



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

In the Matter of

[REDACTED]

DECISION

MPA/143345

PRELIMINARY RECITALS

Pursuant to a petition filed August 21, 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 October 23, 2012, at New Richmond, Wisconsin. A hearing scheduled for September 20, 2012, was rescheduled at the petitioner's request.

The issue for determination is whether the petitioner is entitled to medical assistance reimbursement for occupational therapy.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:

[REDACTED]

Respondent:

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

By: Mary Chucka

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 resident of St. Croix County.

2. On July 19, 2012, the petitioner with St. Croix Therapy Inc. (formerly known as Special Children Center) requested occupational therapy twice a week for 26 weeks at a cost of \$7,416. The Office of Inspector General asked for additional information on July 23, 2012. After St. Croix resubmitted the request, the Office of Inspector General denied it on August 15, 2012.
3. The petitioner is a six-year-old boy diagnosed with muscular incoordination and developmental delays. He was born at 27 weeks gestation and has suffered from low muscle tone and chronic lung disease.
4. The petitioner's fine motor skills and manual coordination are at or below the first percentile according to the Bruininks-Oseretsky Test of Motor Proficiency.
5. The petitioner cannot thoroughly brush his teeth or wash and dry his hands, wipe his nose, snap and unsnap or zip and unzip clothing, put on and fasten his pants, or tie his shoelaces.
6. The petitioner needs to use his arms to get on and off from a toilet seat and instructions to get in and out of car seat and car.
7. St Croix's first primary goal for the petitioner is to help him improve his "self-regulation for increased independence in daily activities." The subgoals within this primary goal are:
 - a. [Petitioner] will attend a therapist-directed activity for 5 minutes, with setup and minimal facilitation.
 - b. [Petitioner] will demonstrate a 50% decrease in negative responses to auditory stimuli for increased independence in daily activities.
 - c. [Petitioner] will participate in and demonstrate appropriate social interaction in a 3-step gross motor activity with a peer, with setup and minimal facilitation.
8. St. Croix's second primary goal is for the petitioner to "demonstrate fine motor, visual motor, and bilateral coordination skills for improved independence in daily activities." The subgoals within this primary goal are:
 - a. [Petitioner] will demonstrate improved visual motor skills by copying 3 out of 3 shapes (circle, square, triangle) with appropriate grasp on a utensil.
 - b. [Petitioner] will demonstrate improved bilateral coordination skills to zip/unzip his backpack, sweatshirt, etc. with minimal assistance in 3 out of 5 trials.
9. St. Croix's plan of care for each of the subgoals included the following two provisions:
 - a. Neuromuscular re-education of movement, balance, kinesthetic sense, coordination, posture and proprioception.
 - b. Therapeutic activities to improve functional performance.
10. Each day the petitioner's school district provides him with 30 minutes of instruction in attending and completing tasks and 15 minutes in developing fine motor activities, including writing letters appropriately.
11. The petitioner received occupational therapy from the Birth-To-Three Program from November 2, 2007, through November 8, 2008. He also received prior authorization for occupational therapy from private providers from February 2, 2010, through July 20, 2010, and from September 2, 2011, through January 27, 2012. The therapy he received in 2010 pertained to feeding issues after a g-tube was removed. The remaining therapy addressed poor coordination, sensory processing issues, and lack of ability to care for himself.

DISCUSSION

The petitioner is a six-year-old boy who was born three months before his due date and suffers from poor fine motor skills, an overall lack of coordination, and developmental delays. With his provider St. Croix Therapies Inc. (formerly known as. Special Children Center), he seeks authorization for occupational therapy twice a week for 26 weeks at a cost of \$7,416. Medical assistance covers occupational therapy if the recipient obtains prior authorization after the first 35 visits. Wis. Adm. Code, § DHS 107.17(2)(b). When determining whether a service is necessary, the Division must review, among other things, the medical necessity, appropriateness, and cost of the service, the extent to which less expensive alternative services are available, and whether the service is an effective and appropriate use of available services. Wis. Adm. Code, § DHS 107.02(3)(e)1.,2.,3.,6. and 7. “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. 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.

In addition, medical assistance does not cover “[p]rocedures considered by the department to be obsolete, inaccurate, unreliable, ineffectual, unnecessary, imprudent or superfluous.” Wis. Adm. Code, § DHS 107.03(5).

