

ACCESSING ASSISTIVE TECHNOLOGY

Chapter 10

Medi-Cal

From a 17-Chapter Manual
Available by Chapter and in Manual Form

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Written by:

DISABILITY RIGHTS CALIFORNIA

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Chapter 10

MEDI-CAL

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Chapter 10

MEDI-CAL

Medicaid, known as “Medi-Cal” in California, is a state and federally funded program. It pays for medically necessary treatment services, medicines, durable medical equipment (DME), and medical supplies. It covers people with disabilities who satisfy income and resource guidelines. As a condition of California receiving federal Medicaid funds for its Medi-Cal program, California must follow federal Medicaid requirements.

You will probably find this chapter to be the most complex and confusing of any in this manual. You are in good company. Federal judges have also found the Medicaid system to be difficult to understand. An appellate court termed the Medicaid statutes “almost unintelligible to the uninitiated.” *Friedman v. Berger*, 547 F.2d 724, 727, n. 7 (2nd Cir. 1976). The trial court in the same case found the Medicaid statutes to be “an aggravated assault on the English language, resistant to attempts to understand it.” *Friedman v. Berger*, 409 F.Supp. 1226, 1226 (S.D.N.Y., 1976).

Medi-Cal is a world populated by “Pickle People,” “Pseudo-Pickle DACs” and “QMBs” (Quimbies). Most of the complexity is in the eligibility rules. If you are already eligible for Medi-Cal¹, that part is behind you. Now you can concentrate on whether the item of technology you need is a benefit of the Medi-Cal program. But first, we will discuss some of the Medi-Cal programs available to persons with disabilities.

Programs

1. What Medi-Cal programs are available to persons with disabilities?

There are a number of programs available to persons with disabilities. You may qualify automatically if you are eligible for a “linked” program such as SSI or by meeting a separate set of factors. Depending on how you qualify, Medi-Cal may pay for all of your medical care, some of your care, or just part of another source of care.

¹ Please refer to The Overview of Medi-Cal System Manual at <http://healthconsumer.org/Medi-CalOverview.pdf> for Medi-Cal eligibility information.

SSI and Section (§) 1619b: You get Medi-Cal automatically if you receive regular SSI. Also, if you lost your SSI cash benefit *because of your earnings*, you may qualify for Medi-Cal under the § 1619b program.

The § 1619(b) program provides benefits if your income is too high for cash benefits, but below the income level that would suspend your SSI status. Under § 1619(b), you are considered to be an SSI beneficiary. You get benefits (such as Medi-Cal) you would receive if you were receiving regular SSI. You can be eligible for §1619(b) benefits if your gross income does not exceed the set threshold amount.²

Waiver Programs: The Home and Community-Based Waiver (HCBW) is a mechanism that allows the state, with federal approval, to target extra services at home to individuals who would otherwise qualify for placement in a Medi-Cal funded long-term care facility. There are a number of waivers that waive federal requirements for deeming income and resources from a parent to a minor child and from one spouse to another. This is sometimes called institutional deeming because under the waiver financial eligibility for Medi-Cal is determined using the deeming rules that apply when the minor child or spouse is in a medical facility.³ These

² 42 U.S.C. §1382h. In 2007 the threshold amount for an SSI recipient who is not blind is \$32,920. For blind individuals, the threshold amount is \$34,480. See POMS SI 02302.200 for a chart of 2007 threshold amounts for all states and an explanation of how the threshold amounts are calculated. NOTE: The threshold amount *may* be increased by funds set aside through a Plan to Achieve Self Support (PASS), Impairment Related Work Expenses (IRWE), Blind Work Expenses (BWE), or by Medical and attendant care costs in excess of the state's average. Talk to your Social Security representative about increasing your threshold amount.

³ If a child is in a long-term care facility funded by Medi-Cal, the parents' income and resources are not counted because Medi-Cal, like SSI, only counts the income and resources of the parents *if* the child is living with the parents. 22 C.C.R. §50351(b)(4).

If one spouse is in a long-term care facility and the community spouse is not on Medi-Cal, the income of the spouse in the facility is counted either of two ways: First, only count the income that comes in the name of the spouse in the facility and do not count the income received by the community spouse. Second, combine the income that is received by both spouses with the share of cost determined by the amount the income exceeds the \$35 personal needs allowance of the spouse in the

waivers enable the minor child and spouse to qualify for full scope Medi-Cal *without considering (deeming)* the income of a parent or spouse:

- The waiver for developmentally disabled regional center clients who would qualify for placement in one of the ICF/DD health facilities (ICF/DD, ICF/DD-H, ICF/DD-N). Contact the regional center for more information about the waiver;
- The waiver for persons who would qualify for placement in a nursing facility level A or B, adult or pediatric subacute or acute care hospital levels of care (named: the Nursing Facility/Acute Hospital [NF/AH] waiver effective 1/1/07);
- The waiver for persons who have continuously been enrolled in an In-Home Operations (IHO)- administered HCBW since prior to 1/1/02 *and*
- have and continue to receive care primarily by a licensed nurse *or* have been receiving continuous care in an acute hospital for more than 36 months; *and*
- have doctor-ordered direct care that is in excess of the NF/AH waiver level of care (named: the In-Home Operations Waiver, effective 1/1/07);
- The waiver for frail persons 65 years of age or older that provides comprehensive case management and other services (named: the Multipurpose Senior Service Program or MSSP);⁴ *and*

facility plus the minimum monthly maintenance need allowance (MMMNA) of \$2,541 (2007 figure) for the spouse in the community without dependents. The exempt resources include \$2,000 for the spouse in the facility and \$101,640 for the spouse in the community. The spousal allowance and MMMNA go up each year. See: California Advocates for Nursing Home Reform's website at <http://www.canhr.org/index.html> for more information.

⁴ For more information on the MSSP waiver see <http://www.aging.ca.gov/html/programs/mssp.html> or call (800) 510-2020. To locate a service center in your area see http://www.aging.ca.gov/html/programs/mssp_contacts.html.

- The waiver for persons with HIV whose T-cell count *at any time* was below 500 and where HIV infection complicates another medical condition's clinical course or management, or AIDS.⁵

To apply for the Nursing Facility/Acute Hospital [NF/AH] waiver or the In-Home Operations Waiver contact the California Department of Health Care Services- In-Home Operations at (916) 552-9151.

