



STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

DECISION

MPA/147820

PRELIMINARY RECITALS

Pursuant to a petition filed March 04, 2013, 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 May 15, 2013, at Milwaukee, Wisconsin.

NOTE: The record was held open until May 24, 2013, to give Petitioner's mother an opportunity to submit documentation from his dentist and pediatrician. On May 21, 2013, Petitioner's dentist submitted a letter. It has been marked as Exhibit 5 and entered into the record. On May 24, 2013, Petitioner's mother submitted a letter from Petitioner's Applied Behavioral Analysis therapist. The letter has been marked as Exhibit 6 and entered into the record. Petitioner's pediatrician also submitted a brief letter recommending continued occupational therapy. It has been marked as Exhibit 7 and entered into the record.

The issue for determination is whether the Division of Health Care Access and Accountability (DHCAA) correctly denied Petitioner's request for prior authorization of occupational therapy.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Respondent:

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

By: Office of Inspector General (OIG) by letter
Division of Health Care Access and Accountability
1 West Wilson Street, Room 272
P.O. Box 309
Madison, WI 53707-0309

ADMINISTRATIVE LAW JUDGE:

Mayumi M. Ishii
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner is a resident of Milwaukee County.
2. On November 28, 2012, Karrie Erdman, Petitioner's occupational therapist, submitted on Petitioner's behalf, a request for prior authorization for occupational therapy, one session per week for 20 weeks consisting of neuromuscular reeducation and sensory integration therapy. (Exhibit 3, pg. 7)
3. Petitioner's occupational therapist stated the following goals in the prior authorization request that she submitted:
 1. *Show improved self-organization by using a visual chart in the morning and evening to wash his face and brush his teeth 3 out of 5 days a week.*
 2. *Stop rocking (stim) when a gentle cue of a hand is placed on his head and remain calm and organized for 60 seconds following the inhibition.*
 3. *Track and object crossing midline 2 times at the end of each session, following proprioceptive and vestibular input. (sic)*
 4. *Sequence 4-5 steps in an event 2/3 trials*
 5. *Design, plane and execute an activity without cues or directions 3 times.*

(Id.)
4. Petitioner's Individualized Education Program (IEP) for the 2012/2013 school year states the following goals:
 1. *Independently maintain organization of school materials 80% of the time.*
 - a. *Arrange/maintain notebooks*
 - b. *Arrange/maintain desk/locker/backpack*
 - c. *Select and use strategies for problem solving*
 - d. *Obtain and use supplies, dark pencil, graph paper, magnifier, notebook as slant board.*
 2. *Independently use visual functioning/strategies to complete school tasks 80% of the time.*
 - a. *Systematically scan material, left to right/top to bottom*
 - b. *Systematically scan classroom environment to located information at a distance.*
 - c. *Seat self at the most appropriate location for class activities according to visual needs.*
 - d. *Identify strategies that assist in performing near/distance tasks*
 - e. *Use strategies for maximizing visual efficiency to complete classroom tasks, positioning materials, highlighting, using a line marker, or taking a break.*
 3. *Will learn foundational concepts of "T" and "+" intersections to identify at least 3 out of 5 characteristics that make crossing a street safe.*
 4. *Will learn visual scanning skills (with and without an assistive device – monocular) to perform target tracing, tracking and location to identify visual targets at far or near with 80% accuracy out of 4 trials.*
 5. *Per How Does Your Engine Run" program, the student will*
 - a. *Define engine speeds (high, low, just right) at 100%*
 - b. *Label how his "engine" is running when asked by an adult 80% of opportunities*
 - c. *Identify 2-3 sensorimotor strategies he can utilized to get his "engine" to "just right" for the activity in which he is participating.*
 - d. *Use sensorimotor strategies to change his "engine" speed 50% of opportunities.*

(Exhibit 3, pgs. 24-29)

5. Petitioner's IEP does not include an extended school year. (Id.)
6. On January 22, 2013, the DHCAA sent Petitioner a notice indicating that the request for services was modified. (Exhibit 3, pgs. 47-50)
7. On January 22, 2013, the DHCAA sent Ms. Erdman a notice indicating that the requested services had been denied. (Exhibit 3, pgs. 51 and 52)
8. Petitioner filed a request for Fair Hearing that was received by the Division of Hearings and Appeals on March 4, 2013. (Exhibit 1)
9. Petitioner is nine years old and suffers from Autism Spectrum Disorder with sensory integration issues/Pervasive Developmental Disorder – Not otherwise specified, anxiety, bilateral optic nerve hypoplasia, bilateral congenital nystagmus, bilateral high hyperopia, and bilateral amblyopia. (Exhibits 1 and 4, testimony of Petitioner's mother)
10. Petitioner's parents use Applied Behavioral Analysis techniques to help address Petitioner's behaviors. (Testimony of Petitioner's mother; see also Exhibit 3)
11. Petitioner stopped receiving occupational therapy services in December 2012. His condition has worsened since that time. (Testimony of Petitioner's mother; Exhibit 6)

