



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

In the Matter of

[REDACTED]

DECISION

MPA/142933

PRELIMINARY RECITALS

Pursuant to a petition filed August 09, 2012, under Wis. Stat. § 49.45(5), and Wis. Admin. Code § HA 3.03(1), to review a decision by the Division of Health Care Access and Accountability in regard to Medical Assistance, a hearing was held on September 18, 2012, at Superior, Wisconsin.

The issue for determination is whether the petitioner is entitled to medical assistance reimbursement for Child/Adolescent Day Treatment Services.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:

[REDACTED]

Petitioner's Representative:

[REDACTED]

Respondent:

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

By: Jo Ellen Crinion

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

ADMINISTRATIVE LAW JUDGE:

Michael D. O'Brien
Division of Hearings and Appeals

FINDINGS OF FACT

1. The petitioner is a Wisconsin resident.

2. On March 8, 2012, the petitioner with his provider, Northwest Journey Superior, requested Child/Adolescent Day Treatment Services (CADT) five hours a day, five days a week for 13 weeks at a cost of \$26,000. Those services had begun on March 1, 2012.
3. On March 8, 2012, the Division of Health Care Access and Accountability requested that the petitioner submit the following documentation:
 - a. PA/RF
 - b. PA/CADTA
 - c. HealthCheck Referral
 - d. Prescription
 - e. Psychiatric Evaluation
 - f. Initial Treatment Plan
 - g. Initial Assessment
 - h. Schedules
 - i. KU Center for Child Health & Development
 - j. Psychological Evaluation
4. Northwest Journey submitted the additional information on March 27, 2012. The Division then asked for additional information and explanation on April 18, 2012, and June 6, 2012, before denying the request on July 12, 2012.
5. The petitioner is an eight-year-old boy diagnosed with attention-deficit/hyperactivity disorder, a disruptive behavior disorder, and a possible pervasive development disorder. An anxiety disorder and oppositional defiant disorder have been ruled out.
6. The petitioner's current IEP from the Superior School District determined that he does not meet the Wisconsin criteria for an Autism Spectrum Disorder but qualified for special educational services under an emotional behavioral disability.
7. The petitioner attended the Partial Hospitalization Program at Miller Dwan in Duluth from February 13, 2012 until February 27, 2012. His treating psychologist there, Rhonda P. Krossner, found that he is in the likely range for having Asperger's but did not conduct a full range of tests to confirm this diagnosis. Upon discharge, Miller Dwan recommended that he attend day treatment fulltime. He left the Miller Dwan program because he could not obtain funding for it.
8. A psychiatric report by Dr. Margaret Saracino on January 27, 2011, found that the petitioner had attention-deficit hyperactivity disorder and some features of pervasive development disorder but did not meet the full criteria of that disorder.
9. A March 2010 psychological report by the University of Kansas Center for Child Health & Development found that an autistic assessment did not yield enough information to support any form of autistic spectrum disorder but did conclude that he "would benefit from social skills instruction." It determined that his only diagnosis was ADHD and that is what he should be treated for. The report noted that he had been diagnosed with a pervasive developmental disorder, NOS, by another agency before he was two years old.
10. The petitioner has a history of angry outbursts at school and at home. His behavior was described as disruptive 80% of the time. He had five to 10 outbursts a day, each lasting 30 to 60 minutes. He also threatened others three to five times a day. He threw chairs and hit the school staff. He banged his head against the wall daily when he did not get his way.
11. The petitioner's behavior at school prevents him from making it through a full day of classes and led to his suspension last year.
12. Northwest Journey's plan called for the following:
 - a. Individual Counseling: 1 hour weekly by a Mental Health Clinician

- b. Group Counseling: 5 hours daily by a Mental Health Professional. Areas targeted include: anger management, emotional development, positive coping skills, conflict resolution, adult/authority figure communication skills, appropriate peer interaction, independent living skills, and positive relationship development.
 - c. Medication Monitoring: monthly and as needed, by a Registered Nurse
 - d. Occupational, Recreational, Art or Music Therapy: 2 hours weekly by a certified provider
 - e. Educational Services: 55 minutes daily by a licensed teacher
 - f. Family Counseling Sessions: as needed by a Mental Health Clinician
 - g. Case Management Services: 30 minutes weekly by a qualified Case Manager
 - h. Clinical Team Reviews: once per month or more frequently if indicated by the client's condition or requested by a multi-disciplinary team member
13. Since completing the CADT program, the petitioner has imposed timeouts on himself, increased his ability to listen to criticism, and decreased his outbursts.

