

# Speaking Up in Court

## Recent federal court decisions pave the way for Medicaid funding of AAC devices.

By Lewis Golinker

**M**ajor decisions issued by federal courts in Texas and Florida in mid-1996 and by a federal court in Mississippi in mid-1995 significantly strengthen the foundation of Medicaid coverage and funding for augmentative and alternative communication devices.

The court system has rarely been involved in deciding Medicaid coverage for AAC devices and related funding questions. Although there have been thousands, perhaps tens of thousands, of Medicaid claims for AAC devices during the past 17 years, only 11 made their way to court. At

press time, only three Medicaid AAC-related court cases were pending anywhere in the United States. This is mostly because at least 45 of the 50 state Medicaid programs decided voluntarily to cover and provide funding for augmentative communication devices or AAC

devices, and almost half of those do so with specific AAC funding criteria (see Tables 1 and 2).

In most of these states, issues related to coverage and funding overwhelmingly have been resolved through statewide policy changes and the advocacy efforts of speech-language pathologists on behalf of individual claimants.

Although a historic exception, the

court decisions in Texas, Florida and Mississippi address issues that go to the heart of Medicaid's duty to cover and provide AAC devices: Are AAC devices "covered" by Medicaid? Are AAC devices "medically necessary"? And is Medicaid the "payer of last resort"?

In the Florida and Texas cases, known as *Hunter* and *Fred C.*, respectively, the issue was coverage: Florida refused to cover AAC devices for any Medicaid recipients, and Texas claimed it could provide AAC devices to some but not all Medicaid populations. Essentially, the state attempted to draw a dividing line between children, who could get AAC devices, and adults, who could not.

In Mississippi, in a case known as *Myers*, the issue was medical necessity—specifically, whether a state-employed physician, who admittedly knew nothing about AAC intervention, could issue a statewide declaration that AAC devices were never medically necessary.

The Florida case also raised a "payer of last resort" issue. Florida Medicaid that claimed AAC funding for children was never appropriate because other

funding programs, such as special education, were required to provide the devices.

The federal courts rejected the states' positions on all of these issues, creating a much stronger foundation for Medicaid funding for AAC devices—and other assistive devices.

One part of that foundation is a straightforward "test," stated for the first time in *Myers* and then adopted by *Fred C.* It requires three distinct questions be asked by therapists and advocates, as well as courts, to analyze Medicaid's duty to cover and fund AAC devices and any form of treatment.

- Is the person who is seeking the treatment a Medicaid recipient?
- Is the treatment being sought covered: Is it within the scope of at least one of Medicaid's covered services?
- Is the treatment being sought medically necessary?

### Addressing Coverage

The courts divided the coverage question into two parts. Do AAC devices fall within the scope of at least one covered Medicaid service and, if they do, can a state nonetheless refuse to provide

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that treatment? The first question was answered “yes” by all three courts. They concluded that AAC devices fall within the scope of “durable medical equipment,” which is a required part of the Medicaid home health care service (42 C.F.R., section 440.70).

The *Fred C.* court went further and also addressed whether AAC devices fit within the definition of the Medicaid “prosthetic device”

service, which also is covered by Texas Medicaid. The court said “yes” to this question as well. Currently, prosthetic devices, although an optional Medicaid service, are covered for both children and adults in every state but two (Alabama and North Carolina), and they are the second most common Medicaid service for AAC device classification.

Another benefit of these decisions is that they tie AAC devices—which are equipment—to the two Medicaid services that focus on equipment. Previously, the only court decision reviewing “coverage” of AAC devices concluded they were “equipment,” but within the Medicaid “speech-language pathology” service (*Meyers v. Reagen*, 1985).

This optional service is covered for adults by only 40 states, and only two states, California and Minnesota, classify AAC devices under this service. Thus, *Fred C.* and *Hunter* provide a more direct connection between AAC devices and Medicaid-covered equipment, and they bring AAC devices within the definition of Medicaid services that are more widely available throughout the United States.

The second part of the coverage inquiry arises because Medicaid programs are not required to provide every conceivable medical treatment or procedure that might fit within a covered service’s definition. States have discretion to set the “amount, duration and scope” of the Medicaid services they provide [42 C.F.R., section 440.230(b)], but both *Fred C.* and *Hunter* clearly state that Medicaid cannot exclude AAC devices.