DISCUSSION

The Department of Health Services sometimes requires prior authorization to:

1. Safeguard against unnecessary or inappropriate care and services;
2. Safeguard against excess payments;
3. Assess the quality and timeliness of services;
4. Determine if less expensive alternative care, services or supplies are usable;
5. Promote the most effective and appropriate use of available services and facilities; and
6. Curtail misutilization practices of providers and recipients.

Wis. Admin. Code § DHS107.02(3)(b)

Medical assistance covers occupational therapy if the recipient obtains prior authorization after the first 35 visits. Wis. Adm. Code § DHS 107.17(2)(b).

“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.”

Wis. Admin. Code §DHS107.02(3)(e)

“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.

Emphasis added

Wis. Adm. Code. §DHS 101.03(96m)

Petitioner has the burden to prove, by a preponderance of the credible evidence that the requested level of therapy meets the approval criteria.

According to the letter from the OIG, Petitioner’s request for occupational therapy was denied because, in its opinion, the requested therapy failed to meet the legal definition of “medically necessary”. The OIG based its opinion on three assertions:

1. Petitioner’s occupational therapist failed to include objective measurements of Petitioner’s current ability, as compared to objectively measurable goals.
2. The requested therapy was duplicative of services Petitioner was already receiving through his Individualized Education Program (IEP)
3. The requested therapy, which includes sensory integration therapy, is not of proven medical value or usefulness in treating Autism Spectrum Disorder.

Objective Measurements

The on-line Provider Handbook found on the Forward Health website at www.forwardhealth.wi.gov, discusses what must be provided with a request for prior authorization for physical therapy (PT), occupational therapy (OT) and speech therapy (SLP):

Provider Enrollment and Ongoing Responsibilities : Documentation

Topic #2778

Evaluations

PT, OT, and SLP providers are required to include a written report of the member's evaluation in the member's medical record. The evaluation report must be signed and dated and include the following:

- Assessment of the member's condition and recommendations for therapy intervention.

- Baseline measurements that establish a performance or ability level using units of objective measurement that can be consistently applied when reporting subsequent status of the member's progress.
- Chronological history of treatment provided for the diagnosis.
- Diagnosis(es) with date(s) of onset, current medical status, and functional status of the member.
- List of other PT, OT, and SLP service providers who are currently treating the member to the extent known by the evaluating PT, OT, or SLP provider.
- Previous level of function and change in medical status since previous prior authorization requests if performing a re-evaluation.
- Reason for the referral.
- Test charts or forms used in the evaluation.
- Underlying conditions or impairments to be treated.

After reviewing the prior authorization request submitted by Petitioner's occupational therapist, as well as a supplemental letter provided by the occupational therapist, it is apparent that the OIG is correct that the therapist did not include in her initial evaluation any objective measurement of Petitioner's ability at the time of the authorization request. In the absence of such information, there is no way to measure Petitioner's progress when the requested period of therapy ends.

Duplication of Services

Per Wis. Adm. Code. §DHS 101.03(96m), a service is not considered medically necessary if it is duplicative of other services being provided to the recipient.

Ms. Erdman, Petitioner's occupational therapist, stated the following goals in the prior authorization request that she submitted:

1. Show improved self-organization by using a visual chart in the morning and evening to wash his face and brush his teeth 3 out of 5 days a week.
2. Stop rocking (stim) when a gentle cue of a hand is placed on his head and remain calm and organized for 60 seconds following the inhibition.
3. Track and object crossing midline 2 times at the end of each session, following proprioceptive and vestibular input. (sic)
4. Sequence 4-5 steps in an event 2/3 trials
5. Design, plane and execute an activity without cues or directions 3 times.

(Exhibit 3, pgs. 16 and 46)

Petitioner's therapist further indicated that, "Therapy focus is to help him get organized within his own body (self-regulation) and organize his tasks, such as his ADL's, his homework and his personal and school items...Visual limitations with writing and reading are to be addressed and worked on as well as problem solving skills." (Exhibit 3, pg. 16)

Petitioner's IEP states the following goals:

1. Independently maintain organization of school materials 80% of the time.
 - a. Arrange/maintain notebooks
 - b. Arrange/maintain desk/locker/backpack
 - c. Select and use strategies for problem solving
 - d. Obtain and use supplies, dark pencil, graph paper, magnifier, notebook as slant board.
2. Independently use visual functioning/strategies to complete school tasks 80% of the time.
 - a. Systematically scan material, left to right/top to bottom
 - b. Systematically scan classroom environment to locate information at a distance.

