STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. B-07/13-483
	)	
Appeal of	)	

INTRODUCTION

The petitioners appeal a decision by the Department of Vermont Health Access (DVHA) denying a request for retroactive prior authorization from the Medicaid program to pay for several weeks of "intensive constraint induced therapy" (CIT) they obtained for their son in April 2013 at an out-of-state facility. The issue is whether the therapy in question met the criteria in the Medicaid regulations for prior authorization.

The following discussion is based on the written materials submitted by the parties pursuant to several telephone status conferences that have been held in the matter.

DISCUSSION

The petitioners are the parents of a five-year-old boy who was born with cerebral palsy. He suffers from right sided paralysis, and wears a right leg brace and thumb

splint. He has been receiving physical and occupational therapies since he was seven months old.

The petitioners maintain that on the advice of their son's treatment providers they had placed their son on the "waiting list" for intensive CIT at the Kennedy Krieger Institute (KKI) in Baltimore, Maryland, and that in February 2013 they had been on the waiting list at KKI for over two years. They state that in late February 2013 they were informed by KKI that their son could receive a one-month program of intensive CIT services there beginning on April 1, 2013. The start date was then pushed back to April 15, 2015.

It appears from the record that on March 27, 2013 the boy's doctor in Vermont, a specialist in physical medicine and rehabilitation, sent the Department a request for prior approval for one month of in-patient "intensive" CIT at KKI. There is no indication that any such request was made during the two years the petitioners' son was on the KKI waiting list. From the records provided by the parties, it is not clear if KKI is, or could become, a certified Vermont Medicaid provider, but there does not appear to be any dispute that it is not part of the existing "network" of pre-approved providers.

The Department did not act on the request for prior approval before the scheduled start date of the therapy, although there is also nothing in the record indicating that the Department knew, or should have known, the dates of the therapy. The petitioners allege that they were "under the assumption that we had been approved", but there is no allegation or indication in the record that such a decision had ever been communicated to them by the Department, their providers in Vermont, or KKI itself. Although the petitioners allege that they would have suffered considerable inconvenience if they had further postponed their son's admission to KKI, there is no evidence or allegation that the services were of an urgent or emergency nature. There is also no claim or indication in the record that the Department had given any indication whatsoever to either the petitioners, their son's providers in Vermont, or KKI that the services were likely to be approved.

At any rate, the petitioners traveled with their son to Baltimore while he received in-patient services at KKI from April 16 to May 16, 2013. Upon their return, the petitioners renewed their request for Medicaid coverage, which the

Department denied. The petitioner filed a request for fair hearing on July 1, 2013.[1]

A hearing in the matter was convened by telephone on August 20, 2013. The parties agreed to continue the matter to allow the petitioners to submit additional medical evidence. At that time the hearing officer advised the petitioners that their burden of proof could well be considerable, and he strongly advised them to try to obtain an attorney. However, at all times during this appeal the petitioners have proceeded *pro se*.

Over the next several months additional continuances were granted, additional documentary evidence was received, and telephone status conferences were held, the final one occurring on January 22, 2014. At that time the hearing officer, without objection from either party, ordered that the record be closed upon receipt of the Department's final written review in the matter (which was received by the Board on January 24, 2013).

[1] The petitioners have indicated that they are not seeking Medicaid coverage for their own or their son's transportation or lodging costs.

In considering the petitioners' case, it is important to understand the regulations guiding prior authorization, which are set out in DVHA Rule 7102 as follows:

> Prior authorization is a process used by the department to assure the appropriate use of health care services. The goal of prior authorization is to assure that the proposed health service is medically needed; that all appropriate, less-expensive alternatives have been given consideration; and that the proposed service conforms to generally accepted practice parameters recognized by health care providers in the same or similar general specialty who typically treat or manage the diagnosis or condition. It involves a request for approval of each health service that is designated as requiring prior approval before the service is rendered. The department shall notify each patient and provider of its decision, which is arrived at by applying the criteria set forth in Rule 7102.2

The criteria for approving prior authorization of a health service are set out in Rule 7102.2, which states:

> A request for prior authorization will be approved if the health service:
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> A. is medically necessary (see rule 7103);
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> B. is appropriate and effective to the medical needs of the beneficiary;
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> C. is timely, considering the nature and present state of the beneficiary's medical condition;
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> D. is the least expensive, appropriate health service available;
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> E. is FDA approved, if it is FDA regulated;
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> 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.

This case is complicated considerably by the fact that the petitioners obtained the service in question without prior approval; and they are now, in effect, seeking "prior" approval retroactively. While such relief is not necessarily precluded (see e.g. Fair Hearing No. 19,735), in order to prevail in this matter the petitioners must now establish *ex post facto* that the Department would have been compelled under the above criteria to have granted prior approval *before* the service was actually rendered. Unfortunately, the evidence submitted by the petitioners, discussed below, falls short of their considerable burden of proof in the matter.