The Department has ruled on when therapy from one provider duplicates that from another. Deputy Secretary Susan Reinardy held in *DHA Final Decision No. MPA-37/80183*, a speech therapy appeal, that “the deciding factor in whether services are duplicative is not the [therapy] technique utilized by the therapists, but the goals and outcomes being addressed by the therapists.” *Id.* at 2. It does not matter, for example, if one provider addresses group activities with peers and the other one-on-one activities with an adult. A requested service duplicates “an existing service if the intended outcome of the two services is substantially the same.” *Id.* at 3. Her decision specifically rejected additional therapy because the recipient “‘needs’ more intense services than the school provides.” The holding rests on the principle that “Medicaid may not pay for two services if both services have the same intended outcome or result with respect to the medical condition the services are intended to address.” *Id.* at 4. The deputy secretary has made it clear that the “intended outcome” test must be read broadly. In *DHA Final Decision No MPA-49/82886*, a decision reiterating the principle laid down in *MPA-37/80183*, she pointed out that the intended outcome was the same if both therapists were working to develop similar functional skills. The unstated rationale underlying the deputy secretary’s decision, at least as it pertains to private therapy that

duplicates school therapy is that federal law requires school districts to meet the special needs of its students and the department will not allow a district's failure to comply with this obligation to provide the reason for funding another source of therapy. The deputy secretary's decisions are binding on administrative law judges, meaning that they must follow those decisions.

Each day the petitioner's school district provides him with 30 minutes of instruction in attending and completing tasks and 15 minutes in developing fine motor activities, including writing letters appropriately. St Croix's two primary goals for the petitioner are for him to improve his "self -regulation for increased independence in daily activities" and to "demonstrate fine motor, visual motor, and bilateral coordination skills for improved independence in daily activities." Its subgoals include paying attention and copying shapes. It does seek to teach the petitioner to do a couple things that the school does not such as zip and unzip various items and to participate in and demonstrate appropriate social interaction. Still, the basic intended outcome of each is to improve his concentration and his fine motor skills.

Even if St. Croix's therapy differs enough from the school's to not duplicate that therapy, it must still show that it will effectively treat the petitioner's problems. It has not done so. First, much of St Croix's proposal seems to assume that the petitioner's problems are caused by sensory processing issues despite his clear mental and physical problems related to being born three months prematurely. That St. Croix found a sensory root for his problems is not surprising. It has been noted more than once that it almost always finds sensory causes at the root of its clients' problems and prescribes sensory techniques to alleviate those problems. For example, *DHA Decision No. MPA-16/82875*, issued in March 2007, noted that Special Children Center did not rule out other more obvious causes before attributing his problems to sensory issues and stated: "This follows a long pattern in which Special Children Center finds sensory issues in almost every occupational therapy matter. "

There is little evidence that sensory techniques provide any benefit other than temporarily calming the recipient of the technique. Rather, the scientific evidence indicates that it has no lasting effect on a person's ability to function in any specific way, which is the purpose of occupational therapy.

In past cases involving St. Croix, the Department has submitted several scientific studies, including one published in 2002 by Dr. Steven Shaw, the lead school psychologist at Children's Hospital in Greenville, South Carolina and an associate professor at the Medical University of South Carolina. That study questioned the effectiveness of sensory integration techniques. Dr. Shaw contends that several aspects of sensory integration are "dangerously close" to the criteria used to define pseudoscience:

Among these criteria are: a) Reliance on subjective validation (i.e., failing to consider maturity, errors in initial diagnoses and the effects other valid treatment regimens in cases where children improve); b) nearly exclusive reliance on anecdotes, rumor, common sense and eyewitness testimony to support a treatment validity; c) an indifference to facts (i.e., despite advances in developmental cognitive neuroscience and a large body of research on SI, there have been no major changes in theory of SI since Jean Ayres's 1979 book, *Sensory Integration and the Child*); d) beginning with a spectacular and emotionally appealing hypothesis and only acknowledging supporting items while ignoring all contrary evidence; e) deliberately creating mysteries and mysterious new constructs (i.e., SI theorists invented the concept of "near senses" and refers to mysterious plasticity of the CNS without explanation of how SI uses neural plasticity toward a restructuring of brain structure); f) the literature is aimed at the general public rather than the academic or clinical community; and g) convinces people by appeals to hope and faith in cases where the scientific and clinical community has no scientifically accepted answers. Moreover, the original SI therapy was developed for use for children with learning disabilities. This application of SI therapy is nearly universally discredited (see MiMatties and Quirk [1991] for an exception). Now SI therapy is being applied to children with autism, developmental dyspraxia, mental retardation, nonverbal learning disabilities and children with general motor clumsiness and