DISCUSSION

The petitioner and his provider, Northwest Journey Superior, seek reimbursement for three months of Child/Adolescent Day Treatment Services at a cost of \$26,000. The Division of Health Care Access and Accountability denied the request because the services were provided before the request was granted and they are allegedly for a pervasive development disorder.

The Division indicates that this a "HealthCheck—Other Service" covered under Wis. Admin. Code, § DHS 107.22(4), a catch-all category applying to any service described in the definition of "medical assistance" found at 42 USC 1396d(a). When determining what law to apply, one looks first to the one that most specifically covers the situation. Day treatment mental health services for children under 18 are specifically covered by Wis. Admin. Code, Chapter DHS 40. I will rely upon that provision to determine whether the petitioner qualifies for services.

To qualify for services, a child "must have a primary psychiatry diagnosis of mental illness or severe emotional disorder." Wis. Admin. Code, § DHS 40.08(3)(a). *Mental illness* is defined as a "medically diagnosable mental health disorder which is severe in degree and which substantially diminishes a child's ability to carry out activities of daily living appropriate for the child's age." Wis. Admin. Code, § DHS 40.03(16). Each child is evaluated by a psychologist or psychiatrist and has a treatment plan approved by a program. Wis. Admin. Code, §§ DHS 40.08(4) and 40.09(2)(c). Like any medical assistance service, it must be medically necessary, cost-effective, and an effective and appropriate use of available services. It must also meet the "limitations imposed by pertinent...state...interpretations." Wis. Admin. Code § DHS 107.02(3)(e)1.,2.,3.,6., 7, and 9. Wis. Admin. Code.

"Medically necessary" is defined in Wis. Admin. Code § DHS 101.03(96m) as 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. HFS 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.

The pertinent interpretation of the requirements that must be met to receive adolescent day services is found at *Wisconsin Medicaid and BadgerCare Update* No. 96-20. It states:

Child/adolescent day treatment services are covered when the following are present:

- Verification that a HealthCheck screen has been performed by a valid HealthCheck screener dated not more than one year prior to the requested first date of service (DOS).
- A physician's prescription/order dated not more than one year prior to the requested first DOS.
- Evidence of an initial multidisciplinary assessment that includes all elements described in HFS 40.09, Wis. Admin. Code, including a mental status examination and a five-axis diagnosis.
- The individual meets one of the following criteria for a determination of "severely emotionally disturbed" (SED):
 - Is under age 21; emotional and behavioral problems are severe in degree; are expected to persist for at least one year; substantially interfere with the individual's functioning in his or her family, school, or community and with his or her ability to cope with the ordinary demands of life; and cause the individual to need services from two or more agencies or organizations that provide social services or treatment for mental health, juvenile justice, child welfare, special education, or health.
 - Substantially meets the criteria previously described for SED, except the severity of the emotional and behavioral problems have not yet substantially interfered with the individual's functioning but would likely do so without child/adolescent day treatment services.
 - Substantially meets the criteria for SED, except the individual has not yet received services from more than one system and in the judgment of the medical consultant, would be likely to do so if the intensity of treatment requested was not provided.
- A written multidisciplinary treatment plan signed by a psychiatrist or clinical psychologist as required in HFS 40.10, Wis. Admin. Code, that specifies the services that will be provided by the day treatment program provider, as well as coordination with the other agencies involved.
- Measurable goals and objectives that are consistent with the assessment conducted on the child and written in the multidisciplinary treatment plan.
- The intensity of services requested are justifiable based on the psychiatric assessment and the severity of the recipient's condition.

