DELAYING NECESSITIES
DENYING NEEDS

An Assembly Investigation of New York State's
Handling of Medicaid Durable Medical Equipment Claims.

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TABLE OF CONTENTS

THE NEW YORK
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Dear Reader:

New Yorkers long ago decided to provide health insurance to children and adults with severe disabilities, perhaps the most vulnerable people in our society. Many have life-long diseases that disable and weaken their bodies, making them unable to sit in normal chairs, or prevent them from walking or talking. Those of us who can get up in the morning, go to work, shuttle around our kids, often take for granted our capabilities.

While we certainly do not have a complete picture of how well the State Department of Health (DOH) manages the portion of Medicaid that funds equipment for people with severe disabilities — as DOH was either unable or unwilling to provide much of the requested information — we do have many snapshots … and they do not look good.

DOH has violated many of its guiding regulations. DOH should have clear guidelines so applicants know what information to provide when requesting funding; it does not. DOH's job is to approve specific funding requests if ordered by an approved provider and are proven to be medically necessary and appropriate. And only a health care professional within the same medical profession should be allowed to deny or modify a treating practitioner's order or prescription. Yet, DOH reviewers (generally nurses and physical therapists) often deny medically necessary items ordered by physicians, and regularly change requested items to less expensive, inappropriate items that are ill-suited for the patient. DOH is supposed to issue determinations within 21 days, but despite having installed a new, costly computer system, it is not capable of monitoring this and, in fact, it seems the department is engaging in deliberate measures to stop the clock.

Discussion of this program at times can seem arcane, if not tedious. Most of this report is devoted to analyzing finer points of legal, management and bureaucratic issues. While focusing on details can obscure the larger picture, the details are, as is said, where the devil is.

The Committee Chairs' conclusion is that DOH uses, and misuses legal and bureaucratic means to unfairly prevent people with severe disabilities from getting equipment they should have. DOH's actions often hurt vulnerable people and are likely resulting in greater spending.

Sincerely,

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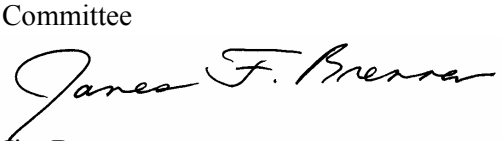

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EXECUTIVE SUMMARY

The New York State Department of Health has been systematically depriving poor people with severe disabilities — many of them children — of wheelchairs and other "durable medical equipment" they need to reduce their pain, preserve their health, and enable them to live more productive lives. The mechanism is the Department's "prior approval" process under Medicaid. Whether this has been caused by callous pursuit of short-term savings, negligence, or incompetence, the results are cruelty and long-term increased costs. Widespread complaints by patients, their families, and service providers; intensive press scrutiny; and persistent legislative investigation and exposure (as described in this report) have produced some gradual improvement within the Department. Much more needs to be done.

When this issue first came to public attention, it seemed to be a consequence of turmoil caused by the closing of the Department's regional office in New York City, which handled two-thirds of the statewide volume of prior approval applications. However, it turned out to be a long-standing systemic statewide problem that had largely not afflicted the New York City office.

This report details the failure of the Department to comply with State regulations and properly support Medicaid recipients with severe disabilities. The report — jointly issued by the Chairs of the Assembly Committees on Oversight, Analysis and Investigation, and Health, and of the Task Force on People with Disabilities — offers recommendations to improve the durable medical equipment prior approval system and to spend taxpayer dollars more efficiently. It also suggests areas for future study.

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The New York State Department of Health (DOH) manages the State's Medicaid program, which provides health insurance for those who cannot otherwise afford it. DOH is responsible for assuring that children and adults with severe disabilities get funding for the equipment their physicians say they need to prevent suffering and to achieve their capacity for normal activity.

The New York State Assembly began reviewing DOH's prior approval program for funding durable medical equipment (DME) following DOH's closure of its New York City regional Medicaid office, which served most of Downstate. DME requiring prior approval includes a variety of different-priced items ranging from commodes to power wheelchairs with molded seating and other accessories.

After DOH transferred operations to Albany, claims processing slowed to a crawl statewide, preventing many people with disabilities from getting equipment they needed to get around, go to school or work, or simply to sit up. To conform to procedures Upstate, DOH stopped processing emergency requests and funding items used for daily activities, like eating and grooming. Clinicians in the Downstate area said their trained medical opinions were no longer respected, their orders were being changed, and, their prior approval requests were coming back repeatedly as DOH sought more and more information, which clinicians often considered irrelevant, redundant and otherwise unreasonable. Each missing information request, or "pend"

as DOH calls them, could add months to a process that formerly was completed within two to three months. Applicants reported waiting six months, nine months, a year or more.

After two public hearings and a more thorough review of this program, the Assembly Chairs have found that DOH has supported a badly run statewide prior approval system, with no real guidelines, and has largely ignored its own agency regulations. DOH's numerous inefficiencies, bureaucratic bungling and attempts to contain costs, have often resulted in a diminished quality of life for recipients and their caregivers ***and*** quite likely greater long-term costs. Despite treating people with lifelong disabilities as though they are trying to commit fraud, DOH does not do enough to help identify and prevent fraud.

But, perhaps the most far-reaching and potentially devastating violation is in regard to providing equipment that is deemed medically necessary by qualified providers. DOH's interpretation of the legal term "medical necessity" is clearly narrower than that of most practicing clinicians; it has denied items that would promote independence and were prescribed by physicians as part of a plan of care to prevent suffering and infirmity. The DOH prior approval process is more restrictive and dramatically slower and more wasteful than the processes of commercial insurers.

Taken together, these actions prevent Medicaid recipients with severe disabilities from getting what they need to continue living at home and to live independent lives. Federal and state laws, case law, as well as common sense, support the goal of keeping people in their homes and in the community; it is more humane and more cost effective than putting them in nursing homes or other institutional care.

PRIMARY FINDINGS:

- DOH has overstepped its authority by denying certain items deemed medically necessary by physicians and treating practitioners, and by proposing alternative plans of care. This is a violation of State regulation and this practice can be costing the State more money.
    - DOH has ignored the definition of medically necessary — a violation of state and federal rules, and, often not cost effective.
    - DOH has allowed improperly credentialed people to overrule the orders or prescriptions of recipients' ordering or treating practitioners. This practice violates DOH's regulations and industry standards.
    - DOH has proposed alternative items that are less expensive, but sometimes not appropriate for the patient and/or are poorly made. In either instance, this could cost more money in the long term.

- The prior approval program for durable medical equipment is badly managed and is rife with inefficiencies.
    - While DOH does have written guidelines, they are much too vague. Even when providers comply with the guidelines they are often pended and asked other questions, often irrelevant, redundant, or otherwise unreasonable.
    - Medicaid recipients have experienced long delays waiting for funding approval and getting their equipment. Providers blame DOH and DOH blames equipment vendors, although DOH has not provided any data or evidence to support its

claims. In fact, DOH does not have the ability to track the length of time it takes to process all claims despite a State regulation setting a 21-day limit.
    - DOH does not know how many prior approval requests come in the door, yet claims to be approving 95 percent of them. Clearly, DOH is misrepresenting the share of prior approval requests that are approved.
    - DOH has contributed to long delays by asking for irrelevant and redundant information, which can delay requests by months. Some responses give the impression that reviewers may not be well qualified.
    - DOH's explanations for closing the New York City regional Medicaid office — and transferring two-thirds of statewide prior approval claims to Albany — remain unsatisfactory.
    - DOH did not properly prepare the Albany office for quadrupling its workload.
    - Delays have been exacerbated because DOH does not have or has been slow to take advantage of technological advances.

- DOH does not do enough to determine whether patients get the equipment for which they were funded. This undermines the prevention and detection of fraud and abuse.

- For the past seven years or so, people who are dually eligible for both Medicare and Medicaid have been caught in a catch-22, making them ineligible for both Medicare and Medicaid. The reason this happens: Medicare requires an item be purchased first, and Medicaid requires prior approval before an item is approved for funding. So, if an applicant applies for Medicare, thereby first purchasing the item, and is then denied, they cannot then seek Medicaid. DOH has not resolved this seemingly simple problem, even though several administrative law judges have pointed out remedies.

- The DME Workgroup — established by DOH (after the Assembly announced DME hearings) to tackle many of the problems with the prior approval process — is a great concept, and is responsible for helping establish emergency procedures and having the prior approval unit use a fax machine. But its most important tasks — developing guidelines and streamlining the prior approval process — are still not done, and Workgroup members, which include clinicians, providers and users, have good reason to question whether DOH is taking it seriously as it recently issued new DME rules without consulting with the Workgroup.

- The number of fair hearings has decreased by 50 percent in the past few years, which does not square with the rising level of complaints. Also, DOH regularly ignores decisions made by Administrative Law Judges, which reverse DOH decisions about 50 percent of the time.

RECOMMENDATIONS:

- DOH must comply with its own regulations. Almost every finding in this report is a violation of the State's regulations.

- DOH must comply with the procedures in its own regulations for determining "medical necessity," which means medical supplies would be medically necessary if they prevent, diagnose, correct or cure a condition of the recipient which: (1) causes acute suffering; (2) endangers life; (3) results in illness or infirmity; (4) interferes with the capacity for normal activity; or (5) threatens to cause a significant handicap. DOH should pursue in good faith the goal of independence for people with long-term, severe disabilities. Providing children and adults with the equipment that better meets their medical and physical needs, lasts longer, and helps prevent future problems will save money in the long-term.

- DOH should follow State regulations and only overrule the opinions of ordering practitioners based on the opinions of those within the same medical profession. To the extent that the language of the regulation lacks clarity, it should be clarified either by amending the regulation, or by statute, if necessary.

- DOH should promulgate clear and concise criteria for prior approval applications. DOH could adopt (and adapt where necessary) Medicare's medical equipment justification guidelines so that all reviewers have a common unbiased basis for approval. Guidelines should be specific and list documentation required.

- DOH should aggregate and use the data in its system to figure out where the delays are. It should then respond accordingly to help assure Medicaid recipients with severe disabilities get the equipment they need in a timely manner, and use the information to detect and prevent instances of fraud.

- DOH should require Computer Sciences Corporation, which installed the new eMedNY system, to fulfill the terms of the DOH "request for proposals" (under which the system was developed) and the system's specifications, both of which suggest the system should have been designed to enable DOH to track the length of time it takes to process all prior approvals (even pended ones) and to use email.

- DOH should hire appropriate staff with appropriate credentials and experience in seating, positioning, and mobility, and/or provide appropriate training.

- DOH should require reviewers to identify their professional titles on responses to prior approval requests. They must identify their credentials on all correspondence, including any relevant licenses or certifications.

- DOH should consider using a peer review consultant staff to review any preliminary denials or modifications. Look into similar changes made in Utah, which is reportedly saving that state a lot of money.

- DOH must assure that people who are dually eligible for both Medicaid and Medicare are entitled to the same coverage as Medicaid-only recipients.

- DOH must provide to the Legislature its planning documents for closing the New York City office (with personnel information redacted).

- DOH should notify the applicant every time a request (in entirety or in part) is pended, denied, rejected, voided, inactivated or omitted, and notify them as to whether the determination applies to all or part of a request so that the applicant is always informed of his or her right to a fair hearing.

- DOH should install an online status reporting system, similar to those offered by UPS and FedEx. Using a tracking number, interested parties could track the progress of their applications.