Pickle Program: You may be eligible for Medi-Cal with no share of cost under the Pickle program if:

- You received SSI (Title XVI) in addition to Social Security Disability benefits at any time after April of 1977; and
- You are no longer eligible for SSI because cost-of-living increases in your Social Security benefits were greater than the increases in SSI, so that your Social Security benefit is now too high for you to qualify for SSI; and
- You meet all SSI eligibility requirements other than income.⁶

Medically Needy/Indigent: You are eligible to receive Medically Needy Medi-Cal if you meet the resource and other eligibility standards for SSI or the former AFDC program, but your income is too high. That includes persons who would otherwise

⁵ For more information see:

<http://www.dhs.ca.gov/aids/Programs/ProgramFactSheets/2383MCWP070105.pdf>

See also:

<http://www.dhs.ca.gov/mcs/mcpd/RDB/DPU/Links/Office%20of%20AIDS%20Me>
[di.doc](http://www.dhs.ca.gov/mcs/mcpd/RDB/DPU/Links/Office%20of%20AIDS%20Me) and Disability Rights California's publication:

<http://www.disabilityrightsca.org/pubs/543501.htm>.

⁶ In our opinion, earned income would not disqualify an individual as "Pickle" unless his/her earned income were adequate in itself to render the person ineligible for SSI under the 1619b program. This is because without the intervening Title II Cost of Living (COLA) increases, the individual would qualify for continued SSI beneficiary status and Medi-Cal under Social Security's 1619(b) program, 42 U.S.C. § 1382h. See <http://healthconsumer.org/cs020Pickle.pdf> for more information.

qualify for SSI on the basis of age, blindness or disability. Often, there is a *share of cost*⁷ (required payment) for services and equipment.⁸

You must meet your share of cost each month before Medi-Cal begins to pay. You may meet your share of cost either by paying for, or by agreeing to pay for, medical goods and services.

You can meet your share of cost by paying for services or things Medi-Cal does cover or does not cover. For instance, you could pay for occupational therapy, which Medi-Cal would not cover: (1) under its stringent medical necessity standards; or (2) under its two-visits-a-month service limitation. Another example is over-the-counter medications and supplies your doctor ordered. Ask your doctor to write the order on a prescription form. Pay for the item at the pharmacy window so that what you paid can be entered against your share of cost.

You may meet a share of cost by paying off or paying down an old medical bill. You may use a bill only once. However, if the bill is more than the share of cost, you can carry the excess over into other months. That is, you may pay part of what you owe in one month, and more of what you owe in the next month.

You can use medical bills from other ineligible family members to meet your share of cost if they are not subject to payment by a third party.⁹ For instance, in a family where the children are eligible but not the parents, the parents' medical bills will reduce the share of cost.¹⁰

When you are in a nursing facility, you may use your share of cost to pay for services and equipment other than nursing facility care. The services or equipment

⁷ See: <http://www.healthconsumer.org/Medi-CalOverview.pdf>, Chapter 5, for a discussion on share of cost.

⁸ See <http://healthconsumer.org/cs044ABD-MN.pdf> for more information. If you have been determined to be eligible for Medi-Cal with a share of cost, always check to see if you would be eligible for Medi-Cal under one of the federal poverty level programs for persons with disabilities.

⁹ 42 C.F.R. §435.831(b).

¹⁰ Also see <http://healthconsumer.org/brochures.htm#share> for more information on meeting your share of cost.

must be consistent with the plan of care ordered by your physician.¹¹ For instance, you may be able to satisfy your share of cost by making installment payments on a needed wheelchair instead of trying to get Medi-Cal to pay directly.

In addition, you meet your share of cost by incurring an obligation to pay. It does not matter if a relative, a friend, or the regional center pays the bill afterwards. If the regional center reimburses you for your Medi-Cal share of cost, there are no income consequences. This is assistance with state funds based on need, which Medi-Cal does not count as income. However, if your relative or friend gives you the money instead of paying the bill directly, you must count that money as income.

Disabled Adult Child (DAC)¹²: You may be eligible for Medi-Cal with no share of cost under a special program for people who receive Social Security Disabled Adult Child (DAC) benefits if:

- You received SSI in July of 1987 or later; and
- You first qualified for Title II DAC benefits, or for an increase in DAC benefits, on June 1, 1987, or after, and your DAC benefits have increased so that they make you ineligible for and SSI grant; and
- You would be eligible for SSI now but for (a) the Title II DAC benefits you first started receiving in July 1987 or later, or (b) the increases in your Title II DAC benefits received in July 1987 or later.

People in this category are known as *pseudo-Pickle DACs* – believe it or not.

Disabled/Early Retirement/Widows/Widowers¹³: If you are in this category, and you were eligible for SSI immediately before you received Social Security widow/widowers benefits, you are eligible for Medi-Cal as long as:

- You are *not* eligible for Medicare Part A (See Chapter 11 of this manual);

¹¹ *Johnson v. Rank*, Case No. 84-5979-SC, consent decree 11/22/85, modified effective 10/1/89, E.D.Cal., CCH MEDICARE AND MEDICAID GUIDE New Dev. ¶ 35,026; DHS ACWDL Mp/ 90-54 (7/24/89).

¹² 42 U.S.C. §1383c(c).

¹³ 42 U.S.C. §1382c(d). Also see 20 C.F.R. §404.335 for eligibility rules.

- You were receiving SSI at the point your widow/widower benefits began; and
- But for the widow/widowers benefits, you would be eligible now for SSI.

Aged and Disabled Federal Poverty Level (A&D FPL) program¹⁴: Individuals with disabilities including children as well as seniors may qualify for this program if their countable income does not exceed 100% of the Federal Poverty Level (FPL) plus \$230.¹⁵ In 2007 that equals \$1,081 for an individual or \$1,502 for a couple applying. Any out-of-pocket expenses for health, vision or dental premiums are deducted when determining countable income. Under this program, like the other Federal Poverty Level programs, you either qualify or you do not. You cannot spend down excess income on medical expenses to qualify.¹⁶

The 250% Working Disabled Program: Individuals whose countable income is at or below 250% of the Federal Poverty Level (In 2007 this means: \$2,042 for an individual and \$2,750 for a couple applying) may if they meet other criteria pay a small premium every month for full-scope Medi-Cal. This program exempts retirement accounts as a resource and does not include any form of disability income from consideration when arriving at your countable income.¹⁷

Eligibility under the federal poverty level (FPL) programs is based on the amount of countable income compared to the applicable federal poverty level. The federal government issues the annual FPL in about February of each year. The Department of Health Care Services' (DHCS') Medi-Cal program will issue an All-County

¹⁴ Welf. & Inst. Code §14005.40. This program went into effect in January of 2001. In determining Medi-Cal eligibility under this program, Medi-Cal does not count the Social Security cost of living increase until April when the new FPLs go into effect. Eligibility for this FPL program is determined before any Medicare premium deduction. If someone is eligible for the program, Medi-Cal pays the Medicare premium.