As noted above, there is no claim or evidence that the services provided by KKI were of an emergency or *medically* urgent nature. The petitioners admit that their son had been on a waiting list for these services for more than two years, during which time they did not submitted any request for prior approval. While their desire to promptly take advantage of an opening at KKI was understandable, it must be

found that they assumed a considerable risk in going ahead with the services without confirming that their request for prior approval for Medicaid coverage had been granted. As noted above, the record shows that the boy's treating physician in Vermont submitted a request for prior approval on March 27, 2013. The petitioners took their son to KKI on April 15, 2013. Absent any claim or indication of medical urgency, it cannot be concluded that the Department's failure to have responded within that less-than-three-week period negates or diminishes the petitioners' evidentiary burden in this matter.[2]

Turning then to the regulations themselves, in particular the first 4 criteria under Rule 7102.2, *supra*, there are several hurdles that the petitioners have failed to overcome. Based on the documents submitted it is clear (and uncontroverted) that the boy's medical providers had recommended and promoted "intensive" CIT for him at KKI. It

[2] The record indicates that the request form submitted by the boy's doctor on March 27, 2013 was incomplete. As a general matter, the regulations require the Department to issue a notice of decision with 30 days "even if all necessary information has not been received". Rule 7102.4. It does not appear that the Department issued a decision in this case until July 11, 2013. However, it is clear from the record that any decision issued within 30 days would have been a denial on the basis of incomplete information. The fact that the petitioners began their son's therapy 20 days after they had filed their PA request defeats any claim of detrimental reliance on their part regarding any failure by the Department to have issued a more timely decision.

is also clear from the record that one of the main purposes of "intensive" CIT is to develop a "program" of CIT that local providers can learn and follow. The record is also clear that the boy's providers were and are of the opinion that these "intensive" services are not available in Vermont. The above notwithstanding, it cannot be concluded that the evidence submitted to date addresses, much less resolves, several concerns the Department has legitimately raised, and specifically noted in its written decisions, regarding the medical necessity, appropriateness, timing, and cost of the therapy the petitioners' son received at KKI.

One concern raised by the Department in its decisions is the availability of other facilities, including one in Massachusetts, that offer similar "intensive" CIT, and are part of the Vermont Medicaid "network" of preapproved providers. The petitioners challenge the "relevance" of this concern, and maintain that none of their son's providers ever informed them about any alternative to KKI. The record shows that the boy's doctor has provided inconsistent and conflicting opinions on this issue. In his initial March 27, 2013 request the doctor noted only that the petitioners' son needed "intermittent periods of intensive therapy *such as that provided by* (KKI)" (emphasis added). In a letter dated

August 2, 2013 he stated only that KKI's program is "not available in the state of Vermont or its surrounding areas". In a phone conversation with the Department's reviewer on September 20, 2013 he stated: "Intensive services may exist in other places but not centers of excellence". There is no evidence in the record that any of the boy's providers ever considered, or even knew about, any other facility than KKI. (The Department also noted that the boy's doctor stated that he had done his fellowship at KKI.)

At this time the Board need not make findings regarding the availability of less costly alternative treatment. It is part of the petitioners' burden of proof to show that suitable alternative facilities at lower cost were *not* available. On the basis of the record submitted by the parties it cannot be concluded that the petitioners have met that burden.

Another concern noted in the Department's decision is "records" showing that the petitioners' son "went to an out of state program for additional intensive services" in Alabama in 2010. There was no acknowledgment of these services (or dispute raised regarding them) either in the request for prior authorization made by their son's doctors in March 2013, or in any of the materials furnished

subsequently by that doctor or KKI. The boy's current therapist in Vermont has informed the Department that she knew about this prior therapy, but that it came before her involvement in the boy's treatment. The unanswered question raised by the Department regarding this prior therapy is why another "round" of "intensive" inpatient therapy was medically necessary three years later.[3] Again, at this point in the proceedings the Board need not make any findings regarding the prior therapy itself, other than to note that it was the petitioners' burden of proof to have refuted this aspect of the Department's decision, and that the petitioners have failed to meet that burden.

There is no question that the petitioners in this matter are at a disadvantage in having to argue their case *ex post facto*. However, one of the main purposes of the prior approval process is to address such issues in advance, and to allow the Department to work with Medicaid recipients and their providers to collaboratively arrive at the most medically appropriate and cost effective treatments available. In this case, the petitioners' decision to avail

[3] In light of the petitioners' claim that they had placed their son on the KKI waiting list two years prior to his admission, it can be queried why such services were deemed medically necessary only *one* year following the treatment he had received in Alabama in 2010.

themselves of the services before obtaining prior approval effectively eliminated that process, placing a significant burden of proof on them to establish *in retrospect* that the Department would have been compelled to approve the service in advance. As noted above, the record submitted by the parties falls short of that evidentiary burden. Accordingly, the Department's decision must be affirmed. 3 V.S.A. § 3091(d), Fair Hearing Rule No. 1000.4D.

ORDER

The Department's decision is affirmed.

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