



RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
MICHIGAN ADMINISTRATIVE HEARING SYSTEM  
Christopher Seppanen  
Executive Director

SHELLY EDGERTON  
DIRECTOR

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██████████ MI ██████████

Date Mailed: April 17, 2017  
MAHS Docket No.: 17-000667  
Agency No.: ██████████  
Petitioner: ██████████

**ADMINISTRATIVE LAW JUDGE: Janice Spodarek**

**DECISION AND ORDER**

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and upon the Petitioner's request for a hearing.

After due notice, a hearing was held on April 11, 2017. ██████████ Parent, Guardian and Hearing Representative appeared on behalf of Petitioner. Petitioner appeared but did not testify.

Dorian Reed, Medicaid Fair Hearing Officer, represented the Respondent, subcontracting CMH with the Michigan Department of Health and Human Services—the Detroit Wayne Mental Health Authority of Detroit, Michigan. Witnesses included ██████████ ██████████ Psychologist, and ██████████ Operations Director at ██████████

**ISSUE**

Did Respondent properly deny Petitioner benefits under the Autism Benefit Waiver?

**FINDINGS OF FACT**

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. Petitioner is a 19 year old, Medicaid beneficiary, who date of birth is ██████████ 1998.
2. Petitioner's diagnoses include at her first evaluation moderate intellectual disability and ADHD; and at a re-evaluation on March 3, 2017 mild intellectual disability, ADHD, and unspecified mood disorder. (Exhibit A).

3. Petitioner resides in her family home in [REDACTED] MI in [REDACTED] MI (Exhibit A).
4. Petitioner has private pay insurance through Petitioner's parent, with HAP.
5. On November 8, 2016, Respondent issued an Adequate Notice of Action denying Petitioner's request for the Autism Benefit Waiver on the grounds of 42 CFR 440.230(d) and the MPM, Chapter 3.
6. Petitioner receives speech and occupational therapy services through the school system.
7. Subsequent to the requests here for the Autism Benefit Waiver, Petitioner also requested services for speech and occupational therapy outside the school.
8. Testimony on the record was that Petitioner cannot get the Autism Benefit Waiver without a diagnosis of autism; Petitioner is not entitled to speech and/or occupational therapy services paid for by taxpayer Medicaid monies without having first exhausted private pay insurance. To date, Petitioner has not requested these services from her private pay insurance. (Testimony).
9. On January 20, 2017 a hearing request was initially filed on Petitioner's behalf.

### **CONCLUSIONS OF LAW**

The Medical Assistance Program (MA) is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program:

Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.

*42 CFR 430.0*

The State plan is a comprehensive written statement submitted by the

agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

*42 CFR 430.10*

Section 1915(b) of the Social Security Act provides:

The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection (s) of this section) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State...

*42 USC 1396n(b)*

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915 (c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS) the Department of Health and Human Services (DHHS) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c).

The Medicaid Provider Manual addresses screening for ASD:

#### **SECTION 18- BEHAVIORAL HEALTH TREATMENT SERVICES/ APPLIED BEHAVIOR ANALYSIS**

The purpose of this policy is to provide for the coverage of Behavioral Health Treatment (BHT) services, including Applied Behavior Analysis (ABA), for children under 21 years of age with Autism Spectrum Disorders (ASD). All children, including children with ASD, must receive EPSDT services that are designed to assure that children receive early detection and preventive care, in addition to medically necessary treatment services to correct or ameliorate any physical or behavioral conditions, so that health problems are averted or diagnosed and treated as early as possible.

According to the U.S. Department of Health & Human Services, autism is characterized by impaired social interactions, problems with verbal and nonverbal communication, repetitive behaviors, and/or severely limited

activities and interests. Early detection and treatment can have a significant impact on the child's development. Autism can be viewed as a continuum or spectrum, known as ASD, and includes Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder-Not Otherwise Specified (PDDNOS). The disorders on the spectrum vary in severity and presentation, but have certain common core symptoms. The goals of treatment for ASD focus on improving core deficits in communication, social interactions, and restricted behaviors. Changing these fundamental deficits may benefit children by developing greater functional skills and independence.

BHT services prevent the progression of ASD, prolong life, and promote the physical and mental health and efficiency of the child. Medical necessity and recommendation for BHT services is determined by a physician, or other licensed practitioner working within their scope of practice under state law. Direct patient care services that treat or address ASD under the state plan are available to children under 21 years of age as required by the EPSDT benefit.