Both courts rejected Medicaid’s claim that it had the discretion to limit AAC device access on the basis of recipient age. Both described expressive communication as “vital” and, thus, treatment for this functional ability cannot simply be ignored. Moreover, neither Medicaid program presented anything to show that children had a greater ability to benefit from AAC intervention than adults.

These decisions clearly reject the idea that state discretion or choice will sup-

**Table 2.**

## State Medicaid Programs with ACD Funding Criteria

State	Policy Reference
Arkansas	<b>OMS-91-J-8, Arkansas Department of Human Services (September 4, 1991); OMS-92-J-2, Arkansas Department of Human Services (February 27, 1992)</b>
California	<b>Medi-Cal Policy Statement 96-4: AAC Devices (July 5, 1996)</b>
Illinois	<b>Illinois Department of Public Aid, Informational Notice, Re: Communication Devices (November 1, 1995)</b>
Indiana	<b>470 Indiana Administrative Code, section 5-8-12 (1992)</b>
Iowa	<b>Medical Equipment and Supply Dealer Manual, Chapter E, page 12, paragraph D (October 1, 1988)</b>
Maine	<b>Medical Assistance Manual, section 60, Appendix#3, section XI (A) (December 31, 1991)</b>
Michigan	<b>MSA-94-11, Michigan Department of Social Services (October 31, 1994)</b>
Minnesota	<b>Minnesota Department of Human Services, Medicaid Provider Manual, section 6603.21</b>
Missouri	<b>Memorandum dated July 9, 1993, Missouri Department of Social Services</b>
Montana	<b>Montana Medicaid, Certificate of Medical Need, section 2 (Augmentative Communication Device), Medical Supplies 8 Equipment Supplier Manual (March 1992)</b>
Nebraska	<b>Nebraska Department of Social Services Manual, 471 NAC, section 7-012 (January 26, 1990)</b>
New Hampshire	<b>New Hampshire Medicaid ACD Funding Criteria (1993)</b>
New York	<b>New York State Department of Health, Guidelines: Augmentative Communication Systems (November 1991), replacing memorandum dated April 18, 1980, to Mr. Williams, Bureau of Ambulatory Care Services, from Mr. Baehm, director, Bureau of Medicaid Standards, New York State Department of Health</b>
North Dakota	<b>Durable Medical Equipment Guidelines, section 5b (May 1989)</b>
Ohio	<b>Ohio Administrative Code, section 5101: 3-1-49 (1993; amended January 1996)</b>
Oklahoma	<b>Position paper on augmentative communication devices, undated</b>
Oregon	<b>Oregon Department of Human Resources, OMAP, section 41 O-I 29-220 (1992)</b>
South Dakota	<b>Annotated Rules of South Dakota, ARSD, section 67:02:05</b>
Tennessee	<b>Bureau of TennCare, Chapter 1200-13-12-.01(23) (1994)</b>
Utah	<b>Medicaid ACD Funding Guidelines, February 1, 1993, attached to Letter dated August 7, 1995, to parents of B.S. from L. Stuart, R.N., Public Health Program Manager, Bureau of Coverage &amp; Reimbursement Policy</b>
West Virginia	<b>Department of Health and Human Services, Medicaid Program Instruction, MA-9547 (November 15, 1995)</b>
Wisconsin	<b>Augmentative Communication System Evaluation; Prior Authorization Guidelines Manual, DME (January 1, 1988)</b>

**For a copy of any of these state policies, contact the author.**

port age-based distinctions, when there is no accompanying objective medical basis for the exclusion of the treatment in question. This is particularly important for AAC devices, for which perhaps as many as 10 states still attempt to distinguish coverage for children from coverage for adults. On the other hand, the policy reform trend is in the other direction. Since 1994, California, Georgia, Kentucky and New Hampshire, by their own volition; Louisiana, by administrative hear&decision; and Texas and Florida, by court order, have expanded their programs to eliminate child-adult distinctions.

