

STATE OF VERMONT

HUMAN SERVICES BOARD

In re ) Fair Hearing No. B-04/13-286  
 )  
Appeal of )

INTRODUCTION

This appeal concerns the denial of Medicaid coverage for occupational therapy (OT) services for a minor child with Autism Spectrum Disorder. The request was made pursuant to the Department of Vermont Health Access's (Department) prior authorization process. The appeal is brought by the minor child's mother. The following facts are adduced from testimony and documents admitted during a hearing held July 12, 2013. The petitioner and Department submitted legal briefs on July 19 and August 2, respectively.

FINDINGS OF FACT

1. Petitioner is the mother of a now-three year old child (D.C.) with autism spectrum disorder. He received this diagnosis in October of 2012. He receives services through a local mental health agency and has an Individualized Education Plan (IEP) that was developed for him in April of 2013.

2. D.C. began receiving occupational therapy (OT) services in January of 2013, covered by Vermont Medicaid. The OT provider is licensed to provide OT services in Vermont and is an enrolled Medicaid provider. Among the treatment techniques she utilizes is "equine-assisted" OT, which is often referred to as "hippotherapy." Her provision of services using this technique has been reimbursed by Vermont Medicaid as well as private insurers.

3. Hippotherapy or equine-assisted therapy utilizes a horse's movements in the OT process. The OT provider testified that she considered the use of a horse similar to the use of any tool in therapy, such as a therapy ball, but that the reciprocal movement of the horse is more effective.

4. D.C. received coverage for six OT sessions and in order to receive coverage for additional sessions was required to submit a request to the Department for Prior Authorization (PA).

5. The PA request, made on March 3, included an initial evaluation by the OT provider in January which stated (in part) that:

[D.C.] is an engaging [two and half year old] little guy who was readily engaged in play activities, lots of smiles but very little talking. He is willing to attempt to imitate tasks demonstrated by the examiner but does have difficulty, particularly with balance tasks. Mom

reports that [D.C.'s] motor skills are significantly delayed. Based on the HELP [D.C.] demonstrates gross motor skills strongly established at 18-20 months with scattered skills up to 26 months. Fine motor skills are established at 24 months. [D.C.] presents with very low muscle tone overall and poor postural and head control. Mom reports that he frequently loses his balance in sitting and falls over. She says that once a month the PT works on stair skills as he is quite delayed in that area.

6. The evaluation noted that D.C. had made improvements after one session of OT and included four treatment goals: "(1) [D.C.] will demonstrate improved postural and head control while sitting on a dynamic surface for 20 minutes with minimal assistance 5 out of 6 sessions. (2) [D.C.] will demonstrate improved balance by walking down stairs alone both feet on step and walking upstairs alternating feet. (3) [D.C.] will demonstrate improved bilateral coordination and fine motor skills by completing bilateral motor tasks at midline 5 out of 6 times. (4) Therapist will work with mom on a home program and consult with both PT and SLP."

7. The PA request initiated a series of exchanges between the Department's clinical consultant and D.C.'s OT provider. The exchanges initially dealt with information of a routine nature, such as the diagnostic code, the form of

the request, and provider numbers for the OT and D.C.'s treating physician.

8. Once these routine issues were addressed, the Department requested additional information from the OT provider, issuing a notice of decision dated March 15 with the following comments (uppercase in original):

