



**DISABILITY  
LAW  
CENTER**  
Utah's Protection and Advocacy Agency

**Public Comment on  
Proposed Medicaid Rules**

April 16, 2007

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**PUBLIC COMMENT ON PROPOSED MEDICAID RULES REGARDING DME**

**HEALTH, HEALTH CARE FINANCING, COVERAGE AND REIMBURSEMENT POLICY  
R-414-70-MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT, AND PROSTHETIC DEVICES  
DAR FILE NO.:29535**

Submitted on April 16, 2007 to:

Health Care Financing, Coverage and Reimbursement Policy  
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**Background**

On February 21, 2007, the Division of Health Care Financing (DHCF) filed a proposal<sup>1</sup> designed to formalize existing coverage and reimbursement practice for durable medical equipment (DME). In addition, the Division has issued a Request for Proposal (RFP) seeking a single contract for the provision of manual and power wheelchairs to all eligible Medicaid beneficiaries.<sup>2</sup>

Beginning with the Rehabilitation Act of 1973 and continuing through President Bush's New Freedom Initiative, the U.S. has built a strong tradition of integrating persons with disabilities into work, family, and community life. Congress has made it clear that the purpose of the Medicaid program is to "furnish medical assistance...and rehabilitation and other services to help [recipients] attain or retain capability for independence or self-care."<sup>3</sup>

The Disability Law Center (DLC) is concerned that there are provisions in the rule that represent a step backward and could reverse much of the progress that has been made over the years. We feel that the RFP has some positive components, but that it could also hurt beneficiaries if not implemented with the proper safeguards.

**About the Proposed Rule**

Dr. David K. Sundwall, Executive Director for the Utah Department of Health states, "[This policy] should be continued to curb unnecessary expenditures in the Medicaid program for durable medical equipment that is not medically necessary."

While we applaud the effort to manage costs, and reduce fraudulent billing in Medicaid, we are concerned that the rule will restrict Medicaid enrollee's access to medically necessary DME.

<sup>1</sup> Notice of Proposed Rule-DAR File No. 29535, accessible online at: [http://www.rules .utah.gov/publicat/bulletin/2007/20070315/29535.htm](http://www.rules.utah.gov/publicat/bulletin/2007/20070315/29535.htm)

<sup>2</sup> State of Utah Solicitation # RC7912-Wheelchairs for Medicaid Recipients. Available online at [www.rfpdepot.com](http://www.rfpdepot.com)

<sup>3</sup> 42 U.S.C. § 1396.

## Comments on the Proposed Rules for Durable Medical Equipment

### The Rule (R.414-70-6)

“Medically necessary durable medical equipment...are benefits for recipients residing at home...All special **adaptations and design of DME is limited to utilization in the home.**”

### DLC Comment

According to a 2000 letter to state Medicaid directors from the Centers for Medicare and Medicaid Services the ... ***‘homebound’ requirement is a Medicare requirement that does not apply to the Medicaid program...The restriction of home health services to persons who are homebound to the exclusion of other persons in need of these services ignores the consensus among health care professionals that community access is not only possible but desirable for individuals with disabilities.***<sup>4</sup> This restriction on access to any home health services, including durable medical equipment and supplies, violates both the comparability requirement of the Medicaid Act<sup>5</sup> and the prohibition on diagnosis-based decision making.<sup>6</sup>

The proposed rule goes against CMS’ intent and federal law by restricting not just wheelchairs, but all medically necessary durable medical equipment to use in the home. Access to medically necessary services that fall within a category of services included in the state’s Medicaid plan, such as Utah’s inclusion of DME, cannot be denied without a “reasonable and meaningful procedure for requesting items” that are not included in the state’s list of approved devices.<sup>7</sup> Further, Senate Bill No. 3677, the “Medicare Independent Living Act of 2006” seeks to amend title XVIII of the Social Security Act to eliminate the “in the home” restriction on Medicare coverage of mobility devices for individuals with expected long term needs. It is appropriate for DHCF to update its interpretation of previous policy to reflect the current social, legal, and technological landscape.

### The Rule (R.414-70-6 (5))

The proposed rule limits wheelchairs to individuals who are **“confined to bed or chair at least 19 hours or more each day...”**

### DLC Comment

Many people who can move short distances within their homes require wheelchairs in order to independently access their community. This criterion is a barrier to an individual’s ability to be an active, productive, and self-sufficient member of their community. In May of 2005,<sup>8</sup> CMS issued Medicare wheelchair coverage criteria which did away with the outdated “bed or chair confined” standard in favor of criteria based on the functional abilities of the individual. Utah Medicaid must not reverse this progress.

4 Olmstead update no. 3. July 25, 2000. Accessible online at <http://www.cms.hhs.gov/smdl/downloads/smd072500b.pdf>

5 42 U.S.C. § 1396a(a)(10)(B)

6 42 C.F.R. § 440.230(c).