¹⁵ For couples, eligibility is 100% of the FPL plus \$310 or the couple SSI/SSP rate, which ever is greater. Welf. & Inst. Code § 14005.40(c)(1). If one member of the couple is in particular need of Medi-Cal, that member can apply as an individual.

¹⁶ See <http://healthconsumer.org/cs029AgedDisabled.pdf>. for more information.

¹⁷ See <http://healthconsumer.org/cs032WorkingDisabled.pdf> for more information.

Welfare Directors Letter (ACWDL) in early to mid March setting out the year's new FPLs to go into effect usually April first.¹⁸

Special Medi-Cal programs. Medi-Cal has special programs if you need:

- kidney dialysis or parenteral hyperalimentation (intravenous nutrition), but you do not otherwise qualify for Medi-Cal.¹⁹

In either program you would pay an amount equal to 2% of your nonexempt annual worth or 1% of your nonexempt annual worth if working. The dialysis program requires that you have an SSI eligible condition. The parenteral hyperalimentation program does not.

There are also other programs such as:

- For persons who have tuberculosis.²⁰ You would apply for this program through a clinic that treats tuberculosis; and
- For breast and cervical cancer treatment.²¹

Medicare-related programs. If you qualify for Medicare, Medi-Cal has programs to help pay your Medicare premiums.

- **Qualified Medicare Beneficiaries (QMB or Quimbies):** Under this program, Medi-Cal will pay Medicare Part A or Part B premiums, and deductibles and co-insurance required under Medicare. You would qualify as a QMB if:
 - You are eligible for Part A (even if not enrolled);
 - Your resources are \$4,000 or less (\$6,000 or less for a couple);

¹⁸ The DHCS' ACWDLs can be found at:
<http://www.dhs.ca.gov/mcs/mcpd/MEB/ACLs/default.htm>.

¹⁹ Welf. & Inst. Code §§ 14140 through 14144.5. 22 C.C.R. §§ 50801-50831

²⁰ Welf. & Inst. Code § 14005.20.

²¹ See <http://www.dhs.ca.gov/mcs/mcpd/MEB/BCCTP/default.htm> for information.

- Your countable family monthly income is not above 100% of the FPL (\$851 per month for one person and \$1,141 for couples); and
- Meet all other Medi-Cal requirements

In figuring countable income to see if you qualify as a QMB, you have deductions for children and an ineligible spouse just as you would have under SSI.

- Specified Low Income Medicare Beneficiaries or SLMB: Medi-Cal will pay your Medicare Part B premium if:
 - You are eligible for Part A (even if not enrolled);
 - Your countable monthly income is between 100% - 120% of the FPL (\$1,021 for an individual and \$1,369 for a couple);
 - Your resources are \$4,000 or less (\$6,000 or less for a couple); and
 - Meet all other Medi-Cal requirements
- **Qualified Individual Program (QI-1) and Q2:** This program will pay for Medicare Part B premiums if:
 - You are eligible for Medicare Part B;
 - Have countable income less than 135% of the Federal Poverty Level (\$1,149 per month for an individual and \$1,541 for couples);
 - Have assets at or below the limit (\$4,000 for individuals, \$6,000 for couples); and
 - Meet all other Medi-Cal eligibility requirements.

Under the QI-2 program, Medi-Cal will give you a very small grant toward your Part B premium if your countable income is below 175% of the FPL.

- Qualified Disabled Working Individual (QDWI)

This program for Medicare Part A premiums for SSDI beneficiaries who have lost their Medicare Part A due to earnings. To qualify you must:

- Be less than 65 years old;

- Be eligible for Medicare Part A only;
- Have income at or below 200% of the Federal Poverty Level (\$1,702 for an individuals and \$2,282 for couples);
- Have assets at or below the limit (\$4,000 for individuals, \$6,000 for couples); and
- Meet all other Medi-Cal eligibility requirements.

Services, Prior Authorization & Medical Necessity

2. What services does Medi-Cal provide?

Federal law requires that Medi-Cal provide certain services. These services include:

- Physicians' services;
- Inpatient hospital care;
- Outpatient hospital care;
- Laboratory & x-ray services;*
- Skilled nursing facility services for persons 21 and older;*
- Home health services for persons 21 and older;*²²
- Rural health clinic services; and
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children under age 21.

California has chosen to provide certain other services. Having agreed to provide them, California must do so in accordance with federal law and regulations. Those non-mandatory services which are most important to the provision of assistive technology include:

- Rehabilitation services;*

²² Includes medical supplies, equipment and appliances.

- Physical therapy;*
- Occupational therapy;*
- Speech therapy;*
- Audiology;*
- Services provided by intermediate care facilities for the developmentally disabled;*
- Hemodialysis;*
- Emergency and essential diagnostic and restorative dental services;*
- Home health care services;*
- Prosthetic and orthotic devices and eyeglasses;*
- Hearing aids;*
- Durable medical equipment (DME);*
- Medical supplies; and
- Transportation to doctor visits and to other medically necessary covered services.*

With some exceptions noted below, your service provider must get Medi-Cal approval before providing the “*” services. To get approval, the provider completes a *Treatment Authorization Request* (TAR) and submits it to Medi-Cal along with documentation including a medical justification (medical necessity) letter from a health care provider.²³ Medi-Cal then has 30 calendar days to approve or deny the TAR. If Medi-Cal does not approve or deny it, or ask for more information within 30 days, the law says the TAR *must be* approved.²⁴

²³ The medical necessity standard will be different for children under 21 years of age, adults, and persons living in long term care facilities. DME and other services will be approved (provided other criteria is met) only if it meets the applicable medical necessity standard. The standards are outlined below.

²⁴ Welf. & Inst. Code § 14103.6.

Medi-Cal puts assistive technology in a number of categories. For example it may be called medical supplies, DME, or a prosthetic device. Medi-Cal often places “utilization controls,” or limits, on its services. For example, Medi-Cal limits physical and occupational therapy visits to two per month.

3. Is it true that there are extra services for children under Medi-Cal?

Yes. The EPSDT program is a federal Medicaid requirement. It is the Medicaid/Medi-Cal program for people up to age 21. States must follow EPSDT requirements in order to receive federal Medicaid money. EPSDT does not limit Medi-Cal services like the adult program does. That means EPSDT recipients may, based on medical necessity, receive more benefits than adults.

