



**STATE OF WISCONSIN
Division of Hearings and Appeals**

In the Matter of

[REDACTED]

DECISION

MPA/142354

PRELIMINARY RECITALS

Pursuant to a petition filed July 12, 2012, under Wis. Stat. § 49.45(5), and Wis. Admin. Code § HA 3.03(1), to review a decision by the Office of the Inspector General (OIG) for the Department of Health Services (DHS) in regard to Medical Assistance, a hearing was held on September 12, 2012, at Waukesha, Wisconsin.

The issue for determination is whether the evidence offered on behalf of Petitioner demonstrates that a prior authorization request for physical therapy meets the standards necessary for Wisconsin Medicaid approval.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:

[REDACTED]

Respondent:

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

By: Pamela J. Hoffman, PT, DPT, MS
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 is a resident of Waukesha County.

2. A prior authorization request (PA) seeking Wisconsin Medicaid payment for physical therapy (PT) for Petitioner was filed on, or about, May 7, 2012. That PA sought the Medicaid payment for 26 sessions commencing May 22, 2012 at a frequency of once per week. The cost was noted to be \$4966.00.
3. Petitioner is almost 6 years of age (10/19/06). He lives with his family and does attend school. He is diagnosed with lack of normal development and muscle weakness. He did receive physical therapy in school at the time of this prior authorization (PA) but did not have it available in the summer.
4. This PA was denied and the reasons for the denial are detailed in the letter from the department, dated August 20, 2012 and written by Pamela Hoffman. Exhibit # 3. In brief, the reasons for the denial were that this request did not demonstrate that the PT was medically necessary as defined in the Wisconsin Administrative Code.

DISCUSSION

When determining whether to approve therapy, the DHCAA 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.

The Office of the Inspector General's (OIG) detailed explanation for the denial is found in its letter dated August 20, 2012. Exhibit # 3. I am not going to reproduce that whole summary here but as I understand the rationale, the OIG concluded that the evidence submitted on behalf of Petitioner did not demonstrate that the needs of the professional therapist are needed. It notes that the record is not clear as to whether deficits in motor planning, safety and keeping up with peers is a result of the inability to follow directions or physical deficits. Further, the letter notes that Petitioner has actually fallen behind in age appropriate skills while receiving the private PT services thus calling the efficacy of the treatment into question. The OIG reasons that school based PT teaches Petitioner how to manage in a natural environment. Finally, the OIG notes that the Wis. Admin. Code limits PT services beyond a 35 day spell of illness where there is no progress, maintenance of goals or carry-over of abilities over a six month period. See Wis. Admin. Code DHS 107.16(3)(e)1.

Petitioner's mother represented him at the hearing. She indicated that Petitioner has trouble sequencing and multitasking; that he is weak and has braces for his ankles. She is especially concerned about Petitioner's inability to protect himself because he lacks the reflex to block danger coming toward him. She also notes that his delays cause problems with keeping up with his peers.

I am sustaining the Department denial. Petitioner receives PT in school thus this is duplicative; the provider has not demonstrated efficacy of treatment thus calling into question the appropriateness of this service. Finally, there is a limit on services where there is a lack of progress or carryover.

NOTE: Petitioner's provider will not receive a copy of this Decision from the Division of Hearings and Appeals but Petitioner's parents are free to share it if they so desire.

CONCLUSIONS OF LAW

That the evidence offered on behalf of Petitioner is not sufficient to demonstrate by a preponderance of the evidence that the May 7, 2012 prior authorization request filed on behalf of Petitioner seeking Medicaid payment for PT is warranted.

THEREFORE, it is

ORDERED

That this appeal is dismissed.

REQUEST FOR A REHEARING

This is a final administrative decision. If you think this decision is based on a serious mistake in the facts or the law, you may request a rehearing. You may also ask for a rehearing if you have found new evidence which would change the decision. Your request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and tell why you did not have it at your first hearing. If you do not explain these things, your request will have to be denied.

To ask for a rehearing, send a written request to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707-7875. Send a copy of your request to the other people named in this decision as "PARTIES IN INTEREST." Your request for a rehearing must be received no later than 20 days after the date of the decision. Late requests cannot be granted.

The process for asking for a rehearing is in Wis. Stat. § 227.49. A copy of the statutes can be found 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 appropriate court no more than 30 days after the date of this hearing decision (or 30 days after a denial of rehearing, if you ask for one).

For purposes of appeal to circuit court, the Respondent in this matter is the Department of Health Services. After filing the appeal with the appropriate court, it must be served on the Secretary of that Department, either personally or by certified mail. The address of the Department is: 1 West Wilson Street, Room 651, Madison, Wisconsin 53703. A copy should also be sent to the Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400.

The appeal must also be served on the other "PARTIES IN INTEREST" named in this decision. The process for appeals to the Circuit Court is in Wis. Stat. §§ 227.52 and 227.53.

Given under my hand at the City of Milwaukee,
Wisconsin, this 10th day of October, 2012

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

c: Division of Health Care Access And Accountability - email
Department of Health Services - email



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The preceding decision was sent to the following parties on October 10, 2012.

Division of Health Care Access And Accountability