environmental sensitivities. SI proponents may eventually find or create a disorder that SI therapies effectively treat. At this point, the search continues.

Shaw, "A School Psychologist Investigate s Sensory Integration Therapies: Promise, Possibility, and the Art of Placebo." *NASP Communiqué*, p.2 (www.nasponline.org/publications/cq312si.html)

More recently, Han M. Leong and Mark Carter from the Macquarie University Special Education Centre in Sydney Australia reviewed research on the efficacy of sensory integration theory through 2007. See "Research on the Efficacy of Sensory Integration Therapy: Past, Present and Future." *Australian Journal of Special Education*. Volume 32, No. 1, April 2008, pp.83-99. Their findings are less polemical than Dr. Shaw's but at least as damning. What support they found for sensory integration lies in studies exhibiting dubious methodology.

This is especially true of studies done before 1994. A review of eight earlier studies in 1982 by Ottenbacher that was published in volume 36, pp. 571-578 of the *American Journal of Occupational Therapy*, is often cited to support sensory integration. Leong and Carter indicated that later studies found that the flaws in Ottenbacher's paper "included the design issues in the primary studies themselves, such as lack of comparison of experimental treatment groups to alternative treatment control groups, as well as lack of control for bias arising from use of multiple outcomes from the same studies." *Leong and Carter*, p.85. Design flaws from other studies favorable to sensory integration include "placebo effects, maturation, observer bias and possible positive reinforcement of other behavior." *Id.* For example, many problems disappear with age, or maturation. Yet the studies often do not compare the improvements of those who receive sensory integration therapy with those who do not. As a result, any improvement is attributed to the therapy even if that improvement probably would have occurred without it.

The studies were also found to be "fraught with serious methodological errors' due to lack of random assignment, absence of comparison to alternative intervention groups, lack of blind testing, non-equivalent groups, lack of clear reliability data, and unclear definitions of participant populations." *Id.*, p.86. Later studies showing some improvement among those with autism indicate that any improvement shown lasted for a short time; these studies had inconsistent results across participants, meaning that challenging behavior did not decrease among some participants. *Id.*, p.91.

Beyond the flaws with sensory techniques, there is little evidence that St. Croix's plan of care will lead to effective treatment of the petitioner's problems. As Mary Chucka pointed out in her letter supporting the denial of this request, the petitioner has been receiving occupational therapy on and off since he was a year old for these same problems and has shown little improvement. In order to ensure that its therapy is effective it is necessary to know what did not work in the past so that these methods are not repeated or, if they are, that they are now justified based upon the petitioner's age and maturity. The Prior Authorization Request contains no discussion comparing past and present techniques and why the proposed techniques will work now. In fact, it contains no real discussion of the current techniques. Each of the five listed subgoals has exactly the same two provision in its plan of care:

1. Neuromuscular re-education of movement, balance, kinesthetic sense, coordination, posture and proprioception.
2. Therapeutic activities to improve functional performance.

There is no way to determine specifically how St. Croix plans to implement these techniques for the petitioner, and without knowing exactly how St. Croix plans to treat her, there is no way to evaluate the techniques' effectiveness.

The petitioner and St. Croix must prove by the preponderance of the credible evidence that the requested services are medically necessary. Because of the duplication of school services and the failure to

demonstrate that the proposed plan of care will lead to any improvement, they have not met this burden. Therefore, I must uphold the Office of Inspector General's denial of the request.

CONCLUSIONS OF LAW

The requested occupational therapy is not medically necessary.

THEREFORE, it is **ORDERED**

The petitioner's 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 served and 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 7th day of December, 2012

\sMichael 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 December 7, 2012.

Division of Health Care Access And Accountability