



2. J. has a number of severe medical problems, including autism, auto-immune disease, dietary problems and developmental delays.

3. Since last Fall, the petitioner has had difficulty obtaining Medicaid approval for transportation for J.'s twice yearly appointments. The first denial came for the round of November 2004 appointments. The petitioner kept the appointments and tried to seek reimbursement for those visits while also trying to persuade DCF to pay for the upcoming March visit. At that time she provided DCF with the following information:

- a. A letter and a form dated March 10, 2005 from J's local treating physician stating that evaluations and therapeutic planning performed by the two out-of-state physicians, (a pediatric psychiatrist in Maryland who specializes in autism and a pediatrician in the New York City area who specializes in auto-immune diseases) are "medically necessary" and that there are no closer facilities to provide treatment.
- b. A letter dated February 25, 2005 from the pediatric psychiatrist, Dr. G., stating that J. evidences a form of static encephalopathy (ICD-9 742.9) with speech and language, motor, sensory, and affective dysfunction. Static encephalopathy is a medical disorder for which a comprehensive treatment program is necessary. J. has, along with his developmental challenges, unique sensory processing, motor function and language challenges along with social-emotional challenges. He has been responding very well to a program we have developed for him. The expertise to develop and maintain this type of special program is not widely

available. It is critical for his family to maintain continuity with the current program and the professionals who have helped his parents implement this program. It is essential that he and his family continue their periodic visits to Maryland and New York in order to assist J. in the progress he has made otherwise he is at risk for regression and loss of critical gains.

4. On March 16, 2005, four days before the appointments, DCF, acting through its local transportation agent, denied the transportation expense saying "more information needed to show that these are the closest providers to meet individual medical needs." As the appointments were four days away, the petitioner attended with her son anyway, seeing the pediatric psychiatrist on March 21, 2005 and the pediatric rheumatologist on March 25, 2005. The petitioner borrowed the money for these trips.

5. On May 11, 2005, the petitioner asked for reimbursement for both the November and March trips in a long letter reiterating the evidence she had presented.

6. In a letter dated June 21, 2005, DCF agreed to pay the transportation and lodging expenses for November because the transportation provider had failed to provide the petitioner with "a written denial of prior authorization" and "your fair hearing rights." However, the March expenses were denied because the providers she chose were (1) not

"generally available to other Vermonters nor are they being utilized by other members of your community", (2) not enrolled as Vermont Medicaid providers, (3) were not to its knowledge used by other members of the community and locality and finally because (4) the agency was "confident the services offered by the providers that you have chosen: a psychiatrist, pediatrician and dietitian are available in the state of Vermont." The notice concluded with a notation that "A recipient's freedom of access to health care does not require Medicaid to cover transportation at unusual or exceptional cost in order to meet a recipient's personal choice of provider."

7. The petitioner appealed that decision on July 6, 2005. At a status conference held on July 21, 2005, the petitioner agreed to provide more specific information in writing regarding the specific services her providers in Maryland and New York give to her son. At that point, DCF would review the information and either approve the transportation or give the petitioner the names of physicians who were closer to her who could provide those special services to her son. DCF was also asked to clarify its reasons for refusal in light of DCF's notice of June 21, 2005 which seemed to indicate that Medicaid transportation could

never be provided to any out-of-state providers not generally used by Medicaid recipients.

8. On August 12, 2005, DCF confirmed that it does interpret its rule as covering out-of-state travel in three instances: (1) if the out-of-state provider is generally used by Medicaid recipients in a community and it is within thirty miles distance; (2) for the first sixty days after a family moves thirty miles from a prior provider; or, (3) if the transportation is for "medically necessary trips to specialists, unique medical conditions or other good cause". In the latter case, DCF said that its procedures manual requires that "out-of-state trips must be pre-authorized, with the attending physician's certification that the trip is medically necessary."

9. In response to this directive, on August 22, 2005, the petitioner filed a statement saying that her son needs to see a child psychiatrist who is also a psychoanalyst who specializes in the prevention of treatment of developmental disabilities in children and one who prescribes a 24 hour/7 day program that includes home, school and community recommendations and who has vast experience treating the Autism population. She also stated that J. needs to see a pediatrician who is trained in rheumatology and who has

extensive expertise treating children who are Autistic. She stated that Medicaid had suggested no doctors with these qualifications who were closer to their home and had not stated why verification she had provided in the past and which was approved was no longer acceptable. In support of her contentions, the petitioner provided the following:

- a. A letter dated August 18, 2005 from J's local treating physician who made the referrals to the out-of-state physicians which states as follows:

I have had the honor of being [J.'s] primary care Pediatrician since his birth. Despite [J's] extremely rocky, almost impossible start on life, he has continued to amaze those who get to know him with his incredible personality, intelligence, motor skills, musical skills and willingness to learn.