- DOH should conduct post-audits to ensure: 1) recipients get the proper equipment for which they were awarded funding; and, 2) the equipment is working properly and meeting recipients' needs.

- Enact legislation requiring DOH to institute a comprehensive, aggressive program of enlisting Medicaid recipients and the public in preventing and uncovering Medicaid fraud, waste, and abuse. Recipients are in the best position to know whether payments are legitimate, and whether the funded items or services were legitimate. Modeled on a Federal Medicaid program, and already in place in a number of other states, the proposal would make it as easy as possible for recipients and family to forward tips of suspected abuse to state officials.

- This Assembly review revealed that "explanations of medical benefits," which DOH sends to recipients to ensure Medicaid payments were accurate, are confusing and have not been effectively used. Very few are sent out, in fact each Medicaid recipient might receive one every 65 years, and they do not clearly identify the equipment purchased, the total cost, and when the item was delivered. DOH should improve the quality of EOMBs and consider increasing the number sent.

- DOH should identify and contract only with quality vendors. Many vendors support a requirement that they be certified or accredited — that is, undergo more scrutiny — so they can be separated from less credible vendors. DOH should require that where Medicare requires its vendors be accredited, Medicaid would require its vendors to undergo that process.

- DOH should systematically examine the fairness of its so-called "fair hearings," which are conducted by the New York State Office of Temporary and Disability Assistance (OTDA). This examination should include participation of consumers, providers, and independent experts.

- OTDA should create a publicly accessible fair hearing database enabling users to break out, on a case-by-case basis, the dollar amount, who represented the recipient and the item requested.

- Establish the DME Workgroup as a permanent body and give it a substantial oversight role.

- DOH must report the number of and credentials of their reviewers and supervisory staff in the DME prior approval units in Albany and Buffalo, including answering whether staff has been in active clinical practice and has board certification.

METHODOLOGY

The following report is being jointly issued by the present and former Chairs of the Assembly Oversight, Analysis and Investigation Committee Sam Hoyt and James Brennan, Assembly Health Committee Chair Richard N. Gottfried, and Task Force on People with Disabilities Chair Amy Paulin. This review began under the Oversight Committee chairmanship of Assembly Member James Brennan and was then pursued by his successor Assembly Member Hoyt.

The purpose of the Committee Chairs' review was to evaluate the State Department of Health's management of the prior approval program for durable medical equipment (DME). This report explains the Committees Chairs' findings and offers recommendations to improve the system and spend taxpayer money more efficiently and intelligently.

To accomplish this review, Committee staff attended DME Workgroup meetings, spoke with and reviewed documents from the Department of Health (DOH), the Office of Temporary and Disability Assistance, durable medical equipment (DME) providers and vendors, physicians of related specialties, therapists, Medicaid recipients (or their representatives), state and national associations, the State Comptroller's Office, lawyers representing Medicaid recipients, the U.S. Government Accountability Office, the U.S. Senate, the U.S. Center for Medicare and Medicaid Services, and the National Health Law Program. Staff also reviewed testimony and documents submitted at the two public hearings, State regulations, State and Federal law, case law, and dozens of State Administrative Law decisions.

DOH was unable or unwilling to comply with many of the different data and information requests made by the Committees over a period of 15 months. Therefore, this report of necessity relies heavily on anecdotal information, data and documents provided by recipients and providers, or their representatives, and others.

OVERVIEW

This report details the failure of the New York State Department of Health (DOH) to comply with State regulations and properly support Medicaid recipients with severe disabilities. The report — jointly issued by the Chairs of the Assembly Committees on Oversight, Analysis and Investigation, and Health, and of the Task Force on People with Disabilities — offers recommendations to improve the durable medical equipment prior approval system and to spend taxpayer dollars more efficiently. It also suggests areas for future study.

DOH manages the State's Medicaid program, which provides health insurance for those who cannot otherwise afford it. DOH is responsible for assuring that people with severe disabilities get funding for the equipment their treating practitioners' say they need to prevent suffering and to achieve their capacity for normal activity. Instead, the Assembly Oversight, Analysis and Investigation and Health Committee Chairs and the Chair of the Task Force on People with Disabilities have found that DOH has badly managed this program. The department's numerous inefficiencies, bureaucratic bungling and attempts to contain costs, have often resulted in a diminished quality of life for recipients and their caregivers ***and*** quite likely greater long-term costs.

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The New York State Assembly began reviewing DOH's prior approval program for funding durable medical equipment (DME) — sophisticated, and often expensive items like power wheelchairs with molded seating and other accessories — when DOH closed its New York City regional office. That office had processed two-thirds of all DME prior approval claims in the State, which total less than $15 million a year statewide, or less than one-tenth of one-tenth percent of the State's Medicaid budget.

When DOH transferred operations to the Albany office, claims processing slowed to a crawl statewide, preventing many people with disabilities from getting the equipment they needed to get around, go to school or work, or simply sit up. To conform to procedures Upstate, DOH stopped processing emergency requests and funding items used for daily activities like eating and grooming. Clinicians in the Downstate area said their trained medical opinions were no longer being respected, and their prior approval requests were coming back repeatedly as DOH sought more and more information, which they deemed irrelevant, redundant and otherwise unreasonable. Each missing information request, or "pend" as DOH calls them, could add months to a process that formerly was completed within two to three months.

As a result, children and adults with disabilities, such as cerebral palsy (CP) and ALS (amyotrophic lateral sclerosis, also known as Lou Gehrig's Disease), were bed bound, unable to attend school or work, and suffered both physical and psychological setbacks resulting in hospitalization or dependence on others.

After learning about delays in the processing of requests for Medicaid funding in early 2005, the Committee Chairs immediately met with DOH officials. DOH assured the Chairs that the

backlog of prior approval requests that built up as a result of the transfer of operations to Albany would be resolved.

But, a few months later, after visiting several providers and talking with DME prior approval applicants (or their representatives), the Chairs learned complaints of delays persisted. In fact, the Assembly was hearing a host of complaints about violations of State regulations. These came from applicants and providers *throughout* the State, not just in the New York City region.

In May 2005, the Assembly Chairs announced they would hold a public hearing to explore reasons for and repercussions of the delays. More than 70 people asked to testify at the July 19, 2005 hearing in New York City. Based on the overwhelming response and requests for a hearing Upstate, the Chairs held a second hearing November 15 in Albany.

In June, DOH held the first meeting of a newly formed DME Workgroup, comprised of representatives from DOH, providers, clinicians and Medicaid recipients. The group was formed to tackle many problems in the DME prior approval process, including developing guidelines, establishing emergency procedures and streamlining the prior approval process.

After public hearings and a more thorough review of this program, the Assembly Chairs have found that DOH has supported a badly run statewide prior approval system with no real guidelines. In effect, DOH has largely ignored its own agency regulations, especially in regard to how the definition of "medically necessary" is interpreted; the number of days DOH has to issue determinations, or rather its inability to track the number of days; and, following physicians' orders. Furthermore, DOH sends multiple information requests on many prior approval requests, often seeking irrelevant or redundant information, thereby delaying the process by months. The Committee Chairs have heard from many providers and applicants who have waited nine months, one year or more for a final determination from DOH. Some ask DOH to simply deny the claim so they can end the process and go to fair hearing.

In short, State regulations define "medical necessity" as preventing suffering and infirmity and achieving capacity for normal activity. In many cases presented to the Committee Chairs, DOH has withheld funds for certain badly needed items, which could not only potentially harm lives, but could lead to greater costs in the long run. For instance, in a story that follows, DOH denied a wheelchair mechanism that was prescribed by a physician in a patient's plan of care to help prevent pressure sores. Lacking that mechanism and appropriate care, the man was hospitalized for eight months with severe pressure sores that nearly killed him.

DOH has misinterpreted State regulations, federal law and case law by allowing nurses to overrule physicians' prescriptions, and has changed requested items to ones less expensive, but ill-suited to the patient. For instance, one physician said DOH has been approving low-cost wheelchairs that will break down easily and will not last as long as other, slightly more expensive chairs.

And often DOH has not denied, approved or modified the request, but has written "void" or "rejected" on the request, neither of which are regulatory options. Responding in these ways precludes the applicant from being informed of their right to a fair hearing. Sometimes, to end

the cycle of missing information requests, some providers ask DOH to deny the claim so they can at least request a fair hearing.

Additionally:

- DOH cannot track the total length of time it takes to process prior approval requests that are returned to providers for more information, even though it is required to process all requests, including pends, within 21 days.
- DOH did not properly prepare for closing the New York City office, and still has not provided the Committee Chairs with its planning documents.
- DOH has still not resolved a problem that denies coverage to the growing population of people who are dually eligible for both Medicaid and Medicare. They are often caught in a catch-22 making them unable to receive coverage under either form of insurance.
- DOH has often treated applicants, most with a long history of the same disease(s), as if they were attempting to commit fraud. Yet DOH has not done enough to intelligently combat fraud.
- DOH regularly ignores Administrative Law Judge decisions, which reverse DOH determinations in 50 percent of the hearings.

It seemed to many that the DME Workgroup was a good faith effort on the part of DOH to resolve some outstanding problems. The department has developed emergency procedures and installed a fax, but, one year later, it still has not issued guidelines and criteria for the prior approval process, figured out where the delays are occurring, dealt with the dual eligible issue, and most of the other tasks they set out to do. And, DOH just recently issued new rules affecting the DME prior approval process, but did not consult with the Workgroup, which disheartened some members who have dedicated much time and energy.

While 50 percent of fair hearings for DME prior approval denials and modifications result in a reversal of DOH's determination, the number of fair hearings has decreased dramatically over the past three years, by about 50 percent. Some speculate the process has become too intimidating, or that applicants are not informed of their right to a fair hearing, or do not have representation.

Many suspect DOH has established these obstacles to purposely wear down providers and applicants, which often does happen, as many simply give up and stop requesting an item or service.

Regardless, a real consequence of all of these behaviors is that Medicaid recipients with severe disabilities may not be getting what they need to continue living at home and to live independent lives. Federal and state laws, case law, as well as common sense, support the goal of keeping people in their homes and among the community; it is not only more humane, but more cost effective than putting them in nursing homes or other institutional care.

FINDINGS AND RECOMMENDATIONS

I. FINDING: DOH has overstepped its authority by denying items deemed medically necessary by treating practitioners to prevent suffering and infirmity and promote independence, and by proposing alternative plans of care. These actions violate state regulations and may be costing the State more money.

A. DOH has ignored the definition of medically necessary — a violation of state and federal rules, and, often not cost effective.

DOH seems to be wrongly denying many funding requests for items it contends are not medically necessary. Sometimes the items would help a person achieve a small degree of independence, like stand or feed himself, or in other instances the item would appear to prevent suffering and infirmity.

The definition of medical necessity is clear in State regulation, in State law, in federal law and in case law. In short, each legal definition of medical necessity covers medical supplies needed to correct or prevent a condition which interferes with normal activity and causes suffering and infirmity. This rule is the basis on which DOH should be deciding whether to approve items.[1]

> New York State regulations define the term medically necessary as:
>
> NYCRR Title 18, §513.1 (c): "Necessary to prevent, diagnose, correct or cure a condition means that requested medical, dental and remedial care, services or supplies would: meet the recipient's medical needs: reduce the recipient's physical or mental disability; restore the recipient to his or her best possible functional level; or improve the recipient's capacity for normal activity. Necessary to prevent, diagnose, correct or cure a condition must be determined in light of the recipient's specific circumstances and the recipient's functional capacity to use or make use of the requested care, services or supplies and appropriate alternatives."