### **18.1 SCREENING**

The American Academy of Pediatrics (AAP) endorses early identification of developmental disorders as being essential to the well-being of children and their families. Early identification of developmental disorders through screening by health care professionals should lead to further evaluation, diagnosis, and treatment. Early identification of a developmental disorder's underlying etiology may affect the medical treatment of the child and the parent's/guardian's intervention planning. Screening for ASD typically occurs during an EPSDT well child visit with the child's primary care provider (PCP). EPSDT well child visits may include a review of the child's overall medical and physical health, hearing, speech, vision, behavioral and developmental status, and screening for ASD with a validated and standardized screening tool. The EPSDT well child evaluation is also designed to rule out medical or behavioral conditions other than ASD, and include those conditions that may have behavioral implications and/or may co-occur with ASD. A full medical and physical examination must be performed before the child is referred for further evaluation.

### **18.2 REFERRAL**

The PCP who screened the child for ASD and determined a referral for further evaluation was necessary will contact the Pre-paid Inpatient Health Plan (PIHP) directly to arrange for a follow-up evaluation. The PCP must refer the child to the PIHP in the geographic service area for Medicaid beneficiaries. The PIHP will contact the child's parent(s)/guardian(s) to arrange a follow-up appointment for a comprehensive diagnostic

evaluation and behavioral assessment. Each PIHP will identify a specific point of access for children who have been screened and are being referred for a diagnostic evaluation and behavioral assessment of ASD. If the PCP determines the child who screened positive for ASD is in need of occupational, physical, or speech therapy, the PCP will refer the child directly for the service(s) needed.

After a beneficiary is screened and the PCP determines a referral is necessary for a follow-up visit, the PIHP is responsible for the comprehensive diagnostic evaluation, behavioral assessment, BHT services (including ABA) for eligible Medicaid beneficiaries, and for the related EPSDT medically necessary Mental Health Specialty Services. Occupational therapy, physical therapy, and speech therapy for children with ASD who do not meet the eligibility requirements for developmental disabilities by the PIHP are covered by the Medicaid Health Plan or by Medicaid Fee-for-Service.

### **18.3 COMPREHENSIVE DIAGNOSTIC EVALUATIONS**

Accurate and early diagnosis of ASD is critical in ensuring appropriate intervention and positive outcomes. The comprehensive diagnostic evaluation must be performed before the child receives BHT services. The comprehensive diagnostic evaluation is a neurodevelopmental review of cognitive, behavioral, emotional, adaptive, and social functioning, and should include validated evaluation tools. Based on the evaluation, the practitioner determines the child's diagnosis, recommends general ASD treatment interventions, and refers the child for a behavior assessment. The provider who conducts the behavior assessment recommends more specific ASD treatment interventions. These evaluations are performed by a qualified licensed practitioner working within their scope of practice and who is qualified and experienced in diagnosing ASD. A qualified licensed practitioner includes:

- a physician with a specialty in psychiatry or neurology;
- a physician with a subspecialty in developmental pediatrics, developmental-behavioral pediatrics or a related discipline;
- a physician with a specialty in pediatrics or other appropriate specialty with training, experience or expertise in ASD and/or behavioral health;
- a psychologist;
- an advanced practice registered nurse with training, experience, or expertise in ASD and/or behavioral health;
- a physician assistant with training, experience, or expertise in ASD and/or behavioral health; or
- a clinical social worker, working within their scope of practice, and is qualified and experienced in diagnosing ASD.

The determination of a diagnosis by a qualified licensed practitioner is accomplished by direct observation and utilizing the Autism Diagnostic Observation Schedule-Second Edition (ADOS-2), and by administering a comprehensive clinical interview including a developmental symptom history (medical, behavioral, and social history) such as the Autism Diagnostic Interview-Revised (ADI-R) or clinical equivalent. In addition, a qualified licensed practitioner will rate symptom severity with the Clinical Global Impression Severity Scale. Other tools may be used if the clinician feels it is necessary to determine a diagnosis and medical necessity service recommendations. Other tools may include:

- cognitive/developmental tests, such as the Mullen Scales of Early Learning, Wechsler Preschool and Primary Scale of Intelligence-IV (WPPSI-IV), Wechsler Intelligence Scale for Children-IV (WISC-IV), Wechsler Intelligence Scale for Children-V (WISC-V), or Differential Ability Scales-II (DAS-II);
- adaptive behavior tests, such as Vineland Adaptive Behavior Scale-II (VABS-II), Adaptive Behavior Assessment System-III (ABAS-III), or Diagnostic Adaptive Behavior Scale (DABS); and/or
- symptom monitoring, such as Social Responsiveness Scale-II (SRS-II), Aberrant Behavior Checklist, or Social Communication Questionnaire (SCQ).