There are two parts to the program: (1) screening and (2) diagnosis and treatment. Screening services include periodic screens (like physical assessments, lead screening, developmental assessments, etc.) and interperiodic screens (like doctor visits for follow-up evaluations).²⁵ In California, Medi-Cal often provides periodic screens under the Child Health and Disability Prevention (CHDP) program.²⁶

EPSDT says that services found to be necessary in a screening must be provided. Ordinarily, states have the option of not covering certain services in their state plan. However, under EPSDT, states must cover all optional services.²⁷

4. What kinds of services are not available under regular Medi-Cal but are available under EPSDT?

EPSDT includes services beyond the visit or treatment limits under regular Medi-Cal. For example, Medi-Cal allows only two physical therapy visits a month for adults, but that limitation does not apply for children. Although Medi-Cal covers only short visits under its home health services, shift nursing and other services are available to children. In-home behavior management, behavior aides and private duty nursing are also available to children, even if those services are not available to adults. EPSDT may require that Medi-Cal provide services in less restrictive and

²⁵ 42 U.S.C. § 1396d(r)(1)(A).

²⁶ For low income children who are not eligible for Medi-Cal, CHDP evaluations, assessments and follow-up treatment services are funded by money from the Proposition 99 tobacco tax. Health & Safety Code §§ 124025-124110.

²⁷ 42 U.S.C. §1396d(r)(5).

more natural environments when the treating physician believes that is medically necessary, even though Medi-Cal normally provides those services only in institutions. Technology should be more readily available under EPSDT as well.

5. How can I get Medi-Cal authorization for EPSDT diagnostic or treatment services?

Your EPSDT TAR *must* explicitly say that you are submitting it pursuant to EPSDT and include the following information:

- Primary diagnosis and other important diagnoses;
- Prognosis;
- Date of onset of the illness or condition, and origin if known;
- Impairment caused by the illness or condition;
- Specific types of services to be rendered by each discipline with physician's prescription where applicable;
- The goals to be achieved by each service and anticipated time for achievement of goals;
- The extent to which health care services have been previously provided to address the illness or condition, and the results; and
- Any other documentation necessary to show that the services are needed.

We recommend that any TAR documentation include headings that track these categories. They are found in regulation 22 C.C.R. §51340(d).

6. What is the EPSDT medical necessity standard?

The definition of medical necessity under EPSDT is broader than the definition for regular Medi-Cal for adults. Children eligible for Medi-Cal have the right to *“necessary health care, diagnostic services, treatment, and other measures ... to correct or ameliorate defects and physical and mental illnesses and conditions*

discovered by the screening services, whether or not such services are covered under the state plan.”²⁸

7. What does Medi-Cal consider to be medically necessary for the regular Medi-Cal (non-EPSDT) program?

State law defines medically necessary as those services, medicines, supplies and devices necessary to “*protect life, to prevent a significant illness or disability, or to alleviate severe pain*”.²⁹ Medically necessary services include rehabilitation and other services needed to attain or retain the capability for normal activity, independence or self care. Medi-Cal will not pay for treatment, medicines or devices that it considers *experimental*.³⁰ Medi-Cal will cover, with prior authorization, services that are investigational, provided they meet the criteria in 22 C.C.R. § 51303(h).³¹ What may appear to be “investigational” may not be. If the treatment is generally accepted by health care professionals who treat the disability, then it is not “investigational.”

Federal courts have said that your treating physician should be the primary person to decide the question of medical necessity, not Medi-Cal personnel or even Medi-

²⁸ 42 USC §1396d(r)(5); 22 C.C.R. §§51340(e), 51184(b).

²⁹ Welf. & Inst. Codes §§14059.5, 14133.3.

³⁰ 22 C.C.R. §51303(g).

³¹ Regulation criteria include demonstrating that conventional therapy will not adequately treat the condition nor prevent progressive disability or premature death, that the provider has a record of safety and success, and that there is a reasonable expectation that the investigational service will significantly prolong life or will maintain or restore a range of physical and social function.

However, if you otherwise qualify for inpatient care, treatment involving “Investigational New Drugs, clinical trials or other ancillary or investigational services...shall not in itself be construed to be part of a research study protocol, and shall not constitute grounds for denial on that basis.” Welf. & Inst. §14137.8.

For persons with AIDS, ARC or who are HIV positive, Medi-Cal covers medications classified by the Food and Drug Administration or the State Department of Health Services as an Investigational New Drug. Welf. & Inst. § 14137.6.

Cal physician consultants. Case law favors the treating doctor to determine medical need but Medi-Cal can still review your doctor's recommendations. *Weaver v. Reagan*, 886 F.2d 194, 200 (8th Cir. 1989); *Pinneke v. Preisser*, 623 F.2d 546, 550 (8th Cir. 1980). You may still need to go to a hearing to challenge a denial.

8. We have discussed the child (EPSDT) and adult medical necessity standards. Are there other standards that I should know about?

Yes.

Persons living in long term care facilities: Federal law says that people who are in long-term care facilities³² are entitled to “*the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.*”³³ This standard is broader than California's medically necessary standard for adults.

Medi-Medis: Individuals who are eligible for both Medicare and Medi-Cal, known as Medi-Medis, may use the Medicare standards of medical necessity. Medicare defines medically necessary more broadly than does Medi-Cal. For example, Medi-Cal will pay for cataract surgery for loss of vision in one eye only if both eyes are affected; Medicare will pay for cataract surgery to restore sight even if only one eye is affected.

Dual eligible (CCS & Medi-Cal) children: Children who are covered by both Medi-Cal and CCS can have CCS evaluate TARs for services related to their physically handicapping condition using its own definition of medical necessity. CCS uses a common sense medical necessity standard, providing services to minimize the long-term disabling effects of an eligible condition. CCS should act as

³² Long-term care facilities include skilled nursing facilities (SNFs) and intermediate care facilities (ICFs). However, federal regulations [42 C.F.R. § 483.5] provide that the various intermediate care facilities for the developmentally disabled (ICF/DD, ICF/DD-H, and ICF/DD-N) are not “Nursing Facilities” even where the ICF/DD facilities otherwise meet the criteria of nursing facilities under federal Medicaid law. 42 U.S.C. § 1396r(a). As a consequence, residents of ICF/DD facilities are denied the benefit of the protections and care standards afforded residents of other nursing facilities through the Nursing Home Reform Laws.

³³ 42 C.F.R. § 483.25

case manager for services such children need because of their CCS-eligible condition. CCS should ask Medi-Cal to provide services when necessary.

9. How can I get prior authorization for a medical service or assistive device?³⁴

Your doctor or medical provider must submit a TAR form that describes why you need the requested services, medicine or device. Documentation from your healthcare provider *must address the applicable medical necessity standard*. The report from your doctor for example should:

- Include information about your disability and functional limitations;
- Establish why the requested device meets the medical necessity standard, i.e. why it is necessary to increase your independence, safety or functional abilities, or to alleviate the impact of disability;
- Explain why the recommended device is the least expensive one that will adequately meet your needs;
- Describe alternatives considered and rejected, and why;
- Attach any written material that describes the requested device, it's use; and
- Document any cases where Medi-Cal (or other private health benefit plans or Medicare) has bought a similar device.

