FH

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION

MPA/146988

PRELIMINARY RECITALS

Pursuant to a petition filed January 30, 2013, under Wis. Stat. § 49.45(5), and Wis. Admin. Code § HA 3.03(1), to review a decision by the Department of Health Services' Office of the Inspector General (OIG) Division of Health Care Access and Accountability in regard to Medicaid, a hearing was held on May 21, 2013, at Kenosha, Wisconsin.

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

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: Pamela J. Hoffman, PT, DPT, MS – written submission
OIG
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 Kenosha County.
2. Petitioner is 30 years of age (8/19/82). His primary diagnosis is noted to be arthrogryposis *("….a neuro-musculo-skeletal disorder that affects various joints in the body. The condition is congenital and non progressive. The medical terminology for the disorder is Arthrogryposis Multiplex Congenita. The joints in the body show contractures, stiffness, poor mobility or immobility and muscle fatigue." Per*

http://www.arthrogryposis.net/). He also suffers seizures. He is noted to be cognitively challenged; with intellectual capabilities of a third grader and socially is about 3 years old. He does attend a day program 5 days per week.

3. A prior authorization request (PA) seeking Wisconsin Medicaid payment for physical therapy (PT) for Petitioner was filed on, or about, November 1, 2012 by his provider, Doctors of Physical Therapy seeking Medicaid payment for therapeutic exercises, neurological re-education, therapeutic activities and manual therapy. That PA sought the Medicaid payment for 24 sessions of physical therapy (PT) at a frequency of twice per week for 12 weeks. The cost was noted to be $2918.04.

4. Petitioner has been receiving PT services since birth. His current physical therapist has treated him for 8 to 10 years. He has private insurance which pays for 60 PT sessions per year. From 2009 through May 2012 Petitioner had PT though the Family Care program. He is currently enrolled in the IRIS program.

5. The Department of Health Services' Office of the Inspector General (OIG) denied this prior authorization request. The denial was based upon the conclusion that the request did not meet legal standards necessary for approval found 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 OIG submitted a letter dated February 11, 2013 that explained in detail the rational for the denial. See Ex. # 3. The reasons for the denial were that the provider did not document the change in Petitioner's functional limitations as a result of PT, a lack of documentation as to how Petitioner's impairments have changed as a result of PT, a lack of documentation as to what Petitioner is capable to do at the time of the PA vis-à-vis the goals established for him and because it appears to the Department that Petitioner's usual activities of daily living, his participation in an adult the program along with a home exercise program will work to maintain his strength and capabilities. Thus the Department did not find that the physical therapy that was requested necessary to prevent, diagnose or treat Petitioner's disability and is not, therefore, an appropriate level of service. Further, the Department did not find the requested services to be cost-effective and concluded that they were duplicative of the general exercise that he gets in daily activities at home and in his day program.

Petitioner's therapist argues that Petitioner's contractures will increase; he will no longer be able to stand or ambulate and his care requirements will escalate if he does not receive the requested physical therapy. He bases this on his 25+ years of experience as therapist. Petitioner's physicians echo that concern indicating that without physical therapy he will regress and the contractures and stiffness in the muscles and ligaments of his legs will affect his ability to walk. His physicians believe that physical therapy is necessary to counteract the progression of his physical problems and, further, that neglecting physical therapy will put Petitioner at risk of pneumonia.

This case is really a close call. On one hand there is the need for documentation and objective measurement as noted by the Department as well as the concern that without demonstration of functional abilities and limitations and the effect of physical therapy upon Petitioner's physical problems there is not documentation that the standards necessary for expenditure of Medicaid funds has been met. On the other hand there are the anecdotal, and quite frankly, rather conclusory, statements from Petitioner's therapist and his treating physicians.

I am, therefore, partially approving this prior authorization request. I am limiting it to one session per week for 12 weeks. Petitioner last received PT for payment by the Medicaid for service program in 2009. The Department is correct, updated documentation with measurements wherever possible are necessary to demonstrate medical necessity. Further the Department's question as to why activities of daily living combined with the adult day program combined with cares available through the IRIS program are not meeting Petitioner's PT needs are valid. Nonetheless, the anecdotal evidence as to Petitioner's needs is also compelling.

NOTE: Petitioner should be aware that Petitioner's provider will not receive a copy of this Decision. In order to have the physical therapy approved, Petitioner must provide a copy of this Decision to his provider. The provider must then submit a new prior authorization request to receive the approved coverage.

CONCLUSIONS OF LAW

That the evidence does demonstrate that the requested PT sessions may be approved for partial payment by the Wisconsin Medicaid program.

THEREFORE, it is **ORDERED**

That Petitioner's provider, Doctors of Physical Therapy, is hereby authorized to submit its claim for 12 PT session at a frequency of once per week, along with a new prior authorization request and a copy of this Decision, to ForwardHealth 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 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 3rd day of June, 2013

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\sDavid D. Fleming
Administrative Law Judge
Division of Hearings and Appeals

State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

David H. Schwarz
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 June 3, 2013.

Division of Health Care Access And Accountability
fparise@fjpllc.com