



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

In the Matter of

[REDACTED]
[REDACTED]
[REDACTED]

DECISION

HMO/148602

PRELIMINARY RECITALS

Pursuant to a petition filed April 04, 2013, 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 June 05, 2013, at Milwaukee, Wisconsin.

The issue for determination is

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:

[REDACTED]
[REDACTED]
[REDACTED]

Petitioner's Representative:

Attorney Jeff Wilson
1572 E. Capitol Drive, 4th Floor
PO Box 11946
Milwaukee, WI 53211-0946

Respondent:

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

By: Meri DeGarmo, Nurse Consultant
Division of Health Care Access And Accountability
One West Wilson St.
Madison, WI 53707

ADMINISTRATIVE LAW JUDGE:

John P. Tedesco
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner is a resident of Milwaukee County.
2. Petitioner is enrolled with iCare as an HMO providing services for the state of Wisconsin Medicaid program.

3. Petitioner is sometimes forgetful.
4. ICare contracts with Southeast Dental Associates (SEDA) to obtain prior authorization and perform covered dental services.
5. Petitioner's provider, Marquette University School of Dentistry sought prior authorization for services as follows: Bridge for teeth #6-8; Root canal at tooth #28; Root canal at teeth #12 and 13.
6. SEDA determined that the sought services were not covered services and denied the services.
7. Petitioner filed an appeal.

DISCUSSION

Under the discretion allowed by Wis. Stat., §49.45(9), the Department of Health Services (DHS) now requires MA recipients to participate in HMOs. Wis. Adm. Code, §DHS 104.05(2)(a). MA recipients enrolled in HMOs must receive medical services from the HMOs' providers, except for referrals or emergencies. §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. Adm. Code, §DHS 104.05(3), which states that HMO enrollees shall obtain services "paid for by MA" from the HMO's providers. The DHS must contract with the HMO concerning the specifics of the plan and coverage. Wis. Adm. 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 the DHS or appeal to the Division of Hearings and Appeals. Just as with regular MA, when the DHS denies a grievance from an HMO recipient, the recipient can appeal the DHS's denial within 45 days. Wis. Stat., §49.45(5), Wis. Adm. 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 requested service must satisfy the generic prior authorization criteria listed above. At their core, those criteria include the requirement that the service be medically necessary (as opposed to being needed, *e.g.*, for cosmetic, social or academic reasons). *Id.*, 1.

I wish to note that the burden of proof in a prior authorization case lies with the petitioner to establish the medical necessity of any requested MA services. That is, the provider must submit enough documentation to convince the MA consultant or failing to do so, the Administrative Law Judge.

SEDA denied the root canal procedure on tooth #28 on the basis that it is a repeat of a prior root canal procedure and that MA only covers one root canal per lifetime. Respondent argued at the hearing that the BC+ and Medicaid Dental Handbook articulates this position. At the time of hearing, petitioner did not argue that the root canal should be permitted. Instead, she argued that a fixed denture should be allowed if the tooth is extracted. That argument is addressed below.

SEDA denied the root canal on teeth #12-13 on the basis that the sought service does not meet the criteria for a root canal procedure (Code D3320). In this case, the respondent asserts that the denial of coverage is appropriate. The following is from the approval criteria from the *Prior Authorization Guidelines Manual*, 124.004.03 (1/29/08):

1. No more than five teeth will require root canal therapy, and no anterior tooth in the same arch is missing or indicated for extraction. The recipient must have adequate posterior occlusion per Program criteria of at least two posterior teeth bilaterally in occlusion with the opposing arch; or have fewer than six missing teeth in the same arch and therefore would not be a partial denture candidate. If the recipient already qualifies for a partial denture due to missing anterior teeth in the same arch, or inadequate posterior occlusion, or has six or more missing teeth in the same arch, the request for root canal therapy will be denied and the provider asked to submit a request for a partial denture. The provider has the option to complete the root canal therapy on the indicated tooth or teeth at the recipient's expense.

The respondent argues that petitioner has fewer than two posterior teeth in occlusion per quadrant, is missing six or more teeth in the arch in question, and is missing one or more anterior teeth in the arch in question. At the time of hearing, petitioner did not argue that the root canal should be permitted. Instead,

she argued that a fixed denture should be allowed if the teeth are extracted. That argument is addressed below.

Finally, with regard to the bridge that was sought, the procedure codes were D6240 and D6750. SEDA denied the request on the basis that these procedure codes are not covered under MA. SEDA contacted petitioner to inform her that a removable partial denture, however, would be a covered service. The removable partial is not a satisfactory alternative for petitioner. At hearing petitioner argued that the removable partial denture that was offered presents a safety risk for petitioner and that the fixed denture should be covered as medically necessary. She explained that she has documented memory problems and loses things regularly and that this would cause safety issues in that she might try to use her mouth at a time when she has forgotten to put in her denture, or at a time in which she has lost her denture.

While a fixed prosthodontics device may be allowed under the rules in certain cases in which the member cannot wear a removable partial, I do not see that as the case here. Petitioner's argument is that she might lose it. I accept that. It is possible that she might lose it. But, I will not overrule what appears to me to be proper application of the rules simply because the appropriate covered item may someday be lost by the petitioner. As for the argument that this presents a safety risk I simply find that argument to be more of a stretch than I can accept in order to find that the burden is met. Frankly, I note that petitioner's counsel, when asked specifically how this would be a safety risk, could not really articulate the scenario. I suppose it is something like petitioner forgets to put in her partial and decides to eat a tortilla chip which then causes a laceration in her mouth. Again though, it may be possible that something like that could happen at some point in the future, but I am not going to conclude that the MA rules should be disregarded simply because something remote could happen. This possibility does not mean that petitioner cannot wear a partial denture.

CONCLUSIONS OF LAW

The Department agent did not err in its denial of the requested services.

THEREFORE, it is

ORDERED

That this 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 16th day of July, 2013

\sJohn P. Tedesco
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 July 16, 2013.

Division of Health Care Access And Accountability
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