others are not. The following is a basic overview of how it works.

Resource Test

A single person can have no more than $2,000 in assets (bank accounts, stocks, bonds, or other types of securities). For couples, the asset cut-off is $3,000. Individuals are allowed up to $1,500 for burial expenses, and an additional $1,500 for a spouse's burial expenses. The first family car usually does not count as a resource. Life insurance policies with a total face value of $1,500 or less per person and personal belongings may also be exempt. Finally, the home in which a person lives and the land that the house is on are not counted as resources. However, owned real estate other than a person's residence may be counted unless the property is essential to an individual's self support (such as rental property or land used to produce food for personal/private consumption).

Income Test & Benefit Amounts

Under the SSI program, the initial determination of eligibility also includes consideration of whether the applicant's income is less than the appropriate SGA amount income listed above. SGA is not applied under SSI to people who are blind. Income is divided into two categories: earned and unearned. Earned income includes wages, net earnings from self-employment, and income received from sheltered workshops. Unearned income includes all income that is not earned, such as Social Security benefits, workers' or veterans' compensation, pensions, support and maintenance in kind, annuities, rent, and interest.

Generally, a person who has an unearned monthly income of less than $810 for 2004 will qualify for federal SSI payment. In order to determine SSI eligibility and the amount that will be awarded, the Social Security Administration must consider an individual's income level. However, not all income is counted. The first $20 of unearned income, the first $65 of earned income, and half of the person's wages over $65 are not counted in determining the benefit amount. The formula starts with subtracting the first $20 of unearned income [called the General Income Exclusion (GIE)] and the first $65 of wages [called the Earned Income Exclusion (EIE)] from total income. Then, half of what remains after subtracting that $85 is subtracted from the SSI monthly maximum income level of $564 to arrive at the SSI benefit amount.

To illustrate, let's perform the calculation for a person who receives a monthly income of $885.

Gross Monthly Income	$885
GIE	- $20
	$865
EIE	- $65
	$800
(Then, dividing the remainder in	x 50%
half, we get **countable income** ---->)	$400

The countable income figure is then subtracted from the $564 SSI maximum monthly income level to determine the benefit amount:

SSI Max Income Level	$564
Countable Income	-$400
SSI Benefit Amount	$164

The $164 would be the amount of the SSI beneficiary's monthly check. So the person's total monthly income is $885 + $164= $1,049.

The current (2004) maximum federal SSI monthly payment is $564 for an eligible individual and $864 for an eligible couple. However, the law gives states the option of supplementing that figure and varying the payment amounts based on living arrangements and geographical area. Delaware provides a modest supplement only to those who are in protective care arrangements.

As with SSDI, there are ways of setting aside income under SSI for the purchase of AT devices and services. Setting the money aside reduces reported income and increases the benefit award by the same amount, so the money spent on the device or service is replaced. Related information is contained in the section on Work Incentive Programs.

Social Security Work Incentive Programs

Anyone receiving SSI or SSDI benefits can purchase AT through one of the work incentive programs if the equipment is in some way related to getting or keeping a job. Note that self-employed SSI or SSDI recipients may also qualify for these programs. There are now several types of work incentive programs for people with disabilities other than blindness: the Impairment Related Work Expense (IRWE), the Plan to Achieve Self Support (PASS), and the "Ticket to Work" program. The IWRE and the "Ticket to Work" are available to both SSI and SSDI recipients; the PASS program is usually limited to SSI recipients. Persons who are blind may utilize the Blind Work Expense (BWE) program, which is also limited to SSI recipients. A blind or visually impaired consumer may also have access to PASS and IRWE programs if the BWE option is not available.

Impairment-Related Work Expense (IRWE)

www.ssa.gov/notices/supplemental-security-income/spotlights/spot-work-expenses.htm

The IRWE is money that is set aside from income to pay for equipment or services a person may need in order to work. Some examples are transportation (including vehicle purchases), medication, medical equipment and other adaptive devices, and home modifications (including ramps). The basic requirements of IRWE are as follows:

Items or services must be purchased directly by the beneficiary (remember to keep all receipts/records of purchase).

Items/services should not be reimbursable by other funding sources such as public or private insurance.

The items/services must be needed to enable the person to work.

Items/services must be related specifically to the individual's impairment.

IRWEs can cover a very broad range of devices and services. Examples include: any equipment or service a person needs to prepare for work before leaving home, such as ramps or medical equipment; transportation to and from work (including the purchase of a car or van); ostomy or incontinence supplies (including diapers and catheters); and even personal assistance in the home for a short time before or after work. The IRWE program is available to both SSI and SSDI beneficiaries.

Ticket to Work

www.ssa.gov/work/Ticket/ticket_info.html

The "Ticket to Work and Work Incentives Improvement Act of 1999" was enacted by Congress to increase beneficiary choice in obtaining rehabilitation and vocational services and to remove barriers forcing people with disabilities to choose between health care coverage and work. Beginning in 2001, Delaware was one of 13 states chosen for the first phase of the "Ticket to Work." In early February 2002, the SSA began distributing "tickets" to all SSDI and SSI recipients in Delaware age 18 or over, which can be used to obtain vocational rehabilitation and other employment support services (including AT) from an approved provider of the recipient's choice. There will be a limit of one "ticket" per period of disability but people may receive multiple "tickets" during their lifetime. The "Ticket to Work" program is voluntary. Those with disabling conditions classified as "medical improvement expected" (MIE) will have to wait until long after their initial eligibility determination—after their first "continuing disability review" (CDR)—to receive their "tickets." This legislation also expanded Medicaid coverage so that persons with disabilities who work and have incomes up to 250% of the federal poverty level can purchase Medicaid coverage.

Plan to Achieve Self Support (PASS)

www.ssa.gov/work/ResourcesToolkit/pass.html

Available only to SSI recipients, the PASS is another way of setting income aside to purchase equipment or services. The set-aside can be done in a way that keeps income, as well as resources considered for SSI eligibility, below the qualifying cutoff so that there is no reduction in benefits. Therefore, when the Social Security Administration calculates a beneficiary's SSI payment amount, income set aside under a PASS is not counted. A PASS does not affect SGA determination for the initial eligibility decision. Set-aside money may be used for AT devices and services, education, or even business start-up. In other words, it might include any items or services that would make a person vocationally self-sufficient. Although somewhat similar to the IRWE, the PASS is different in several respects:

The PASS must be in writing and approved by the Social Security Administration before it can be implemented; the IRWE does not carry this requirement. The SSA prefers that beneficiaries use its PASS form (SSA-545-BK). The PASS plan should describe a specific work goal that the beneficiary is capable of performing and a specific time frame for reaching that goal.

A separate account needs to be established for PASS set-aside money, and payments into the account must be made according to the schedule stated in the PASS. It is not just a question of saving receipts for reimbursement.

The PASS's time frame cannot exceed 48 months.

A note of caution: Once money has been set aside for a PASS, spending it for something else can result in loss of SSI benefits.

Blind Work Expenses (BWE)

www.ssa.gov/work/ResourcesToolkit/workincentiveschart.html#BWE

The Blind Work Expense functions in much the same way as the IRWE. It covers every expense that the IRWE covers and more. However, it is distinct from the IRWE in several important respects:

The BWE program is only available to SSI recipients who are blind, while IRWEs are available to both SSI and SSDI recipients.

BWEs need not be "impairment-related." For example, regular transportation expenses such as cab or bus fare or other expenses that a non-disabled person might routinely incur would not be deductible as an IRWE, but would be as a BWE. Expenses such as lunch, childcare, and federal/state/local income taxes are all legitimate BWEs.

BWE requests must be made in writing, but unlike the PASS, they need not be approved before making the actual purchase. Nonetheless, it may be safer to check with the SSA before making such purchases.

Trial Work Period (TWP) & Extended Period of Eligibility (EPE)

Once an SSDI recipient is ready to return to work, s/he may be entitled to a nine month trial work period. The rules and features of the TWP are as follows:

The person must earn over $580 in a given month in order for that month to be considered part of the trial work period. If the person is self-employed, the requirement is 80 or more hours of work in a month.

The nine months do not have to be consecutive, but the TWP ends after the ninth month in which the person earns over the limit.

SSDI and Medicare benefits continue during the TWP, no matter how high the person's earnings are, as long as the disability continues.

One is not eligible for disability benefits or a TWP if s/he works at SGA level within 12 months of the start of the impairment and before the Social Security Administration approves the claim for disability benefits.

If a person has a medical recovery prior to the end of the TWP, benefits may stop.

A new SGA determination is made after the TWP.

Up to 36 months after the trial work period ends, a person can still receive an SSDI benefit check for any month in which earnings fall below the SGA level. This is called the Extended Period of Eligibility (EPE). This will be true provided that the person is still disabled at the time and has proof of sub-SGA earnings. If earnings fall below SGA in the final months of the EPE and beyond, or if the person discontinues work before the 36th month and remains disabled, benefits could continue indefinitely. However, if the person's earnings are at or above SGA during the final month of the extended period of eligibility (even if they were below SGA for several months beforehand), benefits will cease. If, after benefits have been discontinued, earnings fall below the SGA level, it is possible to obtain (through a new application) another trial work period, but the disability may have to be proven again before any additional benefits are awarded.

Since January 2001, the SSA has permitted expedited benefits for those whose SSDI or SSI disability benefits have ended because of earnings from work. The beneficiary can request reinstatement of benefits, including Medicare and Medicaid, without filing a new application when s/he has become unable to work because of a medical condition. Requests for reinstatement must be filed within 60 months from the month when benefits were terminated. In addition, temporary benefits, including Medicare and Medicaid, may be paid for up to six months while the case is being reviewed.

Appeal Process

If a claim for benefits is denied for any reason, the applicant has the right to appeal that decision. Submission timeframes are similar to those of public insurance carriers such as Medicaid and Medicare, but the process itself is somewhat different.

Request for Reconsideration

Review requests must be submitted in writing within 60 days of the denial. The claimant has the right to review his/her own claim file (upon request) and to submit new information that may have a bearing on the eligibility decision. Such information should be included in the letter requesting a review. If the SSA requires the claimant to be examined by an independent doctor, the claimant must comply. At the reconsideration stage, personnel at the SSA who did not participate in the initial decision to deny benefits review the claim.

Most reconsiderations are based upon a file review without the claimant being present. However, in the case of benefits termination due to the claimant's improved medical condition, the claimant has the option of meeting with a disability hearing officer. At that meeting, the claimant will need to explain why the disability continues to qualify him/her for benefits.

The reconsideration process typically lasts approximately three months. Most requests for reconsideration are unsuccessful, but it is important to not get discouraged. Instead, one should persevere and consider requesting a hearing before an Administrative Law Judge.

Request for Hearing Before an Administrative Law Judge

If the claim is denied at the review stage, the claimant may file for a hearing before an Administrative Law Judge (ALJ). The request must be made within 60 days of the review decision. The claimant has a right to be accompanied by a representative (attorney or non-attorney) at the hearing. According to the SSA, approximately 80 percent of claimants have representatives assist them at these hearings. Again, any new and relevant information should be submitted at the time of the request.

The hearing before the ALJ is particularly important because it is, typically, the first time a decision-maker meets face-to-face with a claimant. The ALJ can take into account a claimant's subjective complaints of pain, though these complaints must be supported by evidence. At the hearing, the claimant and other witnesses testify under oath or affirmation, and the testimony is recorded verbatim. The ALJ listens to witnesses' testimony, receives documentary evidence, and considers arguments made by the claimant and/or his/her representative. If the ALJ believes it necessary, the ALJ may arrange for consultative examinations to be performed at a later date and may obtain additional medical evidence from those who have treated the claimant.

At a later date, the ALJ will issue a written decision and a copy of this decision will be mailed to the claimant and his/her representative. If the ALJ denies the claimant's appeal, the next step is an appeal to the Appeals Council.

The ALJ hearing process can take approximately 12 to 18 months before a decision is made.[17] However, since it often provides the best chance of success for a claimant compared to the other administrative steps in this process, claimants should take advantage of this opportunity. Claimants who need an attorney can contact Community Legal Aid Society, Inc.'s Disabilities Law Program at (302) 575-0660, 575-0696 (TTY/TDD) in New Castle County, (302) 674-8500 (voice and TTY/TDD) in Kent County, and (302) 856-0038 (voice and TTY/TDD) in Sussex County to inquire about the possibility of free representation.

Appeals Council

An appeal to the Appeals Council must also be filed within 60 days of the ALJ's decision. The Appeals Council represents the final step in the administrative appeals process. If the Appeals Council grants a request to review the ALJ's denial, it will review all of the evidence in the claimant's file as well as the ALJ's decision. However, the claimant does not have an opportunity for a hearing before the Appeals Council. The Appeals Council can: 1) decide in the claimant's favor; 2) send the case back to the ALJ for another hearing or the gathering of additional evidence; or 3) deny the claimant's request for review of the ALJ's decision. The Appeals Council process typically takes approximately 15 months, after which written notice of its decision is sent to the claimant.

Federal Court or Reapplication

If the Appeals Council sustains the denial, a claimant has 60 days from the date of that denial to file a civil suit in Federal District Court. Another option, which can be pursued at the same time as a suit in federal court, is to file a reapplication for benefits with the SSA.

[17] (February 2002). "Social Security Disability: Disappointing Results from SSA's Efforts to Improve The Disability Claims Process Warrant Immediate Attention" (GAO-02-322) Washington, D.C.: U.S. General Accounting Office.

