BEFORE THE OKLAHOMA HEALTH CARE AUTHORITY
STATE OF OKLAHOMA

[redacted]	)	
	)	
Appellant,	)	
	)	
v.	)	Case No. 17-0512
	)	
OKLAHOMA HEALTH CARE AUTHORITY,	)	
	)	
Appellee.	)	
	)	

ORDER

Eight-year-old [redacted] appeals from a decision of the Oklahoma Health Care Authority ("OHCA") denying her request for up to 20 hours per week of Applied Behavior Analysis ("APA") therapy, services that she contends are necessary to correct or ameliorate conditions relating to her diagnosis of Autism Spectrum Disorder ("ASD"). For the reasons set forth herein, the appeal will be **GRANTED IN PART AND DENIED IN PART** and OHCA is hereby ordered to authorize up to 12 hours of ABA services per week, effective January 1, 2019.[1]

This matter came before me for hearing on December 11, 2018. [redacted] was represented at the hearing by Joy Turner and Brian Wilkerson of the Oklahoma Disability Law Center. The Oklahoma Health Care Authority ("OHCA") appeared through its legal counsel, Susan L. Eads, the agency's Director of Litigation. Witnesses appearing and testifying on Appellant's behalf were were Kendra [redacted] ([redacted] mother); April Bryant, a Board Certified Behavior Analyst ("BCBA") in Oklahoma; and Dr. Derek Landis, [redacted] treating pediatrician. The agency's

[1] This order supersedes my interim order of January 17, 2019 and constitutes my final order for purposes of any subsequent appeal by either party.

witnesses included Dr. John Raizen, a licensed psychiatrist who serves as a Senior Medical Consultant for OHCA; Patricia Teter, a speech language pathologist under contract with OHCA; and Jennifer King, Director of Behavioral Health at OHCA. At the outset of the hearing, the parties were informed of their right to examine and cross-examine witnesses. All witnesses affirmed to tell the truth. During the course of the hearing, OHCA Exhibits 1 and 2 and Appellant's Exhibits A through L were introduced and admitted into evidence without objection.

The central question in this appeal is whether [redacted] is entitled to receive ABA therapy in order to "correct or ameliorate" conditions relating to her ASD. ABA is not currently covered by Oklahoma's Medicaid program. However, under the Early and Periodic Screening, Diagnosis and Treatment benefit ("EPSDT"), federal law effectively entitles Medicaid beneficiaries under the age of 21 to medically necessary screening, diagnostic and treatment services within the scope of the Social Security Act, regardless of whether such services are covered under the State Plan, so long as such services are necessary to "correct or ameliorate defects and physical and mental illnesses and conditions." 42 U.S.C. § 1396d(r)(5); OAC § 317:30-3-65-5.[2] Services

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[2] Section 1905(r) of the Social Security Act defines the EPSDT benefit to include comprehensive preventive, diagnostic, and treatment services for low-income infants, children and adolescents under age 21. As the Centers for Medicare and Medicaid Services ("CMS") describes it,

> [s]tates are required to arrange for and cover for individuals eligible for the EPSDT benefit any Medicaid coverable service listed in Section 1905(a) of the Act that is determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. The EPSDT benefit is more robust than the Medicaid benefit package required for adults and is designed to assure that children receive early detection and preventive care, in addition to medically necessary treatment services, so that health problems are averted or diagnosed and treated as early as possible.

CMCS Informational Bulletin re: Clarification of Medicaid Coverage of Services to Children with Autism, July 7. 2014. There is no dispute that ABA therapy is within the scope of services authorized by Section 1905(a) the Social Security Act, 42 U.S.C. § 1396d(a), a point that CMS specifically clarified for states in 2014. *Id.*

available under EPSDT require prior authorization and are subject to a determination of medical necessity. *Id.* As discussed below, [redacted] is currently receiving ABA therapy through her private insurer. She requests approval for up to 20 hours of ABA services per week through SoonerCare in order to supplement services currently being paid for by private insurance, to cover her out-of-pocket (co-pay) expenses, and to cover services in the event that private insurance is exhausted or otherwise discontinued.