The challenge has always been "how do you educate and care for this remarkable young man[?]" During his lifetime his parents, [petitioner and her husband's names] have worked daily to provide the best education and medical care they can for their son. Their efforts to get the best care possible for their son at times has lead to challenges but also successes.

This letter is in reference to Fair Hearing #19,735 concerning [J.], a minor, represented by his mother, [petitioner's name]. [J.] has been diagnosed with autism, with secondary diagnoses of hyperacusis, broncho-pulmonary dysplasia and autoimmune disorder. As his primary care physician this letter is to inform and advise the Board and other interested parties in the matter of the requisite specialties and subspecialties of physicians who provide treatment for [J.].

First, in the matter of his primary diagnosis, [J.] is treated by a Board Certified Pediatrician who is a practicing child psychiatrist/psychoanalyst with specialties in behavioral sciences and learning

disorders. This practitioner has extensive knowledge and practice in the prevention and treatment of emotional and developmental disorder in infants and children. This last item is integral to the physicians prescription of a "24/7" treatment program which emphasizes the blending of home, school and community in a holistic, comprehensive paradigm.

For his secondary diagnosis, the patient sees a Board Certified Physician whose specialties are pediatric, infectious disease medicine and rheumatology. Since [J.] presents a complicated picture regarding his nutritional needs and other aspects of his medical history, it is advisable the [sic] he is examined and treated by one who has extensive training and proven expertise in such area. This physician, Dr. [H.] has had significant success in using these techniques to treat children with Autism.

Because [J.] has an extensive successful history with these physicians and there is sound medical cause for him to continue seeing them I believe that it is in [J.'s] best interest to continuing seeing these physicians at the present frequency.

b. A computer printout of an on-line "physician quality report" showing that Dr. H. specializes in infectious disease medicine, pediatrics and rheumatology along with a definition of those specialties.

c. A two-page curriculum vitae of Dr. G. showing his medical degree of some forty years as well as numerous publications, honors and professional activities and in which he describes himself as a "practicing child and adult psychiatrist and psychoanalyst", a "clinical professor of psychiatry and behavioral sciences and pediatrics" at George Washington University medical school, a "supervising child psychoanalyst" at the Washington Psychoanalytic Institute, the "Chair" of the Interdisciplinary Council on Developmental and Learning Disorders and "Co-Chair" of the Council on Human Development" as well as a researcher on the prevention and treatment of emotional and developmental disorders in infants and children and the recipient of a prize from the American Psychiatric Association for

outstanding contribution to Child Psychiatry Research, among many other notations.

d. Three pages of abstracts and descriptions of articles, books and videos authored by Dr. G. primarily involving child language research, developmental and learning disorders.

10. On October 11, 2005, DCF responded to the petitioner's submission by asking for dismissal of her appeal. The response criticized the referring physician's letter as insufficient. (A copy of the entire letter is provided to the Board as part of DCF's legal argument.) The entire medical evidence offered in response to the petitioner's submission was a compilation of statistics in the petitioner's county showing that she could obtain transportation to thirty-three different pediatricians, twenty-nine different psychologists and five different psychiatrists.

11. At a further hearing held on October 13, 2005, the hearing officer advised DCF that she considered its submission inadequate as it did not say whether any of the available medical personnel had training and experience sufficient to treat the special needs identified by J.'s treating physician, it did not identify any of these physicians and did not address the issue of continuity of care. DCF asked for and was given leave to submit additional

evidence by October 21, 2005. That deadline was imposed not only because the matter had been pending for four months but also because the petitioner needed a decision before J.'s next appointment scheduled in November of 2005. No further evidence was supplied by DCF by the deadline.<sup>1</sup>

12. Based on all the evidence presented in this matter, it is found that the petitioner's treating psychiatrist referred J. to Dr. H. and Dr. G., two out-of-state physicians; that he has certified that they are the closest available physicians to meet J.'s special needs; that he has clearly described what those special needs are as well as the qualifications of those physicians to provide for those needs; and he has confirmed that continuity of care with these providers is important. The petitioner has also provided evidence from which it can be and is concluded, in combination with the opinions offered by J.'s in-state treating physician, that both out-of-state physicians have a

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<sup>1</sup> DCF filed a new packet of information with the Board on October 24, 2005, three days past the deadline. The information was forwarded to the hearing officer who received it on October 25, 2005 too late to analyze the information and include it in the recommendation to be mailed to the Board for the November 2 Board meeting. The hearing officer's recollection is that she made clear to the Department on October 13, 2005 that she had to receive the evidence by October 21, 2005. Regardless of the above, the evidence submitted by the Department does not address the continuity of care issue. Thus, even if admitted, it would not be sufficient to rebut the petitioner's *prima facie* showing of eligibility (see *infra*).

unique combination of qualifications which ideally suit them to provide the services needed by her son. The evidence presented by DCF in response is vague, undetailed and unresponsive to much of the evidence provided by the petitioner and is thus found to be insufficient to refute the detailed and salient information provided by the petitioner.