In reviewing denied TARs for assistive devices and durable medical equipment, we often find that there is not enough information to enable us to represent the person in a Medi-Cal fair hearing. The doctor usually has to resubmit the TAR with more information. Sometimes Medi-Cal then approves the TAR without the need for a fair hearing.

If the TAR is for a custom or power wheelchair, or other durable medical equipment, it is particularly important that the report be detailed.³⁵

³⁴ With regard to children, see prior discussion on getting prior authorization from Medi-Cal for EPSDT services.

NOTE: The best assessments can often be obtained through the outpatient clinic at a rehabilitation facility.

10. What happens once the TAR and other documentation is submitted to Medi-Cal?

Medi-Cal must return the TAR form to your provider, with an approval or denial and the reason for the denial or a request for more information, within 30 days. If within 30 days after receiving, it Medi-Cal does not do one of these things, the TAR is deemed approved by operation of law.³⁶ If Medi-Cal denies your TAR, it must send you a written notice that explains why it denied the authorization and with information about your appeal rights.

If you need the requested device or service on an emergency basis, such as repair of a power wheelchair, the provider can make the initial request over the phone. If Medi-Cal approves over the phone, the provider will then send in a written TAR.

If Medi-Cal denies the request, you have the right to a fair hearing to challenge the denial.

DME, Prosthetics and Orthotics

11. What is DME?

Federal law does not define DME. California regulations define DME as:

- Equipment prescribed by a licensed practitioner to meet medical equipment needs of the patient and must:
 - a) withstand repeated use;
 - b) serve a medical purpose;³⁷

³⁵ See www.nls.org/av/winter06.htm - Newsletter of the National Assistive Technology Advocacy Project on “Preparing Letters of Medical Justification.” Also see <http://www.nls.org/av/av-0798.htm>.

³⁶ Welf. & Inst. Code §14103.6.

³⁷ In *Blue v. Bonta* 99 Cal.App.4th 980 (2002) the California appellate court found that a stairway chairlift served a medical purpose and therefore met the definition of

- c) not be useful to an individual in the absence of an illness, injury, functional impairment or congenital anomaly; and
- d) be appropriate for use either in or out of the patient's home.³⁸

This is a broad definition. It includes equipment such as canes, crutches, walkers, grab bars, hospital beds, water or gel pressure mattresses, oxygen therapy equipment, basic and custom wheelchairs, augmentative communication devices and other devices.³⁹ It also specifically includes DME needed to assist a disabled parent, stepparent, foster parent or legal guardian to care for a child.⁴⁰

12. What are prosthetic and orthotic appliances?

Prosthetic and orthotic appliances are those appliances prescribed by a physician, dentist or podiatrist to restore function or replace body parts.⁴¹

13. Does California have an exclusive list of covered DME?

Although California has a list of pre-approved DME, a policy letter from the federal Health Care Financing Administration (HCFA – later renamed Centers for Medicare & Medicaid) issued on September 4, 1998 clearly states that although states may have pre-approved lists for administrative convenience, states must also provide beneficiaries “a meaningful opportunity for seeking modifications of or exceptions to its pre-approved list.”⁴²

DME. For more on this case and other decisions concerning assistive technology see <http://www.nls.org/av/winter06-07.htm>.

³⁸ 22 C.C.R. §51160.

³⁹ 22 C.C.R. §51521

⁴⁰ Welf. & Inst. Code §14132(m).

⁴¹ 22 C.C.R. §51161.

⁴² The letter can be found at:

<http://www.cms.hhs.gov/smdl/downloads/SMD090498.pdf> .

14. When is prior authorization not necessary?

In almost all instances Medi-Cal will provide DME, and prosthetic or orthotic appliances, only after prior authorization (submission and approval of a TAR). However, you do not have to submit a TAR for:

- Prosthetic devices or services that cost less than \$500;⁴³
- Orthotic devices or their repair if the cost is less than \$ 250;⁴⁴
- DME if it costs less than \$100;⁴⁵ and
- Repair and maintenance of DME if the cost does not exceed \$250 within the calendar month.⁴⁶

15. Aside from meeting the applicable medical necessity standard, what else must I consider?

Medi-Cal has a provider manual that deals with DME, prosthetic and orthotics. It is called the “Allied Health Provider Manual.” It contains information on these categories, program coverage, policy statements and billing policies. It should be consulted when dealing with these items.⁴⁷

Medi-Cal’s Manual of Criteria with respect to DME outlines the criteria for covering antidecubitus care support surfaces, home blood glucose monitors and osteogenesis stimulator devices.⁴⁸

⁴³ 22 C.C.R. §51315(a)(2)

⁴⁴ Welf. & Inst. Code § 14132.765; 22 C.C.R. §51315(a)(1).

⁴⁵ 22 C.C.R. §51321 (b)(1)

⁴⁶ 22 C.C.R. §51321(b)(2)

⁴⁷ This manual can be found at: http://files.medi-cal.ca.gov/pubsdoco/Pubsframe.asp?hURL=/pubsdoco/ah_search.asp

⁴⁸ This manual can be found at: http://www.dhs.ca.gov/mcs/mcpd/MBB/PDF/Manual_of_Criteria.pdfA

California does not claim that its list of DME includes all of the equipment it will buy. .However, California seems unwilling to buy some devices that it should provide as DME such as environmental control devices.

Medi-Cal has a policy that states that : “Durable medical equipment items are covered as medically necessary only to preserve bodily functions essential to activities of daily living or to prevent significant physical disability.” Medi-Cal Policy Statement 82-21. Note, that this is only policy and not the law.

Medi-Cal sometimes argues that you have not shown medical need unless the device is necessary for you to get medical care. Medi-Cal argues that a device used for *social* or *educational* purposes is not medically necessary. This is a common argument when you request a device that Medi-Cal does not normally acknowledge as a benefit. However, it is not consistent with Welf. & Inst. Code § 14059, which sets out the purposes of Medi-Cal services:

...for conditions that cause suffering, endanger life, result in illness or infirmity, interfere with capacity for normal activity, including employment, or for conditions which may develop into some significant handicap. (Emphasis added.)

Medi-Cal does not make such an argument when considering other DME such as wheelchairs. These items, of course, may also serve social or educational purposes as well as help with trips to the doctor. The key to demonstrating medical necessity is to show that the proposed device is the most reasonable treatment for your disability. Whether you need it to help you to walk, speak, or perform other activities of daily living, the DME does not just help you get medical services.