The procedural posture of this case is somewhat unique. [redacted] applied for services in the fall of 2017. While the record does not reflect when or even if the agency issued a formal notice of denial, an email dated October 18, 2017 from an OHCA employee (Nichole Burland) advised [redacted] mother that ABA therapy was not a covered benefit and thus that OHCA was "unable to authorize the services." That is, of course, not entirely accurate; under EPSDT, OHCA is obliged to provide medically necessary services that correct or ameliorate a medical condition, and a blanket denial of ABA treatment, without consideration of whether such services might be required under EPSDT, could be problematic. *See, e.g., K.G. ex rel. Garrido v. Dudek,* 981 F.Supp.2d 1275, 1288 (S.D. Fla. 2013). Here, although [redacted] request was not (at least initially) handled as a request for prior authorization of services under EPSDT, it ultimately was treated as such. However, as of the date of hearing, [redacted] had not received a formal, final decision from OHCA regarding whether the requested services would be covered under the EPSDT benefit.[3] Instead, the parties agreed that this appeal could serve as the basis for both the agency's initial determination of medical necessity and, if necessary, [redacted] appeal. While unorthodox, I agreed to proceed in this fashion, consistent with the parties' agreement. As

[3] Testimony at the hearing established that the agency had requested, and was waiting on the member to provide, additional records and information in support of her request.

a result, it was not until the conclusion of the Appellant's case that OHCA made its final determination that the requested services were, in its view, medically necessary.

By way of background, [redacted] was first diagnosed with ASD in January 2012, shortly before her second birthday. This underlying diagnosis is not contested by OHCA. At that time, her pediatrician recommended "early and aggressive therapy," including speech therapy ("ST"), occupational therapy ("OT"), physical therapy ("PT"), and behavioral therapy. The family researched ABA, but was unable to locate a provider near their home in Norman, where they lived at the time. [redacted] was approved, however, for two speech therapy sessions per month.

Dissatisfied with the progress they were seeing, [redacted] parents investigated early childhood intervention services (ECI) and moved to Texas, where [redacted] was approved for, and began receiving, ST, OT, and PT through the Texas school system. According to testimony at the December 11 hearing, [redacted] received PT and OT twice per week, and ST five times per week. Mrs. [redacted] testified that the closest provider of ABA therapy services in Texas was located in Fort Worth, which was not feasible. Nevertheless, Mrs. [redacted] testified that they saw significant improvement in communication and speech (with some concomitant improvement in [redacted] behavior), but that issues relating to certain dangerous behaviors (e.g., elopement, climbing on furniture) continued.

The family returned to Oklahoma in 2017, where [redacted] has continued to receive OT, ST and PT at school, albeit on a less-frequent basis than had been the case in Texas. The family also located a provider of ABA therapy services in Ardmore, and [redacted] was initially approved for 20 hours of ABA services weekly through HealthChoice, the family's primary health care

insurer.[4] [redacted] began receiving ABA therapy from Ms. Bryant, a BCBA with FUNdamentals Therapy, beginning in October 2017. For reasons not made clear on the record, HealthChoice discontinued coverage for ABA services and [redacted] stopped receiving such services on or about July 18, 2018. Apparently as a result of an appeal of HealthChoice's decision, the insurer reconsidered and subsequently approved eight hours of ABA services per week, beginning in October 2018.[5]

After listening to Appellant's witnesses, Dr. Raizen offered his opinion that ABA services were not – at least at this juncture – medically necessary. Dr. Raizen characterized ABA therapy is the "most intense treatment" available, and testified that, before prescribing ABA therapy, lesser interventions, including conventional treatment, psychotropic medications to control behavior, and protective gear (e.g., a helmet) should all be explored as "less restrictive" or "less intrusive" alternatives to ABA therapy. It is noteworthy that Dr. Raizen also testified that he did not believe he could authorize ABA in [redacted] case – or, indeed, in *any* member's case – because OHCA does not currently have a policy in place authorizing its use. Dr. Raizen candidly acknowledged the effectiveness of ABA therapy generally, and testified on cross-examination that he believed the ABA services provided to [redacted] had, in fact, served to lessen or ameliorate her underlying medical condition (i.e., ASD). Still, he testified that OHCA

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[4] By statute, health care insurance companies in Oklahoma are required to provide coverage for medically-necessary ABA services, subject to maximum benefit of 25 hours per week and an annual cap of $25,000. 36 O.S. § 6060.20.