Delaware Division Of Developmental Disabilities Services (DDDS)

www.state.de.us/dhss/ddds/index.html

Director's Office
Woodbrook Professional Center
1056 South Governor's Ave., Suite 101
Dover, DE 19904
(302) 744-9600

Intake Coordinator - (302) 739-3202
Community Services - (302) 739-5533
Stockley Center - (302) 934-8031
Early Intervention Program - (302) 995-8579 New Castle County
(302) 739-4386 Kent County
(302) 422-1335 Sussex County

The Division of Developmental Disabilities Services (DDDS), formerly known as the Division of Mental Retardation (DMR), provides services and supports to persons with mental retardation/developmental disabilities and their families. DDDS programs provide AT and related services (purchase, training, maintenance, and repair) to qualified persons with mental retardation/developmental disabilities either directly or by facilitating the application of appropriate resources. That is, DDDS intake coordinators, case managers, and/or social workers assist DDDS eligible consumers in accessing services and devices either by helping them to apply to appropriate federal, state and/or private insurance programs, or at times by purchasing devices/services directly if alternatives do not exist. DDDS has begun an AT screening program to evaluate client needs.

Community Services

The Community Services section of DDDS include family supports, foster care placements, group and neighborhood homes, supported living, day habilitation, pre-vocational, vocational, supported employment, and the Adult Special Population or Post 21 program for individuals with severe behavioral challenges. Any requests for DDDS clients, including those living in group homes, to obtain an AT evaluation and/or AT devices or other services, need to be coordinated through the DDDS.

The Community Services unit, with the assistance of the Arc of Delaware, manages the Kris Boyer Fund. This fund was established in memory of a former DDDS employee. It has provided emergency support, such as housing, clothes, and assistance with utility bills, for DDDS clients residing in the community.

DDDS intends to expand this fund to cover some AT repairs and, possibly, the purchase of AT for DDDS clients. Those interested in assistance from the Kris Boyer Fund should contact their caseworker. Either the Director or Deputy Director of DDDS must approve applications for assistance.

Another funding option for DDDS clients in need of AT devices such as Aids for Daily Living (ADL), Environmental Control Units (ECU), and Augmentative and Alternative Communication (AAC) is to contact the Independent Living program administered by the Delaware Division of Vocational Rehabilitation (DVR). (Refer to page 83 for contact information.)

Early Intervention Program

The Early Intervention Program is part of the Department of Health & Social Services' (DHSS) Child Developmental Watch program. It works with families to prevent or minimize developmental delays in "at risk" children from birth to age three as required under the Individuals with Disabilities Education Act (IDEA).

Stockley Center

The Stockley Center in Georgetown is an intermediate care facility that provides residential services for persons with various types of physical and mental disabilities. Stockley has a Recycling Center for AT. The Recycling Center accepts devices such as wheelchairs, walkers, augmentative and alternative communication (AAC) devices, environmental control units (ECUs), computers, and positioning devices; donations must be clean and in working order. The Recycling Center does not accept items such as hearing aids, non-adaptive furniture, and clothing. Donations are subject to space limitations. The Recycling Center will track all devices "recycled" or loaned to DDDS clients. Those who wish to donate should contact Dawn Stewart at Stockley, (302) 934-8031 ext. 359, for further information and a more complete list of acceptable and non-acceptable items.

The Stockley Center also operates a wheelchair and specialized seating (e.g., reclining dining chairs, harness systems, etc.) repair shop. The shop does this work primarily for Stockley residents but it has done some limited work for DDDS clients living in the community.

Department of Veterans Affairs & Tricare Military Health Insurance

Department of Veterans Affairs:

(302) 994-2511
www.va.gov

The DVA provides income supplements and medical benefits to former military personnel and their families. There are three general classes of eligibility, which depend on the applicant's income level. Through its Prosthetics and Sensory Aids programs, the DVA purchases AT devices for those who have disabilities as a result of "service-related" illness or injury. A disorder is considered service-related if it occurred "in the line of duty." The DVA will also purchase hearing aids or glasses for veterans, even if the need is not "service-related," as long as the veteran's primary physician certifies that it is "medically necessary." The Prosthetics Services Division of the DVA is located on the ground floor of the VA hospital in Wilmington.

The DVA's Home Improvement and Structural Alteration (HISA) grants also provide funds to disabled veterans for home modifications. The maximum lifetime benefit is $4,100 for service-connected conditions and $1,200 for non-service connected conditions. Those interested in assistance should contact Sam Kalb at (302) 633-5343 in the Prosthetics Department at the VA hospital.

DVA Housing and Home Modifications

DVA also has a Specially Adapted Housing Grant that will pay up to $48,000 toward the cost of a wheelchair-accessible home. This grant is limited to veterans with certain service-connected permanent and total disabilities. Another program, Special Housing Adaptations for Disabled Veterans, provides up too $9,250 for home modifications for those with certain service-connected permanent and total disabilities. For more information on these programs, visit www.homeloans.va.gov/sah.htm.

Coverage of AAC Devices for Military Members & Dependents

The military reauthorization bill passed by Congress at the end of 2001 extends coverage under Tricare (formerly CHAMPUS), the health insurance program for dependents of both active duty service members and retirees, to augmentative and alternative communication (AAC) devices. Previously, "communication devices" were expressly excluded from the applicable definition of "durable medical equipment." This development marks the first time that Congress has explicitly referred to coverage of AAC by name. Other provisions of this law contain new, expansive definitions of DME as well as rehabilitative therapies.

Coverage of Hearing Aids

Tricare now covers hearing aids under its prosthetics benefit. Coverage is restricted to "dependent(s) of a member of the uniformed services on active duty and only if the dependent has a profound hearing loss" as determined by standards set by the Department of Defense.

Benefits for Veterans Exposed to Agent Orange

The VA provides special health care and compensation benefits to all veterans who served in Vietnam between 1962-1975. Federal law contains a "presumptive policy" which presumes that certain illnesses (e.g., chloracne, Hodgkin's disease, multiple myeloma, non-Hodgkin's lymphoma, porphyria cutanea tarda, respiratory cancers, soft-tissue sarcoma, acute and subacute peripheral neuropathy, and prostate cancer) suffered by these veterans are due to Agent Orange exposure. Diabetes mellitus will be added to this list. Consequently, the "presumptive policy" eliminates the normal requirement of proving that an illness began or was worsened during military service.

In addition, the VA provides monetary benefits, health care, and vocational rehabilitation to Vietnam veterans' children who were born with spina bifida. Finally, Vietnam veterans are eligible for a complete physical examination and, if a VA doctor suspects that a veteran's disease might be related to Agent Orange, the VA will provide free medical care.

Contact information:

(800) 827-1000
http://vabenefits.vba.va.gov

Delaware Division for the Visually Impaired

1901 North DuPont Highway, Biggs Building
New Castle, DE 19720
(302) 577-3333
www.state.de.us/dhss/dvi/index.html

The Division for the Visually Impaired (DVI) provides various types of low-cost technology devices and training in the use of many other types of equipment to people of all ages with visual impairments. DVI is required to cover these items for persons who are legally blind and may cover these items for those who have low vision. Higher tech equipment may be purchased as part of DVI's Vocational Rehabilitation (VR) services, which are offered to legally blind adults (20/200 or worse in best eye with correction). DVI's VR services operate in much the same way as those of the Division of Vocational Rehabilitation (see the DVR section on page 82), so DVI/VR counselors may assist with employment, independent living services, and locating other options for equipment, such as the work incentive programs available under Social Security. Contact the DVI office for additional information.

DVI also provides accessible curricular materials and technology to any school district requesting such items. The costs for this are sometimes shared with the school district.

DVI's services also include an Education Program, in which teachers and counselors work to minimize the effects of a visual handicap on the development of infants and toddlers (birth to age three) and on the academic performance of students, ages 4-21, who are blind or visually impaired. DVI has a variety of other services, including a Business Enterprise Program which provides employment opportunities in the food service industry, the Delaware Industries for the Blind which includes skills training and competitive and supported employment, and a Materials Center which provides consumers with materials in reading mediums of their choice for personal, educational, and/or professional use.

DVI provides services to persons age 55 and over through its Independent Living Services Unit. There are no income or eligibility limits for the elderly population, and the array of services includes assessment, low vision evaluation, and training.

Some persons served by DVI may also be eligible for a variety of services through the Division of Developmental Disabilities Services (DDDS) (see the DDDS section on page 99).

Division of Services for Aging and Adults with Physical Disabilities (DSAAPD)

www.dsaapd.com

New Castle County

University Plaza
Oxford Building, Suite 200
256 Chapman Road
Newark, DE 19702
(302) 453-3820
(800) 223-9074
(302) 453-3836 (fax)
(302) 453-3837 (TDD)

Kent & Sussex Counties

Milford State Service Center
18 N. Walnut Street
Milford, DE 19963
(302) 422-1386
(302) 422-1346 (fax)
(302) 422-1415 (TDD)
(800) 223-9074 (voice or TDD)

DSAAPD, a division of the Delaware Department of Health and Social Services, assists individuals who are age 65 and older, and adults of all ages who have physical disabilities, to obtain needed AT devices and services. The Division's case managers typically assist qualified individuals in identifying and accessing other AT funding sources to which they are entitled before applying DSAAPD's limited allocation. Eligible applicants should be prepared to:

- Furnish documentation of genuine need for the requested equipment (a written evaluation from the appropriate health care professional or a doctor's prescription are the preferred methods); and
- Provide evidence (such as denial notices from insurers) that the requested device is not available through other sources. Some examples of other sources include Medicaid, Medicare, private insurance, Division of Vocational Rehabilitation, and Division of Developmental Disabilities Services.

Specialized Services Fund (SSF)

DSAAPD has a Specialized Services Fund (SSF) that provides money for transportation, home modification, and AT devices. Home modification funds may be used to modify the primary residence of a person with a physical disability to allow greater independence within the residence or to improve

access to the residence. This fund is intended to be used only when no other funding source is available or sufficient. DSAAPD must also determine that the proposed modification is reasonable and cost effective. The maximum lifetime funds available for any person or residence are $10,000. To access SSF funds, call the appropriate number (listed on page 104) and ask for the Intake Unit.

CARE Delaware: Caregiver Assistance-Respite-Education

DSAAPD's Caregiver Assistance program is intended to help families care for older persons (60 and over) at home so they can remain in the community. The program also supports grandparents and older relatives raising children 18 and younger. At this point, the program pays for some limited home modifications (grab bars, lifts, ramps) as a "supplemental service" for those caregivers caring for someone who is 60 and over when that older person needs assistance with at least two activities of daily living (ADL). The program potentially will pay for other types of AT for these caregivers, as long as it helps them support the cared for person in the community. The contact numbers are the same as the above numbers for DSAAPD (see page 104).

Medicaid Waivers

DSAAPD administers two Medicaid Waivers: Elderly and Disabled and Assisted Living. (Refer to the Medicaid section on page 20 for further information.)

Type of Equipment Needed

General

American Association of People with Disabilities/Digital Federal Credit Union Access Loans

DCU: (800) 328-8797 or (800) 395-5146 (TTY)
www.aapd-dc.org/docs/benefits.html#3

Members of the American Association of People with Disabilities (AAPD) can apply through the Digital Federal Credit Union (DCU) for loans for AT or home modifications to assist a person with a disability. The membership fee to join AAPD is $8 and one can join the DCU with a $5 deposit into a checking or savings account. The borrower need not be the person with the disability. All loans are nonguaranteed. DCU offers flexible terms, including up to 10 years to repay loans for adapted vehicles. DCU attempts to offer competitive rates, and though they review an applicant's credit rating, they state that they will consider unusual expenses like medical bills.

Delaware/Maryland Paralyzed Veterans Association

28 Peddler's Row
Newark, DE 19702
(302) 368-4898
www.pva.org/aboutPVA/chap/delaware.htm

The Delaware/Maryland Paralyzed Veterans Association (PVA) provides funds for the purchase of equipment (e.g., ramps, prostheses, wheelchairs, etc.) and other assistance (van adaptations, home modifications) to people with disabilities. One does not need to be a veteran to use PVA services, nor is their assistance limited by age or type of disability. The maximum award per person is approximately $1,500. If a prosthetic device is solely funded by PVA, the client is responsible for 10 percent of the total cost. The prosthetics program also repairs used equipment and takes donations of equipment for recycling. Contact the PVA office for further details.

The Disabled Children's Relief Fund (DCRF)

(516) 377-1605
www.dcrf.com

The Disabled Children's Relief Fund (DCRF) provides modest grants, typically ranging between $25 and $200, to help with the purchase of assistive devices. The maximum grant is $1,000. Although the DCRF has no eligibility restrictions with regard to disability type, preference is given to applicants with physical disabilities in need of prosthetic devices. Computers are excluded from this program.

Helen F. Graham Grants Program

Wilmington, DE 19884-0711
(302) 432-5250
(800) 441-7048, ext. 25250
www.mbnafoundation.org/hfggrants.html

The Helen F. Graham Grants Program provides funding for teaching programs, equipment, and other initiatives that create opportunities for the education and development of children and adults with cognitive disabilities. Grant requests must meet the following criteria to be eligible for consideration under this program:

School projects or programs must be managed by a public school or a tax-exempt 501(c) (3) private or parochial school located in Delaware.

Community projects or programs must be managed by a non-profit 501(c) (3) private or parochial school located in Delaware.

You may apply for a grant at any time. The Grants Committee meets monthly to review the applications. There is no limit to the number of applications you may submit or to the funding you may receive. The minimum grant request is $250; there is no maximum. The Grants Program can assist callers by phone or they will schedule a meeting to assist you.

