

2. A prior authorization (PA) request was filed on behalf of Petitioner on or about March 7, 2016. It sought Medicaid payment for a physical therapy evaluation and 52 physical therapy (PT) sessions to be provided at a frequency of 2 times per week for 26 weeks. The total cost was noted to be \$15,835.00. This is the first PA requested for Petitioner.
3. Petitioner is 3 years of age (DOB [REDACTED]). He lives in the family home with his parents and 3 sisters. The PA form lists his primary diagnosis as Down syndrome and his secondary diagnosis as generalized muscle weakness. He has hyperextension issues.
4. Petitioner was in a birth to three program but is ended in February 2016 and there was no PT carryover from that program. He does attend school – ½ days, 4 days per week. He has had physical therapy in school 3 times per month – once in a general setting and twice in special education class. The total time in special education PT is a total of 40 minutes though that includes the time it takes him to ambulate to the PT; it is not clear how long the general education session is but it is directed at integrating skills worked on in special education PT while he participates in groups of other students in the general education setting. There is no gym class or recess. He will be attending school in the fall of 2016; again - ½ days, 4 days per week.
5. This PA was denied as the Department concluded that the requested services did not meet Medicaid standards necessary for payment.

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.

The Department contends that there is no need for PT at a frequency of twice per week in addition to 3 time per month at school. It also understood from the PA that Petitioner attends a community playgroup and a gymnastics class. Further, it maintains that the birth to three program provided home instructions as to the use of kinesiotape to address Petitioner's hyperextension. The Department also assumes that the birth to three program provided a home exercise program.

Petitioner's parents and the requesting physical therapist all testified at the hearing. That testimony was that the birth to three program did not provide a carryover home program because it assumed that Petitioner would be receiving private PT. Further, Petitioner has regressed as he has not had physical therapy beyond the rather limited school therapy. There is no school for the summer, therefore, no PT at this time. Petitioner's hyperextension issues are getting worse. The school has not provided a home based program. Finally, Petitioner has not participated in a gymnastics class since December 2015.

I am partially approving PT for Petitioner. The testimony of his parents and therapist was persuasive. The Department does, however, have a point as to the need for a home program and that Medicaid cannot pay for duplication of services. I am, therefore, approving PT at a frequency of 2 times a week through the end of August 2016 and at a frequency of 1 time per week through October 2016. The provider can submit a new PA but I would expect it to include a detailed home program and coordination with school based services.

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 physical therapy may be approved for Medicaid payment at a frequency of 2 times a week through the end of August 2016 and at a frequency of 1 time per week through October 2016.

THEREFORE, it is

ORDERED

That Petitioner's provider is authorized to bill the Wisconsin Medicaid program for PT for Petitioner at a frequency of 2 times a week through the end of August 2016 and at a frequency of 1 time per week through October 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 25th day of July, 2016

\s _____
David D. Fleming
Administrative Law Judge
Division of Hearings and Appeals



State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

Brian Hayes, Administrator
Suite 201
5005 University Avenue
Madison, WI 53705-5400

Telephone: (608) 266-3096
FAX: (608) 264-9885
email: DHAmail@wisconsin.gov
Internet: <http://dha.state.wi.us>

The preceding decision was sent to the following parties on July 25, 2016.

Division of Health Care Access and Accountability