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Case in Point — Thomas L.

A nurse practitioner and physical therapist requested funding for a stander on behalf of Thomas L., a 30-year-old man diagnosed with cerebral palsy and spastic quadriplegia. He was

[1] NYS Law: Social Services Law §365-a, 2. provides in part: " "Medical assistance" shall mean payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, as authorized in this title or the regulations of the department, which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with this title and the regulations of the department. …" Federal law indicates that the primary goal of Medicaid is to provide medical assistance to persons in need and to furnish them with rehabilitation and other services to help them "attain or retain capacity for independence or self-care."

wheelchair bound and unable to stand unassisted. (A stander is a $4,500 piece of equipment that would help Thomas stand.) DOH denied the request, saying it was not medically necessary. The decision was appealed, but at fair hearing, the administrative law judge (ALJ) agreed with DOH's decision.

Thomas' representatives filed an Article 78 proceeding and the case went before the Supreme Court of the State of New York, Appellate Division, 4th Department, in April 2005.[2] Based on the same evidence provided at fair hearing, the Appellate Court judge reversed DOH's denial and ordered DOH to pay for the requested stander.

The judge agreed that the stander was medically necessary, as already indicated by his caregivers, to decrease contractures in his legs, provide prolonged stretching to elongate his leg muscles and increase bone density. The stander would decrease the risk of broken bones from spasms, decrease muscular atrophy in his legs, decrease the risk of skin breakdown, increase functional mobility, improve circulation and elimination, and improve his comfort and ability to socialize. The judge also agreed that the stander would "restore (him) to his … best possible functional level."

The judge quoted state regulations in noting that the physical therapist's testimony "is entitled to significant weight and cannot be outweighed solely by the opinions of non-medical personnel or persons not within the same medical profession as the ordering or treating practitioner."[3]

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Case In Point — Joey L.

Joey L. is a 35-year-old man with CP, mild retardation and a degenerative neuromuscular condition, but fully capable of getting around in a power wheelchair and communicating with people (via an electronic speaking device). His chair was old and broken and he was being treated for pressure sores. As a result, his physician and therapists at United Cerebral Palsy (UCP), each with many years experience and expertise in assistive technology and seating, wrote to DOH requesting Medicaid pay for a new power wheelchair with a power tilt. The power tilt would enable Joey to lift himself, thereby improving his circulation and helping to prevent pressure sores.

After some back and forth with DOH, about four months later, DOH denied the power tilt while approving a scaled-down version of the chair and other accessories. The Agency agreed Joey needed a tilt, but argued the power tilt was not medically necessary and he could do with a manual tilt. Having a manual tilt would mean Joey would have to rely on someone to lift him every half hour for 10 minutes, and he would be unable to leave the facility.

DOH's reasoning for denying the power tilt: 1) Joey's degenerative neuromuscular condition might make him unable to use the tilt someday; and, 2) staff at his residential center could use the manual tilt to lift him every half hour for 10 minutes. A manual tilt costs about $2,800, while the power tilt would have cost $3,900 (in addition to the chair and its features).

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2 Layer v Novello, 17 AD3d 1123 (4th Dept. 2005)

3 18 NYCRR 513.6 (e).

In the meantime, Joey went to a camp for people with CP for eight days and had to use a manual tilt chair. Staff at the camp did not lift him enough. Soon thereafter, Joey was hospitalized with stage 4 pressure sores, the worst progression for sores, which sometimes extend into muscle, tendon or even bone. His family and support team were worried he may die. "He is not a demanding guy," said his mother Diane L. "He would rather smile at someone than demand something."

They appealed DOH's denial, and the fair hearing was held in September 2005. Agreeing that evidence supporting the medical necessity of the power tilt was credible, the State administrative law judge (ALJ) canceled DOH's denial. The ALJ also "rejected" DOH's argument that staff at Joey's group home could lift him as often as he needed lifting. The ALJ, however, did not grant approval for funding of the power tilt, and suggested Joey re-apply to DOH.

His family did re-apply and DOH rejected the second request in December 2005, writing: "Our decision stands. If Joseph is at such high risk for developing pressure sores he requires repositioning every 30 minutes for 10 minutes at a time, then his plan of care must address this medical need with adequate staffing and power tilt is not sufficient to replace hands on care." This denial was signed only by a nurse.

Joey was finally released from the hospital in March 2006, eight months later, and at least part of that bill will be paid by Medicaid. His mother said she does not want to re-apply again and wait another year, and she has decided to figure out a way to pay for the chair herself. She said she worries what will happen to Joey after she is gone.

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While no one can say for sure, some do speculate that if Joey had had the power chair with a power tilt his ordeal could have been prevented. Tens, perhaps even hundreds of thousands of dollars spent on eight months of hospitalization could have been saved.

It is DOH's job to responsibly oversee the Medicaid program, to have objective criteria and written guidelines, and to provide equipment that is deemed medically necessary when ordered by a qualified provider. None of this happened.

Instead, DOH still does not have objective criteria or specific written guidelines. DOH reviewers, which are mostly registered nurses, overruled a physician's order, which violates State regulations.

DOH's actions exacerbated Joey's pain and discomfort and denied him independence — all contrary to the case law, the federal Medicaid Act, the State's definition of medically necessary, as well as human decency. Also, DOH was given no indication that Joey's degenerative condition could worsen to the point he could not use the power tilt.

The Administrative Law Judge canceled DOH's denial, but effectively told Joey that despite waiting for almost two years to get a final determination on this request, he must start the process all over again. And when Joey did re-apply, DOH again denied the request, ignoring the ALJ's

decision, which rejected the presumption that clinical staff could lift Joey every half hour for 10 minutes at a time.

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Other items DOH seems to be denying on a regular basis include strollers for children above the age of three, shower chairs or any other kind of items used for daily living that would help the caregiver as much as the consumer, power tilts when a person lives in a facility (as opposed to living at home), customized seating that is not molded to the person's body (which would be called custom-made), and lap trays for wheelchairs (which are often used to support a person's body as well as for eating and other daily activities). DOH has recoded some of these items, whereby the maximum reimbursable amount (MRA) is sometimes less than the cost of the equipment. Vendors obviously do not want to lose money.

Examples of DOH responses to such requests:

- A 55-year-old man with cerebral palsy, mental retardation and visual impairment, who is married and works, needed a new tub chair, as the one he had successfully used for more than 10 years was broken and unable to lift him. His physician and physical therapist requested, on his behalf, a new $661 bath chair. While waiting, he was receiving sponge baths from a home health aide. Initially DOH claimed a "procedural error" on its end delayed by a month the first missing information letter it sent his provider. After one year of back and forth with DOH, a DOH reviewer sent another missing information request. It did not deny the item, but suggested the patient should "break away" from his preference for this piece of equipment and "it is not clear why he needs to be submerged in his tub." According to UCP, the patient has reportedly given up and is trying to find another source of funding.
- After one DOH denial and one subsequent fair hearing denial, the representatives of a 6-year-old girl with cerebral palsy and spastic quadriparesis sought another fair hearing. The second fair hearing judge approved the requested feeding chair, which was recommended by two physicians, a speech pathologist and a physical therapist. DOH had initially denied the chair saying it was not medically necessary and that, despite not having examined her, she could be fed from her existing wheelchair. The first fair hearing judge confirmed DOH's decision. The second fair hearing judge, however, agreed that because of her body size, weight and configuration she needed the chair so her parents could properly feed her and hold her head up at the same time. The judge wrote: "The Agency's determination to again deny the prior approval request for a Tomato multi-positioning chair for the Appellant was not correct."
- A mother tried to get funding for a stroller to more easily transport her daughter up four flights of stairs in their New York City walkup. She fell carrying her daughter upstairs and broke her arm. The daughter injured her head. The wheelchair is too heavy, but is the only item DOH will approve, saying the stroller is a convenience for the caregiver, not a medical necessity. (It is difficult to understand the point of paying for a wheelchair, which is actually more expensive than a stroller, if caregivers cannot use them.)
- A physician, two therapists and a nurse together signed a letter requesting a power wheelchair with power tilt for a 61-year-old man with severe degenerative disease, who

could not walk, had a skin ulcer at the base of his spine and was well over 300 pounds. The power tilt would enable him to relieve the pressure on his lower spine so the ulcer would not worsen. DOH approved the wheelchair, but "rejected" the power tilt, saying "power w/c is for mobility only it is not a lazy boy recliner substitute."

- A mother requested a shower chair so that she could wash her 40-year-old daughter in the tub. Without it she would have to hold her up and wash her at the same time. One reviewer wrote on a prior approval request: "…while the notion of independence is a desirable benefit, it is not medical in nature."
- A young man seeking a power wheelchair while attending college in Rochester was told there was no medical justification for the power wheelchair to go through the Rochester snow.

Testimony of Lisa Borgen, a parent and client of UCP of Nassau County, from the Assembly DME Hearing in July 2005:

Items like strollers, lap trays, feeding seats, metal shower chairs and conformed backs for wheelchairs are ridiculously considered items of convenience or are no longer covered…As President of the PTA at United Cerebral Palsy of Nassau, along with other groups for parents with disabilities, I come in contact with hundreds of parents with children who have disabilities. I can promise you that no one wants equipment they do not absolutely need for their child. The equipment is ugly, cumbersome, takes up an entire room in our homes, and it is a constant reminder of our children's disability. But it is a necessity for my daughter to live and it is our reality. All I want is to be able for my daughter to be able to get around in our community and get to school. All I want is to be able to keep my daughter home with me for as long as I possibly can and durable medical equipment plays a crucial role in order to allow this to happen.

Jean Minkel, who is Director of the Seating Program for Independent Care Systems and has some 20 years experience in seating and mobility, provided about six hours of training to a dozen or so DOH prior approval reviewers in late 2005. Based on that experience, she said she believes the reviewers and clinicians have different views of what medically necessary means, despite what might seem like a clear definition in law and regulation. To the reviewers, medical necessity, she believes, makes them question 'how they can directly meet medical need,' while the therapists view it as 'how can they maximize independence.'

Minkel, who supports the goal of functional independence for people with long-term, severe disabilities, conceded that it is much easier to identify medical necessity when a patient requires medicine, such as antibiotics. That is clear. It is less clear when a patient has a disability that makes him unable to walk or talk, but is basically healthy. The patient may need equipment to sit up, support his head, stand, or get around. These items help improve circulation, prevent sores and other serious complications. Also, these DME items often both prevent illness and promote small degrees of independence, and then some go a step further providing greater independence.

While a newcomer to this DME prior approval process would not be able to determine by reading the State regulations or DOH guidelines that Medicaid will not cover certain items

mentioned, providers and vendors say they have learned this from experience. As providers learn which items DOH will not fund, they no longer ask for them because it takes too much time and energy to get a final determination. DOH either denies the item or postpones making a determination by requesting more and more information.

It is rare that a denial goes to fair hearing, and even more rare that one goes to court, as in the case above. (Only when it issues a denial or modification is DOH required to inform the applicant of their right to a fair hearing. About 50 percent of the fair hearing decisions reverse DOH's decision.) A paralegal, who works at a nonprofit organization that represents Medicaid recipients at fair hearing, likened going to fair hearing for many recipients using this equipment as formidable as climbing Mount Everest.