The Kaitlin Marie Bell Foundation, Inc.

P.O. Box 355
Seaford, DE 19973
Phone: (302) 629-3874
Fax: (302) 629-7386
www.kmbfoundation.org
KMBFoundation@aol.com

The Kaitlin Marie Bell Foundation is a non-profit organization that supports the needs of medically and physically challenged children up to age 21. The Foundation funds equipment and/or services to those in financial need who have been unable to acquire such assistance through insurance. In addition to an application, the Foundation requires submission of a recent letter from a doctor or other health care professional stating how the equipment and/or service would benefit the child. Recent testing results verifying the need for the equipment and/or service should also accompany the application.

Lend a Hand

Rehoboth-Lewes Association of Churches
Contact:
Joy Troop of DHSS (302) 856-5574
Chuck Smith (302) 644-1343

Lend a Hand is sponsored by the Rehoboth-Lewes Association of Churches. Their assistance is limited to persons living in the Rehoboth and Lewes area. Their goal is to provide short-term assistance, such as rent payments, to help people become more self sufficient. They also have "work days" in the spring and fall at which time their volunteers do home repairs and modifications such as installing wheelchair ramps, putting on new roofs, etc.

United Cerebral Palsy (UCP) Bellows Fund

National Contact:
Charlotte Safos
(202) 387-0272
Csafos@aol.com
Local UCP chapter: (302) 764-2400
www.ucp.org/ucp_general.cfm/1/11365

The UCP Bellows Fund provides funds to persons with disabilities for the purchase of AT. Eligibility is not limited to persons with cerebral palsy. Each year, the national UCP organization allocates between $2,250-$3,750 to each local UCP chapter for persons with disabilities in their service area. The program focuses on those in financial need and covers both equipment purchases and repairs. Eligible equipment includes wheelchairs, AAC devices, ECUs, computers, lifts, and hearing aids. The program will not fund automobiles or AT services, including evaluations.

Variety - The Children's Charity

2711 Centerville Rd., Suite 108
Wilmington, DE 19808
(302) 993-0896
www.varietyphila.org

Variety supports The Direct Care for Kids Program, a last resort medical equipment program for families in need. Applicants' AT requests must be denied by their insurance company before contacting Variety. Equipment funding by the program includes wheelchairs, walkers, strollers, sitter, standers, prosthesis, bathing needs, hearing aids, braces, adapted tricycles, car seats, helmets, educational and recreational components. They will not fund ramps, vans, lifts, bed rails, computers, utility bills, home repairs or modifications.

Communication

Muscular Dystrophy Association

New Castle County:
17 Bishop Hollow Road, Unit A
Newtown Square, PA 19073
(610) 325-5758

Kent and Sussex County:
8501 LaSalle Road
Towson, MD 21286
(888) 484-7072

www.mdausa.org/publications/mdasvcs/progsvcs.html

The Muscular Dystrophy Association (MDA) will pay up to $2,000 for the one-time purchase of a communication device such as a speech generator or speech synthesizer for persons whose neuromuscular disorder has left them with an inability to speak. The communication device must be prescribed by an MDA clinic physician. Those who receive MDA assistance are asked to return the speech devices to MDA when it is no longer being used so that it can be placed in MDA's loan closet.

Computers

The Beaumont Foundation

(866) 505-2667
www.bmtfoundation.com/grants/

The Beaumont Foundation has given computer equipment to persons with disabilities in approximately half of the States throughout the U.S. in 2003. Delaware is one of the States slated for distribution of computer equipment in 2004. The Foundation considers many factors in evaluating individual grant applications, including income. Applicants who can demonstrate both a strong need for this equipment and a place to use it will more likely be funded.

Goodwill Industries of Delaware, Computer Recycling Center (CRC)

300 East Lea Boulevard
Wilmington, DE 19802
(302) 761-4646
(302) 761-4649 (fax)
www.goodwillde.org/shopping.html#puter

Goodwill's Computer Recycling Center accepts donations of used computers, printers, modems, software, etc. CRC refurbishes the donated equipment and sells it at Goodwill stores at a low cost.

National Cristina Foundation

181 Harbor Drive
Stamford , CT 06902-7474
(203) 967-8000
(203) 406-9725 (fax)
www.cristina.org/

The National Cristina Foundation (NCF) donates commercially obsolete computers, software, and related equipment to non-profit organizations and public agencies. Priority is given first to NCF partner organizations and then to organizations that train people with disabilities in an educational or rehabilitative environment.

Share the Technology

http://sharetechnology.org/

Share the Technology is a non-profit organization that repairs, upgrades, and donates used computers to persons with disabilities, schools, and non-profit organizations. Refer to their website for a listing of available computers.

Hearing

Delaware State Fire Marshal

New Castle County (302) 323-5365
Kent County (302) 739-5665
Sussex County (302) 856-5600

The State Fire Marshal's Office provides smoke detectors for persons with hearing impairments. The detectors have a flashing strobe and a louder than usual horn. Contact the Fire Marshal's office for program details.

Hear Now

6700 Washington Avenue South
Eden Prairie, MN 55344
(800) 648-4327
www.sotheworldmayhear.org/forms/hearnow.php

Hear Now is a national non-profit agency that accepts donations of hearing aids. Donated hearing aids should be sent to Hear Now in a padded envelope. Include your name and address in the envelope so that Hear Now can send a letter of acknowledgement. Hear Now sells the hearing aids to a manufacturer for parts. The generated revenue is used to underwrite the cost of hearing aids for low-income children and adults. To apply for help, call and request an application. The completed application should be accompanied by a $35 non-refundable processing fee and supporting documentation, including information about the applicant's income and assets. If the application is approved, Hear Now sends an order form to the applicant's hearing health care provider. The hearing health care provider sends the order to the manufacturer, which sends the hearing aid to the hearing health care provider. The hearing health care provider fits the hearing aid to the client. This entire process takes approximately four to six weeks.

Lions Clubs

www.lionsclubs.org/

The Lions Clubs are nationwide service clubs that have local chapters within each state. Their assistance to disabled persons includes donations of eyeglasses, guide dogs and white canes for the blind, wheelchair lifts for vans, hearing aids, and recycled AT equipment such as wheelchairs. Not every chapter provides all of these services, so you should contact your local chapter with any requests.

Nemours Health Clinic

1801 Rockland Road
Wilmington, DE 19803
(302) 651-4408
www.nemours.org/no/nhc/

The Nemours Program provides hearing aids to Delaware residents 65 and over who are U.S. citizens. One's income must be below $12,500 if single and below $17,125 if married. The Nemours Program considers social security payments, gross pension, rental income, interest on savings, dividends, and work earnings in making this determination.

Self Help for Hard of Hearing People (SHHH)

3204 Powhatan Dr.
Wilmington, DE 19808
(302) 292-3066
www.hearingloss.org
shhhdel@comcast.net

Self Help for Hard of Hearing People (SHHH) is a national organization dedicated to helping people with hearing loss. Their activities include education, advocacy, training, and hearing screenings. They have worked successfully in several states on legislation mandating insurance coverage for hearing aids. SHHH has a Delaware chapter, which has on occasion provided used AT such as hearing aids, captioning devices, and TTYs to persons with hearing loss.

Home Modification

Citizens Bank EZ Home Improvement Loan

(888) 337-6500 or visit a branch office

Citizens Bank EZ Home Improvement Loans are designed for persons whose income meets guidelines set by the U.S. Department of Housing and Urban Development. At the present time, residents of New Castle County with income of $56,000 or less, and residents of Kent and Sussex Counties with income of less than $40,000, are eligible. These are unsecured loans, available to renters as well as homeowners. Citizens' offers low rates ($1,000 loan at 1 percent, $1,000 - $10,000 loan at 6 percent) as well as flexible terms. For example, one who borrows $1,000 at 1 percent for 36 months has a monthly payment of $28.20. Citizens also has modified credit scoring for these applicants.

City of Wilmington Community Development Neighborhood Rehabilitation Program

(302) 576-3000
www.ci.wilmington.de.us/departments/housing.htm

The city of Wilmington's Community Development Neighborhood Rehabilitation Program makes loans to low to moderate homeowners with disabilities so they can rehabilitate their home.

Delaware State Housing Authority

New Castle County

Beatrice M. Cheseroni, Housing Rehabilitation Loan Supervisor
Delaware State Housing Authority Finance Section
820 North French Street, 10th Floor
Wilmington, DE 19801
(302) 577-5001
(302) 577-3713 (fax)

Kent & Sussex County

18 The Green
Dover, DE 19901
(302) 739-4263
www2.state.de.us/dsha/hrlp_frame.htm

The Delaware State Housing Authority (DSHA) provides home improvement loans through its Housing Rehabilitation Loan Program (HRLP) to owner-occupants or landlords for the purpose of moderate rehabilitation of an existing property. Owner occupants must have a low to moderate income and be credit worthy. These loans, which can be used to help make properties accessible, have a maximum of $35,000 per unit for owner-occupants with an interest rate of 3 percent over 15 years. The maximum loan for a rental unit is $25,000. Mobile

homes are eligible in certain circumstances. Those persons with low incomes may be eligible for a Neighborhood Revitalization Fund (NRF) grant, also with a maximum of $35,000.

To apply, contact DSHA at (302) 577-5001.

First State Resource Conservation and Development Council, Inc. Emergency Home Repair Program

125 Causey Avenue, Suite 108
Milford, DE 19963
(302) 424-6744
www.volunteersolutions.org/volunteerway/org/218252.html

First State Resource Conservation and Development Council, Inc. (RC&D) is a non-profit organization that provides assistance to low income residents who own their own home through its Emergency Home Repair Program. RC&D receives a grant from the Delaware State Housing Authority for this program. RC&D will donate building materials to those needing a ramp. If a person also needs someone to build the ramp there may be an additional wait while volunteers are recruited to do the job. They also repair heaters, roofs, etc. Depending on the type of work that needs to be done, the work may be done right away or there may be up to a year wait. Funds are limited and they do not have the money for major renovations such as making a bathroom accessible. Eligibility decisions are based on income, according to limits set by the U.S. Department of Housing and Urban Development (HUD). Most of the work they do is in Kent and Sussex County.

Lend a Hand

Rehoboth-Lewes Association of Churches
Contacts:
Joy Troop of DHSS (302) 856-5574
Chuck Smith (302) 644-1343

Lend a Hand is sponsored by the Rehoboth-Lewes Association of Churches. Their assistance is limited to persons living in the Rehoboth and Lewes area. Their goal is to provide short-term assistance, such as rent payments, to help people become more self sufficient. They also have "work days" in the spring and fall at which time their volunteers do home repairs and modifications such as installing wheelchair ramps, putting on new roofs, etc.

Lions Clubs

www.lionsclubs.org/

The Lions Clubs are nationwide service clubs that have local chapters within each state. Their assistance to disabled persons includes donations of eyeglasses, guide dogs and white canes for the blind, wheelchair lifts for vans, hearing aids,

and recycled AT equipment such as wheelchairs. Not every chapter provides all of these services, so you should contact your local chapter with any requests.

National Multiple Sclerosis Society

2 Mill Road, Suite 106
Wilmington, DE 19806
(302) 655-5610 or (800) FIGHT MS
www.nmss.org/specialevents/chapter.asp?ChapterID=37&state=DE

The MS Society has developed a pilot program called "HomeAble," designed to modify homes for people with MS. The purpose of this program is to allow persons with MS to remain in their homes. The home modifications range from widening doorways to adding ramps. To be eligible for the program, one must a) be registered with the MS chapter, b) have completed a financial assistance form, c) be a homeowner, and d) live in New Castle County. The maximum amount of assistance is $5,000.

New Castle County Department of Community Affairs

Grant program (302) 395-5600
Low-interest Loan program (302) 395-5648

New Castle County's Department of Community Affairs provides grants for emergency home repairs. The maximum amount is $5,000. They also make low-interest loans for homeowners to make major renovations. Usually there are waiting lists for both programs.

Rebuilding Together Wilmington

100 West 10th St., Suite 106
Wilmington, DE 19801
(302) 655-5488
www.rebuildingtogetherwilmington.org

Rebuilding Together Wilmington is the local branch of a national, nonprofit organization which uses donated materials and volunteers to repair and rehabilitate houses. Its primary focus is the elderly and persons with disabilities.

United States Department of Agriculture (USDA)

Rural Housing Service
3600 South DuPont Highway
Dover, Delaware 19901
(302) 697-2600 ext. 4
(302) 697-4303 (TTY)
www.rurdev.usda.gov

The United States Department of Agriculture (USDA) provides low-interest loans and grants to low income persons for home repairs and modifications. Applicants

must own and occupy their homes, and those homes must be in rural areas. The home must need repairs or improvements and applicants must submit cost estimates for the work. An applicant's credit history is evaluated and, if approved, the maximum loan is $20,000. If the applicant is 62-years-old or older and their income is very low, the repayment interest rate can be as low as 1 percent. The length of repayment term is based upon an applicant's financial ability, with a maximum of 20 years. There is a very small amount of funds available for loans for those 18-62 years old. These also have a maximum of $20,000 but the interest rate is between 2-3 percent.

The grants program is available only to those 62-years-old or older. The maximum grant is $7,500.

Mobility

AMBUCS

(336) 896-2166
www.AMBUCS.com

AMBUCS is an organization that provides AmTryke therapeutic tricycles to children with disabilities free of charge. Once a child has outgrown a bike, it is returned and the child is given the next size bike. The old bike is then refurbished and given to another child.

