



FH
[REDACTED]

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

DECISION

MPA- 173653

PRELIMINARY RECITALS

On April 11, 2016, the above petitioner filed a hearing request under Wis. Stats., §49.45(5), to challenge a decision by the Division of Health Care Access and Accountability regarding Medical Assistance. The hearing was held on May 18, 2016, via phone.

The issue for determination is whether additional physical therapy sessions may be approved.

PARTIES IN INTEREST:

Petitioner:

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, Wisconsin 53703

By: [REDACTED], PT
Division of Health Care Access and
Accountability
1 West Wilson Street, Room 272
P.O. Box 309
Madison, WI 53707-0309

Administrative Law Judge:
David D. Fleming
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # [REDACTED]) is a resident of Racine County.
2. A prior authorization request (PAR) seeking Medicaid payment for physical therapy for Petitioner. Thirteen PT sessions were requested, once every other week for 26 weeks.

3. The Department approved 6 PT sessions for the period from March 14, 2016 through September 12, 2016. The reason for the denial of the remainder sessions is that the Department found that the requested therapy did not meet the legal definition of medical necessity.
4. Petitioner is 3 years of age (██████). He lives in the community with his parents. The PAR notes his diagnosis as Down Syndrome and lack of coordination. He will attend school in the fall – 3 hours per day, 4 days a week. He had surgery in the 3rd week of April and has surgery scheduled again for the summer of 2016.

DISCUSSION

When determining whether to approve therapy, the Department 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).

As with most public assistance benefits the initial burden of demonstrating eligibility for any particular benefit or program at the operational stage falls on the applicant, *Gonwa v. Department of Health and*

Family Services, 2003 WI App 152, 265 Wis.2d 913, 668 N.W.2d 122 (Ct.App.2003). In other words, it is a Petitioner's burden to demonstrate that s/he qualified for the requested continued services by a preponderance of the evidence. It is not the Department's burden to prove that s/he is not eligible.

Further, I note that Medicaid is meant to provide the most basic and necessary health care services at a reasonable cost to a large number of persons and must authorize services according to the Wisconsin Administrative Code definition of medical necessity and other review criteria noted above. It is not enough to demonstrate a benefit; rather, all of the tests cited above must be met. Ultimately a decision by the Division of Hearings and Appeals requires an application of law to the facts of the case. As such, a Division of Hearings and Appeals decision is a determination as to whether those facts meet the requirements of the law, thus the decision is a legal one not a medical one.

Petitioner's mother represented him at the hearing. The evidence offered on behalf of Petitioner is that he has had a number of hospitalizations for various illnesses including pneumonia which required a week hospital stay and that he has regressed after his hospitalizations. The PAR indicates that Petitioner was only seen 2 times for PT between December 21 and the submission of the PAR at the end of February 2016. The Department argues that Petitioner has made progress and achieved functional goals and that a short term setback because of hospitalization does not justify additional PT. The Department opines that Petitioner's home exercise program should be enough to improve strength and balance.

Both sides have valid points here but I am concluding that the more persuasive is the argument that Petitioner needs extra help before, and as he starts school, and that the regressions after surgery are significant setbacks for a 3 year old... I am therefore, approving PT at a frequency of one session every other week from the date of this decision through September 12, 2016.

The provider will not receive a copy of this Decision. Petitioner's family may provide a copy of this Decision to the provider.

CONCLUSIONS OF LAW

That the evidence presented on behalf of Petitioner is sufficient to demonstrate that this prior authorization request for additional physical therapy may be approved for Medicaid payment for a total of one PT session every other week from the date of this Decision to the end of the time originally requested, September 12, 2016.

THEREFORE, it is

ORDERED

That Petitioner's provider is authorized to bill the Wisconsin Medicaid program for physical therapy sessions at a frequency of one every other week commencing with the date of this decision and to be provided no later than September 12, 2016. Petitioner's provider should submit a copy of this decision to Forward Health, along with its invoice, for the additional time allowed herein.

In all other respects, this appeal 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, **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 8th day of July, 2016

\s _____
David D. Fleming
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 July 8, 2016.

Division of Health Care Access and Accountability