- c. Seat self at the most appropriate location for class activities according to visual needs.
- d. Identify strategies that assist in performing near/distance tasks
- e. Use strategies for maximizing visual efficiency to complete classroom tasks, positioning materials, highlighting, using a line marker, or taking a break.
3. Will learn foundational concepts of “T” and “+” intersections to identify at least 3 out of 5 characteristics that make crossing a street safe.
4. Will learn visual scanning skills (with and without an assistive device – monocular) to perform target tracing, tracking and location to identify visual targets at far or near with 80% accuracy out of 4 trials.
5. Per the How Does Your Engine Run” program, the student will
 - a. Define engine speeds (high, low, just right) at 100%
 - b. Label how his “engine” is running when asked by an adult 80% of opportunities
 - c. Identify 2-3 sensorimotor strategies he can utilize to get his “engine” to “just right” for the activity in which he is participating.
 - d. Use sensorimotor strategies to change his “engine” speed 50% of opportunities.

“...When observed rocking [Petitioner] has been given two sensorimotor choices. He willingly makes a choice and participates in the activity. Nathan will be introduced to How Does Your Engine Run at an alert program for self-regulation. He will learn to recognize when he is at a state of high arousal and be able to use sensorimotor strategies to calm himself.”

(Exhibit 3, pgs. 24-29)

When looking at the stated goals of private therapy and the goals of Petitioner’s IEP, there does appear to be significant duplication of services in terms of addressing Petitioner’s rocking behavior/need to self-regulate, his ability to scan his reading materials and surroundings, his ability to problem solve and complete tasks, and his ability organize his belongings. In addition, both the requested therapy and the school based occupational therapy provided to Petitioner included the use of sensorimotor strategies to calm him and address his rocking.

Usefulness of the Requested Therapy

The prior authorization request asks for Neuromuscular Re-education sessions and Sensory Integration therapy sessions. It is the OIG’s opinion that Sensory Integration is not a covered service, because it has not been shown to have medical value.

The OIG is correct in that Wis. Admin. Code DHS §107.03(4) states that services that are experimental in nature are not covered by Medical Assistance. In addition, Wis. Adm. Code. §DHS 101.03(96m), states that a requested service is not considered medically necessary if it does not have proven medical value or usefulness AND if it is experimental in nature.

However, occupational therapy using sensory integrative skills is a specifically covered service under Wis. Admin. Code §DHS 107.17(1)(b) and there are no stated exclusions in the administrative rule to treating sensory deficits related to autism:

- (1) **COVERED SERVICES.** Covered occupational therapy services are the following medically necessary services when prescribed by a physician and performed by a certified occupational therapist (OT) or by a certified occupational therapist assistant (COTA) under the direct, immediate, on-premises supervision of a certified occupational therapist or, for services under par. (d), by a certified occupational therapist assistant under the general supervision of a certified occupational therapist pursuant to the requirements of s. [DHS 105.28 \(2\)](#):

....

(b) sensory integrative skills as follows:

1. Reflex/sensory status;
2. Body concept;
3. Visual-spatial relationships;

4. Posture and body integration; and
5. Sensorimotor integration;

The OIG's letter is not entirely clear, but it may be that the OIG is arguing that sensory integration therapy does not have specific medical value in treating autistic children with sensory integration issues, but as discussed above, the administrative rules do not specifically exclude sensory integration therapy for autistic children. Thus, it can be a covered service, as long as prior authorization criteria are met. In addition, one of the two articles provided by the OIG states that sensory integration therapy might have some medical value.

The article Sensory Integration Therapies for Children with Developmental and Behavior Disorders was published by the American Academy of Pediatrics on May 28, 2012. According to that article, "the amount of research regarding the effectiveness of sensory integration therapy is limited and inconclusive..." and that one small study found that "behavior intervention was more effective in reducing challenging behavior and self-injurious behavior than was the sensory integration therapy." (Exhibit 4, pg. 9) However, that same article also indicated, "Occupational therapy with the use of sensory based therapies may be acceptable as one of the components of a comprehensive treatment plan" and that, "Despite the challenges of defining and studying the effectiveness of sensory integration therapy, it is possible that the treatment of sensory processing difficulties is helpful to children who have problems identified in sensory processing measures. Some published case series and observational studies have reported positive outcomes of sensory integration therapy for children with sensory processing disorders." (Id.)