Prosthetics

The Barr Foundation

136 Northeast Olive Way
Boca Raton, Florida 33432
(561) 394-6514
www.oandp.com/barr

The Barr Foundation provides prostheses to amputees who are unable to secure funding for their prosthetic devices. The Barr Foundation focuses on those who cannot afford limbs. They provide reimbursement for materials and maintenance costs to prosthetists who provide limbs to amputees who have no other source of funding. To receive an application, have a board certified or state licensed prosthetist request the application directly from the Barr Foundation. It is suggested that the amputee be evaluated by the sponsoring prosthetist prior to the application being requested in the amputee's name. The application must be completed within 30 days and returned to the Barr Foundation with proof of denial by other funding sources. Applications are processed within three to five weeks and the prosthetist will be notified as to approval or denial.

Limbs for Life

5929 N. May Street
Suite 511
Oklahoma City, OK 73112
(405) 843-5174
www.limbsforlife.org/

Limbs for Life is a foundation that provides prosthetics to persons who have had limbs amputated. Those interested in assistance should write a letter explaining their circumstances and need. In addition to the applicant's name, the letter should include the applicant’s phone number and e-mail address (if the applicant has one). Limbs for Life asks applicants to not call or e-mail their office. Limbs for Life also accept donations of used limbs. These limbs should be sent to Limbs for Life c/o IDS.

Vision

Association of Blind Citizens AT Fund

www.assocofblindcitizens.org/assistive.html

The Association of Blind Citizens AT Fund covers 50 percent of the retail cost of adaptive devices or software. Eligible persons are: (1) those who are legally blind; (2) with a family income of less than $50,000; and (3) cash assets of less than $20,000. The AT must have a retail cost of between $200-$6,000.

Delaware Association for the Blind

800 West St.
Wilmington, DE 19801
(302) 655-2111
(888) 777-3925 (Kent & Sussex Counties)
www.dabdel.org

Delaware Association for the Blind (DAB) provides financial assistance toward the purchase of AT (e.g., CCTVs) in those cases in which the Delaware Division for the Visually Impaired is not able to provide such assistance. Applicants must be legally blind in order to receive help from the DAB.

Federal Income Tax Deduction for the Blind and Elderly

Internal Revenue Service

Service Headquarters
1111 Constitution Avenue, N.W.
Washington, DC 20224
For tax forms, call (800) TAX-FORM
For tax information, call (202) 622-5000
www.irs.gov/faqs/faq7-3.html

People who are legally blind or those over age 65 may claim certain exemptions on their federal tax returns each year. One deduction per qualifying individual is allowed, and the deduction amounts depend on the individual's filing status. The standard deduction may have more than one component: the basic standard deduction, an additional standard deduction amount for age (65 and older), blindness, or both.

For example, a single taxpayer who was age 65 and legally blind by the last day of the 2003 tax year is entitled to a basic standard deduction of $4,750 and an additional standard deduction of $2,300 (which is $1,150 for being age 65, and $1,150 for being blind). This person's total standard deduction then is $7,050.

The following table provides the standard and additional deduction amounts for the 2003 tax year by filing status. Note that deduction amounts generally change from year to year.

Tax Year 2003 Deductions

Deduction: Standard
Single: $4,750
Married Filing Separately: $4,750
Married Filing Jointly: $9,500
Head of Household: $7,000

Deduction: Age 65 Addition
Single: $1,150
Married Filing Separately: $950
Married Filing Jointly: $1,900
Head of Household: $3,940

Deduction: Blindness Addition
Single: $1,150
Married Filing Separately: $950
Married Filing Jointly: $1,900
Head of Household: $3,940

Lions Clubs

www.lionsclubs.org/

The Lions Clubs are nationwide service clubs that have local chapters within each state. Their assistance to disabled persons includes donations of eyeglasses, guide dogs and white canes for the blind, wheelchair lifts for vans, hearing aids, and recycled AT equipment such as wheelchairs. Not every chapter provides all of these services, so you should contact your local chapter with any requests.

National Federation of the Blind Loans for Assistive Technology and Newsline

1800 Johnson Street
Baltimore, MD 21230
(410) 659-9314
www.nfb.org

AT Loans

This program provides low interest (three percent) loans to people who are blind or visually impaired for the purchase of AT devices, by which they mean computers and related information processing technology. The maximum loan is $3,000. Loans must be repaid within four years, with minimum payments of $50 monthly. Mr. Curtis Chong, who administers this program, may be reached at (515) 277-1288.

Business loans are available to those needing funds for business development or for job-related purposes. Inquiries may be addressed to Mr. Donald Capps at:

1829 Belmont Drive
Columbia, SC 29206
(803) 254-3777

Newsline

This is a free service, available to blind subscribers, that reads newspapers through any touch-tone telephone. Access it by using a touch-tone phone to dial (888) 882-1629, listen to the menu, and choose options by tapping numbers on the phone keypad. This service is being expanded to allow users to read any of more than 50 newspapers across the country.

Tobin Foundation for the Visually Impaired

P.O. Box 2685
Wilmington, DE 19805
1704 Augustine Cut-off
Wilmington, DE 19803
(302) 655-5046
(302) 655-3909 (fax)
tobinfnd@aol.com

The Tobin Foundation for the Visually Impaired provides financial assistance for devices and services such as guide dog support through the Guiding Eyes for the Blind, computer hardware, and adaptive software. The Foundation generally provides funds for clients from the Delaware Division for the Visually Impaired and Independent Resources, Inc., when those agencies cannot provide financial support.

Vehicle Modification Programs for Persons with Disabilities

Chrysler Motors Automobility Program

Chrysler Corporation
Attn: Automobility Program
P.O. Box 3124
Bloomfield Hills, MI 48302
(800) 255-9877
www.automobility.daimlerchrysler.com/

Chrysler's Automobility Program reimburses up to $1,000 for adaptive driving equipment and its installation in minivans and full size conversion vans and up to $750 for all other Chrysler models. The offer is limited to retail purchases and leases of new Chrysler vehicles. Applications may be obtained from any authorized dealer. Reimbursement is for after-market equipment only. That is, the program does not apply to factory-installed equipment of any kind. Modifications must be completed within six months of vehicle delivery.

Ford Mobility Motoring Program

Ford Motor Company

Attn: Mobility Program
P.O. Box 529
Bloomfield Hills, MI 48303
(800) 952-2248
(800) TDD-0312 (TDD)
www.mobilitymotoringprogram.com/home.asp

This program reimburses up to $1,000 for installation of adaptive driving aids in new model Ford Motor cars, trucks or vans for persons with disabilities. The program also provides up to a maximum of $200 reimbursement for running boards, lumbar supports, and alerting devices. Installation must be initiated within 12 months of the vehicle's purchase, and the request for reimbursement must be submitted within 12 months of completion of the modifications. The program also provides 24-hour roadside assistance.

General Motors Mobility Program For Persons with Disabilities

General Motors

P.O. Box 9011
Detroit, MI 48202
(800) 323-9935
(313) 974-4383 (fax)
(800) TDD-9935 (TDD)

(800) 594-4886 (reimbursement applications)
www.gm.com/automotive/vehicle_shopping/gm_mobility/

This program reimburses up to $1,000 for installation of adaptive driving aids in new or leased GM cars, trucks, or vans for persons (driver or passengers) with disabilities. The dealer from whom the vehicle was originally purchased must submit applications for reimbursement. Reimbursement does not apply to factory-installed equipment of any kind. Modifications must be completed within 12 months of vehicle delivery, and the claim form must be submitted within 90 days after the conversion has been completed. Those interested in reimbursement must contact the Mobility Program at the above number. GM also maintains a list of adaptive equipment manufacturers nationwide as well as a list of mobility equipment installers in Delaware.

Saturn Mobility Program for Persons with Disabilities

Saturn Corporation

Attn: Assistance Center
100 Saturn Parkway
Mail Drop 371-999-S-24
Spring Hill, TN 37174
(800) 553-6000
(800) 833-6000 (TDD)
www.saturn.com/saturn/contactus/customer/faq/mobility/index.jsp?nav=4210&page=1

This program reimburses up to $1,000 for installation and purchase of aftermarket driver or passenger mobility equipment. Saturn also reimburses up to $200 for alerting devices. If both adaptive and alerting devices are needed, Saturn will reimburse up to $800 for the adaptive equipment and up to $200 for the alerting device. The adaptive equipment must be installed and the application for reimbursement must be submitted within 12 months from the date of purchase. Alerting devices must be installed within 60 days of the date of purchase and the claim must be submitted 30 days thereafter. Communication equipment such as cellular phones is excluded from the program.

Toyota Mobility Assistance Center

Mail Drop H200 19001 S. Western Avenue
Torrance, CA 90509-2714
(800) 331-4331
(800) 443-4999 (TTY)
www.toyota.com/mobility/

Toyota Motor Sales USA is the first Japanese auto manufacturer to offer a cash reimbursement for adaptive driving or passenger equipment for persons with disabilities. The reimbursement can be applied toward the cost of purchasing and

installing such equipment, with a maximum of $1,000. This program covers new purchased and leased Toyota vehicles. Leased vehicles require written lessor approval of adaptive equipment installations. Adaptations must be performed within 12 months of the delivery date and a Reimbursement Application Form must be submitted to the above address within 90 days of complete installation of adaptive equipment. Extended financing up to 84 months is available for both the new vehicle and installed adaptive equipment.

Volkswagen of America, Inc.

(800) DRIVEVW

The Volkswagen Mobility Access program offers up to $1,500 reimbursement for adaptive equipment added to a new or leased Volkswagen vehicle. A maximum of $1,000 is offered for a wheelchair lift and up to $500 for hand control devices.

Mobility by Volvo

1-800-803-5222
1-800-833-0312 (TDD)
http://www.volvocars.us/VolvoOwnership/VolvoMobility

This program reimburses up to $1,000 towards the cost of installing adaptive equipment to an eligible Volvo. The program also provides up to a maximum of $200 reimbursement on alert hearing devices. Modifications must be completed and the request for reimbursement must be submitted within 180 days of the vehicle purchase.

Workers Compensation

By law, every employer must provide workers compensation coverage. In some instances, employers of farm workers or part time employees may be exempt, but they will usually provide some form of coverage to protect against lawsuits or direct payments for work-related illness or injury.[18] The types of benefits that are available depend on the nature of the person's problem and the insurance policy itself. Medical benefits will usually cover the purchase of AT, and rehabilitation benefits may be used for both equipment purchase and training. Services are generally geared toward getting the employee back to work. The employer usually files the original benefits claim, and the insurer assigns a claims adjuster to the case. The claims adjustor may contact the injured party and his/her doctor, the employer, and others who may have a bearing on the case to determine the nature and extent of the injury and entitlement to benefits. If the employee disagrees with the decision that has been made, an appeal can be filed, but that must occur within the timeframes specified by the insurance carrier. Consult the employer's personnel office or the insurance claims adjustor about the terms of the policy and the appeal process. Once entitlement has been determined, the beneficiary may express a need for AT to the claims adjustor either directly or through the doctor.

[18] A work-related illness such as cancer or asbestosis may be covered even when the actual condition does not occur for several years after its cause.

Feedback & Information Request Form

Name: _____

Affiliation: _____

Address: _____

_____

City: _____State: _____Zip: _____

Phone: (____)_____ Fax: (____) _____

Please tell us what you think about this *Guide:*_____

_____

_____

_____

What other information would you like to see included in the *Guide*?

_____

_____

_____

_____

What is your interest in assistive technology funding issues? _____

_____

_____

_____

Would you like additional information on any AT topic? (please specify)

_____

_____

_____

_____

After completing this form, please mail to:

Delaware Assistive Technology Initiative
Center for Applied Science & Engineering
University of Delaware/Alfred I. duPont Hospital for Children
P. O. Box 269, 1600 Rockland Road
Wilmington, Delaware 19899-0269

APPENDIX A
Letters of Medical Necessity

December 10, 1998

To Whom It May Concern:

XXXX has poor oral motor coordination due to her **[diagnosis name here]** and **[diagnosis here]**. These factors prevent her from producing verbal communication. It has been deemed as a medical necessity that **XXXX** continue to use an Augmentative Communication Device (speech prosthesis). **XXXX** is mentally alert and recognizes her needs. Medically she needs to be able to communicate when she is not feeling well, and specifically what her symptoms are to staff and her physician. In addition the speech prosthesis will help her communication in situations of emergency. An upgrade in her communication system would increase her ability and opportunity to communicate. It would also increase her control over her environment decreasing her dependency upon staff. Her current communication system has proven to be inefficient and inadequate in for environmental and computer access, access to messages on her screen, and ability to efficiently generate new messages. Her use of an upgraded Augmentative Communication System would increase her ability in the above listed areas and thus improve her quality to life.

Therefore, I recommend a **[device name]** and warranty.

The **[device name]** with its accessories would promote independence, self care, and self respect. **XXXX** increase in independence will have a positive impact upon her mental health. The **[device name]** is built to withstand use and is the most cost effective medical device deemed appropriate for her. Also the warranty is excellent covering everything except theft and loss. This device will replace for **XXXX** an abnormally enervated body part (oral musculature) and insufficient body function (oral speech). If you have any questions please don't hesitate to contact me. Thank You.

Sincerely,

XXX

Patient: **XXXXX**

Diagnosis: **XXXXX**

Concerning: Letter of Medical Necessity

To whom it may concern:

This letter is to emphasize the necessity of an augmentative communication device as a rehabilitative device and a life long communication requirement for **XXXX**.