THIS IS NOT A DENIAL FOR OCCUPATIONAL THERAPY. CLINICAL REVIEW CANNOT BE PERFORMED BECAUSE ADDITIONAL INFORMATION IS REQUIRED. (MEDICAID RULE 7102). THERAPIST, PLEASE SUBMIT THE FOLLOWING INFORMATION: 1) COLLABORATION WITH SLP, PT, BEHAVIORIST IF APPLICABLE; 2) FUNCTIONAL STATUS RE: ACTIVITIES OF DAILY LIVING; 3) MD ENDORSEMENT OF THE CARE PLAN; 4) GOAL 4 IS A PLAN, NOT A GOAL, PROVIDE GOALS WHICH ARE BENEFICIARY-ORIENTED; 5) PT IS ALREADY WORKING ON STAIR GOAL, CLARIFY RATIONALE FOR DUPLICATION OF SERVICES; 6) THERAPIST'S ACTIVE FACILITATION OF SCHOOL-BASED SERVICES EVALUATION; 7) PROVIDE COPY OF HOME PROGRAM; 8) CLARIFY HOW GOAL 4 WILL BE OBJECTIVELY MEASURED.

9. On March 18, petitioner's pediatrician sent the Department her written approval of the treatment plan.

10. On March 20, the OT provider sent the Department's clinical consultant an addendum to her initial evaluation which indicated, among other things, that:

- she had left a message for D.C.'s physical therapist but had not heard back;
- the physical therapist was seeing D.C. only once per month, was not focusing on stair climbing, and that she and D.C.'s mother would request that goal be taken out of the PT goals;

- she was waiting to receive the phone number of D.C.'s speech-language pathologist from his mother; and
- the school evaluation process had begun and D.C.'s mother was not requesting her assistance at that time.

11. The March 20 addendum also included the following update:

As far as [D.C.]'s functional skill level his gross motor skills are firmly established at an 18-20 month level. He walks downstairs with one hand held (19-21), squats in play (20-21), throws ball into a box (18-20), walks upstairs holding rail both feet on step (15-18). He is unable to jump in place (22-30), ride a tricycle (24-30), catch a large ball (24-26) or imitate one foot standing (24-30). Fine motor skills are established at a 22-24 month level. He builds a tower with 6 cubes (22-24), imitates a horizontal stroke (24-30), strings 3 one inch beads (23-25) and imitates a circular scribble (20-24). He is unable to snip with scissors (23-25), hold a crayon with thumb and fingers (23-25) or imitate a three block train (23-26).

Home program thus far has included blowing through a straw and blowing bubbles which is going quite well, to work on oral muscle tone.

12. The Department's clinical consultant replied to the OT provider on March 21 with a request for additional information regarding "his current ADL skills, particularly around feeding, grooming, dressing and hygiene and your plan to address any issues in those areas. Also, please clarify his oral motor status which is not mentioned in the

documentation I received, and clarify why his home program so far only relates to oral motor function.”

13. The OT provider responded on the same day with the following:

We have not yet started on ADL skills and have focused on gross and fine motor control as THEY are the foundation of developing ADLs. I have only been able to see [D.C.] for 4 weeks so have been unable to complete an assessment of all areas of function particularly when Medicaid only gives me half an hour to bill for that code. On page one of the evaluation report you will note that I referred to [D.C.] “presenting with very low muscle tone overall, and poor postural and head control.” Overall would include the face, head and neck. As I mentioned before I have only been seeing [D.C.] for a little over a month and don’t want to overwhelm the family with too many assignments. One of [D.C.]’s most significant area of dysfunction is speech and language and working on oral motor control will help that. I am treating the whole child.

Please let me know when you have authorized further services as the mom is getting quite anxious about the delay.

14. The Department’s clinical consultant wrote back later that same day and stated the request would be forwarded to the Department’s physician reviewer.

15. On March 25, the Department’s medical reviewer issued a decision that the request “requires additional information,” writing the following note: “would like to see more OT goals targeting ADLs and other functional goals.

Sounds like the child is responsive to interventions - would like to see fewer redundancies [between] OT and PT."