16. What are some of the limitations Medi-Cal puts on DME and medical supplies?

DME and medical supplies always require the prescription of a qualified provider. Medi-Cal does not cover:

- Household items, items not used primarily for medical care, and articles of clothing - even if they meet a legitimate medical need. If a household item will serve your medical needs, Medi-Cal will not authorize a medical device. Medi-Cal does not cover air conditioners, air filters, food blenders, orthopedic mattresses or automobile modifications.

- Medi-Cal limits authorization for DME to the lowest-cost item that will adequately serve your medical needs.⁴⁹

17. When will Medi-Cal provide a light weight or power wheelchair?

Medi-Cal will buy a lightweight or power wheelchair only when you can justify it.

Lightweight wheelchairs:

Essentially, Medi-Cal will buy lightweight or ultra lightweight chairs only if you do not have the arm strength to self-propel a heavier chair. Medi-Cal Policy Statement 88-11. Sports chairs are not a Medi-Cal benefit.⁵⁰

Power wheelchairs

If you lack the upper arm mobility or strength to operate a manual chair, Medi-Cal may approve a power wheelchair. The type and nature of the power wheelchair and the attachments or modifications Medi-Cal may approve will be based on your medical needs. You must show that your need for power or modifications is central to your mobility and necessary for you to perform daily living activities. Medi-Cal considers mobility inside and outside your home a basic activity of daily living. If you ask only for social, educational or job placement needs, Medi-Cal will deny your request. Medi-Cal Policy Statement 82-21. In our opinion, however, Medi-Cal cannot rely on its policy statement when the statement conflicts with state and federal Medi-Cal/Medicaid statutes and regulations.

18. Will Medi-Cal provide DME if I live in a skilled nursing facility or intermediate care facility?

Federal regulations require that skilled nursing facilities, intermediate care facilities (long term care facilities) and intermediate care facilities for persons with mental retardation provide some necessary technology for their residents.⁵¹

⁴⁹ Title 22 C.C.R. §51321(g).

⁵⁰ Also see: http://files.medi-cal.ca.gov/pubsdoco/Pubsframe.asp?hURL=/pubsdoco/ah_search.asp

⁵¹ See <http://www.nls.org/conf2004/medicaid%20and%20nursing%20facilities.htm> for an article on seeking reimbursement for assistive technology in nursing facilities.

Long term care facilities must provide residents with the services they need to attain and maintain the highest possible mental and physical functional status, as defined by the comprehensive assessment and plan of care. 42 C.F.R. § 483.25. Residents must receive services that will enhance their ability to “use speech, language or other functional communication systems”, 42 C.F.R. § 483.25(a)(1)(v), and their “ability to transfer and ambulate”, 42 C.F.R. § 483.25(a)(1)(ii). Available devices should include wheelchairs, medical equipment, some prosthetics, and even some augmentative and alternative communication devices. Long term care facilities must provide supportive services including speech, occupational and physical therapy and audiology services.⁵²

Intermediate care facilities for the developmentally disabled (ICF/DD) must provide active treatment. This includes necessary assistive technology such as communication aids,⁵³ and mechanical supports.⁵⁴ ICF/DD's must also provide speech, occupational and physical therapy, and audiology services.⁵⁵

Long term care and ICF/DD facilities only have to provide *common* equipment and devices, not unusual or customized devices. Regulations provide that Medi-Cal will provide DME *if the equipment is necessary for your continuous care, or to meet your unusual medical needs*. Medi-Cal may authorize canes, crutches, wheelchairs, and walkers when you need a custom made or modified item to meet your unusual medical needs, and the needs are expected to be permanent. A custom wheelchair is one which has been uniquely constructed or assembled to address a particular patient's individual medical needs for positioning, support and mobility. Medi-Cal may authorize suction and positive pressure apparatus when you will use the item continuously or when you must have it immediately available for one month or more.⁵⁶ Medi-Cal also says it will pay for such items as alternating pressure mattresses, portable aspirators, portable gas oxygen systems and variable height beds.⁵⁷

Custom wheelchairs when in a nursing facility

⁵² Welf. & Inst. Code §14132(c).

⁵³ 42 C.F.R. §483.470(g)(2).

⁵⁴ 42 C.F.R. §483.440(c)(6).

⁵⁵ Welf. & Inst. Code §14132(c).

⁵⁶ 22 C.C.R. §51321(h)(3).

⁵⁷ 22 C.C.R. §51511(c).

Medi-Cal has been reluctant to custom wheelchairs (whether power or manual), for people who live in long-term care facilities. Medi-Cal's theory is that staff is available to push you where you want to go. Medi-Cal does not consider the limitation this places on your ability to choose activities or companions. It does not consider your inability to be mobile in the community, even though that is a factor in determining whether Medi-Cal will buy a power chair for you if you live in your own home. This policy is questionable. If you live in a long-term care facility, you have a right to services and equipment that will maximize your mental, physical and social well being under the Nursing Home Reform Act. Thus, you are entitled to services that enhance your mobility. When residents of nursing facilities have had strong advocacy, Medi-Cal has agreed to buy custom chairs.

You should ask the facility to provide necessary devices. If the facility refuses, you should be prepared to ask your doctor to submit a TAR to Medi-Cal for the device. Do not let the facility and Medi-Cal bounce you back and forth. If Medi-Cal says the facility is responsible for purchase of a device, tell Medi-Cal to make sure the facility buys it for you. If necessary, you can file for a joint Medi-Cal hearing against both Medi-Cal and the facility and ask the administrative law judge to decide who must provide the device you need.

Finally, residents of nursing facilities and ICF/DD facilities have a right to passes for overnight visits with family, friends, etc. The regulations and laws do not specifically say that you have a right to equipment that goes with you when you visit family, but that seems to be required by the intent of the Nursing Reform Act.

19. Will Medi-Cal pay for home alterations?

Medi-Cal will not pay for home alterations through the regular Medi-Cal program, except when necessary to provide home dialysis services. However, if you are a person who would otherwise require care in a Medi-Cal funded long-term-care facility, Medi-Cal may cover home alterations for accessibility under one of several home and community based waivers. (See question 1.)

20. Will Medi-Cal pay for the self-help aids I need to complete activities of daily living?

Yes. Medi-Cal will pay for self-help aids essential to the performance of common activities of daily living. Such aids include specially designed eating utensils, utensil holders, buttoning aids, raised toilet seats, flexible shower hoses, standing tables, and many other items. Since Medi-Cal does not list them as DME, they all

require prior approval, regardless of cost. Medi-Cal Policy Statements 49-73 & 73-11.