7 Lankford v. Sherman, 451 F.3d 496 (8th Cir. 2006); T.L. v. Colorado Department of Health Care Policy and Financing, 42 P.3d 63 (Colo. App. 2001).

8 The clinical criteria for MAE coverage may be viewed in detail (including a diagram) in Chapter 1, Part 4, Section 280.3 of the Medicare National Coverage Determinations Manual available at [www.cms.hhs.gov/manuals/IOM/list.asp](http://www.cms.hhs.gov/manuals/IOM/list.asp) on the CMS website.

**The Rule** (R.414-70-6 (5)(f))

"A recipient who requires a wheelchair for employment, vocational development, or educational purposes **must seek this benefit through the appropriate funded state agency.**"

**DLC Comment**

The proposed rule directly opposes the federal Ticket to Work and Work Incentives Act of 1999 by denying wheelchairs to individuals who could otherwise obtain meaningful employment. Kansas Medicaid explicitly recognizes the link between mobility, education, and employment by providing coverage for a power chair if it is needed for school or work.<sup>9</sup> Utah's limitation would undermine the Legislature's intent to expand access to adaptive technology through its recent \$1 million allocation to the Division of Rehabilitation's assistive technology fund.

**The Rule** (R.414-70-6 (5) (a))

"Medicaid will pay for **one wheelchair** for a recipient"

**DLC Comment**

Precluding access to a backup wheelchair when it is shown to be medically necessary violates the Medicaid Act.<sup>10</sup> The Medicaid Provider Manual allows for a standard manual second wheelchair when the aggregate weight of the client and power wheelchair exceeds the limitations of the power lifts on transportation vehicles. However, the proposed rules do not address this issue in any way. Further, the provision does not recognize the necessity of a backup chair when the primary chair is being serviced or when traveling in an inaccessible vehicle or visiting an inaccessible location, among other essential purposes.<sup>11</sup>

**Comments About the Proposed Rules for Non-Covered Items**

**The Rule** (R.414-70-9 (3))

"Items used primarily for hygiene, education, exercise, convenience, cosmetic purposes, social interaction, or comfort of the recipient."

**DLC Comment**

Utah defines a "medically necessary" device as something necessary to "prevent, diagnose or cure conditions in the recipient that endangers life, causes suffering or pain, causes physical deformity or malfunction, or threatens to cause a handicap"<sup>12</sup> Under the proposed rule, Medically Necessary DME that promotes hygiene becomes subject to denial<sup>13</sup> This violates the basic Medicaid mandate that medically necessary services must be provided to an eligible Medicaid recipient, as articulated in *Hern v. Beye*, 57 F.3d 906 (10<sup>th</sup> Cir. 1995). It likewise violates the "Reasonable Standards" mandate of the Medicaid Act found in 42 U.S.C. § 1398a(a)(17).

9 Exline, C.M., "The Impact of State Budget Shortfalls on Access to Assistive Technology Through State Medicaid Programs," RESNA Technical Assistance Project, February, 2004.

10 *Gartz v. Wing*, 654 N.Y.S.2d 702 (N.Y.A.D. 4 Dept. 1997); *Dobson v. Perales*, 572 N.Y.S.2d 562 (N.Y.A.D. 4 Dept. 1991).

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12 UAC. R. 414-1-2(18)(a)

13 Examples of medically necessary devices that promote hygiene include specialized bath and shower chairs, among various other devices.

### **The Rule** (R.414-70-9(4))

Here the Division proposes to eliminate access to all “[e]quipment permanently attached or mounted to a building or a vehicle such as ramps, lifts, and bathroom rails.”

### **DLC Comment**

This would eliminate certain types of lifts that are required for the individual to have access to all critical parts of their home and to be independent within their home. The fundamental purpose of the Medicaid Act, to promote “independence or self care,” is applicable to the home as well as the community. The exclusion of certain types of lifts is inconsistent with a fundamental policy of the Medicaid Act, and, like the limitation of DME to that necessary for use in the home, violates the “Reasonable Standards” mandate of 42 U.S.C. § 1396a(a)(17). The provision also violates the Medicaid mandate that services be sufficient in amount, duration and scope to reasonably achieve their purpose; here, to help the individual maximize their independence.<sup>14</sup>

The types of lifts excluded under this subsection are frequently necessary for individuals with more severe disabilities. They may also be more frequently needed due to a manifestation of their particular medical condition. As a consequence, they are denied a form of DME, lifts, that is available in different forms (not permanently attached to a building) to others who have a less severe impairment. This violates the standards of the Medicaid Act which prohibit the reduction of services because of the nature or severity of the individual’s disability. 42 C.F.R. 440.230(c) It likewise violates the Medicaid Act requirement that services be comparable for most all participants in the state’s Medicaid program.<sup>15</sup>

### **The Rule** (R.414-70-9(9))

This rule categorically excludes lifts in furniture to aid a patient to a standing position.