16. The Department issued a Notice of Decision on March 26 with the following comments (uppercase in original):

REQUEST FOR OCCUPATIONAL THERAPY IS DENIED PENDING ADDITIONAL INFORMATION PER THE PHYSICIAN REVIEWER. YOU MAY SUBMIT A NEW REQUEST WHEN THE ADDITIONAL INFORMATION REQUESTED BECOMES AVAILABLE: GOALS TARGETTING ACTIVITIES OF DAILY LIVING, GOALS TARGETTING FUNCTION, GOALS THAT ARE NON-DUPLICATIVE OF PHYSICAL THERAPY GOALS. ALSO PLEASE PROVIDE DOCUMENTATION OF AN EXPANDED HOME PROGRAM AND PLAN FOR OCCUPATIONAL THERAPIST COLLABORATION WITH SCHOOL BASED OCCUPATIONAL THERAPIST WHEN THE BENEFICIARY TURNS 3 WHICH IS WITHIN THE UPCOMING CERTIFICATION PERIOD. (MEDICAID RULE 7102)

17. An IEP was developed for D.C. dated April 16, 2013. The IEP did not call for or mention OT services. The IEP described D.C.'s low muscle tone, challenges with balance, and deficits in gross motor skills.

18. The Department subsequently issued a Medical Basis Statement dated May 2, 2013, signed by the clinical consultant, related its denial of OT coverage. The statement included that the clinical consultant found the OT provider's answers to her questions "troubling" and "disturbing" and that "it appears [D.C.] has not been well-served by the provider of OT services."

19. The clinical consultant's main areas of concern were what she considered to be the lack of more specific

goals related to activities of daily living (ADLs), the level or existence of collaboration between the OT provider and other service providers, the robustness of the OT home program, and facilitation and involvement of the OT in the IEP process. The statement also made reference to questions about whether the benefits of hippotherapy have been established with peer-reviewed studies or research.<sup>1</sup>

20. The Medical Basis Statement provides that "[D.C.] would benefit from obtaining Occupational Therapy services for his condition of autism spectrum disorder," a statement that the clinical consultant also acknowledged during her testimony at hearing. This fact is reiterated by the Department's physician reviewer (see paragraph 15, supra), and supportive of the OT provider's evaluation of D.C.'s medical need for OT and his positive response to treatment.

21. The evidence established, and there is no dispute in fact, that D.C. has a medical need for OT services and that he benefited from this intervention during the short period of coverage which led to the PA request for additional coverage.

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<sup>1</sup>Petitioner objected to the consideration of this issue, because it was never mentioned in the Department's notice of decision. For the reasons stated below, this issue does not affect the outcome.



22. At the center of this dispute was an ongoing exchange between the Department's clinical consultant and the OT provider regarding her approach and level of collaboration with other providers.

23. At hearing, the clinical consultant's testimony was consistent with her points made in writing and quoted above. Her primary emphasis was the importance of functional goals in a treatment plan. She referenced more than once that it was "very unusual" that D.C. had never had OT before, and that it was not in his IEP. Despite raising this question, she did not elaborate in any way on how that informed her opinion. The clinical consultant also acknowledged in testimony that the OT provider gave a "specific description of what [D.C.'s] limitations are and what she wanted to work with him on."

24. The OT provider's testimony was also consistent with her written exchanges quoted above. She further testified that she believed she had answered each of the clinical consultant's questions.

25. The Department's physician reviewer testified at hearing in support of the Department's decision to deny coverage because of a lack of sufficient information. In the judgment of the hearing officer, his opinion rests almost

entirely on the opinion of the clinical consultant. His review was limited to the Department's file and assessment of the clinical consultant. He did not speak directly to the OT provider.

26. In reviewing OT coverage requests, the clinical consultant relies in part on guidelines developed by the Department titled "The Department of Vermont Health Access Medical Policy" under the subject of "Physical, Occupational, and Speech Services and dated June 28, 2012. The clinical consultant referenced these guidelines on multiple occasions during her testimony. The guidelines are not formally incorporated into the Medicaid promulgated rules or referenced in the rules.

27. When questioned by the hearing officer, the Department's clinical consultant could not provide a specific answer as to the content of a PA request that would be satisfactory to her under the guidelines.