21. Will Medi-Cal pay for augmentative and alternative communication devices (AAC)?

Medi-Cal will provide augmentative and alternative communication (AAC) devices and services when determined to be medically necessary. This benefit is available to Medi-Cal recipients who have been diagnosed with a significant communication disorder. Recipients can get these devices and services the same way as all other speech and language therapy services. In order to be approved, TAR's for AAC devices must include a medical assessment showing: (1) the recipient's condition, and (2) the benefits he/she will realize through use of an appropriate device.

Under Medi-Cal's policy, an AAC device is a therapy option that a speech therapist selects as part of a patient's treatment. Coverage extends to all three phases of access to AAC - (1) initial assessment, (2) device acquisition, and (3) services such as setup and training after delivery. A speech and language therapist, licensed by the State of California, must conduct the initial assessment. As part of a treatment plan, a speech therapist needs to consider a patient's physical impairments in selecting appropriate speech equipment, the assessment must include other health care professionals such as occupational and physical therapists. A general practitioner must prescribe the device before Medi-Cal will authorize a treatment request.

The assessment report must cover three distinct areas. The first section must include the following information about the patient:

- Medical diagnosis,
- Significant medical history,
- Sensory and receptive communication impairments,
- Current communication abilities and limitations,
- Physical abilities and limitations,
- How the beneficiary will use AAC given physical abilities and limitations,
- Current and future communication needs,

- Communication partners,
- Communication environments, and
- Any previous treatment of communication problems.

The second part must contain specific information about the device including:

- Vocabulary requirements,
- Representational systems,
- Display organizations,
- Message characteristics,
- Access techniques,
- Portability and durability,
- Cost, and
- Whether the beneficiary has had a trial period to use the recommended device.

The last portion of the assessment is (1) the doctor's prescription and (2) the therapist's treatment plan. In the therapist's plan, he/she describes:

- How long the beneficiary will need the device;
- How much, how long, and why the beneficiary will need any related services;
- Short-term and long-term goals;
- How to measure the beneficiary's progress toward those goals;
- What service providers the beneficiary will need to carry out the plan; and

Medi-Cal will also pay to modify, repair and replace the devices it authorizes. To get these services, the recipient must submit a separate treatment authorization request with adequate justification.

Persons who have Medicare and Medical

22. What special problems are encountered by individuals who are eligible for both Medicare and Medi-Cal?

Before October 1990, people who qualified for both Medicare and Medi-Cal (known as Medi-Medis) had many problems getting reimbursement for DME. Medi-Cal said you had to go to Medicare first for funding of DME. Unfortunately, Medicare will not provide prior approval for DME. In addition, the amount that Medicare authorizes for many items of DME is very low. Medi-Cal would only pay the reasonable rate established by Medicare, even though it was often much lower than what Medi-Cal would otherwise pay.

In October 1990, in the case of *Charpentier v. Kizer*, the Federal District Court for the Eastern District of California ordered Medi-Cal to stop this procedure for buying DME. Under *Charpentier*, the provider submits a TAR to Medi-Cal. Once approved, the provider submits the claim to Medicare and Medi-Cal. Medicare decides on the reasonable rate and pays the 80%. The claim is then forwarded to Medi-Cal which pays the remaining 20% of the Medicare rate and will also pay any amount above the Medicare rate that it would pay if it were the sole provider under its own rate schedule. (Medi-Cal's rate for equipment is normally more than Medicare's.) This procedure is intended to result in a consumer who is Medi-Medi not having any more costs than if he was Medi-Cal eligible only.

Legal Aid organizations and disability rights organizations such as Disability Rights California should all be familiar with *Charpentier*.⁵⁸

23. I have both Medicare and Medi-Cal. Why won't Medi-Cal pick up the 20 percent Medicare doesn't pay?

Medicare pays 80 percent of the approved cost of a covered benefit. If you are covered by both Medi-Cal and Medicare, you look to Medi-Cal to pick up the 20 percent differential. However, Medi-Cal will not supplement Medicare above what Medi-Cal would pay if it were the only source of payment. For instance, if Medicare says \$100 is a reasonable cost for a procedure, it pays \$80. If Medi-Cal

⁵⁸ Medi-Cal Allied Provider Manual (see footnote 47) has information on the *Charpentier* process. Disability Rights California also has a publication on this subject found at <http://www.disabilityrightsca.org/pubs/528501.htm>

says that it would not pay more than \$90 for the procedure, it will pay only \$10 after Medicare pays \$80.

Appeal Rights

24. What can I do if I disagree with Medi-Cal?

You have the right to challenge any decision Medi-Cal, or a Medi-Cal funded facility such as a skilled nursing facility, makes or doesn't make that you believe to be wrong. This could be denial of your request for DME, or denial of the repair or servicing of a device, or refusing to continue equipment rental.

You challenge Medi-Cal decisions by asking for a fair hearing. You do not have to have a written notice of action to request a fair hearing, but you should ask for one anyhow because it will tell you why Medi-Cal has denied your request.

25. What actions can I challenge in a fair hearing?

In a fair hearing, you can challenge Medi-Cal's or a Medi-Cal funded facility's actions in any or all of the following areas:

- Refusal to process or delay in processing your Medi-Cal application;
- Determination that you are not eligible for Medi-Cal, or are no longer eligible for Medi-Cal;
- Amount of your monthly share of cost;
- Denial of a prior authorization request (be sure to check the packet you sent to Medi-Cal to see if you want to resubmit with more complete documentation instead of appealing; and/or
- Termination of a service, such as medical transportation to receive dialysis.

26. What can I do if Medi-Cal denied a device or service that my doctor prescribed because it was not a covered service?

First: Review the request or TAR that the doctor sent to Medi-Cal requesting prior authorization. If the TAR does not include a letter from the treating doctor, or other documents explaining why the service or device is medically necessary, have the

doctor send the TAR again and include a letter or documents and any records that support your need for the item requested.

Second: If Medi-Cal denies the prescription despite the submission of a TAR with documentation of medical necessity, you will have to file for a fair hearing to challenge the denial.

Third: As soon as you get an acknowledgement of your fair hearing request with the hearing number, write to the Medi-Cal field office that denied the TAR. The address is on the TAR denial notice. Ask to review the file and the authority Medi-Cal is relying upon including statutes, regulations and any provisions of the DHS Manual of Criteria and any policy letters. Your letter might follow the example attached to the end of this chapter.

Some of the Medi-Cal policies you may ask for are Field Instruction Notices (FINs), Policy Statements, and Operating Instruction Letters (OILs). These are important because they explain how the Medi-Cal program defines medical necessity when they approve or deny devices or services like the ones you requested. For instance, some FINs set out the rules the Medi-Cal program will apply when asked to purchase an electric wheelchair. The FINs, Policy Statements and OILs are not regulations but guidelines. The Administrative Law Judge who will hear the case does not necessarily have to follow them.