XXXX has the cognitive ability to produce complex communication, however, her physical limitations severely impair this ability. She needs to communicate critical information concerning medical, emergency, and daily care information to physicians, therapists, and staff in each of her daily environments of home, work and community outings. She also needs to effectively communicate complex issues and emotions in her life to assist in her decision making process.

She currently is utilizing a loaner **[device name here]**. Her original **[previous device name here]** is in need of significant repair. She has been utilizing features on the **[device name]** that are unavailable on her original **[previous device name]** such as word prediction and environmental control. The **[device name]** is the current model of the **[device name]** in production. The **[device name]** would increase **XXXX** efficiency in communicating by decreasing key strokes per message by allowing more messages to a page. This is accomplished through pop-ups that enlarge the portion of the grid she touched allowing her to then further select a specific message. It would also increase her writing efficiency through word prediction. The **[device name]** has a color active matrix screen for greater visual clarity. Finally the **[device name]** would allow her to have independent access and control of items in her environment such as a computer, her TV, VCR, and lights.

In summary, **XXXX** would benefit in many ways by replacing her original **[previous device name]** with a **[device name]**. I strongly urge that funding of such a device be covered for the above noted reasons. If you have any questions please feel free to contact me.

Sincerely,

XXX

August 19, 1996

To Whom It May Concern:

XXXX has poor oral motor coordination due to her **[diagnosis here]** resulting in few poorly articulated words for communication. It has been deemed as a medical necessity that **XXXX** receive and use an Augmentative Communication Device (speech prosthesis). **XXXX** is mentally alert and recognizes her needs. She experiences extreme frustration resulting in self injurious behavior when she is unable to communicate her message. Medically she needs to be able to communicate when she is not feeling well, and specifically what is wrong with her to staff and her physician. In addition the speech prosthesis will aide her communication in situations of emergency. Her current communication system has proven to be inadequate to convey her needs, therefore her medical care is compromised. Her use of a speech prosthesis would also provide **XXXX** with the ability to speak privately with her medical staff preserving confidentiality regarding her medical concerns.

Therefore, I recommend a **[device name here]**, antiglare shield, wall transformer, and an extended warranty.

The **[device name]** with accessories appropriate for **XXXX** would decrease her self injurious behaviors and promote independence, self care and self respect. It would also make a transition to a community setting much smoother ensuring **XXXX** ability to communicate her needs to unfamiliar people. The **[device name]** is built to withstand use and is the most cost effective medical device deemed appropriate for her. Also the warranty is excellent covering everything except theft and loss. This device will replace for **XXXX** an abnormally enervated body part (oral musculature) and insufficient body function (oral speech), restoring her facility for functional speech.

Sincerely,

XXX

Patient: **XXX**
XXX

Diagnosis: **XXX**
XXX

Concerning: Letter of Medical Necessity

To whom it may concern:

This letter is to emphasize the necessity of an augmentative communication device as a rehabilitative device and a life long communication requirement for **XXXX**. Due to **XXXX [diagnosis here]** she is unable to produce verbal speech. She is, however, capable of utilizing verbal speech output when given an avenue of access.

The inability to produce verbal speech is a severe disability, as **XXXX** has the cognitive ability to communicate. She needs to communicate critical information concerning medical, emergency, and daily care information to physicians, therapists, and staff in each of her daily environments of home, work and community outings. An augmentative communication device, specifically the **[device name here]**, would remove much of the obstacle of her communication difficulties and decrease her frustration level and consequently the frequency of her self injurious behavior.

To specifically address the benefits of her communication device:

1. The **[device name]** is necessary for **XXXX** to effectively communicate her physical condition, symptoms, need to be repositioned, etc. to her medical personnel, therapists and her direct care staff.
2. This device would improve self support and reduce her dependency.
3. This device is necessary to allow **XXXX** to function at her optimal level.

In summary, the use of augmentative communication is an accepted avenue in modern medical management and rehabilitative services. I strongly urge that funding of such a device be covered for the above noted reasons. If you have any questions please feel free to contact me.

Sincerely,

XXX

Re:
DOB:

To Whom It May Concern:

I had the pleasure of working with **XXXX** during a recent Augmentative Communication Evaluation at the **[AT Provider agency here]**. This evaluation was conducted to examine some of **XXXX** communication impairments related to **[diagnosis here]**.

One recommendation was for a speech prosthesis to help **XXXX** more effectively express **XXXX** in a way that is consistent with her receptive language skills and her demonstrated expressive language potential. The recommended device is a **[device name here]**, speech output communication system. This is available from **[manufacturer name here]**.

This speech prosthesis will help **XXXX** accurately express **XXXX**:

1. physical and health status (such as specific information about pain, discomfort and distress);
2. personal needs (including nutritional needs, hygiene needs, etc.);
3. requests for assistance (especially in emergency situations when **XXXX** is with adults and caregivers who are not familiar with **XXXX** idiosyncratic speech);
4. personal wants.

This device is durable medical equipment. This and similar devices have been classified as such by insurance carriers in many states, such as Blue Cross-Blue Shield, Aetna US Healthcare, and Medicaid. It is a Speech Generating Device in the Centers for Medicare & Medicaid Services classification system. The Product Code in CMS's system is **[product code here]**. In **XXXX** case, it is medical equipment as:

1. **XXXX** need for it is directly related to **XXXX** medical diagnosis;
2. it replaces an abnormally enervated body part (oral musculature) and abnormal and insufficient body function (oral speech);
3. **XXXX** need for it is projected to be long-term;
4. it is appropriate to **XXXX** current and projected language, visual and motor skills (see Augmentative Communication Evaluation).

Finally, medical equipment like this can be used throughout a child's life, including for multiple purposes. While this equipment directly addresses **XXXX** medical condition and needs, it also will support **XXXX** development of progressively more independent and appropriate skills. This, however, is also one goal of medical/health care treatment for children of **XXXX** age. In fact, our "cost-benefit" analysis of equipment is more positive when a child can benefit in more than one way from his time and learning investment in the device and from a funding agency's financial investment. It is also why we ask vendors who do training in the operation, programming, and maintenance of such equipment to

meet with all of a child's team members at once (e.g., family members, home health providers, therapists, teachers, etc.).

The fact that medical equipment can be used in different environments and for corresponding functional purposes does not deny its medical necessity. If it did, then wheelchairs which help an individual ride on a school bus to school and portable ventilators which enable a person to go to the grocery store would not be considered "durable medical equipment".

I hope this information is helpful to you. Thank you for your assistance in making this equipment available to **XXXX**—and contributing to **XXXX** improved health care through increased independence. Please call me at **[contact number here]** if I can provide any additional information.

Sincerely,

XXXX

APPENDIX B
Delaware Medicaid's AAC policy

Delaware Medicaid's AAC Policy

VI. AUGMENTATIVE & ALTERNATIVE COMMUNICATION DEVICES & SERVICES

A. SCOPE OF COVERAGE

Augmentative and alternative communication (AAC) devices are defined as electronic or nonelectronic aids, devices, or systems that assist a Medicaid beneficiary to overcome or ameliorate (reduce to the maximum degree possible) the communication limitations that preclude or interfere with meaningful participation in current and projected daily activities. Meaningful participation means effective and efficient communication of messages which takes into account the beneficiary's preferences. Examples of AAC devices include:

- communication boards or books
- electrolarynxes
- speech amplifiers
- electronic devices that produce speech and/or written output

AAC devices include devices that are constructed for use as communication devices as well as systems that may include a computer, when an important use of the computer will be as the beneficiary's communication device. AAC devices also include related components and accessories, including software programs, symbol sets, overlays, mounting devices, switches, cables and connectors, auditory, visual, and tactile output devices, and necessary supplies, such as rechargeable batteries.

AAC services are treatment to assist Medicaid beneficiaries in meeting the full range of their communication needs. AAC services are within the scope of practice of speech-language pathologists. The goal of AAC services will be accomplished by:

- developing and improving expressive communication and/or language comprehension skills and abilities that may be adversely affected by (for example) congenital or developmental disabilities
- maintaining and protecting beneficiaries' existing expressive communication and/or language comprehension skills and abilities from loss or deterioration due to (for example) progressive impairments and disabilities; and
- restoring beneficiaries' expressive communication and/or language comprehension skills and abilities damaged or lost due to (for example) diseases, disability, or traumatic injury.

The scope of AAC services includes diagnostic, screening, preventive, and corrective service provided by or under the direction of a speech-language pathologist. Specific activities include evaluation for recommendation of design, set-up, customization, and training related to the use of AAC devices.

Settings in Which AAC Services May be Provided

AAC services are covered under multiple Medicaid categories, including, but not limited to:

- an individual's home as part of home health services, which includes supplies, equipment, and appliances suitable for use in the home;
- inpatient hospital services;
- out-patient hospital services;
- nursing facility services; and
- intermediate care facilities for persons with mental retardation, developmental disabilities and related conditions.

Because all AAC devices are customized to overcome or ameliorate each beneficiary's communication limitations, and are for the sole and exclusive use of a single beneficiary, the cost of AAC devices for residents of nursing facilities and/or ICF/MR-DD facilities is not included in the facility's "per diem" or daily rate for that beneficiary.

Treatment Plan & Physician Endorsement of Medical Necessity Required

Assessment is necessary prior to the development of the treatment plan and physician endorsement. For detailed information, refer to Section B, Assessment, Data Reporting and Procedural Requirements.

A speech-language pathology treatment plan is required for all requests for DMAP funding for AAC devices and AAC services. Other health professionals, as appropriate, may participate in the development of the treatment plan. The treatment plan must be prepared by a speech-language pathologist who:

- has a Certificate of Clinical Competence from the American Speech-Language Association;
- has completed the equivalent educational requirements and work experience necessary for the certificate; or
- has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

A physician must document endorsement of such plan through either completion of a DMAP approved form or letter of medical necessity. For individuals enrolled in a managed care plan, the endorsing physician must be the primary care physician.

The AAC devices and AAC services must be an integral part of the treatment plan. The treatment plan must address each beneficiary's unique communication abilities and the expressive communication or receptive (language comprehension) limitations that preclude or interfere with meaningful participation in current and projected daily activities. It must

- conform to the scope of coverage stated in this policy;
- be based on the evaluation criteria and data reporting requirements stated in this policy;
- satisfy the medical need criteria stated in the policy, and
- indicate that the beneficiary has demonstrated potential to benefit from AAC devices
- and/or services at a basic and reasonable level.

Eligible Individuals

AAC services will be provided to beneficiaries with significant expressive communication or receptive (language comprehension) impairments: beneficiaries who currently lack adequate functional communication skills and abilities through gestures, speech and/or writing. These impairments include but are not limited to: apraxia of speech, dysarthria, and cognitive communication disabilities.

Trial Use Periods for AAC Devices

A trial use period for AAC devices is not required but may be recommended by the speech-language pathologist who conducts the AAC evaluation as described in section C, Review Criteria of this policy. The results of trial use periods are often instructive in determining the most appropriate AAC intervention, and thus are preferred. If the results of the assessment are clinically inconclusive, Medicaid may require a trial use period.

Medicaid authorization for rental of AAC device(s) will be approved for trial-use periods when the speech-language pathologist prepares a request consistent with the requirements as described in the Trial Use Period Request section of this policy. The reasons for a trial use period request include, but are not limited to: the characteristics of the beneficiary's communication limitations; lack of familiarity with a specific AAC device; and concern that the beneficiary has not had sufficient experience with the requested device to permit determination of the device's appropriateness.

Trial Use Period Request

If a speech-language pathologist or Medicaid seeks a trial use period, a plan for this period must be developed by the speech-language pathologist that includes:

- the duration of the trial period;
- description of the speech-language pathologist's qualifications that satisfy Medicaid's provider participation requirements defined in this policy;
- description of the speech-language pathologist's AAC services training and experience (and the AAC services experience of all other professionals, as

appropriate) involved in the assessments of the beneficiary's functioning and communication limitations;

- beneficiary identifying information, such as name, Medical Assistance ID#, date of the assessment, medical diagnosis (primary, secondary, tertiary), and significant medical history;
- the AAC device(s) to be examined during the trial period, including all the necessary components (e.g., mounting device, software, switches or access control mechanism);
- description of the AAC devices assessment components, such as vocabulary requirements, representational system(s), display organization and features, rate enhancement techniques, message characteristics, speech synthesis, printed output, display characteristics, feedback, auditory and visual output, access techniques and strategies, and portability and durability concerns, if any.
- the identification of the service provider(s), e.g., speech-language pathologists, educators, residential providers, etc. who will assist the beneficiary in learning and using the AAC device(s) during the trial period;
- the identification of the AAC service provider(s) who will assess the trial period; and
- the data collection schedule and the evaluation criteria, specific to the beneficiary, that will be used to determine the success or failure of the trial period.

Trial use period proposals must request Medicaid funding for rental of, or otherwise state the source of all necessary components of, the AAC devices, including AAC services provider(s) who will assist the beneficiary during the trial use period.

Trial periods may be extended and/or different AAC devices provided, when requested by the speech-language pathologist responsible for evaluating the trial use period.

Trial Use Period Results

Results of trial use periods must be submitted with a prior approval request. The results must include the following:

- identification of the requested AAC devices including all required components, accessories, peripheral devices, supplies, and the device vendor,
- identification of the beneficiary's and communications partner's AAC devices preference, if any,
- justification stating why the recommended AAC device (including description of the significant characteristics and features) is better able to overcome or ameliorate the communicate limitations that preclude or interfere with the beneficiary's meaningful participation in current and projected daily activities, as compared to the other AAC devices considered; and

- justification stating why the recommended AAC device (including description of the significant characteristics and features) is the least costly, equally effective alternative form of treatment to overcome or ameliorate the communication limitations that preclude or interfere with the beneficiary's meaningful participation in current and projected daily activities.

