



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

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In the Matter of

[REDACTED]

DECISION

HMO/143633

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**PRELIMINARY RECITALS**

Pursuant to a petition filed August 31, 2012, under Wis. Stat. § 49.45(5)(a), and Wis. Admin. Code § HA 3.03, to review a decision by the Division of Health Care Access and Accountability in regard to Medical Assistance, a hearing was held on October 16, 2012, at Milwaukee, Wisconsin.

The issue for determination is whether Independent Health Care, Inc. (the HMO)/the Division of Health Care Access and Accountability (DHCAA) correctly denied Petitioner's request for prior authorization of Sacroiliac (SI) Joint Injections.

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: Denise Landkamer, Nurse Consultant  
Division of Health Care Access And Accountability

Independent Health Care Plan  
1555 N. RiverCenter Dr. Suite 206  
Milwaukee, WI 53212

By: Elizabeth Bartlett, General Counsel

**ADMINISTRATIVE LAW JUDGE:**

Mayumi M. Ishii  
Division of Hearings and Appeals

**FINDINGS OF FACT**

1. Petitioner is a resident of Milwaukee County.

2. On July 12, 2012, Petitioner's physician filed a request for prior authorization of an SI Joint Injection, on Petitioner's behalf. (Exhibit 6, pg. 12)
3. On July 12, 2012, the HMO sent Petitioner a letter denying her request. (Exhibit 6, pgs. 10 and 11)
4. Petitioner filed a grievance with the HMO on July 16, 2012. (Exhibit 6, pg. 9)
5. On August 9, 2012, the HMO upheld its denial of the request for SI Injection. (Exhibit 6, pg. 7)
6. Petitioner filed a request for fair hearing that was received by the Division of Hearings and Appeals on August 31, 2012. (Exhibit 1)
7. Petitioner has a history of back and neck pain. (Exhibits 5 and 6)
8. The SI joint is located in the area of the hips, where one might see dimples in a person's back on either side of the spine. (Testimony of Dr. Davidoff)
9. Petitioner has not taken any medication to address SI joint pain, nor has she attempted any physical therapy to address SI joint pain. (Petitioner's testimony)

### DISCUSSION

Under the discretion allowed by *Wis. Stat.*, §49.45(9), the Department of Health Services (DHS) requires MA (Medical Assistance) recipients to participate in HMOs. *Wis. Admin. Code*, §DHS 104.05(2)(a). MA recipients enrolled in HMOs must receive medical services from the HMOs' providers, except for referrals or emergencies. *Wis. Admin. Code*, §DHS 104.05(3).

The criteria for approval by a managed care program contracted with the DHS are the same as the general MA criteria. See *Wis. Admin. Code*, §DHS 104.05(3) which states that HMO enrollees shall obtain services "paid for by MA" from the HMO's providers. The department must contract with the HMO concerning the specifics of the plan and coverage. *Wis. Admin. Code*, § DHS 104.05(1).

If the enrollee disagrees with any aspect of service delivery provided or arranged by the HMO, the recipient may file a grievance with DHS or appeal to the Division of Hearings and Appeals.

Just as with regular MA, when the department denies a grievance from an HMO recipient, the recipient can appeal the DHS's denial within 45 days. *Wis. Stat.*, §49.45(5), *Wis. Admin. Code*, § DHS 104.01(5)(a)3.

When determining whether to approve any service, the HMO, as with the Division of Health Care Access and Accountability (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)*

For any prior authorization request to be approved, the Medicaid recipient must show that the requested service satisfies the generic prior authorization criteria listed above. At their core, those criteria include the requirement that the service be medically necessary. *Id.*

There is insufficient evidence in the record to support a finding that the requested SI Joint injections are medically necessary at this time. First, there is insufficient documentation in the record to support the conclusion that Petitioner has SI joint dysfunction. Indeed, Petitioner’s medical records indicate a history of back and neck pain, but not a history of SI Joint dysfunction, nor anything that would suggest such a dysfunction. (Exhibits 5 and 6; testimony of Dr. Donna Davidoff) The diagnosis of SI Joint dysfunction first appears in an evaluation done on July 6, 2012, but the evaluation does not explain how the new diagnosis came about. (*Id.*) Second, even if Petitioner does suffer from an SI Joint dysfunction, she has not engaged in any conservative courses of treatment for that specific condition. According to the Local Coverage Determination materials from the Centers for Medicare and Medicaid, SI Joint Injections can only be deemed medically necessary when conservative treatment has been tried without success. (See [www.cms.gov/medicare-coverage-database/details](http://www.cms.gov/medicare-coverage-database/details).)

Petitioner should note that the Pre Grievance Review found in Exhibit 6, pg. 7, suggests that a *diagnostic* injection be considered to establish whether the SI joint is the cause of her pain. Petitioner might wish to consult with her physician about this and submit a NEW request for prior authorization, if further evidence of SI joint dysfunction is found AND conservative treatment proves ineffective.

### **CONCLUSIONS OF LAW**

That the evidence is not sufficient to demonstrate that this request for prior authorization of SI joint injections meets the criteria necessary for Medicaid payment.

**THEREFORE, it is**

**ORDERED**

That the petition 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 Milwaukee,  
Wisconsin, this 1st day of November, 2012

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Mayumi M. Ishii  
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 November 1, 2012.

Division of Health Care Access And Accountability