Based upon the article from the American Academy of Pediatrics, sensory integration therapy has been shown to be of some medical value when used as part of a comprehensive treatment plan. Regrettably, the prior authorization request does not make clear whether the sensory integration therapy is being used as part of a more comprehensive treatment plan and if so, what the rest of the treatment plan entails.

It should be noted that Petitioner's mother testified credibly, that Petitioner's condition has deteriorated significantly since therapy ended in December 2012. According to Petitioner's mother:

1. When therapy ended in December 2012, Petitioner was able to complete the tasks of brushing his teeth or washing his face with 3-4 reminders to stay on task. Since Petitioner's therapy ended, he has required 30-80 reminders.
2. When therapy ended, Petitioner had issues with incontinence 1-2 times per week. Since therapy ended, Petitioner's incontinence has increased 4-5 times a week and he appears to be completely unaware of the fact that he is wet.
3. At the time therapy ended, Petitioner was able to complete 2-3 step tasks with reminders. Since therapy ended, he struggles to stay on task to complete one step tasks.
4. At the time therapy ended, Petitioner responded to reminders to stop rocking for 5-10 minutes. Since therapy ended, Petitioner is not as responsive to reminders and the severity of his rocking has increased such that Petitioner's mother is sometimes concerned Petitioner will hit his head on the floor while rocking. Petitioner will not stop walking in the middle of the street or sidewalk to start rocking himself.
5. At the time therapy ended, Petitioner was able to track the words in his homework well enough that it took him 30-40 minutes to complete his homework. Since therapy ended, Petitioner struggles to track the words in his homework and it now takes 1 ½ to 1 hour and 40 minutes to complete.
6. At the time therapy ended, Petitioner was prone to tantrums 1-2 times per day. Since therapy ended, Petitioner has experienced tantrums 8 times per day.
7. Since therapy ended, Petitioner's proprioception has worsened; he has chewed his fingers until bloody, unaware that they were still in his mouth while eating a sandwich; he has pulled two molars out of his mouth, seemingly unaware of any pain. Petitioner did not previously have serious issues with these specific behaviors.
8. Petitioner's need to chew has increased. Since therapy ended Petitioner has begun chewing on non-food items like utensils and fabric.

9. Prior to therapy ending, Petitioner would be asleep by 9:00/9:30 and wake between 4:00 and 7:00 a.m. After therapy ended, Petitioner had significantly more difficulty winding down to prepare for sleep and he has started falling asleep between 11:00 p.m. and 12:00 a.m., but wakes up at the same time. As such, he has been getting less sleep since therapy ended.

Katerina Norwood, Petitioner's ABA therapist, indicated in a letter dated May 20, 2013, that since occupational therapy ended, Petitioner's need for sensory breaks has increased, which is interfering with the ABA therapy. Ms. Norwood reported that Petitioner's need to self-stimulate has increased since occupational therapy ended and that Petitioner is engaging in spinning, jumping, rocking, sucking on his hand or chewing non-food items. Ms. Norwood also indicated in her letter that Petitioner self-reported that he cannot shut off his brain, so he is having difficulty concentrating on his homework and listening to what people are saying.

Unfortunately, the evaluations submitted by Petitioner's therapist with the prior authorization request did not address all of the behaviors described by Petitioner's mother and ABA therapist and they did not explain what the neuromuscular reeducation was meant to address, as opposed to the sensory integration therapy.

In Summary

While occupational therapy with sensory integration therapy is a covered service under the Administrative Code and while such therapy made a significant difference in Petitioner's life and reduced symptoms related to his autism and visual impairment, the prior authorization request cannot be approved because Petitioner's therapist did not provide any objective measurements of Petitioner's ability at the time of the authorization request and because the requested therapy was duplicative of services provided to Petitioner through his 2012/2013 IEP.

I note to the Petitioner that his provider, Kerry Erdman/Creative Pediatric Therapies, will not receive a copy of this Decision. Petitioner's mother is encouraged to share this decision with Ms. Erdman/Creative Pediatric Therapies.

Petitioner's therapist can submit a new request for prior authorization with clear, detailed, objective and specific information regarding Petitioner's current abilities, what issue each type of therapy is going to address, how the therapy fits into Petitioner's treatment plan, and how the requested therapy differs from Petitioner's most current IEP, which Petitioner's mother indicated is 1) still in the process of being completed, 2) will not include an extended school year and 3) will be reducing services for her son during the 2013/2014 school year.

CONCLUSIONS OF LAW

The DHCAA correctly denied Petitioner's request for Occupational Therapy.

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 29th day of May, 2013.

\sMayumi 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 May 29, 2013.

Division of Health Care Access And Accountability