Purchase or Rental

The speech-language pathologist is required to estimate whether it is more cost effective to rent or purchase the requested AAC device. In addition to price, material factors in determining cost effectiveness include availability, expected useful life, upgradeability, and warranty availability and terms. The determination to rent or purchase will be based upon cost effectiveness and must also take into account the comparative delay in providing the device to the beneficiary. No AAC device will be denied approval solely because it is not available for rental.

AAC devices purchased by the Medicaid program become the property of the beneficiary.

Repair and Replacement

AAC Device(s) Repair

Medicaid will pay for repair to keep AAC device(s), accessories and other system components ("devices") in working condition. Repair will be covered for the anticipated useful lifetime of the device(s), and for as long thereafter as the device(s) continue to be the appropriate treatment for the beneficiary. Medicaid payment for repair will include diagnostic testing of the device, parts, labor and shipping, when not otherwise available without charge pursuant to a manufacturer's warranty.

Medicaid AAC device repair will be subject to the following procedure:

- When a device ceases to function properly, the beneficiary, a person acting on behalf of a beneficiary, or Medicaid staff will notify the device manufacturer or the manufacturer's designee for the purpose of repair, and follow the manufacturer's or designee's instructions to send the device for assessment
- When a device is received by the manufacturer or manufacturer's designee for the purpose of repair, the manufacturer or designee will conduct an assessment of the device to determine whether it can be repaired, and if so, prepare a written estimate of the diagnostics, parts, labor, shipping, and total cost of the repair, as well as the effectiveness (i.e., estimated durability) of the repair.

If Medicaid was the original payment source for the device, the manufacturer or manufacturer's designee for the purpose of repair will:

- repair the device if the total cost of the repair is less than or equal to $300.00; or

- notify the beneficiary or the person acting on the beneficiary's behalf that the total cost of the (non-battery) repair, including shipping, will be greater than $300.00, and that prior approval must first be obtained before the repair can proceed.

  When the repair is completed, the manufacturer or representative for the purpose of repair will return the repaired device to the beneficiary.

  If Medicaid was not the original payment source for the device, the manufacturer or manufacturer's designee for the purpose of repair will notify the beneficiary or the person acting on the beneficiary's behalf of the repair cost and that prior approval must first be obtained before the repair can proceed.

  If the manufacturer or manufacturer's designee for repair concludes the device is not able to be repaired, written notice will be provided to the beneficiary or person acting on the beneficiary's behalf that prior approval must be sought to replace the device.

  Procedure for Repair or Replacement of AAC Device Batteries

  If the assessment conducted by the manufacturer or manufacturer's designee for repair identifies the device battery as the malfunctioning or non-functioning part, the following procedure will be followed;

- repair of the battery will occur independent of the $300.00 prior approval threshold; and
- independent of whether Medicaid was the original payment source for the device, or replacement of the battery will occur without the need of prior approval.

  Repair or replacement of an AAC device battery will be performed, and the device returned to the beneficiary, or person acting on the beneficiary's behalf, as soon as possible.

  Rental of AAC Device During Assessment Repair and/or Replacement Period

  When the manufacturer or manufacturer's designee receives notification from the beneficiary or a person acting on the beneficiary's behalf that an AAC device is malfunctioning or nonfunctioning, and is being returned for assessment, the manufacturer is authorized to provide the beneficiary, on a rental basis, an AAC device during the assessment, repair and/or replacement period. The rental period is authorized to continue without regard to the need for prior approval for the repair and/or replacement of the beneficiary's AAC device. Rental of an AAC device during the assessment repair and/or replacement period is not limited to devices for which Medicaid was the original payment source.

  AAC Device Repairs Greater Than $300.00 and AAC Device Replacement

  Requests for prior approval for AAC device repairs greater than $300.00 and for AAC device replacements must be accompanied by the following information:

- description of the speech-language pathologist's AAC services training and experience (and the AAC services experience of all other professionals, as appropriate) involved in the assessments of the beneficiary's functioning and communication limitations; and
- beneficiary identifying information, such as name, Medical Assistance ID#, date of the assessment medical diagnosis (primary, secondary, tertiary), and significant medical history.

The speech-language pathologist also must report whether there have been any significant changes in any of the subject areas identified in the Required Assessment & Data Reporting section of this policy. The information must include the items specifically listed in the Sensory Status, Postural, Mobility & Motor Status, Current Speed, Language & Expressive Communication Status, Communication Needs Inventory, Summary of Communication Limitations, AAC Devices Assessment Components, and the Treatment Plan and Follow-Up sections and whether the device remains the speech-language pathologist's recommendation for beneficiary's use.

AAC Devices Replacement or Modification

Modification or replacement of AC devices will be covered by Medicaid subject to the following limitations:

- All modification or replacement requests will require prior approval;
- Prior approval request for replacement AAC devices may be submitted for identical or different devices;
- Requests for prior approval for replacement of identical AAC devices must explain how replacement is more cost-effective than repair of current device(s). Data must be provided about age, repair history (frequency, duration and cost), and repair projections (estimated durability of repairs).
- Requests for prior approval for modification or replacement of AAC devices with different devices due to changed circumstances may be submitted at any time and must include the following additional information:
    - a significant change has occurred in the beneficiary's expressive communication impairments and/or receptive communication limitations. Modification or replacement requests due to changed individual circumstance must be supported by a new assessment of communication limitations; or
    - although there has been no significant change in the beneficiary's communication limitations, there has been a significant change in the characteristics, features or abilities of available AAC devices (i.e., a technological change) that will overcome or permit a significant further amelioration of the beneficiary's communication limitations as compared to the current AAC device. A detailed description of all AAC device changes and the purpose of the changes must be provided. In assessing such requests, Medicaid will place particular emphasis on whether the existing device reasonably achieves its purpose.

- requests for prior approval for replacement of AAC devices due to loss or damage (either for identical devices or different devices) must include additional information including a complete explanation of the cause of the loss or damage, and a plan to prevent the recurrence of the loss or damage.

B. ASSESSMENT, DATA REPORTING AND PROCEDURAL REQUIREMENTS

Role Of The Speech-Language Pathologist

An assessment of individual functioning and communication limitations that preclude or interfere with meaningful participation in current and projected daily activities is required for Medicaid funding for AAC devices and AAC services. The assessment must provide the information detailed in the Required Assessment & Data Reporting section of this chapter. It must be completed by a speech-language pathologist (with input from other health professionals, e.g., occupational therapists and rehabilitation engineers).

Prior Approval

All requests for AAC device(s):

- require prior approval;
- require physician endorsement consistent with the definition of AAC as discussed in section A, Scope of Coverage;
- must include a sign-off by the beneficiary, guardian or similar representative as well as the vendor, and
- repairs that are greater than $300.00, and requests for modification or replacement of AAC devices require prior approval.

Required Assessment & Data Reporting

The following data are required to be submitted in support of a prior approval request for AAC devices:

Speech-Language Pathologist Identifying Information

- Description of the speech-language pathologist's qualifications that satisfy the requirements of this policy.
- Description of the speech-language pathologist's AAC services training and experience (and the AAC services experience of all other professionals, as appropriate) involved in the assessments of the beneficiary's functioning and communication limitations.

Beneficiary Information

1. Identifying Information:
    - Name
    - Medical Assistance ID number

- Date of the Assessment
- Medical diagnosis (primary, secondary, tertiary)
- Significant medical history

2. Sensory Status:

- Vision
- Hearing
- Description of how vision, hearing, tactile and/or receptive communication impairments or disabilities affect expressive communication

3. Postural, Mobility & Motor Status:

- Motor status
- Optimal positioning
- Integration of mobility with AAC devices
- Beneficiary's access methods (and options) for AAC devices

4. Current Speech, Language & Expressive Communication Status

- Identification and description of the beneficiary's expressive or receptive (language comprehension) communication impairment diagnosis
- Speech skills and prognosis
- Language skills and prognosis
- Communication behaviors and interaction skills (i.e., styples and patterns)
- Indication of past treatment, if any
- Description of current communication strategies, including use of an AAC device, if any

5. Communication Needs Inventory

- Description of beneficiary's current and projected (e.g., within 2 years) communication needs
- Communication partners and tasks including partners' communication abilities limitations, if any
- Communication environments and constraints which affect AAC device selection and/or features (e.g., verbal and/or visual output and/or feedback; distance communication needs)

6. Summary of Communication Limitations

- Description of the communication limitations that preclude or interfere with meaningful participation in current and projected daily activities (i.e., why the beneficiary's current communication skills and behaviors prevent meaningful participation in the beneficiary's current and projected daily activities)

7. AAC Devices Assessment Components

- Vocabulary requirements
- Representational system(s)

- Display organization and features
- Rate enhancement techniques
- Message characteristics, speech synthesis, printed output display characteristics, feedback, auditory and visual output
- Access techniques and strategies
- Portability and durability concerns, if any

8. Identification of AAC Devices Considered for Beneficiary

- Identification of the significant characteristics and features of the AAC devices considered for the beneficiary
- Identification of the cost of the AAC devices considered for the beneficiary (including all required components, accessories, peripherals, and supplies, as appropriate)

9. AAC Device Recommendation

- Identification of the requested AAC devices including all required components, accessories, peripheral devices, supplies, and the device vendor
- Identification of the beneficiary's and communication partner's AAC devices preference, if any
- Justification stating why the recommended AAC device (including description of the significant characteristics and features) is better able to overcome or ameliorate the communication limitations that preclude or interfere with the beneficiary's meaningful participation in current and projected daily activities, as compared to the other AAC devices considered
- Justification stating why the recommended AAC device (including description of the significant characteristics and features) is the least costly, equally effective alternative form of treatment to overcome or ameliorate the communication limitations that preclude or interfere with the beneficiary's meaningful participation in current and projected daily activities

10. Treatment Plan & Follow Up

- Description of short term communication goals
- Description of long term communication goals
- Assessment criteria to measure beneficiary's progress toward achieving short and long term communication goals
- Description of amount, duration and scope of the AAC services required for the beneficiary to achieve short and long term communication goals
- Schedule of data collection
- Identification and experience of AAC services provider responsible for training (these services providers may include, e.g.: occupational therapists, rehabilitation engineers, the beneficiary's parents, teachers and other services providers)

C. REVIEW CRITERIA

Medicaid funding for AAC devices will be approved when the devices are established to be medically necessary and the least costly, equally effective, alternative form of treatment to overcome or ameliorate the communication limitations that preclude or interfere with the beneficiary's meaningful participation in current and projected daily activities.

Medical Necessity

The medical need for AAC devices and services must be established by a speech-language pathologist (and other health professionals, as appropriate) according to the evaluation and data reporting criteria stated in section B, Required Assessment and Data Reporting, and be supported by a physician's completion of a DSS-approved form or letter of medical necessity.

In general, medical necessity is established when the requested device or service meets the criteria of the DSS-approved medical necessity standard. See Appendix H in the General Policy for the DSS-approved medical necessity standard.

Subject to these criteria, assessment of "medical necessity" for AAC devices and services will be guided by the following specific standards:

Medical Need Criteria for AAC Devices

Medical need will be established for beneficiaries:

- who have a diagnosis of a significant expressive or receptive (language comprehension) communication impairment or disability;
- whose impairment or disability either temporarily or permanently causes communication limitations that preclude or interfere with the beneficiary's meaningful participation in current and projected daily activities;
- who have had a speech-language pathologist (and other health professionals, as appropriate) who:
    - perform an assessment and submit a report pursuant to the criteria set forth in section B, Required Assessment and Data Reporting;
    - recommend speech-language pathology treatment in the form of AAC devices and AAC services; and
    - prepare a speech-language pathology treatment plan that describes the specific components of the AAC devices and the required amount, duration and scope of the AAC services that will overcome or ameliorate communication limitations that preclude or interfere with the beneficiary's meaningful participation in current and projected daily activities.
- whose requested AAC devices and AAC services constitute the least costly, equally effective form of treatment that will overcome or ameliorate

communication limitations that preclude or interfere with the beneficiary's meaningful participation in current and projected daily activities.

General Principles Governing Medical Need Determination

- The cause of the beneficiary's impairment or disability (e.g., congenital, developmental, or acquired) or the beneficiary's age at the onset of the impairment or disability may be relevant considerations in the determination of medical need.
- Whether a beneficiary's daily activities, communication partners and communication environments are related to or intersect with other benefits and/or services programs (e.g., school, early intervention services, adult services programs, employment) does not preclude a determination that the beneficiary has a medical need for AAC devices and AAC services.
- No cognitive, language, literacy, prior treatment, or other similar pre-requisites must be satisfied by a beneficiary in advance of a request for AAC devices and AAC services.
- The unavailability of an AAC device, component or accessory for rental will not serve as the basis for denying a prior approval request for that device, component or accessory. The prior approval request must document the manner in which a comparable device may be substituted for assessment purposes in the event that a trial period is required.
- The unavailability of a warranty for an AAC device or other component or accessory will not serve as the basis for denying a prior approval request for that device, component or accessory, although Medicaid encourages providers to consider the availability of a reasonable warranty as a factor within the device selection process.