### **DLC Comment**

This is a variation on a lift, which, in general, is a covered service under the state’s Medicaid plan. The need to be able to get in and out of a chair in one’s home is obvious. This is true not only for independence purposes (otherwise bed-bound), but also for medical reasons (aids in prevention and/or treatment of decubitus ulcers (bed-bound or limited ability to frequently get in and out of a chair). In some situations a lift *may* meet the state’s definition of “Medically Necessary”:

*“a service or supply is medically necessary when it is “(1) reasonably calculated to prevent, diagnose or cure conditions in the recipient that endangers life, causes suffering or pain, causes physical deformity or malfunction, or threatens to cause a handicap; and (2) there is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly. (3) Medical services shall be of a quality that meets professionally recognized standards of health care, and shall be substantiated by records including evidence of such medical necessity and quality.”*

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<sup>14</sup> 42 C.F.R. § 440.230(b)

<sup>15</sup> 42 U.S.C. 1396a(a)(10); 42 C.F.R. 440.240(b)

It may also be the most effective and least costly way to meet an individual's need. Under such circumstances, it must be available to the individual.<sup>16</sup>

## About the RFP

The RFP is an attempt by Utah Medicaid to **enhance cost efficiency** through use of a competitive bidding process for DME suppliers.

We applaud the Division's attempt to enhance cost effectiveness and improve quality assurance through the RFP. However, in a program with total expenditures of around \$1 million in 2006, we are concerned that any potential savings realized by discounting already low Medicare reimbursement rates will result in consumers receiving suboptimal equipment or service.

## Comments on the RFP

"It is anticipated that this RFP may result in a **contract award to a single contractor or multiple contractors.**" (RFP p. 10)

### DLC Comment

We are concerned that the contract may result in a sole source provider. There is a legitimate question as to whether one provider can meet the federal "statewideness" requirement.<sup>17</sup> If it cannot, the freedom, independence, and livelihood of rural residents is at risk. While DHCF can establish "special procedures" for the purchase of medical devices (such as the contract proposed in the RFP), it still must assure that a sufficient array of wheelchairs is available throughout the state for all eligible recipients.<sup>18</sup> Any effort to control cost and ensure quality should encourage freedom of choice and healthy competition, not discourage it.

"The Contractor will **provide or contract for...professional evaluation and wheelchair fitting**" (RFP p. 13)

### DLC Comment

The provision contains an inherent conflict of interest because it allows the Contractor (DME supplier) to seek out and pay for evaluations by clinicians, (usually occupational or physical therapy practitioners). The elimination of the beneficiary's treating clinicians from the process violates the "Freedom of Choice" mandate of the Medicaid Act. We believe that the initial request for assistive equipment should be driven by the beneficiary and the clinicians who work with them. The DME supplier should become involved by invitation, once the initial determination has been made. The RFP should stipulate that an evaluating or referring clinician does not have any direct or indirect financial tie to the DME supplier.

Notification of denial: The CONTRACTOR will **establish a standard process for registering and resolving complaints and grievances and explain how this process to be used and accessed by clients.** The client will be given a written authorization for services or a written denial of service which will state the reason for the denial and include hearing rights to appeal the action to the DEPARTMENT." (RFP p. 16 – Attachment B)

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<sup>16</sup> *Hern v. Beye*, 57 F.3d 906 (10th Cir. 1995); *A.M.L. v. Department of Health, Division of Health Care Financing*, 863 P.2d 44 (Utah Ct. App. 1993).

<sup>17</sup> 42 U.S.C. §1396a(a)(1).

<sup>18</sup> 42 C.F.R. § 431.54(d)(1).

### **DLC Comment**

DHCF has a responsibility to issue timely and appropriate decisions once a request is received. Inadequate notice has been a systemic problem. Both suppliers and beneficiaries are entitled to receive timely and complete notification whenever DHCF makes an equipment request determination. Endless “price haggling” with no explicit decision on requested equipment hurts both the supplier and the beneficiary, and does not comport with Medicaid due process requirements.<sup>19</sup> It is our hope that this provision will help resolve this long-standing concern.

“The contractor agrees to provide wheelchairs within eight weeks of the receipt of the request, unless extraordinary and extenuating circumstances are encountered. Denials for services will be rendered in writing within 10 business days of the request...Wheelchair repairs will be completed within one month of the client request. During repairs, accommodations for the client will be made to provide the client with mobility during the repair period as reasonably possible.” (RFP p. 13)

### **DLC Comment**

We applaud these efforts to ensure quality customer service for Medicaid beneficiaries, and look forward to working with the Department to ensure that the intention of the provision is realized in practice.

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<sup>19</sup> Medicaid beneficiaries must have their request for services acted upon in a reasonable prompt manner. 42 U.S.C. § 1396a(a)(8); 42 C.F.R. § 435.930. Notice of denials of eligibility or services must include the reasons for the action, the specific regulation supporting the action, and an explanation of the person's right to request a hearing. 42 C.F.R. § 435.912.