[5] There was anecdotal evidence from both Dr. Landis, Mrs. [redacted] and Ms. Bryant that [redacted] did some "backsliding" during the roughly three-month period last fall during which she was not receiving ABA therapy, and that her behavior improved when she resumed services in October. However, testimony also showed an interruption in OT, PT and ST at or about the same time, leaving some question as to whether, and to what extent, the loss of ABA services was the cause of any perceived regression.

is mandated to use the "least restrictive" or "least intrusive" level of care, and that other therapies should be tried first, before ABA services should be considered or approved.

Dr. Raizen's position – that in the absence of specific policy language relating to ABA therapy, such services could not be provided – is arguably at odds with OHCA's obligation to consider and provide services under the EPSDT benefit in appropriate cases. More to the point, OHCA *has* adopted regulations relating generally to the determination of medical necessity, and it is these regulations that I believe govern here, notwithstanding the absence of specific policy relating to ABA or the fact that the services may not be covered under Oklahoma's State Plan. 42 U.S.C. § 1396d(r)(5); OAC § 317:33-65.5.

As noted, there is no question that ABA therapy falls within the broad definition of services listed in Section 1905(a). *See* discussion *infra* at 2 n.2. There is, in addition, no question that ABA therapy for children diagnosed with ASD is both effective and widely-accepted. In this regard, I take judicial notice of the fact that numerous state Medicaid programs have already seen fit to include ABA therapy as a covered service, consistent with its recognition as an effective form of treatment by the American Academy of Pediatrics. Indeed, as both Dr. Raizen and Ms. Teter (OHCA's speech language pathologist) acknowledged, it has been shown to provide excellent results, particularly in combination with other therapies, like ST.

This leaves, then, only the question of medical necessity in [redacted] particular case. Based upon the testimony and evidence of record (or more particularly, the lack of it), I find that the requested services are medically necessary. OHCA's regulations define medical necessity in this context. OAC § 317:30-3-1(f). That regulation provides that medical necessity is established through consideration of the following standards:

> (1) Services must be medical in nature and must be consistent with accepted health care practice standards and guidelines for the

prevention, diagnosis or treatment of symptoms of illness, disease or disability;

(2) Documentation submitted in order to request services or substantiate previously provided services must demonstrate through adequate objective medical records, evidence sufficient to justify the client's need for the service;

(3) Treatment of the client's condition, disease or injury must be based on reasonable and predictable health outcomes;

(4) Services must be necessary to alleviate a medical condition and must be required for reasons other than convenience for the client, family, or medical provider;

(5) Services must be delivered in the most cost-effective manner and most appropriate setting; and

(6) Services must be appropriate for the client's age and health status and developed for the client to achieve, maintain or promote functional capacity.

Dr. Raizen's stated basis for finding a lack of medical necessity in [redacted] case is his opinion that more traditional therapies, in conjunction with the use of psychotropic medications and protective gear, would be less intrusive and must first be explored. From this, the agency maintains that services were properly denied under the regulation's requirement that services must be delivered in the most "cost-effective" manner and in the "most appropriate setting." I disagree. Absent evidence regarding the relative long-term or short-term costs and effectiveness of competing therapies, I am unwilling to disrupt what everyone agrees is effective and ongoing treatment for the sole purpose of trying out a different regimen that may or may not prove to be as effective.

