



STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of



DECISION

HMO/172699

PRELIMINARY RECITALS

Pursuant to a petition filed March 08, 2016, under Wis. Stat. § 49.45(5)(a), and Wis. Admin. Code § HA 3.03, to review a decision by the Division of Health Care Access and Accountability in regard to Medical Assistance (MA), a hearing was held on April 19, 2016, at Milwaukee, Wisconsin.

The issue for determination is whether Children’s Community Health Plan correctly denied the Petitioner’s request for coverage of a TENS Unit.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:



Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, Wisconsin 53703
By:  RN Consultant

ADMINISTRATIVE LAW JUDGE:

Mayumi M. Ishii
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # ) is a resident of Milwaukee County.
2. Petitioner suffers from low back pain, radiculopathy, and sciatica, laterality unspecified. (Exhibit 2)
3. On November 9, 2015, the Petitioner received a TENS unit on a trial basis. The Petitioner has been using the unit ever since. (Exhibit 3; Testimony of the Petitioner)

4. On January 15, 2016, Petitioner's primary care physician saw the Petitioner and reported, "TENS not helping". (Exhibit 2)
5. On January 21, 2016, Petitioner's primary care physician completed a questionnaire for the TENS unit indicating incorrectly that the Petitioner has used the TENS unit between July 1, 2015 and January 16, 2016. In that same document, Petitioner's primary care physician indicated that the TENS unit was "minimally helpful". (Exhibit 2)
6. In an undated letter, Petitioner's HMO, Children's Community Health Plan, advised the Petitioner that her request for coverage of the TENS unit was denied. (Exhibits 1 and 2)
7. The Petitioner filed an appeal that was received by the Division of Hearings and Appeals on March 8, 2016. (Exhibit 1)

DISCUSSION

Under the discretion allowed by *Wis. Stat.*, §49.45(9), the Department of Health Services (DHS) requires MA (Medical Assistance) recipients to participate in HMOs. *Wis. Admin. Code*, §DHS 104.05(2)(a). MA recipients enrolled in HMOs must receive medical services from the HMOs' providers, except for referrals or emergencies. *Wis. Admin. Code*, §DHS 104.05(3).

The criteria for approval by a managed care program contracted with the DHS are the same as the general MA criteria. See *Wis. Admin. Code*, §DHS 104.05(3) which states that HMO enrollees shall obtain services "paid for by MA" from the HMO's providers. The department must contract with the HMO concerning the specifics of the plan and coverage. *Wis. Admin. Code*, § DHS 104.05(1).

If the enrollee disagrees with any aspect of service delivery provided or arranged by the HMO, the recipient may file a grievance with DHS or appeal to the Division of Hearings and Appeals.

Just as with regular MA, when the department denies a grievance from an HMO recipient, the recipient can appeal the DHS's denial within 45 days. *Wis. Stat.*, §49.45(5), *Wis. Admin. Code*, § DHS 104.01(5)(a)3.

In the case at hand, the Petitioner contests a decision by Children's Community Health Plan to deny coverage of a TENS unit to manage Petitioner's back pain.

Wis. Admin. Code DHS §101.03(5) defines "durable medical equipment" as, "equipment which can withstand repeated use, is primarily used for medical purposes, is generally not useful to a person in the absence of illness or injury and is appropriate for use in the home." A TENS unit would fall under this definition.

Wis. Admin. Code DHS §107.24(2)(a) states that, "Durable medical equipment (DME) and medical supplies are covered services only when prescribed by a physician..." In the case at hand, Petitioner's primary care physician did not find the TENS unit to be useful for the Petitioner, so there is no prescription for the TENS unit. As such, coverage for the unit cannot be approved.

In addition, *Wis. Admin. Code* DHS §107.24(2)(b), generally limits coverage of DME to items listed in the Wisconsin Durable Medical Equipment (DME)¹ and medical supplies indices. TENS units are not specifically listed in the indices, so it is questionable whether a TENS unit would be covered at all, and if it were, it would need to go through the prior authorization process.

¹ A link to the DME Index may be found at:

https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Provider/medicaid/MedicalEquipmentVendor/resources_25.htm.spage

When determining whether to approve any service, the HMO, like DHS, must consider the generic prior authorization review criteria listed at *Wis. Admin. Code, §DHS §107.02(3)(e)*:

(e) *Departmental review criteria.* In determining whether to approve or disapprove a request for prior authorization, the department shall consider:

1. The medical necessity of the service;
2. The appropriateness of the service;
3. The cost of the service;
4. The frequency of furnishing the service;
5. The quality and timeliness of the service;
6. The extent to which less expensive alternative services are available;
7. The effective and appropriate use of available services;
8. The misutilization practices of providers and recipients;
9. The limitations imposed by pertinent federal or state statutes, rules, regulations or interpretations, including medicare, or private insurance guidelines;
10. The need to ensure that there is closer professional scrutiny for care which is of unacceptable quality;
11. The flagrant or continuing disregard of established state and federal policies, standards, fees or procedures; and
12. The professional acceptability of unproven or experimental care, as determined by consultants to the department.