The petitioner requested CADT services on March 8, 2012, but began receiving them on March 1, 2012. In addition, its March 8 request included none of the supporting documentation the Division of Health Care Access and Accountability needed to evaluate it. That information was submitted on March 27, 2012. The Division's reviewer, Jo Ellen Crinion, raised additional questions on April 18, 2012, and June 6, 2012, before finally denying the request on July 12, 2012.

Ms. Crinion points out that Wis. Admin. Code, § DHS 107.02(3)(c) states: "If prior authorization is not requested and obtained before a service requiring prior authorization is provided, reimbursement shall not

be made except in extraordinary circumstances such as emergency cases where the department has given verbal authorization for a service.” This rule is not absolute. Wis. Admin. Code, § DHS 106.03(4)(a), which is found in the chapter in the administrative code pertaining to the provider’s rights and responsibilities, allows an exception to this general rule “[w] here the provider’s initial request for prior authorization was denied and the denial was either rescinded in writing by the department or overruled by an administrative or judicial order .”

This rule is needed because it can often take weeks or months for the Division to review requests for needed therapy. This especially creates problems if the request is for continuing or follow-up services and the lack of approval can interrupt ongoing treatment. In addition to the written rule, the Division, as a courtesy, generally accepts requests filed up to two weeks after a service has begun. Still, the preferred method is for the Division to review the request before services begin because it, unlike the Division of Hearings and Appeals, has medical training in the area under review that allow it to provide an expert opinion on whether the service is necessary. When reviewing a matter in which the services begin before being approved, Hearings and Appeals must look at all of the circumstances of the case.

Ms. Crinion argues that Northwest Journey has a history of submitting incomplete requests. I have reviewed several past requests from Northwest Journey and have noticed this. However, there are some extenuating circumstances involved in the current request. The petitioner was being discharged from a “Partial Hospitalization Program” at Miller Dwan in Duluth, and his providers believed he needed immediate follow-up treatment because his medication had not yet been stabilized. The severity of the problem is indicated by the fact that he was discharged to the emergency room.

Moreover, the Division made multiple requests for additional information in this matter. Its first request was clearly necessary because the Prior Authorization Request included little or no documentation. However, even after the provider submitted a large amount of documentation on March 27, 2012, the Division asked additional questions. As a result, it did not dispose of the petitioner’s request until 3 ½ months after his provider submitted the additional information. Mental health cases are complicated, but the repeated requests for documents and information can render meaningless the requirements in Wis. Admin. Code, § DHS 107.02(3), that the Division to act upon 95% of the requests within 10 working days and 100% of the requests within 20 working days. The petitioner had severe mental health problems and required a quick answer to his request, even if the request was ultimately denied. Once his provider submitted the additional documentation on March 27, 2012, the Division had adequate information to make a decision without asking more questions. As discussed earlier, Wis. Admin. Code, § DHS 107.02(3)(c), gives the administrative law judge some discretion over whether to deny an appeal merely because it began before it was approved. After considering the petitioner’s circumstances when his CADT began and the length of time the Division took to deny his request, I will not dismiss it on that ground but rather will determine it on the merits.

The Division’s primary reason for denying the request, other than for its timeliness, is that it contends that the petitioner’s primary diagnosis is a pervasive development disorder. Treatment for pervasive development disorders is considered an habilitative as opposed to a rehabilitative service and is not covered under 42 USC §1396d(a)(13). I note however, that the cited section does not specifically bar medical assistance payment for habilitative services; rather it states that MA does cover the following services, which include rehabilitation services:

other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;

Because the statute specifically indicates that rehabilitative services (including those needed for the reduction of a mental disability) are covered, mental health services are covered if the primary component is rehabilitative, even if it includes an habilitative component. This means that funding for the petitioner's CADT depends upon the primary cause of his problems.