ORDER

The decisions of DCF to deny reimbursement to the petitioner for transportation to her son's March 2005 appointments and to deny funding for his upcoming November 2005 appointments is reversed.

REASONS

DCF has adopted regulations for providing transportation to Medicaid recipients which provides as follows:

Transportation

Transportation to and from necessary medical services is covered and available to eligible Medicaid recipients on a statewide basis.

The following limitations on coverage shall apply:

1. Prior authorization is required. (Exceptions may be granted in a case of a medical emergency.)
2. Transportation is not otherwise available to the Medicaid recipient.

3. Transportation is to and from necessary medical services.
4. The medical service is generally available to and used by other members of the community or locality in which the recipient is located. A recipient's freedom of access to health care does not require Medicaid to cover transportation at unusual or exceptional cost in order to meet a recipient's personal choice of provider.
5. Payment is made for the least expensive means of transportation and suitable to the medical needs of the recipient.
6. Reimbursement for the service is limited to enrolled transportation providers.
7. Reimbursement is subject to utilization control and review in accordance with the requirements of Title XIX.
8. Any Medicaid-eligible recipient who believes that his or her request for transportation has been improperly denied may request a fair hearing. For an explanation, see the "Fair Hearing Rules" listed in the Table of Contents.

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DCF agrees in its memorandum of law that first sentence of the above regulation allows preauthorization for out-of-state transportation for "medically necessary trips to specialists, unique medical conditions or other good cause." Furthermore, DCF states that as part of the pre-authorization process its own procedures manual requires the client to submit "the attending physician's certification that the trip

is medically necessary." *Medicaid Transportation Procedures Manual*, § 4.3.9. The procedures manual authorizes transportation payment to the "service nearest the client's residence." *Id.*, § 3.3.4.3.

In this matter, DCF does not dispute that the petitioner's son has a need for the medical services provided by these out of state providers.<sup>2</sup> The petitioner submitted the referral from her child's attending physician certifying that the treatments in Maryland and New York are medically necessary and that these are the closest facilities that can provide the treatment. DCF questions, however, the accuracy of the physician's statement that there are no closer facilities for these services. It is certainly DCF's prerogative to question this assertion but once such an assertion is made by the treating physician, the burden shifts to DCF to show that the same services are nearby.

Because the child in this case has a severe and complicated constellation of problems, the hearing officer asked the petitioner to provide further information to DCF about the exact services her child receives and the qualifications of the persons who provide these services.

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<sup>2</sup>This clarification was made necessary because DCF's June letter of denial did not seem to recognize that an exception could be made for medically necessary out of state travel.

The petitioner complied with that request on August 22, 2005. DCF's burden at that point was to provide the petitioner with the name(s) of providers who are closer to her residence and who are qualified to and who do provide the same services. Seven weeks later the only response provided by DCF was an enumeration of the numbers of pediatricians, psychologists and psychiatrists who provide Medicaid in her county. No attempt was made to describe the abilities or specialties of these medical providers or to connect them in any way to the special needs of this child. Neither was there any medical evidence refuting the petitioner's medical evidence showing that continuity of care is imperative for this child. DCF has thus failed in its burden and the opinion of the petitioner's child's attending physician must be accepted as an accurate description of the situation.

In its response, DCF said it had a number of questions about statements made by the referring physician. DCF had the ability to pose any questions it had to the physician and to include his answers as part of its response. DCF cannot now blame the petitioner for its failure to do so. The petitioner made out a *prima facie* case for eligibility when she submitted the attending physician's certification of referral as early as March of this year. Nevertheless, she

continued to face months of denials while DCF allegedly investigated her case and, without generating any new information, finally denied her in June based on a misreading of its own regulations. Even after the petitioner appealed and provided additional information in August, DCF has done virtually nothing in over six months to refute her physician's assertions. Since there is no evidence to contradict his detailed submission, the Board is bound to accept it as accurate and to reverse DCF's decision denying the transportation as not consistent with its own regulations and procedures. 3 V.S.A. § 3091(d), Fair Hearing Rule 17.

As the petitioner makes semi-annual trips to these doctors, this matter will arise again in the near future. At that time, the petitioner will need to submit a certification from her child's attending physician of the child's need to travel out-of-state for the child's care. DCF now has a full description of the services provided by these physicians and the reasons the child sees them as well as an assertion that continuity of care is important. With this information in hand, DCF should be able to make a timely decision on the next request. Any future denial by DCF should be accompanied by competent medical evidence which shows either that (1) the child does not need these services or (2) that these same

services can be ably provided by physicians closer to home  
and continuity of care is not medically essential.

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