“Medically necessary” means a medical assistance service under ch. DHS 107 that is:

(a) Required to prevent, identify or treat a recipient's illness, injury or disability; and

(b) Meets the following standards:

1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
2. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider, and the setting in which the service is provided;
3. Is appropriate with regard to generally accepted standards of medical practice;
4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
5. Is of proven medical value or usefulness and, consistent with s. DHS 107.035, is not experimental in nature;
6. Is not duplicative with respect to other services being provided to the recipient;
7. Is not solely for the convenience of the recipient, the recipient's family, or a provider;
8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

Wis. Admin. Code, §DHS 101.03(96m)

Petitioner has the burden to prove, by a preponderance of the credible evidence, that her request for a TENS unit meets the approval criteria. Gonwa v. Department of Health and Family Services, 2003 WI App 152, 265 Wis.2d 913, 668 N.W.2d 122 (Ct.App.2003) At their core, those criteria include the requirement that the service be medically necessary. *Id.*

The Petitioner’s HMO and the Department of Health Services (DHS) argues that the TENS unit is not medically necessary, because it does not have any proven medical value or usefulness for the Petitioner.

The Petitioner testified that her physician reported incorrect information, when he stated that the TENS unit was not helping her chronic pain. The Petitioner testified that she never told her doctor that the TENS unit was not helpful.

The Petitioner testified that she is in the most pain at night and that the TENS unit was, in fact, easing her pain enough for her to be able to fall asleep and get a good night's rest, which in turn was helping her function better during the day. The Petitioner testified that she believes she would be taking more pain medication without the TENS unit.

The statements made by Petitioner's doctor are somewhat contradictory. In one document he states the TENS unit was not helping at all, and in another, he states that it was minimally helpful. Those are two different evaluations concerning the efficaciousness of the TENS Unit. However, this is a request for a new service, so the burden is on the Petitioner to show that her request for the TENS unit meets approval criteria.

Although the Petitioner testified that the TENS unit is helpful in alleviating her back pain, the clinical documentation is not consistent with regard to whether the unit is, in fact, helpful to Petitioner. What little clinical documentation in there is in the record does not support a finding that the TENS unit is effective in treating the Petitioner's medical condition. There is no statement from a physician indicating that TENS units are proven treatment for back pain and that it works for Petitioner.

The Petitioner indicated that she will be seeking a second opinion concerning the TENS unit. If there is any other clinical documentation showing that the TENS unit is generally effective in treating back and that it is effective for the Petitioner, the Petitioner can file a new request for coverage of the TENS unit.

CONCLUSIONS OF LAW

Children's Community Health Plan correctly denied coverage of the TENS unit.

THEREFORE, it is **ORDERED**

The petition is dismissed.

REQUEST FOR A REHEARING

You may request a rehearing if you think this decision is based on a serious mistake in the facts or the law or if you have found new evidence that would change the decision. Your request must be **received within 20 days after the date of this decision**. Late requests cannot be granted.

Send your request for rehearing in writing to the Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400 **and** to those identified in this decision as "PARTIES IN INTEREST." Your rehearing request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and explain why you did not have it at your first hearing. If your request does not explain these things, it will be denied.

The process for requesting a rehearing may be found at Wis. Stat. § 227.49. A copy of the statutes may be found online or at your local library or courthouse.

APPEAL TO COURT

You may also appeal this decision to Circuit Court in the county where you live. Appeals must be filed with the Court **and** served either personally or by certified mail on the Secretary of the Department of

Health Services, 1 West Wilson Street, Room 651, Madison, Wisconsin 53703, **and** on those identified in this decision as “PARTIES IN INTEREST” **no more than 30 days after the date of this decision** or 30 days after a denial of a timely rehearing (if you request one).

The process for Circuit Court Appeals may be found at Wis. Stat. §§ 227.52 and 227.53. A copy of the statutes may be found online or at your local library or courthouse.

Given under my hand at the City of Milwaukee,
Wisconsin, this 19th day of May, 2016.

\s\sMayumi M. Ishii
Administrative Law Judge
Division of Hearings and Appeals



State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

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The preceding decision was sent to the following parties on May 19, 2016.

Division of Health Care Access and Accountability