Additional Information Needed - Request for Peer Review

- When the medical need for an AAC device cannot be established pursuant to the criteria stated in the Medical Need Criteria for AAC Devices in this section, based on the information submitted in support of a prior approval request, Medicaid will determine and take the following steps:
    - if information required by the Medical Need Criteria for AAC Devices in this section is not included in the prior approval request, then Medicaid will make contact directly with the speech-language pathologist who conducted the assessment for the beneficiary, identify the specific additional information that is needed, and request that the additional information be submitted; and/or
    - if an interpretation is required of information in the prior approval request. Then Medicaid will seek the advice of speech-language pathologist(s) with extensive AAC experience recommended to Medicaid by the American Speech-Language & Hearing Association (ASHA), the United States Society for Augmentative & Alternative Communication (USSAAC) and/or RESNA, who will provide the required information

- Requested additional information and/or interpretations must be produced as soon as practicable but in no event more than 21 working days from the date of the request
- Requests for additional information and/or requests for interpretations of information submitted will be made prior to issuance of any denial of a prior approval request

Time Limits and Notice for Decision Making

- Review of prior approval request required by the Medical Need Criteria for AAC Devices in this section will be completed within a reasonable amount of time (in most cases no longer than 60 days). If review has not been completed within 45 days, the beneficiary, guardian, or similar representative will be notified of the status of the pending application.
- Requests for additional information and/or request for interpretations will be made as soon as the need is identified.
- Decisions on prior approval requests that are not timely issued may entitle the beneficiary to pursue an appeal.
- Written notice of decisions to deny prior approval or to approve a funding request with or without modifications will be provided directly to the beneficiary and vendor. Written notice will be provided to other persons, as appropriate.

D. GLOSSARY

Augmentative and Alternative Communication (AAC)

AAC approaches support, enhance, or augment the communication of individuals who are not independent communicators in all situations. An individual's AAC system should not be a single technique, device, or strategy, but rather an array of techniques, devices and strategies from which the individual chooses in order to effectively address the demands of a given communication opportunity.

AAC Devices

Electronic or non-electronic aids, devices or systems that assist a beneficiary to overcome or ameliorate (to the maximum degree possible) the communication limitations that preclude or interfere with meaningful participation in current and projected daily activities. Examples of AAC devices include: communication boards or books, electrolarynxes, speech amplifiers, and electronic devices that produce speech and/or written output AAC devices include devices that are constructed for use as communication devices as well as systems that may include a computer, when an important use of the computer will be as the beneficiary's communication device. AAC devices also include related components and accessories, including software program, symbol sets, overlays, mounting devices, switches, cables and connectors, auditory, visual, and tactile output devices, and necessary supplies, such as rechargeable batteries.

AAC Services

Treatment to assist beneficiaries in meeting the full range of their communication needs. The scope of AAC services includes diagnostic, screening, preventive, and corrective services provided by or under the direction of a speech-language pathologist. Specific activities include evaluation for, recommendation of, design, set-up, customization, programming, and training related to the use of AAC devices.

Beneficiary's Preferences

The means and mode of message transmission a beneficiary prefers to use in a given communication interaction.

Current and Protected Daily Activities

The activities of daily living in which the individual now participates and in which it is anticipated the individual will participate when the individual's communication limitations have been overcome or ameliorated via the application of AAC approaches.

Expressive Communication Limitations

Difficulties in language production via any expressive communication modality (speech, writing, sign language, gesture, facial expression, graphic symbol selection).

Meaningful Participation

Effective and efficient communication of messages, taking into account the beneficiary's preferences regarding means and mode of transmission.

Receptive Communication Limitations

Difficulties in language understanding via any communication modality (speech, writing, sign language, gesture, facial expression, graphic symbol selection).

APPENDIX C
Essential Information Form

Instructions for the Essential Information Form

General

In order to obtain an Assistive Technology device/service, specific information is required when Medicare, Medicaid, and other medical insurance, is being accessed for reimbursement. Your ability to provide complete and accurate information will insure that the process is not interrupted due to missing information. You will be asked to provide the information about insurance several times over the course of obtaining the assistive technology equipment. This form was designed to allow you to collect the information once and respond to the several requests that will be made by service providers, vendors, and payers over the course of obtaining the AT device/service. Please complete each and every blank on this form, as every piece of information is important!

Section I: Please complete this information as it relates to the consumer who is being referred for an AT device/service.

Section II: This information identifies a contact person who could answer questions or has access to information about the individual consumer. This section identifies who can act on behalf of the consumer needing the service.

Section III: This section requests information about the medical insurance coverage. In many cases an individual may be covered under more than one, or even two, plans. Please provide all information about Medicare, private insurance, and Medicaid in this section even when a plan may not cover AT devices/services. If an individual has more than 2 types of coverage please attach additional insurance information. Please be sure to identify who the policyholder is (the name of the individual in whose name the policy is issued, their social security number etc). Attach a copy of BOTH sides of each insurance card.

Section IV: This section requests information about the consumer's primary care physician. Each physician has a Unique Physician Identification Number (UPIN), a State License number, and many will have a Medicaid Provider number. Very often these numbers are listed on the physician's prescription form. If they are not listed on the prescription form, obtain them from the physician’s office.

Section V: You can not procure an AT device/service without a prescription. Depending on the payer’s requirements, you may need to obtain multiple prescriptions to cover the evaluation, the device, and/or other services.

Essential Information Referral Form for AT

Medicare/Medicaid Purchase & Repairs

I. Name _____ Height_____ Weight_____
Address _____-_____
Phone # _____ DOB_____ Social Security # _____

II. Contact Person's Name _____
Relationship to Consumer: _____
Address _____
Phone: Home _____Work _____ Fax _____
Email address_____

III. Primary Insurance _____
Policyholder Name _____
Policyholder Address _____
Policyholder Phone _____ Policyholder Date of Birth _____
Policyholder Social Security # _____
Policyholder Relationship to Consumer_____
Secondary Insurance _____
Policyholder Name _____
Policyholder Address _____
Policyholder Phone _____ Policyholder Date of Birth _____
Policyholder Social Security # _____
Policyholder Relationship to Consumer_____
Copy of Card (Attach copies of card. Copies of all insurance cards will be required)

IV. Referring Physician _____ UPIN # _____
State License # _____
Referring Physician Address _____
Referring Physician Phone Number_____
Medicaid Provider # _____

V. Original (not fax) Prescription (specific to request)
Patient Name_____
Diagnosis (specific to what you are requesting) _____
Service Requested _____
Date of Onset _____ Prognosis _____
Length of Need _____
Equipment Needed (list each item - device, mount, switch, etc.) _____
_____
What other equipment is being used in the home by this individual?
_____

Who provided it? _____
Person Completing Form _____ Date _____
Relationship to consumer_____
Address _____
Phone Number_____ Fax_____
Email address _____

APPENDIX D
Assignment of Benefits

Medicare Beneficiaries

Assignment of Benefits

Once the deductible is met, Medicare pays 80% of the remaining reasonable charges

I understand that Medicare pays for 80% of the allowable charges and that I am responsible for all remaining balances not covered by Medicare. I certify that the information provided in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the release of any information needed to act on this request. I request that the payment of authorized benefits be made directly to the provider – **[provider name here] (Tax ID—XXX)** on my behalf.

_____ _____

Client's Signature Date

_____

Witness (if needed)

_____ _____

Mother/Guardian Signature Date

_____ _____

Father/Guardian Signature Date

*Please note the insured parent signature is required.

Assignment of Benefits

In order for us to bill Medicaid and/or other insurance for your medical supply(s), this form must be completed, signed and returned immediately.

- I, the undersigned, hereby authorize assignments of and direct billing to Medicaid and/or other insurance benefits to **[name of company here]** for supplies furnished to me.
- I further agree and acknowledge that my signature on this document authorizes **[name of company]** to obtain and release any medical and billing information to Medicaid and/or other insurers necessary to process my claim(s), including determining eligibility and seeking reimbursement for supplies provided.
- I request that payment of authorized benefits be made to **[name of company]** on my behalf, for supplies furnished to me.
- I will be responsible for my insurance deductible.
- If my insurance company reimburses me directly instead of **[name of company]**, I will submit payment in the same amount to them.

Print Patient's Name _____

Patient's Signature _____

Guardian Signature _____

Date _____

APPENDIX E
Medicaid Certificate of Medical Necessity*

* Taken from the Supplies and Durable Medical Equipment Program Provider Manual on the Delaware Medical Assistance Program Website, www.dmap.state.de.us/downloads/manuals/DME.Provider.Specific.pdf.

Appendix B – Medicaid Certificate of Medical Necessity

Delaware Division of Social Services

MEDICAID CERTIFICATE OF MEDICAL NECESSITY

(Request for Prior Authorization for Medical Supplies and Equipment)

The following information must be provided in order for the supplier of medical supplies and equipment to receive a Prior Authorization (PA) number to bill Medicaid.

*****Please note that supplies include nutritional supplementation*****

This form must be completed by the DME provider. The bottom of the form must then be completed by the patient's/client's attending practitioner and forwarded to the Medicaid office.

DME Provider Name:_____
DME Provider Address:_____
DME Provider ID#:_____

Patient/Client Name:_____
Medicaid ID#:_____
Patient/Client Diagnosis:_____
Dates of Services (not to exceed six (6) months:_____ **Through** _____

One PA# may be used for up to five items in either category. If more than five items are needed, a second PA# will be issued.

SUPPLIES

HCPCS Code	TOS(1)	Description (2)	# of Units(3)	U & C Charge

EQUIPMENT

(1)TOS-Type of service: Use "NU" for Purchase New, "UE" for Purchase Used, or "RR" for Rental

(2) Include the Brand Name and Serial/Product Number as part of the description

(3) For Enteral Supplements, enter calories in addition to units

Important: The following section must be completed by the patient/client's attending practitioner before supplies/equipment may be considered for payment by Medicaid.

I certify that the services described above are medically necessary for the identified patient/client and that use of other, less technically complex items would be detrimental to the health and functioning of this patient.

_____ _____
(Attending Practitioner's Signature) **(Date Signed)**

PRINT or TYPE the following

Practitioner's Name:_____
Address:_____
_____**Phone #**_____

APPENDIX F
AAC Companies Guide

AAC Companies Guide

AAC Company	Hours of Operation	Rental or Loaner	Repair Time Needed	Battery Replacement (How often)	Std Warranty	Web Site	DE Medicaid Provider	Medicare Provider
Ablenet 1081 Tenth St. S. E. Minneapolis, MN 55414 800-322-0956	Monday-Friday 8 am-5 pm	None	10 business days	N/A (9V battery)	1 year	www.ablenetinc.com	No	No
ADAMLAB 55 East Long Lake Rd. Suite 337 Troy, MI 48085 248-362-9603	Monday-Friday 9 am-5 pm	Loaners are available sometimes	3-4 weeks	2-3 years	1 year	www.adamlab.com	No	No
AMDI 200 Frank Rd. Hicksville, NY 11801 888-353-AMDI	Monday-Friday 9 am-5 pm Eastern time	No loaners	7 days	2 years	1 year	www.amdi.net	No	No
Assistive Tech 333 Elm St. Dedham, MA 02026 800-793-9227	Monday-Friday 8:30 am-5:30 pm Eastern time	None	Up to 10 business days	2 years	1 year	www.assistivetech.com	Yes	Yes
Dynavox 2100 Wharton St., Suite 400 Pittsburgh, PA 15203 800-344-1778	Monday-Friday 8 am-8 pm Eastern time	No loaners, rentals avail.	5-7 business days	1.5 years	1 year	www.dynavoxsys.com	Yes	Yes
Enkidu 17800 N. Capital Dr. Brookfield, WI 53045 800-273-6315	Monday-Friday 8 am-5 pm Central time	Loaners if in stock, wait list for rentals	Up to 4-6 weeks	1 year	1 year	www.enkidu.net	Yes	Yes
Prentke Romich 1022 Heyl Rd. Wooster, OH 44691 800-262-1990	Monday-Friday 7 am-5 pm Eastern time	Loaners may have cost, rentals	7-10 business days	2 years	1 year	www.prentrom.com	Yes	Yes
Words+ 1220 W. Avenue J. Lancaster, CA 93534 800-869-8521	Monday-Friday 6 am-5pm Pacific time	Computer and most software loaners	1-2 business days Medicare, Medicaid funded take longer	1-3 years	1 year	www.words-plus.com	Yes	Yes
Zygo PO Box 1008 Portland, OR 97207 800-234-6006	Monday-Thursday 7:30 am-4 pm Friday 8 am- 2 pm Pacific time	No loaners, weekly rentals avail	No more than 2 weeks	2 years	1 year	www.zygo-usa.com	Yes	Yes

APPENDIX G
Request for Repair Form

Augmentative and Alternative Communication

Request for Repair Form

Date _____

User's Name _____ Phone Number _____

Mailing Address (Location device should be mailed to) _____

_____

Medicaid Number

_____

Original Purchase Date _____ Original Pay Source _____

Contact Person (Person acting on behalf of user)

_____

Phone Number _____ Email Address _____

Device Manufacturer _____ Model _____

Serial Number_____

Manufacturer _____

Address _____

Return Authorization Number _____

Reason for Returning Device _____

Is device being returned to replace batteries? ____ Yes ____ No _____ Not sure

Other _____

Person completing this form _____
Phone Number _____ Email Address _____

Please send a copy of this form, along with the device, to the manufacturer. Retain one for your records.

Follow Up Notes

_____

_____

_____

01/15/02

APPENDIX H
Medicare Certificate of Medical Necessity for Speech Generating Devices*

* Taken from the Supplies and Durable Medical Equipment Program Provider Manual on the Delaware Medical Assistance Program Website, www.dmap.state.de.us/downloads/manuals/DME.Provider.Specific.pdf.

