

## **COMMUNITY FIRST CHOICE OPTION GUIDELINES FOR AUTHORIZING ASSISTIVE TECHNOLOGY**

These guidelines outline the process for authorizing Assistive Technology (AT) under the Community First Choice Option (CFCO), as a covered State Plan service. AT is defined as an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or to improve the functional capabilities of the individual, and/or enhance an individual's independence in performing activities of daily living (ADLs), instrumental activities of daily living (IADLs) and health-related tasks. Additionally, AT under CFCO is limited to those devices that are not available as Durable Medical Equipment (DME) under the Medicaid State Plan and those that do not duplicate a device purchased through a 1915(c) waiver. (A listing of DME covered under the Medicaid State Plan can be found at [www.emedny.org](http://www.emedny.org) under 'Provider Manuals').

AT may include: the evaluation of the AT need of the individual, including a functional evaluation of the impact of the provision of appropriate assistive technology to the individual in his/her customary environment. Services consisting of purchasing, leasing or otherwise providing for the acquisition of assistive technology devices. Training or technical assistance for the individual and other staff who provide services to the individual in the use and application of the device.

AT expenditures must be related to an assessed functional need<sup>1</sup> in an individual's Person-Centered Plan of Care (POC) and intended to increase his or her independence or substitute for human assistance, to the extent that expenditures would otherwise be made for human assistance. AT appropriate for the individual will be identified during the development of a POC and included in the written plan.

When an assessed functional need for AT has been determined, consideration must be given to the individual's physical and developmental abilities and whether the item will assist the individual in maintaining his/her functional status and independence in the community. Once the AT has been identified, the authorizing entity (Managed Care Organization, Local Department of Social Services, or Developmental Disabilities Regional Office, as applicable) must determine whether payment for the AT is accessible through other sources such as private insurance, Technology Related Assistance for Individuals with Disabilities (TRAID) programs, or other local/federal/state agencies. The TRAID Program coordinates statewide activities to increase access to, and acquisition of, AT and serves individuals of all ages and disabilities. Information on the 12 Regional TRAID Centers is provided in the following link: <https://www.justicecenter.ny.gov/services-supports/assistive-technology-traid/locations>

### **Services Included Under Assistive Technology**

AT includes, but is not limited to the following five categories:

- Positioning;
- Mobility;
- Augmentative Communication;
- Computer Access; and
- Instructional Aids

AT costs cannot exceed \$15,000 per year without prior approval from the New York State Department of Health. The Department of Health may delegate this responsibility to Medicaid Managed Care Organizations for their enrollees. Local Districts of Social Services (LDSS) must contact the Department of Health to obtain this approval. The Developmental Disabilities Regional Office (DDRO) must contact the Office for People with Developmental Disabilities (OPWDD) to obtain approval to exceed the service limit. In all cases, service limits

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<sup>1</sup> Functional need will be assessed using a state-approved assessment tool. All functional needs assessments will be completed face-to-face with the individual and will record the individual's needs, strengths, preferences, goals and objectives for maximizing independence and community integration.

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are soft limits that may be exceeded due to medical necessity. If the individual's needs cannot be met within the established limits, an individual may request to exceed the limit by providing sufficient medical justification.

### **Providers of Assistive Technology**

All AT providers must be a Medicaid enrolled provider, an approved 1915c waiver provider or approved by OPWDD, and have a contract with the LDSS, Managed Care Organization (MCO), or DDRO. Providers of AT must ensure that all devices and supplies meet standards established by Underwriters Laboratory and/or comply with Federal Communications Commission regulations, if applicable. The provider is responsible for training the individual who will be receiving the AT, and any informal or formal support persons who will be assisting the individual in using the AT device.