28. The OT provider testified that she uses many OT methods during her sessions, and hippotherapy is among those methods. The parties agreed that hippotherapy does not have its own distinct code for Medicaid billing purposes. The PA request here was submitted under a general OT billing code.

ORDER

The Department's decision is reversed.

REASONS

A request for prior authorization will be approved if the request meets the criteria found in Medicaid Coverage Rule 7102.2:

- A. is medically necessary (see rule 7103);
- B. is appropriate and effective to the medical needs of the beneficiary;
- C. is timely, considering the nature and present state of the beneficiary's medical condition;
- D. is the least expensive, appropriate health service available;
- E. is FDA approved, if it is FDA regulated;
- F. is subject to a manufacturer's rebate agreement, if a drug;
- G. is not a preliminary procedure or treatment leading to a service that is not covered;
- H. is not the repair of an item uncovered by Medicaid;
- I. is not experimental or investigational;
- J. is furnished by a provider with appropriate credentials.

W.A.M. § 7102.2.

Because D.C. is under 21, this case must be considered under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) definition of medical necessity:

"Medically necessary" means health care services, including diagnostic testing, preventive services, and aftercare, that are appropriate, in terms of type, amount, frequency, level, setting, and duration to the beneficiary's diagnosis or condition. Medically necessary care must be consistent with generally accepted practice parameters as recognized by health care providers in the same or similar specialty as typically treat or manage the diagnosis or condition, and

1. help restore or maintain the beneficiary's health; or
2. prevent deterioration or palliate the beneficiary's condition; or
3. prevent the reasonably likely onset of a health problem or detect an incipient problem.

Additionally, for EPSDT-eligible beneficiaries, medically necessary includes a determination that a service is needed to achieve proper growth and development or prevent the onset or worsening of a health condition.

W.A.M. § 7103 (emphasis added)

It is well-accepted in case law and Board precedent that EPSDT mandates an expansive application of "medical necessity" for children, in particular the "preventative thrust" of the benefit intended by Congress. See Fair Hearing No. B-02/09-94 (citing various provisions of federal law and court decisions related to EPSDT).

In this case there is no real dispute about whether D.C. has a medical need for the OT services at issue and that he will benefit from these services. Among D.C.'s most significant challenges are his poor muscle tone, limited oral motor control (affecting his speech), poor balance, and deficits in gross motor skills. Addressing these issues fits squarely within the definition of medical necessity and even more so for EPSDT, in that the OT "is needed to achieve proper growth and development or prevent the onset or worsening of a health condition." W.A.M. § 107, cited *supra*.<sup>2</sup>

The dispute in this case relates, if anything, to what the Department refers to as a problem with "verification" and its inability to make a decision because of a lack of information. Petitioner asserts that what is couched as verification is, at best, a philosophical difference between the Department's clinical consultant and the OT provider and this should not ultimately bear on the question of medical

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<sup>2</sup> The parties extensively briefed the question of the amount of deference owed to D.C.'s medical providers as to the question of medical necessity. See e.g., Urban v. Meconi, 930 A.2d 860, 865 (DE 2007) (State should give "substantial weight" to treating doctors' opinions and less weight to opinion of nontreating doctor.) *contrasted with* Moore v. Medows, 2009 U.S. App. Lexis 8718 (11<sup>th</sup> Cir. 2009) (both the State and treating physician have roles to play in medical necessity determination). That issue is not presented here given the lack of evidence to rebut the medical evidence submitted by petitioner.

necessity. The Department has also raised additional objections to coverage, suggesting that D.C.'s mother should pursue OT services in his IEP, and that the effectiveness of hippotherapy has not been sufficiently established.

It is evident that the questions and subsequent exchange between the Department's clinical consultant and the OT provider, by the Department's admission, were mainly based in the "Department of Vermont Health Access Medical Policy" OT "guidelines." See Paragraph 24, *supra*. These guidelines are not in the Medicaid regulations, nor are they referenced, nor can they ultimately determine the outcome here.