This brings me, then, to the question of "how much"? On the one hand, [redacted] mother testified that the eight hours of ABA therapy currently authorized by HealthChoice merely maintains [redacted] progress to date, but will not substantially move the ball forward. She suggests 16 hours per week is appropriate. Ms. Bryant testified that 20 hours might be appropriate. [redacted] treating pediatrician, Dr. Landis, testified that the more intensive the intervention, the more efficacious it has proven to be. However, he also testified that studies

have suggested that a program that includes as little as 12 hours per week of ABA therapy, combined with ST, PT, and OT, has also proven effective. And all of the witnesses agreed that the appropriate level of treatment must be balanced against potentially disruptive interference with [redacted] academics. The agency's witnesses, on the other hand, did not suggest any specific level of treatment in the event I found ABA services were warranted. After considering the parties' positions, I find that up to 12 hours of therapy per week is appropriate. This provides a level of treatment consistent with Dr. Landis' testimony – particularly where, as here, it is combined with ST, OT, and PT – while paying heed to Dr. Raizen's concerns regarding least intrusive therapies, and strikes what I believe to be a workable balance between therapy and school, based upon the evidence.

To be clear, I am not holding that OHCA must cover ABA services under EPSDT in every case. Obviously, the agency's determination of medical necessity must be made on a case-by-case basis. Moreover, the agency may, by regulation, impose reasonable restrictions on the availability and scope of available treatments. However, based upon the testimony and the weight of the evidence, I do find that ABA therapy is medically warranted and necessary in [redacted] case, and that I would be doing a disservice by requiring her to try out potentially (but not clearly) less-costly or less-demanding alternatives. In this regard, I am mindful not only of the "more robust" nature of the EPSDT benefit, but also of [redacted] age, the importance of early intervention (particularly with ABA therapy), the amount of time that has passed since the filing [redacted] original application for services in October 2017, and the absence of any particular guidance through the promulgation of specific regulations governing ABA services.

Therefore, based upon the testimony and records presented, I find that Appellant has established by a preponderance of the evidence that the agency's decision to deny ABA services

in [redacted] case was improper or without proper foundation and for this reason, the appeal is **GRANTED IN PART AND DENIED IN PART** as follows:

1. OHCA shall cover up to a total of 12 hours of ABA services per week, effective January 1, 2019. As noted in my interim order, and with the exception of the additional four hours per week that I have authorized on top of services currently being provided and paid for through the member's private insurer, the relief granted herein is not intended to be in addition to those services, but is, instead, intended to complement that coverage by assisting with out-of-pocket expenses or in the event that private coverage is discontinued.

2. Authorization pursuant to this order shall remain effective for a period of 180 days from January 1, 2019. Prior to the end of the authorization period, an appropriate reassessment must be completed in order to demonstrate the member's progress against measureable goals and further demonstrating the continuing medical necessity of ABA services going forward.

3. Services need not be reauthorized if they are determined to be no longer medically necessary. Factors to be considered should include, *inter alia,* whether short-term and long-term treatment goals and objectives have been achieved, and whether the member is demonstrating progress towards treatment goals and objectives and measureable functional improvement can still be expected through continued ABA services.

4. A reassessment and subsequent prior authorization shall be required every 180 days for the duration of treatment.

5. In the event that OHCA promulgates regulations relating specifically to the prior authorization of ABA services at any future time, services ordered hereunder shall be subject to

such regulation, which shall control in the event of any conflict between the terms of this order and the promulgated regulation.

This decision may be appealed to the Chief Executive Officer of the Oklahoma Health Care Authority pursuant to OAC § 317:2-1-13. Appeals must be addressed to the Chief Executive Officer, Oklahoma Health Care Authority, 4345 N. Lincoln Blvd., Oklahoma City, OK 73105, and must be **received by the agency** within twenty (20) days of the date of this Order.

Dated this 30th day of January, 2019.

JOSEPH M. YOUNG
ADMINISTRATIVE LAW JUDGE

CERTIFICATE OF SERVICE

This is to certify that on the 30th day of January 2019, a true and correct copy of the *Order* was sent electronic mail to:

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