Recommendation: DOH must comply with the procedures in its own regulations for determining "medical necessity," which means medical supplies would be medically necessary if they prevent, diagnose, correct or cure a condition of the recipient which: (1) causes acute suffering; (2) endangers life; (3) results in illness or infirmity; (4) interferes with the capacity for normal activity; or (5) threatens to cause a significant handicap. DOH should pursue in good faith the goal of independence for people with long-term, severe disabilities. Providing children and adults with the equipment that better meets their medical and physical needs, lasts longer, and helps prevent future problems can only save money in the long-term.

Recommendation: DOH needs to clarify what ADL (activities for daily living) items it will cover under Medicaid, and which ones it will not. Also, consider reinstituting approvals for certain ADL equipment as medically necessary.

Recommendation: DOH should contract with a few physiatrists to review complex requests, evaluate second opinions and respond to appeals. DOH has established a contractual relationship with The State University of New York to act as a consultant. However, DOH needs to consult more with practicing physicians rather than those working only in academia, who may have conflicting standards of care.

Recommendation: DOH must inform all parties of any prior approval request modification and the reason, and include a full disclosure of the applicant's right to a fair hearing.

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B. DOH allows improperly credentialed people to overrule the orders or prescriptions of recipients' ordering or treating practitioner. This practice violates DOH's own regulations and industry standards. To the extent that the applicable DOH regulation lacks clarity, it should be clarified, either by an amended regulation or by statute.

The overriding question in DME cases is medical necessity. Each prior approval request includes a medical justification from the recipient's "ordering practitioner." The ordering practitioner is

usually a physician, but it can also be a dentist, osteopath, optometrist or other health care practitioner or enrolled provider.[4]

The practical problem is that DOH has allowed the opinions of nurses, physical therapists and others to overrule requests made by recipients' physicians or other ordering practitioners. In the most egregious cases, DOH relies on unsigned opinions with no indication of any pertinent credentials.

The decision making process is laid out in DOH's regulations. The ordering practitioner is the "preferred source of information."[5] If the requested supplies are generally available under the program, DOH must approve the request unless there is "clinical information or documentation conflicting with the opinion of the ordering or treating practitioner."

State regulation 18 NYCRR 513.6 (e) specifies the kind of evidence and the credentials necessary to outweigh an ordering practitioner's opinion:

"When the opinion of the ordering or treating practitioner is on matters within the ordering or treating practitioner's professional expertise and within the range of commonly accepted medical practice for the profession, it is entitled to significant weight in reaching a determination and cannot be outweighed solely by the opinions of non-medical personnel *or persons not within the same medical profession as the ordering or treating practitioner.*" (Emphasis added.)

Although it is worded awkwardly, the regulation means that DOH can only use appropriately credentialed people to overrule or outweigh the opinion of the recipients ordering or treating practitioner. Only someone "within the same medical profession" is sufficient. The Appellate Division, Fourth Department, recently used this regulation in finding that DOH's denial of a DME request was conclusory and not supported by substantial evidence.[6]

The wisdom of this policy is rooted in common sense, accepted in industry practice, and echoed in the rules of legal evidence. Physicians, dentists, osteopaths might have reasonable differences of opinion on matters within their respective areas of expertise. But, outside their area of expertise their opinions should carry little, if any, weight. For example, an optometrist's opinion has no bearing on a dental issue.

DOH practice often has been to disregard the regulation in overruling the opinions of recipients' ordering practitioners. DOH apparently has relied on the awkwardness of the regulation's language to allow DOH staff, not within the same medical profession, to overrule the opinions of ordering practitioners. DOH routinely has denied or modified physicians' orders based on the opinions of reviewers who may be nurses or physical therapists, if they are even identified.

In April 2006, DOH made some movement towards mitigating the problem by hiring a physician to help supervise the DOH prior approval unit. Presumably, this might allow DOH to more

[4] 18 NYCRR§ 513.1(d)
[5] 18 NYCRR§ 513.5(c)
[6] Layer v Novello, 17 AD3d 1123 (4th Dept. 2005)

readily provide a physician able to rebut the opinion of a recipient's ordering practitioner when he or she is a physician. Former DOH Deputy Commissioner Kuhmerker credited the Assembly Chairs with motivating staffing changes; she said, "…I think the scrutiny that you helped bring to this has helped and I believe we are and will continue to make progress."

Progress is appreciated, but not enough. Hiring one physician does not necessarily cure the underlying problem. DOH needs to get this right by following the sensible policy contained in its own regulation in all cases.

Recommendation: DOH should follow its own regulation and only overrule the opinions of ordering practitioners based on the opinions of those in the same medical profession. To the extent that the language of the regulation lacks clarity, it should be clarified either by amending the regulation, or by statute if necessary.

Recommendation: DOH should hire appropriate staff with appropriate credentials and experience in seating, positioning, and mobility and/or provide appropriate training.

Recommendation: Consider using a peer review consultant staff to review any preliminary denials or modifications. Look into similar changes made in Utah, which is reportedly saving that state a lot of money.

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C. DOH reviewers, mostly nurses, have changed physicians' orders and approved instead items that are less expensive, but not appropriate for the patient, and more likely to break down and need replacement sooner.

Clinicians and providers have reported that DOH is downcoding requests, that is denying certain items but approving less expensive items in their place. As long as the less expensive items are medically appropriate for the recipient, DOH can do this. However, what people are reporting is that the items are sometimes not appropriate, and causing pain or discomfort for the patient, and that other times the items are so badly made they will need replacement soon.

For instance, Sara Woll-Bollinger, Executive Director of Enable, said that many of her constituents have observed that DOH is approving low-cost wheelchairs, and that "they are so poorly made that they require costly repairs within months of purchase and rarely last five years without significant additional expense."

In another instance, DOH would not approve a custom chest harness for a 19-year-old man with cerebral palsy spastic quadriplegia and other debilitating conditions who need a replacement harness to sit up, in part because of a recently inserted feeding tube. DOH has only one code for seat belts, off the shelf belts, and the MRA on those does not cover the cost of the one he needs.

Dr. Evangelista, a physiatrist, testified at the July public hearing that sometimes the equipment is changed and she complains to DOH that its recommendation is not durable, nor cost effective. She said that she is then told that when it breaks down she should send in another request.

Several clinicians said they are seeing many problems with equipment as a result of this practice, and some suspect that problems will become a lot more apparent in the coming year as more patients begin to receive their downcoded equipment.

Recommendation: State regulations should be amended to include a provision that would prevent DOH reviewers from making changes to ordering or treating practitioner's prescriptions that are not appropriate, i.e. approving the request but changing parts on a wheelchair or the chair itself to parts/or a chair that is perhaps cheaper, but not suitable to the patient's needs.

Recommendation: DOH must assure that the DME Workgroup explores the possibility of adjusting the MRA for custom trays, upper body supports and custom seatbelts.

Recommendation: DOH should require reviewers to identify their professional titles on responses to prior approval requests. They must identify their credentials on all correspondence, including any relevant licenses or certifications.

II. FINDING: The prior approval program for durable medical equipment is badly managed and is rife with inefficiencies.

A. Medicaid recipients have experienced long delays waiting for funding approval and getting their equipment. Providers blame DOH and DOH blames vendors, although DOH has not provided any data or evidence to support its claims. In fact, DOH does not track the length of time it takes to process all claims despite a State regulation setting a 21-day limit.

Many hearing witnesses testified and provided evidence of long delays — six months, nine months, one year and sometimes longer — in the prior approval process, and these lengthy delays have been disrupting and sometimes harmful. However, DOH's new and costly computer system does not appear capable of aggregating reports that allow DOH to disprove or qualify the anecdotal evidence that suggests it is not meeting its 21-day deadline.

Some patients, especially those who do not have a back up wheelchair, have been unable to work or attend school, and some are bed bound, making them prone to pressure sores, bowel problems, congestion and other serious health problems. People needing devises to be able to speak have waited six months.

Here are some examples:

- While waiting more than one year for a new stroller, 8-year-old Brittany B., who has multiple disabilities and is unable to walk or talk, endured many bruises from ill-fitting straps and a tight frame. After a year of back and forth, DOH finally told Brittany's mother Lisa that it would not pay for a stroller, only a wheelchair.
- A patient of UCP-NYC, Jacqueline M., suffered bruising as she had outgrown her wheelchair and her prior approval request was returned three times for what Dara Richardson-Heron, Chief Medical Officer of UCP-NYC, called "unnecessary, duplicative and, frankly, irrelevant information." For example, more than four months after the initial order date, DOH requested the original invoice for Jacqueline's eight-year-old wheelchair.

The guiding rule for DOH regarding how much time it has to issue a determination is a State regulation requiring DOH to determine — deny, approve or modify — all prior approval requests within 21 days.[7] DOH can stop the 21-day clock anytime it chooses, simply by returning a request to the applicant, asking for more information, or what DOH refers to as a "pend." The clock is supposed to resume as soon as DOH receives a response and should total no more than 21 days.

[7] 18 NYCRR Parts 513

Despite these long-standing State regulations, DOH can only retrieve data — on a case-by-case basis and not in aggregate — on prior approval requests that have either been approved or denied.

Furthermore, DOH's new $375 million claims processing computer system — eMedNY — is not capable of producing aggregate data or data for management purposes that show how many prior approval requests are pended, or how long it takes to process pended requests. The design specifications for eMedNY make clear, however, that the system was supposed to have been designed so that this information could be produced.[8] (DOH said it is now working with CSC to develop these reports, and a number of others.) Even prior to the implementation of eMedNY in April 2005, DOH was unable to collect this information.[9]

This revelation is disconcerting because DOH is required by its own State regulations to issue a determination — approve, modify or deny — all prior approval requests within 21 days. If it can not determine when a request came in, there was no way it could have tracked whether it was complying with regulations, or perhaps more importantly, whether it was responding to applicants in an effective and efficient manner. Furthermore, it is difficult to understand how DOH managers would not want to aggregate data to, at the very least, determine how well its system was working.

> ***An exchange between Assembly Member Richard N. Gottfried and former DOH Deputy Commissioner Kathryn Kuhmerker from the July 19, 2005 Assembly DME Hearing:***
>
> **ASSEMBLYMAN GOTTFRIED: … you really don't know whether any cases got settled within 21 days, let alone whether all of them did.**
> **MS. KUHMERKER: I cannot answer that on any statistical basis, but I also did send a sample of seven randomly selected claims. And if you looked at them they really were settled within 21 days. Those are all claims that were pulled from 2004 and 2005 from a random sample of requests that we had received.**
> **ASSEMBLYMAN GOTTFRIED: Although, any statistian (sic) would tell you that a random sample of seven is of limited reliability, but your system, until very recently, was constructed consciously or intentionally or unintentionally to make it impossible to determine even for management, I guess, to keep track of how the work was being processed.**

[8] eMedNY Implementation, Prior Authorization Subsystem Technical Design Document, CSC, 12/03/04, page 32: "This seems a good place to segway into the concept of the PA clock. Because of the 21 day PA turnaround requirement it is important to keep close track of the time it takes to review a PA request and render a decision. … When a 'Pend' determination is assigned the Control status date is updated (the clock is stopped). The reviewer, at his own discretion, may or may not trigger a Missing Information letter. …This column will keep track of the total time in pend status (clock is stopped). Original determination date minus DCN date will give total elapsed time. Total elapsed time minus time pending will give turn around time."

[9] Therefore, data DOH sent to the Assembly Committees in preparation for the July hearing included only requests that had been decided, not any pending requests. DOH did not include any 2005 data.