#### **18.4 MEDICAL NECESSITY CRITERIA**

Medical necessity and recommendation for BHT services is determined by a physician or other licensed practitioner working within their scope of practice under state law. The child must demonstrate substantial functional impairment in social communication, patterns of behavior, and social interaction as evidenced by meeting criteria A and B (listed below); and require BHT services to address the following areas:

- A. The child currently demonstrates substantial functional impairment in social communication and social interaction across multiple contexts, and is manifested by all of the following:
1. Deficits in social-emotional reciprocity ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation, to reduced sharing of interests, emotions, or affect, to failure to initiate or respond to social interactions.
  2. Deficits in nonverbal communicative behaviors used for social interaction ranging, for example, from poorly integrated verbal and nonverbal communication, to abnormalities in eye contact and body language or deficits in

understanding and use of gestures, to a total lack of facial expressions and nonverbal communication.

3. Deficits in developing, maintaining, and understanding relationships ranging, for example, from difficulties adjusting behavior to suit various social contexts, to difficulties in sharing imaginative play or in making friends, to absence of interest in peers.
- B. The child currently demonstrates substantial restricted, repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least two of the following:
1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, and/or idiosyncratic phrases).
  2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, and/or need to take same route or eat the same food every day).
  3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects and/or excessively circumscribed or perseverative interest).
  4. Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, and/or visual fascination with lights or movement).

*MPM, April 1, 2016 version  
Behavioral Health and Intellectual and Developmental Disability Supports  
and Services Chapter, pages 141-143*

In this case, the Petitioner requests the Autism Waiver Benefit as laid out in the MPM above. In attempting to assist Petitioner with this benefit, the Respondent assisted with having Petitioner undergo 2 separate evaluations in order to obtain the necessary diagnoses in order for Petitioner to be eligible for the Autism Benefit Waiver. However, as noted in the Findings of Fact, neither assessment concluded with a diagnosis of autism.

Petitioner also requests that this reviewing forum review a request that Petitioner made after she filed her request for a hearing, and, for which the Respondent has not issued a Notice of Case Action. Specifically, Petitioner requests addition outpatient speech and occupational therapy.

Petitioner mother asserts that her daughter has autism, is on the autism spectrum, and has had a diagnosis of autism for years.

Petitioner's mother also affirmed that she has not attempted to obtain services from her private pay insurance, to date.

Petitioner bears the burden of proving by a preponderance of the evidence that the CMH erred in denying Petitioner's request for Autism Benefits. Based on the documentation available, this reviewing forum finds that the Respondent correctly denied Petitioner as Petitioner has not met her burden of proof. Petitioner offered no evidence to support her claim that her daughter has been diagnosed with autism. Both of the assessments paid for and completed by the Respondent in fact, do not contain a diagnosis of autism. Petitioner's guardian has had ample time to collect and submit any evidence that she believes would support her case. As the evidence stands here, there can be no eligibility where there is no diagnosis of autism, and Petitioner offered no evidence to refute the Respondent's evidence.

In addition, Petitioner's request regarding therapy, for which the Respondent has not issued formal notice, would be denied until Petitioner demonstrates that she has exhausted all other potential benefits; Medicaid is a payer of last resort.


### **DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Respondent properly denied the request for the Autism Benefit Waiver based on the evidence of record, and thus,

**IT IS THEREFORE ORDERED** that

The Department's decision is AFFIRMED.

JS/cg



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**Janice Spodarek**

Administrative Law Judge

for Nick Lyon, Director

Department of Health and Human Services



**NOTICE OF APPEAL:** A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings  
Reconsideration/Rehearing Request  
P.O. Box 30763  
Lansing, Michigan 48909-8139

**DHHS -Dept Contact**

Jeff Wieferich  
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**Authorized Hearing Rep.**

[REDACTED]  
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