The dispute between the two clinicians concerned the provider's level of collaboration with other providers, the robustness of the home program, the inclusion of ADL-based goals in the treatment plan, and whether there was too much overlap between the PT and OT programs. The OT provider gave answers to each question posed by the clinical consultant.

The provider stated that at this stage of treatment she was working to improve D.C.'s fine and gross motor skills as a foundation for ADLs, and that she had only seen D.C. for four weeks and did not have enough information for a complete evaluation in this area, while giving an assessment in several areas in her addendum to her initial evaluation. She

said she had tried to call the PT provider to consult with, but had not heard back. She stated that she had started a home program with the family and in her opinion it was appropriate at this stage, and was told by the Department that it needed to be "expanded." With respect to overlap with PT goals, the provider stated that the PT was only seeing D.C. once per month, and was not focusing on the goal that the Department considered redundant. This goal was the only one identified by the Department that potentially overlapped; the remaining goals OT were independent of the PT goals.

The Department is permitted to apply appropriate criteria for the purposes of utilization control. See 42 U.S.C. § 1396d(r)(5). That is, in essence, the prior authorization process. The Department may query the provider with respect to *clinical* issues as part of the PA process. See W.A.M. §7102.2 (Additional information that may be required includes "a response to clinical questions posed by the department"). However, that process must apply criteria that are appropriate and reasonable.

Even assuming *arguendo* that the areas of inquiry made by the Department are appropriate under the PA rules, it clearly overreaches here in a way that is not reasonable. This is

not a case where the Department's questions went unanswered. The provider had established a home program. The provider was improving D.C.'s muscle tone, balance, and oral motor skills and had provided her functional assessment of him to the Department. Even though the provider stated that the one PT goal which potentially overlapped with hers was not being implemented, the Department's denial still rested on the perceived need to develop "goals that are non-duplicative of physical therapy goals" - and despite the fact that the remaining OT goals were not identified as duplicative.

Pointedly, the Department's clinical consultant could not answer with any specificity what satisfactory answers to her questions would look like. The OT provider gave reasonable answers to the questions posed. The guidelines relied upon by the Department do not have the force of regulation or law, and as the petitioner argues, are comprised in part of standards that are inherently subjective.<sup>3</sup> The Department's approach, while with the laudable *intent* of establishing a practice manual, applies

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<sup>3</sup> For example, the guidelines expect "good communication" with other providers, that services are provided in a "natural environment", that the provider has "maximized" participation in a home-based program, and for the therapist to "actively prepare and advocate the introduction of the child and family into the school system." Whether or not these are desirable goals, they are indeterminate in nature and have the potential of bearing little relation to the actual service being provided in any individual case.



these standards here to the point that they impermissibly supersede the requirements of medical necessity and rules related to prior authorization.

With respect to the issue of sufficient research establishing more broadly the efficacy of hippotherapy, the Board has clearly ruled that this cannot be a determining factor in a prior authorization decision when a petitioner has established there is a medical need and medical benefit to the therapy at issue. See Fair Hearing No. B-02/09-94 (lack of research showing efficacy of "intensive" PT does not supersede individualized evidence of medical necessity, particularly under broad mandate of EPSDT).

Finally, the Department suggests that OT services should be covered under D.C.'s IEP, citing Fair Hearing No. 19,102 (Medicaid coverage for service denied where family failed to seek an IEP for home-schooled children). Fair Hearing No. 19,102 is distinguishable here because D.C.'s mother has participated in the IEP process, and for that matter appears to have actively sought evaluation and services through the school district. She has fulfilled any obligation she has of pursuing IEP services. In these circumstances, requiring more of D.C.'s family is unreasonable.

The Department's denial is therefore inconsistent with the applicable regulations and the Board is required to reverse. 3 V.S.A. § 3091(d), Fair Hearing Rule No. 1000.4D.

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