Nonetheless, DOH Former Deputy Commissioner Kathryn Kuhmerker said DOH turns around requests within five to eight days, although DOH did not provide any evidence to support that claim. DOH contends vendors are not getting the requests out in time, which likely does contribute to long delays, and should not be discounted as part of the problem.[10] On at least two occasions, DOH representatives have said that some public hearing witnesses and persons quoted in a January 2005 New York Times article had erroneously accused DOH of causing the delay with their application, when in fact DOH contends it was the vendors. The Committees did ask for evidence documenting this assertion, but again, have received nothing.

Several hearing witnesses say their requests sat unanswered at DOH for far longer than 21 days. Speaking with providers more recently, this appears to be an ongoing problem.

> ***Testimony of Dr. Dara Richardson-Heron, chief medical officer, United Cerebral Palsy of New York City, Inc., from the July 19, 2005 Hearing:***
>
> **Now, Commissioner Kuhmerker mentioned a five- to eight-day turn around for dispositions. Our records just don't indicate that. Our records indicate that over 20 percent, or 80 of our currently outstanding requests, have received absolutely no response whatsoever from the Department of Health. …**
>
> **Just to give you a few pieces of data. Prior to the downstate office closure, DME prior approval timeframes for selected items from the order date to the actual receipt of the equipment were, as follows: for a new manual chair, it would take about one to two months. And these are average timeframes. For a new power chair, we're talking a little bit longer, but approximately two to three months. And for a power or manual wheelchair part, it would be anywhere from one to three weeks. While these timeframes are clearly not ideal, some of the more recent timeframes are unspeakable. Since the closure of the durable medical equipment office at Five Penn Plaza, many consumers have had to wait nine months or more to get a new replacement chair.**

Pends can delay determinations for months, obscuring the point of a 21-day response requirement. One witness testified that the percentage of items pended increased from 20 percent to 44 percent. Others testified similarly, with a range of 30 percent to 90 percent of their requests pended. And, some witnesses noted even worse scenarios, where all or most of their requests were pended. When she testified in July, Dr. Meg Allyn Krilov, a board-certified physiatrist with St. Vincent's Hospital, said that since the previous November, she had only received a final determination on four of 400 prior approval requests. In June 2006, she said the situation was not much improved.

[10] Sometimes funding requests are returned to the vendor, and the vendor is slow to respond because the patient may need another evaluation and that has to be scheduled or they do not understand what DOH is seeking or they simply do not move quickly. Sometimes funding for items are approved, but the applicant is not informed. Sometimes the medical justification needs to be rewritten and it sits on a doctor's desk. There are many possibilities.

According to Doug Westerdahl, president of Monroe Wheelchair, the largest rehabilitation equipment supplier in New York State, the average number of days it takes his company to obtain prior approval from various insurance agencies is one to 10 days for Empire Plan-United Healthcare, Finger Lakes BC-BS, Preferred Care (Rochester), and MVP (Albany). The average length of time for New York State Medicaid is 168 days.

Enable — an independent living center providing individualized services for children & adults with disabilities — conducted a non-scientific survey via their participant newsletter. More than half of the 66 respondents felt it has taken them a long time to get equipment, and 11 people said they waited over a year for prescribed equipment.

Recommendation: DOH should aggregate and use the data in its system to figure out where the delays are. It should then respond accordingly to help assure Medicaid recipients with severe disabilities get the equipment they need in a timely manner, and use the information to detect and prevent instances of fraud.

Recommendation: DOH should comply with its regulations requiring all determinations be issued within 21 days. (The State of Texas just changed a similar requirement to three days, which is what New York State requires of its managed care contractors.)

Recommendation: State regulations should be amended to allow the 21-day clock to be stopped only with "good cause."

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B. DOH does not know how many prior approval requests come in the door, yet claims to be approving 95 percent of them. Clearly, DOH is misrepresenting the share of prior approval requests that are approved.

Throughout the public hearings, in its written response to Committee Chairs' information requests, and in responses to the media, DOH has referred to a 95 percent approval rating on all requests. However, this percentage is misleading because the denominator does not include the number of outstanding requests, the unknown number returned for more information.

> ***Testimony of former DOH Deputy Commissioner Kathryn Kuhmerker from the November 15, 2005, Assembly DME Hearing:***
>
> **It's a fact that over the past two years the Department has approved ninety-five percent of all requests for prior approval of Durable Medical Equipment.**

The 95 percent figure includes only requests that have been decided, either denied or approved. And as became apparent throughout this review, many prior approval requests, often a significant percentage, remain undecided for months, sometimes a year or more, as DOH sends

out multiple missing information letters or simply does not respond. Often, applicants simply give up.

Comments made to the press were similarly misleading. In a Newsday article, dated May 23, 2005, a DOH spokesperson was quoted as saying that DOH had not reduced its approvals of equipment requests. "The data suggest just the opposite. We have just 1 percent rejected," he said.

***

C. While attempting to "standardize" implementation of the prior approval process throughout the State, DOH still has no clear guidelines that lay the ground rules and spell out what information applicants must submit for equipment.

DOH does not have explicit guidelines that applicants and providers can use to determine what information and documents DOH needs to properly review a prior approval request. While DOH does have general guidelines for wheeled mobility equipment, they have been proven throughout this past year to be too vague. Even after following the existing "Wheeled Mobility Equipment, General Guidelines," providers say their requests are returned for more information, more detail or additional questions not included in the guidelines. Lacking specific guidelines has contributed to the extensive delays consumers and providers have been complaining about because they lead to multiple pends. (See Appendix A for existing wheeled mobility guidelines.)

Recognizing that the existing guidelines were too vague, DOH held training for providers and vendors in late 2004 and early 2005 on how to best complete prior approval requests. It gave attendees copies of what it considered to be model power wheelchair equipment justification letters. One was a six-page, single-spaced document about 3,000 words long, and extremely detailed, including information about the patient's toileting habits. It was clear to many attendees and providers that while this may sometimes provide guidance, these letters were not a replacement for actual guidelines as there are innumerable variations in individuals and equipment needed.

The DME Workgroup is working on developing guidelines. In fact, they have issued three drafts to date, adapting Medicare guidelines, which many hearing witnesses had recommended. This process is clearly technical and time-consuming. The Committee Chairs want to be sure DOH does not drop the ball, and does actually issue guidelines that will help applicants know what information to include in their requests instead of wasting time with continual missing information requests from DOH. This should not be a guessing game.

Recommendation: DOH should follow Medicare DME guidelines until DME workgroup guidelines are finalized. Standard practice in medical utilization is to follow Medicare guidelines unless insurance coverage limits coverage.

Recommendation: Require DOH to promulgate clear and concise criteria for prior approval applications. DOH could adopt (and adapt where necessary) Medicare's medical

equipment justification guidelines so that all reviewers have a common unbiased basis for approval. Guidelines should be specific and list documentation required.

Recommendation: Require DOH to create a standard prior approval form for applicants. The Federal government is requiring a standard form; New York State should do the same.

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D. DOH has contributed to long delays by asking for irrelevant and redundant information, which can delay requests by months. Some responses give the impression that reviewers may not be well qualified.

While these types of complaints seem to be heard less frequently, many applicants and providers said they have received multiple requests for additional information from DOH, often for redundant and irrelevant information, even unreasonable. Each such missing information request, or "pend" as DOH calls them, can add months onto the process.

In one such instance, a Medicaid recipient needed clips to hold the backseat of his wheelchair in place, which would have cost about $180. Despite having years earlier approved funding for that very wheelchair, DOH was now asking for the consumer's complete diagnosis, a full exam to be completed by UCP (which could take hours), the original warranty on the wheelchair, and a copy of the original wheelchair invoice.

Here is another example submitted — with supporting documentation — to the Committee Chairs:

> DOH denied a prior approval request arguing the patient did not need a power chair since he had successfully used a *manual* wheelchair for 14 years and the request did not provide proof he was capable of even using a power chair. However, the physician in his justification letter clearly stated that the applicant had used a manual chair **15 years ago.** But, this was before his disease progressed into its present state leaving him unable to use a manual chair ever since then. The physician also wrote that the applicant underwent an extensive assessment, lasting over three hours, where he successfully used the proposed chair in a mocked up form. After months of back and forth with DOH, this particular case finally went to fair hearing, where the judge reversed DOH's decision. The DOH reviewer was asking for information that was already supplied, and in so doing, added months on to the application time.

It should be noted, however, that DOH said it has corrected a glitch that early into the implementation of eMedNY caused "specific information on missing information letters to be reported as a request even though the information had been supplied." This glitch does not explain many of the examples presented in this report, if any.

Some DOH responses give the impression that the reviewer is not well qualified. DOH reviewers sometimes changed the prescribed item to one that was ill-suited for the client, or denied items

based on photographs or video supplied with the request. According to Lois Tucker, an occupational therapist, DOH changed a requested headrest to one that was incompatible.

> ***Testimony of Lois Tucker, occupational therapist, Certified Rehabilitation Equipment, Inc., from the July 19, 2005 Hearing:***
>
> **We have been asking for a headrest for a young lady who literally has been holding up her head with her hand who has major disabilities now for three and a half months. And we still don't have a solution because the last piece of paper that's come back, and it's come back twice already, came back saying that we could yes, indeed, have those pieces of equipment but she changed the products on that list that she was approving and they're incompatible with the headrest that we recommended.**

Ms. Tucker also testified that in one particular case, DOH denied a headrest based on a photograph. She said:

> **The physical therapist that the DOH had hired, deemed it was already appropriate and we should re-use it, despite the fact that the photos show that the headrest itself is broken. They're in your packet. And the recipient's head, seen in a picture in a static moment, really cannot be evaluated by a therapist anywhere. I would imagine if you reported that therapist they might lose their license. So allowing some kind of recommendation or making a determination based on a photograph is really unprofessional.**

Dr. Lilia Evangelista said she had been sending four or five letters of justification describing the whole child, their environment and needs and she would still get pended for more information. And, often, she said the information was in the original letter. "But nobody knows how to read them, nor interpret them. That's the problem. They are not qualified to do that."

> ***Testimony of Dr. Lilia Evangelista, physiatrist and developmental pediatrician, from the July 19, 2005 Assembly DME Hearing:***
>
> **Now we have to re-do the same thing three or four times, and then we get denied. And on the denial, we go for fair hearing. The fair hearing, the parent comes with the child, therapist, and they win. This is the funny part about it; we win the hearing.**
>
> **Then it goes back to Albany for the decision, final decision of notification will take some longer time. Before when we had the hearing downtown, we knew that we won and we were going to get it, and the parents knew about it. In a short period of time they got the equipment that they need. Now, when I get the decision they will approve the equipment, but they will downgrade it to a less quality of equipment.**

Sometimes, DOH asks for information it should have on file. For instance, it held up approval on a new wheelchair because the applicant did not send in the original invoice on an eight-year-old wheelchair. As each prior approval applicant is Medicaid eligible, DOH should have a file on that person and their Medicaid-funded equipment. Therefore, it should know if someone with CP got a Medicaid funded wheelchair eight years ago and that they will need a new one since most wheelchairs have a life of five to six years.

Many witnesses also testified that DOH has asked unreasonable questions or requests, for example requiring that equipment be tested in a patient's home. Physical therapists say this creates an unreasonable burden of transporting the device and spending extensive time when in almost all instances the therapist can get measurements from the family and simulate a home situation in the clinic.