### **Process for Authorizing Assistive Technology**

1. Through the person-centered planning process, during a POC meeting, the care/case manager, individual, and anyone involved in the development of the POC will determine if any AT is necessary to assist and enhance the individual's independence in performing ADLs, IADLs, and/or health related tasks and/or will substitute for human assistance (to the extent that expenditures would otherwise be made for human assistance).
2. Once an AT has been requested, the care/case manager on behalf of the individual seeks a clinical justification from the appropriate clinician (e.g., Occupational Therapist, Speech Language Pathologist, clinician from Article 16 or 28 clinic, Physical Therapist, or other licensed professional) and/or service specialist to assess the individual's need for the requested service or device. In addition, the clinical justification must include a home environment assessment to determine if there are any obstacles to the use of the AT in the home. If modifications to the individual's residence are required due to the AT, the name of the owner/landlord must be included and a separate Environmental Modification (E-Mod) process must be completed. The AT will not be approved until the E-Mod process has been finished.
3. The care/case manager and the individual will explore potential payment sources for the identified AT including private insurance, community resources, and other State/federal programs before a request for payment under CFCO will be considered.
4. Following the completion of the clinical justification, the care/case manager must submit the *Community First Choice Option (CFCO) Assistive Technology (AT) Description and Cost Projection Form* requesting the service or device to the MCO, LDSS, or DDRO for an authorization determination. In addition, the care/case manager will also submit a copy of the clinical justification and the individual's POC to the MCO, LDSS, or DDRO for review. The documentation submitted by the care/case manager must detail the need and intended purpose of the AT to support the request.
5. The MCO, LDSS, or DDRO should notify the care/case manager and individual of its determination and begin the bid procurement and selection process.
6. Following the authorization determination, the MCO, LDSS, or DDRO (or designee) will initiate the bidding process. The MCO, LDSS, or DDRO is responsible for obtaining the number of required bids (depending on the needed AT) and for selecting the vendor to provide the AT based on the lowest bid that meets the assessed need. Items that cost up to \$1,000 require one bid; those over \$1,000 require three bids. Reasonable efforts must be made to obtain three bids. If not possible to obtain the three required bids without jeopardizing the individual's care, health and/or safety, the LDSS, MCO or DDRO may make the determination to proceed with fewer than three bids.
  - Payment for an assessment completed by the AT provider, for helping select a particular device, or for training in the use of a device, must be included in the cost of the AT if the expertise needed for assessing, selecting and training is NOT available as part of a Medicaid State Plan service (e.g., clinic), or through other sources that are already involved with the individual (such as home health agencies, etc.).

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7. The MCO, LDSS, or DDRO will notify the care/case manager, the individual, and the selected AT provider of its determination. MCOs will follow notification requirements in the Managed Care model contracts. The DDRO or LDSS will issue a Notice of Decision (NOD) to the individual and care/case manager when they authorize a FFS individual for services.
8. Upon completion of the AT service, the AT provider must submit a completed *Uniform Community First Choice Option (CFCO) Assistive Technology (AT), Environmental Modification (E-Mod), Vehicle Modification (V-Mod), and Community Transitional and Moving Services Final Cost Form* to the MCO, LDSS or DDRO including a description of the AT purchased and the final cost.
9. The MCO, LDSS, or DDRO will review the requested form and validate the completion of the specification of the bid/AT service, and, if necessary, request more information. Once all requested information has been obtained, the MCO, LDSS, or DDRO will notify the AT provider that they may submit a claim for payment.

**Additional Assistive Technology Information**

1. The request for AT must be for the least costly alternative to meet the individual's needs. All bids that were received must also be included in the request.
2. Replacements, repairs, upgrades, or enhancements made to existing equipment will be paid if documented as a necessity and approved by the MCO, LDSS or DDRO.
3. Custom-fitting and repairs to AT which are cost effective and approved by the MCO, LDSS or DDRO are allowable.
4. Items worn out through normal everyday use (such as keyboards, switches, etc.), may be replaced using the process above.
5. The MCO, LDSS or DDRO will ensure that, where appropriate, justification from physicians or other clinicians has been obtained.
6. CFCO will not serve as an alternative to fund AT that has been denied through a State Plan or waiver request due to vendor rate or brand, or other justifiable cause.
7. AT is for the specific use of the individual identified in the POC.
8. CFCO funds cannot be used for the purchase of maintenance agreements or additional insurance coverage for the AT device.

**Services and Supports Not Included Under Assistive Technology**

CFCO will not fund services/items/devices that are not for an assessed need including, but not limited to the following:

- Routine maintenance of AT acquired under CFCO. This is the responsibility of the individual /family;
- Devices that are considered "experimental";
- Animal support and assistance (i.e., service and/or therapy pets) or the costs of training an existing family pet;
- Ongoing care and maintenance of animals for support and assistance (e.g. food, veterinarian services, etc.);
- Entertainment equipment or equipment not specifically addressing an assessed need in the POC; and
- Recreational equipment that a typical-age peer would commonly use/need and that a family would normally be expected to provide for a family member without a disability (such as bicycles/tricycles, trampolines, or swings).