### **AAC Devices Are “Medically Necessary”**

In *Myers*, Mississippi Medicaid conceded that AAC devices are covered as durable medical equipment. But it refused to approve funding for any AAC devices because its review-physician’s opinion was that medical need for AAC devices exists only when the

message to be produced by the device is “medical,” e.g., if the device is “used solely (100 percent of the time) to express ‘pain, hunger or medical symptoms.’” Under that interpretation of medical need, AAC devices never are medically necessary, as no person will use an AAC device “100 percent of the time” to convey only medical information.

The *Myers* court rejected this interpretation of medical need and it provided an extremely broad legal definition of AAC devices: “AAC devices are electronic and non-electronic devices that allow individuals to overcome, to the maximum extent possible, communication limitations that interfere with [their users’] daily activities.”

Next, the court reviewed the basis for the Medicaid interpretation of medical need and found it grossly lacking.

At a minimum, Medicaid programs must operate consistently with accepted principles of medical policy, practice and procedure, as demonstrated by

objective scientific evidence, not merely the opinions of state Medicaid staff or consultants (*Daubert v. Merrell Dow Pharm*, 1992). More than a dozen affidavits from nationally respected AAC professionals and AAC professionals from Mississippi described the body of professional literature and current policy and practice related to AAC intervention, and explained that the Medicaid physician’s opinion was wholly subjective, uninformed and scientifically wrong. The court then concluded: Although it was the Mississippi Medicaid physician’s opinion and it was that doctor’s job to make medical need decisions, the decision wasn’t correct. And for that reason, it could not be used.

The court threw out the across-the-board exclusion of AAC devices and required Medicaid to make individualized decisions consistent with accepted practice standards and to use a knowledgeable decision-maker.

### **Payer-of-Last-Resort**

The Medicaid program requires that whenever possible, recipients first use other funding sources to obtain needed care. Only if no other sources exist or after benefits from those sources have been exhausted will Medicaid provide its services. This is known as the “payer-of-last-resort” principle.

In *Hunter*, Florida claimed the payer-of-last-resort provisions authorized Medicaid to refuse to provide AAC devices to children on the basis that other funding programs, such as special education and vocational rehabilitation, were required to provide them. The court summarily rejected this argument because, since 1988, the Medicaid Act has specifically prohibited Medicaid programs from asserting payer-of-last-resort rules in regard to special education [42 USC., section 1396b(c)].

The court also stated that while Medicaid can require a recipient to apply first for coverage of a needed treatment from a vocational rehabilitation program, insurance policy or other funding source, if those programs have said “no” or they have not issued any decision at the time the Medicaid claim is filed, Medicaid must pay in full and the payer-of-last-resort rule does not apply [42 C.F.R., section 433.139(c)].

In other words, Medicaid cannot delay its decision-making until the other program decides, and it cannot force a recipient to pursue any appeals or due-process remedies that might be available under those other programs or funding sources.

### **Conclusion**

Viewed together, these decisions reinforce the long-standing assertion that no basis exists for Medicaid recipients needing AAC devices ever to accept “no” as a final answer to their funding requests. There simply is no legal principle that will support Medicaid’s refusal to cover and provide AAC devices to any Medicaid recipient when those devices have been recommended by a speech-language pathologist following a careful, comprehensive evaluation. |

### **References**

*Daubert v. Merrell Dow Pharm.*, 113 S.Ct. 2786 (1992), see also decision on remand, 43 F.3d 1311 (9th Cir. 1995).  
*Fred C. v. Texas Health & Human Services Commission*, 924 F.Supp. 788 (W.D. Tex. 1996)(appeal pending).  
*Hunter v. Chiles*, No. 95-6881-CIV (S.D. Fla. Oct. 25, 1996).  
*Meyers v. Reagan*, 776 F.2d 241 (8th Cir. 1985).  
*Myers v. State of Mississippi*, No. 3:94 CV 185 LN (S.D. Miss. June 23, 1995; Order Correcting Final Judgment, October 16, 1995).

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**Note:** *The Assistive Technology Law Center will provide individualized assistance at no cost to anyone seeking an device or a professional advocating on behalf of a client seeking an AAC device. This assistance applies no matter what the funding source and is available throughout the United States.*

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