CERTIFICATE OF MEDICAL NECESSITY

Speech Generating Device (SGD)
SECTION A Certification Type/Date: INITIAL / /

SECTION A **Certification Type/Date: INITIAL / / RECERTIFICATION / /**		
PATIENT NAME, ADDRESS, TELEPHONE and MEDICARE ID NUMBER ( ) - MEDICARE ID NUMBER:		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
PLACE OF SERVICE NAME and ADDRESS of FACILITY if applicable (See Reverse)	HCPCS CODE	PATIENT DOB / / SEX: FEMALE ☐ MALE ☐ HEIGHT IN INCHES: WEIGHT IN LBS. PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER ( ) - UPIN

SECTION B Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS) 1-99 (99=LIFETIME) **DIAGNOSIS CODES (ICD-9):**

ITEM ADDRESSED	ANSWERS	ANSWER QUESTIONS 1-6 FOR SGD, OPTIONS/ACCESSORIES; 7 FOR repairs, 8 for UPGRADE/REPLACEMENT. (**Y** for **Yes, N** for **No, D** for **Does not apply** (unless otherwise noted)
SGD and All Accessories	Y☐ N☐ D☐	1. Has the patient had a formal evaluation of cognitive and language ability by a SLP with no financial connection to supplier and a copy of the evaluation submitted to the treating physician?
	Y☐ N☐ D☐	2. Does the patient have a medical condition resulting in a severe expressive speech disability?
	Y☐ N☐ D☐	3. Can the patient's speaking needs be met using natural communication methods?
	Y☐ N☐ D☐	4. Have other forms of treatment been considered and ruled out?
	Y☐ N☐ D☐	5. Will the patient's speech disability benefit from the device?
Accessories	Y☐ N☐ D☐	6. Has the medical necessity for each accessory been documented in the formal evaluation?
Repairs	Y☐ N☐ D☐	7. Does the patient have continued medical need for the device/accessory for which the repairs are requested?
Upgrade/Replacement	Y☐ N☐ D☐	8. Does the upgrade/replacement provide enhanced features or other improvements?

NAME OF PERSON ANSWERING SECTION B QUESTION, IF OTHER THAN PHYSICIAN :
NAME: TITLE: EMPLOYER:

SECTION C Narrative Description of Equipment and Cost

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (*See instruction on back*.) If additional space is needed, list SGD and most costly options/accessories on this page and continue on back.

☐ CHECK HERE IF ADDITIONAL OPTONS/ACCESSORIES ARE LISTED ON BACK.

SECTION D Physician Attestation and Signature/Date

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been review and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE DATE ___/___/___ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE.)

SECTION A:	**(May be completed by the supplier.)**
CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.
PLACE OF SERVICE:	Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 32, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
HCPCS CODES:	List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate the patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
UPIN:	Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).
PHYSICIAN'S TELEPHONE:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B:	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must bereviewed and the CMN signed (In Section D) by the ordering physician.)**
ESTIMATED LENGTH OF NEED:	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
DIAGNOSIS CODES:	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, selecting "Y" for yes, "Y" for no, and "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the ordering physician (e.g., SLP) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier.)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; (2) the supplier's charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.
SECTION D:	**(To be completed by the physician.)**
PHYSICIAN ATTESTATION:	The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C, and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE AND DATE:	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

08/06/02

APPENDIX I
Medicare Certificates of Medical Necessity for:
Manual Wheelchair*
Motorized Wheelchair*
Power Operated Vehicles*

* Taken from the Supplies and Durable Medical Equipment Program Provider Manual on the Delaware Medical Assistance Program Website, www.dmap.state.de.us/downloads/manuals/DME.Provider.Specific.pdf.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO.0938-0679
DMERC 02.03B

CERTIFICATE OF MEDICAL NECESSITY
MANUAL WHEELCHAIRS

SECTION A Certification Type/Date: INITIAL____/____/____ REVISED____/____/____

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(____)____-_____ HICN_____	(____)____-_____ NSC#_____
PLACE OF SERVICE_____ NAME and ADDRESS of FACILITY If applicable (See Reverse)	HCPCS CODE _____ _____ _____ _____	PT DOB___/___/___ SEX___(M/F) HT___(IN.) WT____(lbs.) _____ PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER ( ) - UPIN #

SECTION B Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS) _____1-99 (99=LIFETIME)

DIAGNOSIS CODES (ICD-0) _____ _____ _____ _____

ITEM ADDRESSED	ANSWERS	ANSWER QUESTIONS 1, 5 AND 8 AND 9 FOR MANUAL WHEELCHAIR BASE. 1-5 FOR WHEELCHAIR OPTIONS/ACCESSORIES. (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, unless otherwise noted.)
Manual Whlchr Base and All Accessories	Y N D	1. Does the patient require and use a wheelchair to move around in their residence?
Reclining Back	Y N D	2. Does the patient have quadriplegia, a fixed hip angle, a trunk cast or brace, excessive extensor tone of the trunk muscles or a need to rest in a recumbent position two or more times during the day?
Elevating Legrest	Y N D	3. Does the patient have a cast, brace or musculoskeletal condition, which prevents 90 degree flexion of the knee, or does the patient have significant edema of the lower extremities that requires an elevating legrest, or is a reclining back ordered?
Adjustable Height Armrest	Y N D	4. Does the patient have a need for arm height different than that available using non-adjustable arms?
Reclining Back; Adjustable Ht. Armrest; Any Tpe Ltwt. Whlchr	----------	5. How many hours per day does the patient usually spend I the wheelchair? (1-24) (Round up to the next hour)
Any Type Ltwt. Whlchr	Y N D	8. Is the patient able to adequately self-propel (without being pushed) in a standard weight manual wheelchair?
Any Type Ltwt. Whlchr	Y N D	9. If the answer to question #8 is "No," would the patient be able to adequately self-propel (without being pushed) in the wheelchair which has been ordered?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print)
NAME:_____ TITLE:_____ EMPLOYER:_____:

SECTION C Narrative Description Of Equipment And Cost

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. *(See Instructions On Back)*. If additional space is needed, list wheelchair base and most costly options/accessories on this page and continue on HCFA Form 854.

❑ CHECK HERE IF ADDITIONAL OPTIONS/ACCESSORIES ARE LISTED ON ATTACHED HCFA Form 854

SECTION D Physician Attestation and Signature/Date

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fat in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE_____ DATE____/____/____ (SIGNATURE AND DATE STAMPS NOT ACCEPTABLE)

FORM HCFA-844(5/97)

SECTION A:	**(May be completed by the supplier)**
CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL", and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL" and also indicate the recertification date I the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.
PATIENT INFORMATION	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on this/her Medicare card an on the claim form.
SUPPLIER INFORMATION:	Indicate the name of our company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC)
PLACE OF SERVICE:	Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME	If the place of service is a facility, indicate the name and complete address of the facility
HCPCS CODES	List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address
UPIN:	Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)**
EST. LENGTH OF NEED	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
DIAGNOSIS CODES:	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	This section is used to gather clinical information to determine medical necessity. Answer each question which applies t the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.
NAME OF PERSON ANSWERING SECTION B QUESTIONS	If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicate. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST	Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drug; (2) the supplier's charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.
SECTION D	**(To be completed by the physician)**
PHYSICIAN ATTESTATION:	The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE AND DATE:	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0679. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO.0938-0679
DMERC 02.03A

CERTIFICATE OF MEDICAL NECESSITY
MOTORIZED WHEELCHAIRS

SECTION A Certification Type/Date: INITIAL____/____/____ REVISED____/____/____

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(____)____-_____ HICN_____	(____)____-_____ NSC#_____
PLACE OF SERVICE_____ NAME and ADDRESS of FACILITY if applicable (See Reverse)	HCPCS CODE _____ _____ _____ _____
	PT DOB___/___/___ SEX___(M/F) HT___(IN.) WT____(lbs.) _____ PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER (____)____-_____ UPIN #

SECTION B Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS) _____1-99 (99=LIFETIME) DIAGNOSIS CODES (ICD-0) _____ _____ _____ _____

ITEM ADDRESSED	ANSWERS	ANSWER QUESTIONS 1,6 AND 7 FOR MOTORIZED WHEELCHAIR BASE. 1-5 FOR WHEELCHAIR OPTIONS/ACCESSORIES. (Circle Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted.)
Motorized Whlchr Base and All Accessories	Y N D	1. Does the patient require and use a wheelchair to move around in their residence?
Reclining Back	Y N D	2. Does the patient have quadriplegia, a fixed hip angle, a trunk cast or brace, excessive extensor tone of the trunk muscles or a need to rest in a recumbent position two or more times during the day?
Elevating Legrest	Y N D	3. Does the patient have a cast, brace or musculoskeletal condition, which prevents 90 degree flexion of the knee, or does the patient have significant edema of the lower extremities that requires an elevating legrest, or is a reclining back ordered?
Adjustable Height Armrest	Y N D	4. Does the patient have a need for arm height different than that available using non-adjustable arms?
Reclining Back; Adjustable Height Armrest	----------	5. How many hours per day does the patient usually spend I the wheelchair? (1-24) (Round up to the next hour)
Motorized Whlchr Base	Y N D	6. Does the patient have severe weakness of the upper extremities due to a neurologic, muscular, or cardiopulmonary disease/condition?
Motorized Whlchr Base	Y N D	7. Is the patient unable to operate any type of manual wheelchair?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print)
NAME:_____TITLE:_____EMPLOYER:_____:

SECTION C Narrative Description Of Equipment And Cost

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. *(See Instructions On Back)*. If additional space is needed, list wheelchair base and most costly options/accessories on this page and continue on HCFA Form 854.

❑ CHECK HERE IF ADDITIONAL OPTIONS/ACCESSORIES ARE LISTED ON ATTACHED HCFA FORM 854

SECTION D Physician Attestation and Signature/Date

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fat in that section may subject me to civil or criminal liability.
PHYSICIAN'S SIGNATURE_____DATE____/____/____ (SIGNATURE AND DATE STAMPS NOT ACCEPTABLE)

HCFA-843(5/97) FORM

SECTION A:	**(May be completed by the supplier)**
CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL", and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL" and also indicate the recertification date I the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.
PATIENT INFORMATION	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on this/her Medicare card an on the claim form.
SUPPLIER INFORMATION:	Indicate the name of our company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC)
PLACE OF SERVICE:	Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME	If the place of service is a facility, indicate the name and complete address of the facility
HCPCS CODES	List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address
UPIN:	Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)**
EST. LENGTH OF NEED	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
DIAGNOSIS CODES:	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	This section is used to gather clinical information to determine medical necessity. Answer each question which applies t the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.
NAME OF PERSON ANSWERING SECTION B QUESTIONS	If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicate. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST	Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drug; (2) the supplier's charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.
SECTION D	**(To be completed by the physician)**
PHYSICIAN ATTESTATION:	The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE AND DATE:	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0679. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

CERTIFICATE OF MEDICAL NECESSITY

POWER OPERATED VEHICLE (POV)

SECTION A Certification Type/Date: INITIAL____/____/____ REVISED____/____/____

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(_____)_____-_____ HICN_____	(____) ____ - _____ NSC#
PLACE OF SERVICE_____ NAME and ADDRESS of FACILITY if applicable (See Reverse)	HCPCS CODE _____ _____ _____ _____	PT DOB___/___/___ SEX___(M/F) HT___(IN.) WT____(lbs.) PHYSICIAN NAME, ADDRESS **(Printed or Type)** PHYSICIAN'S UPIN:_____ PHYSICIAN'S TELEPHONE # (_____)_____-_____

SECTION B **Information in this Section May Not Be Completed by the Supplier of the Items/Supplies**

EST. LENGTH OF NEED (# OF MONTHS) _____1-99 (99=LIFETIME)	DIAGNOSIS CODES (ICD-0) _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 6-14 FOR POWER OPERATED VEHICLE (POV) (Circle Y for Yes, N for No, or D for Does Not Apply)
	Questions 1-5, and 9-11, reserved for other or future use
Y N D	6. Does the patient require a POV to move around in their residence?
Y N D	7. Have all types of manual wheelchairs (including lightweights) been considered and ruled out?
Y N D	8. Does the patient require a POV only for movement outside their residence?
Y N D	12. Is the physician signing this form a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology?
Y N D	13. Is the patient more than one day's round trip from a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology>
Y N D	14. Does the patient's physical condition prevent a visit to a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print)
NAME:_____ TITLE:_____ EMPLOYER:_____:

SECTION C **Narrative Description Of Equipment And Cost**

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. *(See Instructions On Back)*

SECTION D **Physician Attestation and Signature/Date**

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fat in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE_____ DATE____/____/____ (SIGNATURE AND DATE STAMPS NOT ACCEPTABLE)

FORM HCFA-850 (4/96)

SECTION A:	**(May be completed by the supplier)**
CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL", and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL" and also indicate the recertification date I the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.
PATIENT INFORMATION	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on this/her Medicare card an on the claim form.
SUPPLIER INFORMATION:	Indicate the name of our company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC)
PLACE OF SERVICE:	Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME	If the place of service is a facility, indicate the name and complete address of the facility
HCPCS CODES	List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address
UPIN:	Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)**
EST. LENGTH OF NEED	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
DIAGNOSIS CODES:	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	This section is used to gather clinical information to determine medical necessity. Answer each question which applies t the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.
NAME OF PERSON ANSWERING SECTION B QUESTIONS	If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicate. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST	Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drug; (2) the supplier's charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.
SECTION D	**(To be completed by the physician)**
PHYSICIAN ATTESTATION:	The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE AND DATE:	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

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