Recommendation: DOH should hire appropriate staff with appropriate credentials and experience in seating, positioning, and mobility, and/or provide appropriate training.

Recommendation: Examine why New York State has not fully adopted the federal coding system, as required by Federal law. But apparently New York State follows it for most items, except custom seating and positioning products.

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E. DOH's explanations for closing the New York City regional Medicaid office — and transferring two-thirds of statewide prior approval claims to Albany — remain unsatisfactory.

DOH has given three distinct reasons for closing the New York City office, each of which have left the Committee Chairs with more questions. According to then DOH Deputy Commissioner Kathryn Kuhmerker, this was not a cost-savings measure. The reasons include:

1) DOH suspected the New York City office was mismanaged, yet it promoted the director of the New York City office to another unit.

DOH claimed the New York City office was not processing claims correctly. On January 26, 2006 ─ almost a year after first asking ─ the Committee Chairs finally received evidence that DOH may have had some legitimate concerns with the way the New York City office was run. The DOH letter to the regional office's acting director dated October 26, 2001 itemized several problems with the New York City office, such as: approval of funding for items not covered by Medicaid, funding for certain items that should have been submitted as direct bill, and a lack of invoices on file to substantiate payment. These all seem to be legitimate concerns. However, this memo is five years old.

If DOH knew there were problems with the New York City office as early as 2001, why did it not take action sooner? Why did DOH, after refusing to promote the "acting" New York City regional office director for some 20 years, do so just before closing the New York City office, if in fact, that office was mismanaged? Furthermore, where is the analysis DOH did before closing

the New York City office that helped them decide to close that office? Kathryn Kuhmerker testified that such a document exists, but the Department has not provided it, despite repeated requests for it (with personnel information redacted).

2) DOH said it had to close the office because it could not find another qualified person to run the office. Given the potential pool of candidates in the New York City metropolitan area, this is difficult to understand.

Given the number of medical schools and business schools in the New York City metro region and, quite simply, the size of the population, certainly the pool of candidates for this position would be much greater in New York City than it is in Albany.

By all accounts, the reviewers in that New York City office were, if nothing else, experienced, knowledgeable and professional. It does not make sense that DOH could not re-train them if they were incorrectly processing claims or send a supervisor from Albany to oversee their work. Given the tumult Medicaid recipients with severe disabilities have experienced, this explanation is insufficient.

3) Closing an office is not a logical remedy for standardizing implementation of the prior approval process.

DOH said it closed the New York City office in part because it wanted to standardize implementation of the prior approval process throughout the State. Standardization sounds like a good idea, but it could have been accomplished without closing an office. The Committee Chairs fully support DOH's goal of standardizing the process so that all applicants play by the same rules, but those rules need to be made clear and need to be implemented in accordance with existing State rules.

Recommendation: DOH must provide to the Legislature its planning documents for closing the New York City office (with personnel information redacted).

Recommendation: DOH must finalize its prior approval guidelines and ensure consistent implementation statewide.

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F. DOH did not properly prepare the Albany office for quadrupling its workload.

Kuhmerker admitted the Agency had not prepared well for the move and that a backlog of prior approval requests developed after quadrupling the Albany office's workload. (The New York City office had handled about two-thirds of the State's claims in 2003 and 2004, the years leading up to the move, amounting to a total of 16,000 out of 24,000 in 2003 and 10,000 out of 17,000 in 2004 (See Chart A below).) Kuhmerker said that DOH took the following actions to prepare, however, the Committees have found that most were reactionary, not preparatory, and some not at all valid.

The lengthy delays and poor quality of DOH responses to prior approval requests contribute to this finding. Despite requests from the Committee Chairs, DOH did not provide reports, memos or any other documentation relating to the assessments of anticipated workload, needed staffing and other resources in the Albany office, number and timing of increased staffing in the Albany office, and other adjustments made to accommodate transfer of prior approval operations from New York City to Albany.

CHART A: New York State Medicaid Program
DME Prior Approval Statistics — Finalized Prior Approvals Only[11]
Based on Prescriber Order Date

Order Year	PA Status	New York City			Statewide Total		
		PAs	% Total	Dollars[12]	PAs	% Total	Dollars
2003	APPROVED	9,876	61.3%	$ 9,086,224	12,450	51.3%	$11,363,984
	PARTIALLY APPROVED[13]	235	1.5%	$ 359,398	249	1.0%	$ 373,697
	APPROVED AS MODIFIED[14]	1,202	7.5%	$ 2,077,550	2,541	10.5%	$ 3,459,235
	EXPIRED APPROVALS[15]	4,564	28.3%	$ 5,450,013	8,603	35.4%	$ 8,371,103
	Approved Subtotal	**15,877**	**98.6%**	**$16,973,185**	**23,843**	**98.2%**	**$23,568,019**
	DENIED[16]	226	1.4%		439	1.8%	
	Total	**16,103**	**100.0%**	**$16,973,185**	**24,282**	**100.0%**	**$23,568,019**
2004	APPROVED	8,428	78.7%	$ 7,736,866	11,752	67.6%	$10,325,675
	PARTIALLY APPROVED	256	2.4%	$ 420,003	289	1.7%	$ 438,628
	APPROVED AS MODIFIED	1,053	9.8%	$ 2,191,223	3,430	19.7%	$ 3,943,272
	EXPIRED APPROVALS	130	1.2%	$ 74,656	233	1.3%	$ 102,799
	Approved Subtotal	**9,867**	**92.1%**	**$10,422,748**	**15,704**	**90.4%**	**$14,810,375**
	DENIED	846	7.9%		1,672	9.6%	
	Total	**10,713[17]**	**100.0%**	**$10,422,748**	**17,376**	**100.0%**	**$14,810,375**
GRAND TOTAL		**26,816**	**100.0%**	**$27,395,933**	**41,658**	**100.0%**	**$38,378,394**

DOH did provide the average number of claims handled per day at each of the three prior approval offices — New York City, Albany and Buffalo — for the years 2004 and 2005. That showed before closing, New York City reviewers processed 14.4 claims per day compared with 4.4 per day in Albany. After the New York City office was closed, Albany reviewers processed 6.4 a day. Buffalo's numbers stayed roughly the same — 4.3 per day in 2004 and 4.1 in 2005.

The following are actions DOH said it took to prepare:

[11] Information provided by the Department of Health to the Assembly Chairs. Chart A does not include PAs (prior approvals) involving unreturned requests for additional information, duplicate requests, or rejections due to incomplete or wrong information in key fields.
[12] Claim amounts actually paid against Prior Approvals ordered within the calendar year.
[13] Partially Approved — only part of the request approved exactly as submitted
[14] Approved as Modified — Item(s)/service(s) approved as requested, but quantity or dollar amount changed.
[15] Expired Approvals — The PA was approved, but expired with units and/or dollars remaining
[16] Denied — all items/services denied on request.
[17] The NYC Office closed October 31, 2004. After that date, all prior approval requests were handled by the Albany office.

1) DOH said it hired and trained new staff in Albany shortly after closing the New York City office, but later said the number of staff in Albany remained the same before and after the change. And it still has not produced any staffing documentation.

The staffing information DOH has provided in testimony, but not on paper, despite repeated requests, indicate no change in the total number of staff persons conducting reviews. The New York City office had processed two-thirds of all requests statewide — 16,000 out of 24,000 in 2003, and 11,000 out of 17,000 in 2004.

Each time the Assembly asked DOH about staffing, it gave different answers. Back in February 2005, DOH said it redeployed several staff persons, intimating it increased the number of employees. However, Kathryn Kuhmerker testified that the number of reviewers was 10 before the New York City office closed and 10 again some time after the office was closed. She did say that her office was looking to hire additional staff as current staff persons were working overtime. Also, there may be some confusion concerning the mix of full-time, part-time and temporary employees, but without any actual documentation from DOH, it is impossible to say.

2) DOH moved 150 prior approval items to DVS (Dispensing Validation System), thereby cutting down on the number of incoming prior approval requests (as these items would no longer require prior approval). However, the department did not make this change until six months after the New York City office was closed.

The billing changes ─ moving items to DVS ─ did not occur until April 2005, six months after the New York City office was closed. So, this could hardly have been considered preparation for the transfer of all those prior approvals from New York City to Albany. DOH reported that the average number of claims processed per day in Albany did not increase much because of all the items moved to DVS; however, why then did Buffalo not experience a decrease in the number of claims processed daily (since their staffing level remained the same, according to Kuhmerker)?

3) DOH reduced the number of prior approval requests by increasing the dollar minimum for repair requests going through automatic approval, although this too happened after the New York City office was closed.

Many witnesses agreed this was a positive move and did help speed up the process for small repairs, although DOH made this change after the New York City office was closed.

4) DOH said it cleared the backlog by automatically approving all pending requests, but this was a little misleading.

In a January 26, 2005 letter from the Office of Medicaid Management, DOH reported that a "sprinkler system feeder line froze and broke, causing considerable damage in the Bureau of Medical Review and Payment."[18] This accident also compromised the telephones in that office. As a result, DOH said it automatically approved all outstanding requests. Actually, DOH

[18] January 26, 2005 letter from Vincent Martiniano, Health Program Administrator II, Bureau of Medical Review and Payment, Office of Medicaid Management, DOH.

approved only those that were sitting in its offices, not the high percentage of requests DOH returned to applicants seeking more information.

Recommendation: DOH must report the number, titles and credentials of its full- and part-time reviewers and supervisory staff in the DME prior approval units in Albany and Buffalo, and include relevant clinical practice and board certification.

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G. Delays have been exacerbated because DOH does not have or has been slow to take advantage of technological advances.

Another factor contributing to the delays, which became clear through two and half hours of inquiry at the July DME hearing, is DOH refuses to use email to communicate with applicants or their representatives. Despite having closed the New York City office, in part, to take advantages of technological advances and to standardize administration of the program throughout the State, almost all correspondence with the prior approval office, up until just recently, has been through regular mail.

While original documents, letters and receipts need to be sent thought the mail, users of the system are requesting that follow-up and simple questions be handled in a speedier manner, through telephone, fax or email.

> *Telephone:* When the Committee Chairs first began reviewing this issue, many former clients of the New York City office complained they could not reach the Albany office on the telephone, but that appears to be improving.
>
> *Fax:* In response to many complaints, DOH finally began accepting faxes in January 2006. While a positive step, the fax papers will not be delivered directly to the DOH reviewers handling the prior approval requests; they will first go to the company scanning all incoming mail — Computer Sciences Corporation (CSC) — which can take up to three days.
>
> *Email:* The Department's new $375 million claims processing system was supposed to be designed to accept emails, but it does not. DOH claims that it still has not figured out how to meet HIPAA restrictions for sending electronic attachments. According to CMS, DOH cannot do much about the quality of a patient's firewalls, and HIPAA does not impose such an obstacle.[19]

The Committee Chairs asked DOH to forward "documentation about that HIPAA problem and some documentation that the Department is, in fact, working on it," but it has not.

[19] HIPAA stands for the Health Insurance Portability and Accountability Act of 1996.

Recommendation: Require DOH to develop and publish a contact list for questions and concerns so that clinicians and perhaps families and consumers have a centralized and consistent point of contact.

Recommendation: DOH should notify the applicant every time a request (in entirety or in part) is pended, denied, rejected, voided, inactivated or omitted, and notify them as to whether the determination applies to all or part of a request so that the applicant is always informed of their right to a fair hearing.