If the Medi-Cal field office does not give you access to the information, call the 800 number on the hearing request acknowledgement and ask them to explain how to have a subpoena duces tecum (pronounced sah-PEE-na due-ses TEK-um) issued. That is a subpoena that orders Medi-Cal to bring the documents to the hearing. Ask for time to go over the materials at that time.

Fourth: If you get copies of relevant material, show them to your treating doctor. The doctor may need to explain the documents submitted with the TAR. It may be necessary for the doctor to translate the documents into simple language.

27. How do I file for a fair hearing?

To file for a fair hearing, fill out and mail the reverse side of the Medi-Cal notice-of-action form. Or, you can send a letter to:

State Hearings Division
Department of Social Services
744 P Street, Mail Station 9-17-37
Sacramento, CA 95814

RE: Medi-Cal Fair Hearing
Your Name
Your State Medi-Cal number or Social Security number

The letter should include a general statement about why you want a hearing. For instance:

- The county is taking too long to process your Medi-Cal application;
- You are eligible for Medi-Cal;
- You need an electric wheelchair because you are too disabled to use a manual wheelchair; and
- You need an electronic speech device because you cannot communicate any other way.

28. How much time do I have to file for a fair hearing?

You have 90 days from the date of the Medi-Cal action to ask for a fair hearing. But see the next question.

29. What happens to my Medi-Cal benefits during the appeal process?

If you ask for a fair hearing within **10 days** of the date of Medi-Cal's written notice, current benefits will continue until an Administrative Law Judge issues a hearing decision. If you receive a notice terminating kidney dialysis, chemotherapy or radiation treatments, transportation, waiver services or a stay in a skilled nursing facility or an intermediate care facility, benefits will continue until the hearing decision if you file for a fair hearing within **10 days** of the notice date or before the benefits end.

In certain circumstances, Medi-Cal services can continue pending a hearing decision when Medi-Cal refuses to reauthorize the services . Some non-acute

hospital services can continue pending a hearing decision (or pending completion of the request for reauthorization if earlier) if:

- Medi-Cal receives the reauthorization TAR within **10 days** after the expiration of a prior authorization; and
- You submit a hearing request within **10 days** of the post mark on the denial notice, or before the prior TAR expires, whichever is later.

The following services are included in this category:

- Long-term care (SNF, ICF and subacute);
- Chronic hemodialysis (including all related services such as transportation);
- Home and community based waiver services;
- Skilled Nursing Facility waiver services (and all related services); and
- All other non-acute services, such as physical therapy, when your treating doctor substantiates on the TAR that services should continue because the treatment goal on the original TAR has not been met.

If Medi-Cal denies a request to reauthorize acute care, including acute inpatient rehabilitation care, that has been approved for at least five days, and a treating doctor determines that you cannot be discharged from the hospital because you still need that level of care or you have not yet met your achievable rehabilitation goals, Medi-Cal funding at the acute care rate can continue pending a hearing. Medi-Cal will have the notice of denial delivered to you personally by the first working day following the denial--unless a treating doctor says the notice should be delivered by other means for health reasons.

Medi-Cal coverage of the acute care services will continue pending the hearing if you ask for a fair hearing within **10 days** of the notice denying reauthorization.⁵⁹

30. What happens to my rights if I am in Medi-Cal managed care?

Managed care under Medi-Cal may come about through a federally approved waiver of your federal right to freedom of choice among providers. The states must

⁵⁹ See, 22 C.C.R. §§51014.1, 51014.2.

operate a program uniformly statewide with no difference in benefits. No federal waiver is required if the state elects managed care under the 1997 Balanced Budget Act.

Your rights under Medi-Cal managed care are the same as under regular Medi-Cal (referred to as fee-for-service) except for limits on your choice of providers.⁶⁰

Your access to the Medi-Cal fair hearing process is the same as under fee-for-service Medi-Cal. When a managed care plan denies or terminates a service, you are entitled to a hearing. You also have access to the managed care plan's internal grievance procedure. You can pursue both a fair hearing and grievance at the same time. We recommend that you pursue both because the grievance may resolve the problem without the need for a hearing.

You have a right to file a grievance or fair hearing even when you have a disagreement with your primary doctor. For instance, if you ask your doctor for a referral to a special clinic but she says no, you should file both a grievance and a fair hearing request. If you need a second opinion -- such as whether you need an assessment or a referral to a specialist -- the administrative law judge can order a second opinion.⁶¹

31. How do I prepare for a fair hearing?

Preparing for a fair hearing can be an arduous undertaking. There is an excellent paper on this topic that can be found at:

[http://www.nls.org/conf2006/medicaid%20outline%20\(2006\).htm](http://www.nls.org/conf2006/medicaid%20outline%20(2006).htm). It covers from the initial client interview through preparing your case for hearing.

⁶⁰ For more information about California's Medi-Cal managed care programs, visit the National Health Law Program at:--

<http://www.healthlaw.org/library.cfm?fa=summarize&appView=Topic&id=1136>

⁶¹ 42 C.F.R. §431.240(b).

ATTACHMENT TO CHAPTER 10

To Review File and Medi-Cal's Authority Sample Letter

(Date)

Medi-Cal Field Office
Address
City, CA, Zip Code

RE: State Hearing No. _____
Medi-Cal No. _____
Your Name, Address, Phone Number

Prior to the hearing, I will want to review my Medi-Cal case file [or the case file of an individual you are authorized to represent]. At that same time, I will want to review the following:

1. The specific regulations (including the applicable Manual of Criteria section) that relate to the requested services/device and
2. Any Field Instruction Notices (FINs), Policy Statements or Operating Instruction Letters (OILs) that concern when or whether the Medi-Cal program covers [the requested service or device].

After reviewing this information, I may want to photocopy some or all of these documents and submit them to the administrative law judge hearing the case. I consider the rules and policies on which you base your decision to be as much a part of my file as the TAR documents.

I will call to set up an appointment to review the file and applicable policies and rules. If you are unable or unwilling to make the requested information available to me, please let me know so that I can ask the Chief Administrative Law Judge to issue a subpoena.

I assume there will be no charge for any copies I make to submit as part of the hearing record.

Sincerely,

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Send a copy of this letter to the Chief Administrative Law Judge at the address indicated in the brochure you receive with the hearing request acknowledgement.

Alternatively, if what you want is a copy of any Field Instruction Notice or Policy Memo, at the time you request a fair hearing you can send a California Public Records Act request to the Department of Health Services Office of Legal Services, 714 P Street, Sacramento CA 95814, with a copy to the field office that denied the TAR. In the letter, indicate that the request for these documents is related to a fair hearing request and ask that copies of the Field Instruction Notices or Policy Memos be sent to you without cost.