The Division arrives at its conclusion that the petitioner's primary diagnosis is a pervasive development disorder through a highly selective reading of his medical file. In March 2010, a psychological report by the University of Kansas Center for Child Health & Development indicated that an autistic assessment did not yield enough information to support any form of autistic spectrum disorder. Although the report's author concluded that the petitioner "would benefit from social skills instruction," he determined that the petitioner's only diagnosis was ADHD and that is what he should be treated for. The following January Dr. Margaret Saracino found in her psychiatric report that the petitioner had attention-deficit hyperactivity disorder and some features of pervasive development disorder but did not meet the full criteria of that disorder. His most recent IEP from the Superior School District determined that he does not meet the Wisconsin criteria for an Autism Spectrum Disorder. The main evidence of a pervasive development disorder is a finding by his treating psychologist, Rhonda P. Krossner, that he is in the likely range for having Asperger's. However, she did not conduct a full range of tests to confirm this diagnosis. In addition, she recommended that upon discharge, that he should attend day treatment fulltime. Taken as a whole, the preponderance of this evidence indicates that the petitioner's most significant diagnoses are ADHD and a conduct problem rather than any pervasive development disorder. Therefore, his request may not be denied because it is for habilitative services.

The remaining question is whether the petitioner has established that the requested therapy was medically necessary. The petitioner, who is eight years old, has had serious behavioral problems that exhibited themselves through a history of angry outbursts at school and at home. This behavior was described in his medical records as disruptive 80% of the time. He had five to 10 outbursts a day, each lasting 30 to 60 minutes. He also threatened others three to five times a day. He threw chairs and hit the school staff. When he did not get his way, he banged his head against the wall, which occurred daily. This behavior prevented him from making it through a full day of classes and led to his suspension last year. Also, as noted, it led to his being placed in Miller Dwan and in the hospital's emergency room upon being released. (He left Miller Dwan's program because he could not get insurance coverage for it rather than because his condition had sufficiently improved.)

Northwest Journey's program dealt specifically with these problems. It consisted of the following:

1. Individual Counseling: 1 hour weekly by a Mental Health Clinician
2. Group Counseling: 5 hours daily by a Mental Health Professional. Areas targeted include: anger management, emotional development, positive coping skills, conflict resolution, adult/authority figure communication skills, appropriate peer interaction, independent living skills, and positive relationship development.
3. Medication Monitoring: monthly and as needed, by a Registered Nurse
4. Occupational, Recreational, Art or Music Therapy: 2 hours weekly by a certified provider
5. Educational Services: 55 minutes daily by a licensed teacher
6. Family Counseling Sessions: as needed by a Mental Health Clinician
7. Case Management Services: 30 minutes weekly by a qualified Case Manager
8. Clinical Team Reviews: once per month or more frequently if indicated by the client's condition or requested by a multi-disciplinary team member

Generally, when one seeks a service, determining whether it will succeed is an educated guess because the services has not yet been provided. In this matter, the requested program can be judged at least in part by its results. Although there was no standardized testing, it was reported that the petitioner now has imposed timeouts on himself, increased his ability to listen to criticism, and decreased his outbursts. This evidence indicates that he had serious behavioral issues, that Northwest Journey put him in a program that

addressed these issues, and that it did so successfully. There is some question whether even with this success the program was cost-effective, given that it cost \$26,000, I find that it was because at the time the petitioner entered it, the alternative appeared to be hospitalization, which would have cost even more. Furthermore, because the Division focused on whether the request was timely and for an uncovered service, it did not provide any meaningful guidance on the service's cost-effectiveness. Given the evidence before me and the Division's silence, I find that the service was cost effective and medically necessary and will approve it.

I note to the petitioner and his mother that Northwest Journey Superior will not receive a copy of this decision. Therefore, in order for it to receive payment for these services, the petitioner must provide Northwest Journey a copy of this decision. Northwest Journey will be required to submit a new Prior Authorization Request to receive payment for the services it has provided.

CONCLUSIONS OF LAW

The petitioner is entitled to medical assistance reimbursement for CADT services because he has established that those services are medically necessary.

THEREFORE, it is

ORDERED

That the petitioner's adolescent day treatment provider, Northwest Journey Superior, is entitled to receive reimbursement for the services provided pursuant to the Prior Authorization Request that is the basis for this action. Northwest Journey Superior must submit its claim along with a copy of this decision and a new prior authorization form to Forward Health for payment.

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, 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 Madison,
Wisconsin, this 30th day of October, 2012

Michael D. O'Brien
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 October 30, 2012.

Division of Health Care Access And Accountability
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