Recommendation: DOH should install an online status reporting system, similar to those offered by UPS and FedEx. Using a tracking number, interested parties could track the progress of their application.

III. FINDING: DOH does not do enough to determine whether patients get the equipment for which they were funded. This undermines the prevention and detection of fraud and abuse.

According to DOH official testimony, the very nature of the prior approval process helps prevent fraud as each request is submitted by several health care professionals who have evaluated the patient. However, according to DOH, two of the primary types of fraud in this prior approval DME area are committed by vendors who either do not deliver the goods or deliver less expensive goods. It is the Committee Chairs' finding that DOH does not do enough to ensure that Medicaid recipients actually receive the items for which they received funding.

> ***Testimony of former DOH Deputy Commissioner Kathryn Kuhmerker from the July 19, 2005 Assembly DME Hearing:***
>
> **I want to emphasize that when medically necessary equipment for Medicaid beneficiaries is properly ordered by an approved practitioner, we are committed to ensuring that these individuals receive the equipment they need in a timely fashion.**

As noted by Ms. Kuhmerker, just because the prior approval process helps prevent consumer fraud, it does not mean that the appropriate piece of equipment is actually delivered to the applicant. DOH claims to be committed to ensuring that items and/or services are delivered to patients, but its actions do not bear this out.

To determine whether equipment paid for by Medicaid was actually delivered, Kuhmerker said DOH: 1) sends out what are called EOMBs (Explanations Of Medical Benefits) to applicants asking whether vendors delivered equipment, and if applicants respond saying they did not receive items, DOH launches an investigation; and, 2) requires providers submit their actual invoices.

Both of these activities are fine, but the department's implementation seems to have plenty of holes. In regard to the EOMBs, each month DOH sends a different 5,000 recipients an EOMB, often to targeted groups. While this may sound like a lot, in reality this means that any single Medicaid recipient could wait up to 65 years before receiving an EOMB.

Furthermore, the EOMBs seem to cause a bit of confusion for the following reasons:[20]

- List "medical appliance dealer" under type of service, which could be a new wheelchair or other item.
- Amount paid refers only to the portion of Medicaid paid, not the entire bill, which may include Medicare or other insurance — generally applicants recognize the total bill, not the Medicaid portion alone. E.g. $18.20 for Medicaid portion, whereas the part actually cost $200, which was on the original invoice the applicant saw.

[20] The Assembly Committees requested copies of EOMBs sent out, but DOH did not provide them. These findings are based on EOMBs provided by DME vendors.

- The date of service on the form refers to a date very different from the date the item was actually delivered (eight months off on one the Committees reviewed).

Taken together, all of these bits of information would make an applicant scratch their head, and wonder what the bill referred to, and possibly make them suspect of the vendor with which they may have had a long-standing relationship.

Another problem is that the EOMBs are only sent out in English.

> ***An exchange between former Deputy Commissioner Kathryn Kuhmerker and Assembly Member Richard N. Gottfried, from the July 19, 2005 Assembly DME Hearing:***
>
> **GOTTFRIED: So if one of the recipients of one of those randomly mailed explanation of medical benefits, doesn't speak English or can't figure out how to sort through that and maybe thinks that they're the one who's being scrutinized and for any number of reasons doesn't respond to the Department, but if, in fact, the Department had paid for something very expensive and either nothing got delivered or something very different got delivered, if the recipient of that random explanation of medical benefits did not get back to the Department, the Department would never know that.**
> **KUHMERKER: Not through that mechanism. You're correct. If the recipient did not send the information back through that mechanism we would not know it.**

DOH is required to pay cost plus 50 percent by regulations under certain circumstances, and it therefore requires from vendors' copies of manufacturers' invoices. DOH then uses these invoices to ensure items are ordered and paid for, and hopefully, then sent to the Medicaid recipient. It can also identify cases of potential fraud if invoices are lacking.

> ***An Exchange between Former Deputy Commissioner Kathryn Kuhmerker and Assembly Member Richard N. Gottfried, From the July 19, 2005 Assembly DME Hearing:***
>
> **GOTTFRIED: You assume that if you've gotten an invoice that that invoice is not a fraudulent document.**
> **KUHMERKER: On its initial face. Yes. If we were to actually be doing an investigation we would be doing a more in-depth visit at a durable medical equipment dealer looking at a variety of things. At some point there is an assumption that an invoice is the actual invoice and that the equipment was delivered to the vendor. And the presumably the vendor did not fail to deliver it to the client.**

Also, as several providers have pointed out, while DOH continues to express concerns about fraud, it has been adding additional items to DVS system, thereby bypassing the prior approval

process. These items are automatically approved with a physician's prescription, and these are generally the less complicated items, ones used by people with less severe disabilities.

Furthermore, DOH just announced in the June 2006 Medicaid Update — a newsletter sent to interested parties and available on DOH's website — it will soon require that each applicant seeking a powered mobility device (PMD) get a face-to-face exam with a privately practicing physician or nurse practitioner. The physician's or nurse practitioner's order for PMD must be received by the DME provider within 45 days.

This requirement is similar to a Medicare rule adopted to curtail abuses with scooter requests. On the face of it, requiring that a physician actually see each patient and approve each order appears to be a worthy effort at preventing fraud. However, Medicaid serves people who have a life-long history of disability, which is generally a different population than who Medicare serves. Therefore, this new rule may add another difficult hurdle as it costs time and money to get to a physician. And if the physician does not get the paperwork in on time, the process must start over again, requiring the patient, usually at the mercy of a caregiver, to get to a physician once again.

Recommendation: DOH should examine data to determine where the delays are and use that information to more effectively ensure that clients get the items they should (and in a timely fashion) and to target and investigate possible instances of fraud.

Recommendation: Enact legislation requiring DOH to institute a comprehensive, aggressive program of enlisting Medicaid recipients and the public in preventing and uncovering Medicaid fraud, waste, and abuse. Recipients are in the best position to know whether payments are legitimate, whether the funded items or services were legitimate. Modeled on a Federal Medicaid program, and already in place in a number of other states, the proposal would make it as easy as possible for recipients and family to forward tips of suspected abuse to state officials.

Recommendation: DOH should improve the quality of EOMBs and consider increasing the number sent.

Recommendation: DOH should use another language in its communications, like Spanish.

Recommendation: DOH should conduct post-audits to ensure: 1) recipients get the proper equipment for which they were awarded funding; and, 2) the equipment is working properly and meeting their needs.

Recommendation: DOH should identify and contract only with quality vendors. Many vendors want to be certified or accredited — that is, undergo more scrutiny — so they can be separated from less credible vendors. DOH should require that where Medicare requires its vendors be accredited, Medicaid would require its vendors to undergo that process.

Recommendation: If the concern is that all equipment being processed is inappropriate, perhaps the Bureau of Medical Review and Payment should consider institutions with wheelchair clinics be Medicaid certified facilities. Many of the individuals in these clinics are certified assistive technology practitioners, who have extensive experience and knowledge of equipment, adequate to support the clients' needs.

IV. FINDING: For the past seven years or so, people who are dually eligible for both Medicare and Medicaid have been caught in a catch-22 making them ineligible to receive either Medicare or Medicaid to cover a needed piece of DME. DOH has not resolved this seemingly simple problem, despite several Administrative Law Judges pointing out remedies.

Witnesses at both the July and November 2005 New York State Assembly hearings complained that the dually-eligible Medicaid/Medicare applicants are often unable to get either insurance. DOH needs to resolve this, especially now that the number of people dually eligible is growing.

The catch-22 is this: Medicaid is a payer of last resort, so applicants who are dually eligible for both Medicaid and Medicare must first seek Medic*are* (the federal health care administrator). Medic*are* requires proof of purchase; whereas applicants seeking Medicaid funds for durable medical equipment requiring prior approval obviously must get prior approval before being able to purchase an item. So if a Medicaid DME prior approval applicant first makes a claim for Medic*are* and purchases the requested item, as Medic*are* requires, and then Medic*are* denies the request, the applicant cannot then get Medicaid through the prior approval process. Medicaid will not reimburse the applicant if they already purchased the item. And it is entirely possible that one item will be covered by Medicaid and not Medicare.

According to several hearing witnesses, DOH continues to deny or ignore prior approval requests of dually-eligible applicants when the applicant has not yet sought Medic*are* funds, even if Medic*are* will not cover such an item or service.

It is confusing as to why this continues to be an issue, especially since New York State administrative law judges recently ruled on this issue. ALJs have pointed out relevant State regulations that require DOH to make a determination based on medical necessity and cost effectiveness, not on insurance-related issues. Furthermore, State regulations advise DOH to thereafter follow ALJs' findings in similar instances.[21]

The specifics of one fair hearing illustrate this:
The physician of Dorothy D. — a 71-year-old woman who has CP and is unable to walk — submitted a prior approval request on her behalf for a customized power wheelchair. She had been propelling her manual wheelchair with her feet, but was unable to do so anymore because of worsening arthritis. The requested wheelchair was intended to meet her mobility needs and prevent any further orthopedic deformity or pain.

Dorothy's prior approval request noted she is eligible for both Medicaid and Medicare, although Dorothy's physician knew Medicare would not pay for the requested item and therefore did not

[21] 18 NYCRR 358-6.2 states: "When a fair hearing decision indicates that a social services agency has misapplied provisions of law, regulations, or such agency's own State–approved policy, the commissioner's letter transmitting such decision to such agency may contain a direction to the agency to review other cases with similar facts for conformity with the principles and findings in the decision." 18 NYCRR 358-6.4 (a) states: "For all decisions, except those involving food stamp issues only, definitive and final administrative action must be taken promptly, but in no event more than 90 days from the date of the request for a fair hearing."

seek Medicare funding first (which obviously would have required him to buy the chair). The DOH Medicaid reviewer denied the request, responding "please bill Medicare."

As a result, Dorothy's representatives requested a fair hearing and the ALJ decided that DOH is required to approve or deny a prior approval request only on the basis of medical necessity or cost effectiveness, and that Dorothy D's request was medically necessary. Therefore, the ALJ ordered DOH to approve the request.

The ALJ noted that contrary to DOH's position that prior approval and payment are inseparable, they are separate issues.[22]

The New York State Comptroller's Office has criticized DOH for paying claims that should have been paid, at least in part, by Medicare. In response, DOH told OSC that its new computer system (eMedNY) would have the ability to identify claims that relate to dual eligible recipients, however it currently does not.

DOH has presented a proposed policy at a DME Workgroup, but has not developed or pursued it. The policy would basically require DOH to put together a list of items more widely covered under Medicaid than Medicare.

It is confusing as to why this continues to be an issue, especially since New York State administrative law judges recently ruled on this issue. ALJs have pointed out relevant State regulations that require DOH to make a determination based on medical necessity and cost effectiveness, not on insurance-related issues. Furthermore, State regulations advise DOH to thereafter follow ALJs' findings in similar instances.[23]

Recommendation: The number of people eligible for both Medicaid and Medicare is growing. DOH needs to resolve this issue. Require DOH to recognize dual eligibility for Medicare and Medicaid recipients and take responsibility in paying for medically necessary equipment that Medicare will not provide. Consider legislative actions taken in Connecticut to address the issues and protect the rights of the dually eligible population.

Recommendation: DOH should consider a process that enables the Medicaid enrolled DME provider to first submit to DOH a prior approval request, attaching the physician's

[22] The ALJ cited relevant state regulations supporting that (Section 540.6(e)(3)(iii) and Section 540.6(e)(5)) which state that a provider shall not deny care or services to a recipient because of the existence of a third party resource to which a claim for payment may be submitted. Dorothy D's representatives also established, the judge agreed, that although Medicaid is the payer of last resort, DOH can still issue prior approvals before Medicare funding is sought. The regulations (18 NYCRR Parts 513 and 540) support this by: 1) requiring DOH to base their determination on whether the requested item is medically necessary and cost effective; and, 2) requiring DOH's decision to approve or deny a request be made regardless of who ultimately is the responsible payer(s) and independent of the order in which they must pay (Parts 513 and 540 of the Regulations at 18 NYCRR.).

[23] 18 NYCRR 358-6.2 states: "When a fair hearing decision indicates that a social services agency has misapplied provisions of law, regulations, or such agency's own State–approved policy, the commissioner's letter transmitting such decision to such agency may contain a direction to the agency to review other cases with similar facts for conformity with the principles and findings in the decision." 18 NYCRR 358-6.4 (a) states: "For all decisions, except those involving food stamp issues only, definitive and final administrative action must be taken promptly, but in no event more than 90 days from the date of the request for a fair hearing."

order and the same medical justification and documentation required to be submitted to Medicare. Then, if appropriate, Medicaid 'medically' approves the request. After dispensing the DME item to the client, the provider submits a claim to Medicare. Upon receipt of the Medicare denial (and documentation of a first level appeal), the provider can then directly bill Medicaid.

V. FINDING: The DME Workgroup is a great concept, and has had some accomplishments, such as setting up emergency procedures and a fax. But its most important tasks — developing guidelines, streamlining the process — are still not done, and Workgroup members have good reason to question whether DOH is taking it seriously as the department recently issued new DME rules without consulting with the Workgroup.

In June 2005, shortly after the Assembly Chairs announced hearings, DOH held the first meeting of a newly formed DME Workgroup, comprised of representatives from DOH, providers, and Medicaid recipients. The group was formed to tackle many problems in the DME prior approval process, including (but not limited to) a lack of: DME prior approval guidelines, an emergency response system, fax and email capability, policy assuring dually eligible (Medicaid and Medicare) applicants have the same coverage as Medicaid-only recipients, enough reviewers or adequate training, and informative correspondence with recipients.

To date the Workgroup has had a few accomplishments, but most tasks are still unsettled. Most importantly there are still no guidelines and criteria for prior approval requests. DOH did develop an emergency process (but it is unclear how well this is working),[24] install a fax machine, and begin sending Medicaid applicants a letter when their prior approval request is approved.

It is important that this Workgroup remain active and, perhaps, be given some authority. Just recently DOH adopted new rules affecting this program, but Workgroup members say they were surprised.

Recommendation: Establish the DME Workgroup as a permanent body and give it a substantial oversight role.

[24] One provider — The Center for Discovery in Harris, NY — said the vendors that service their facility "are very hesitant to use the emergency repair system because of the description of "life and death situation, which is too ambiguous of a description," and they are not confident they will be reimbursed.

VI. The number of fair hearings has decreased by 50 percent in the past few years, which does not square with the rising level of complaints. Also, DOH regularly ignores decisions made by Administrative Law Judges, which reverse DOH decisions about 50 percent of the time.

Medicaid recipients have the right to a fair hearing if their prior approval request is modified or denied.[25] Between 2002 and 2005, the number of fair hearing requests and dispositions dropped by about 50%, yet the percentage of DOH decisions reversed by Administrative law judges remained steady at about 50 percent.

DME Fair Hearing Requests and Dispositions Calendar Years 2001-2005[26]

	2001	2002	2003	2004	2005
Requests	562	622	549	511	312
APP Withdrawn	141	122	146	143	112
Default	99	134	113	96	123
	2001	**2002**	**2003**	**2004**	**2005**
Affirmed	83	107	80	76	48
Reversed	198	188	181	140	79
Agency Withdrawal	26	21	18	14	2
Other	4	12	20	16	5
Correct When Made	38	47	36	38	39

Some possible reasons for the decline in requests for fair hearings, according to providers, may be that applicants and/or providers:

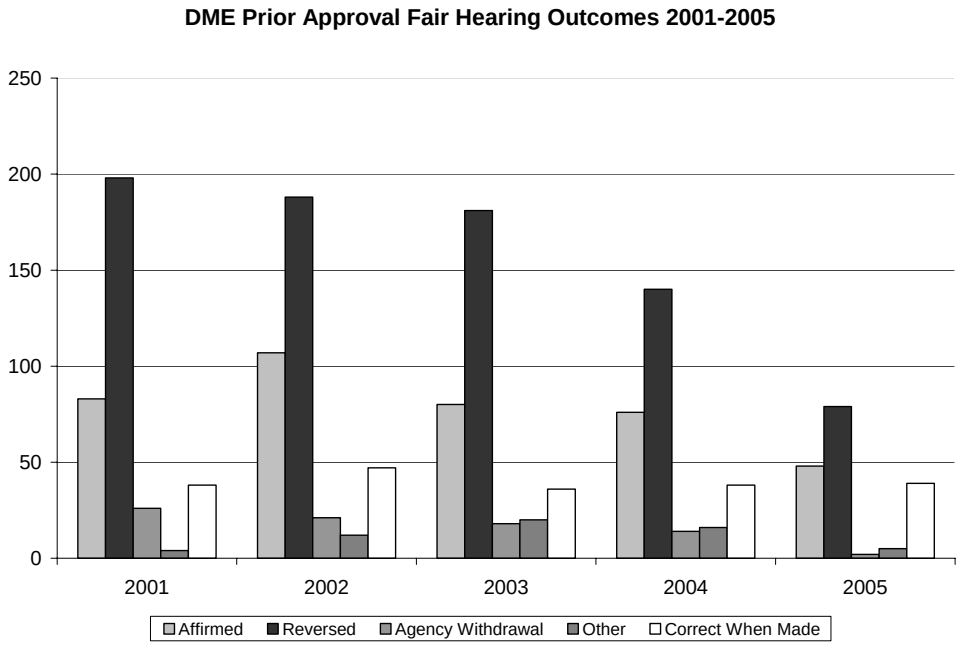
- Are intimidated by the process
- Not informed of their rights to a fair hearing
- Have no legal representation
- Might prefer to raise a few hundred dollars to pay for an item rather than go through the fair hearing process
- Fear retribution from DOH and not getting any items approved
- Make a great effort to gather at the hearing, and then have to reschedule because DOH doesn't show or provide testimony

Recommendation: The Office of Temporary and Disability Assistance, which runs the fair hearings and trains the administrative law judges for DOH prior approval appeals, should systematically examine the fairness of its "fair hearings."

[25] NYCRR Title 18, §513.8 (a) A recipient may ask for a fair hearing from this department to review a denial or modification of a request or the failure of the Department of Health to make a determination within the time period specified in this Part.

[26] Source: NYS Office of Temporary and Disability Assistance, April 2006.

Recommendations: OTDA should issue fair hearing data, breaking out, on a case-by-case basis, the dollar amount, who represented the recipient and the item requested. It could be that 90 percent deserved to win, but only 50 did. It could be that the only people who won at fair hearing had representatives and were not representing themselves. And it could be that only items costing less than a certain amount were approved at fair hearing.



Recommendation: Another question to answer is how often DOH actually sends a representative— either in person or on the telephone. (Based on a sampling of about 25 fair hearing determinations, it seems DOH is more likely to not appear than to appear.) DOH should have the courtesy to respond either in person or on the telephone.

Recommendation: Create a publicly accessible fair hearing database. (A non-profit group — the Empire Justice Center and the Western New York Law Center — does have a database of fair hearings, but it is not complete.)

APPENDIX A

DOH Wheeled Mobility Equipment, General Guidelines (Version 2005-1 (4/1/05) page 34)

Wheeled mobility equipment is covered if the recipient's medical condition is such that without the use of the equipment, the recipient would otherwise be confined to bed, chair or home and the recipient is not ambulatory or not functionally ambulatory. A prior approval request must, at the least, include the following documentation of medical necessity:

1. A list of all ***current wheeled mobility equipment*** (e.g. make, model, serial number, age) and explain why it no longer meets the recipient's medical needs (e.g. give cost estimates of repair of equipment).
2. A description of the ***equipment and accessories as ordered*** (e.g. make, model, size, seat and back dimensions) and provide relevant recipient ***measurements*** (e.g. height, weight, chest, shoulders, thighs, legs).
3. A ***narration of medical necessity*** for the wheeled mobility equipment and related accessories and an estimate of how long the equipment will be needed (e.g. degree of ambulation in customary environment, medical conditions, intended use, amount of time daily the equipment is used).
4. A statement of the ***alternatives*** considered or attempted (e.g. manual versus power, off the shelf versus custom accessories) and why these alternatives do not meet the medical need.

A description of the ***customary environment*** and ***caregiver supports*** (e.g. skilled nursing facility, OMRDD-certified residence, private home, home health or waiver services); give details of the results of ***trial of equipment*** in this environment (e.g. fitting through doorways, access to home, transportable, ability to safely operate).

APPENDIX B

BACKGROUND OF THE PRIOR APPROVAL PROCESS

Congress established Medicaid in 1965 as a funding partnership between the federal government and states to provide health insurance to those who cannot afford it. Since agreeing to provide Medicaid, one of the many types of coverage New York State has elected to offer include durable medical equipment for children and adults with severe disabilities.

Directed by some basic Federal laws, the State has written laws and the State Department of Health has adopted regulations, which provide guidance in the implementation of the DME prior approval program.

This prior approval process is so called because Medicaid eligible applicants must first get DOH approval before payment is made to the vendor and the requested item is provided. Prior approval differs from most other types of Medicaid transactions, which usually only require a physician's prescription for automatic approval (as long as specific amounts/frequencies are not exceeded).

The prior approval process is set out in State Regulations, 18 NYCRR 513, 505, and 10 NYCRR 85.37.

The main features of the prior approval process set out in State regulation include:

- When reviewing a request, DOH must assure that each requested item meets the criteria for durable medical equipment, which is:

Devices and equipment, other than prosthetic or orthotic appliances, which have been ordered by a practitioner in the treatment of a specific medical condition and which have all of the following characteristics:

(i) can withstand repeated use for a protracted period of time;
(ii) are primarily and customarily used for medical purposes;
(iii) are generally not useful to a person in the absence of an illness or injury; and
(iv) are usually not fitted, designed or fashioned for a particular individual's use. Where equipment is intended for use by only one person, it may be either custom-made or customized.

- After establishing the item is DME, DOH must then assure that each item is medically necessary and appropriate for the applicant. This is defined as:

medical … supplies are medically necessary to prevent, diagnose, correct or cure a condition of the recipient which:

(1) causes acute suffering;

(2) endangers life;
(3) results in illness or infirmity;
(4) interferes with the capacity for normal activity; or
(5) threatens to cause a significant handicap.

- The determination to grant, modify or deny a request initially must be made by qualified Department of Health professional staff exercising professional judgment based upon objective criteria and the written guidelines of the Department of Health and the regulations of this Department, and commonly accepted medical practice.

- DOH has 21 days to reach a determination.

- When the opinion of the ordering or treating practitioner is on matters within the ordering or treating practitioner's professional expertise and within the range of commonly accepted medical practice for the profession, it is entitled to significant weight in reaching a determination and cannot be outweighed solely by the opinions of nonmedical personnel or persons not within the same medical profession as the ordering or treating practitioner.

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