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

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In the Matter of

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

DECISION

MPA/150883

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**PRELIMINARY RECITALS**

Pursuant to a petition filed July 25, 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 n/k/a the Office of the Inspector General (OIG) in regard to Medical Assistance (MA), a telephonic hearing was held on September 12, 2013, at Waukesha, Wisconsin. The record was held open to allow the OIG time to respond to new evidence presented at hearing. The OIG provided its response on September 19, 2013.

The issue for determination is whether the OIG correctly modified petitioner's prior authorization (PA) request for physical therapy (PT).

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 written submittal of: Pamela Hoffman, PT, DPT, MS  
Division of Health Care Access and Accountability  
1 West Wilson Street, Room 272  
P.O. Box 309  
Madison, WI 53707-0309

**ADMINISTRATIVE LAW JUDGE:**

Kelly Cochrane  
Division of Hearings and Appeals

**FINDINGS OF FACT**

1. Petitioner is a resident of Waukesha County.
2. Petitioner is 2 years old and lives at home with his family. He is diagnosed with apraxia, autism, hypotonia, muscle weakness, motor incoordination, and difficulty walking.
3. Petitioner began in-home behavior services for autism on April 30, 2013 at 25 hours per week.
4. On May 16, 2013 the petitioner's private PT provider submitted a PA request (PA# [REDACTED]) for petitioner to receive private PT once weekly for 26 weeks starting on June 5, 2013.
5. On June 14, 2013 the OIG issued a notice to petitioner indicating that it was modifying the PA request to 6 PT visits between June and December 2013 because it did not find the level of PT requested to be medically necessary.

**DISCUSSION**

Physical Therapy (PT) is covered by MA under Wis. Admin. Code, §DHS 107.16. Generally it is covered without need for prior authorization (PA) for 35 treatment days per spell of illness. Wis. Admin. Code, DHS §107.16(2)(b). After that, PA for additional treatment is necessary. If PA is requested, it is the provider's responsibility to justify the need for the service. Wis. Admin. Code, DHS §107.02(3)(d)6.

In determining whether to grant prior authorization for services or equipment, the OIG must follow the general guidelines in DHS §107.02(3)(e). That subsection provides that the OIG, in reviewing prior authorization requests, must consider the following factors:

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.

The key factor of the 12 listed above is "medical necessity", which is defined in the administrative code as any MA service under chapter 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. Adm. Code, DHS §101.03(96m).

“Medically necessary” is therefore more of a *legal* term as opposed to a *medical* term. Therefore, while a medical professional or provider may conclude an item is “medically necessary”, it is the OIG which must adjudicate the request and determine whether the item or service for which payment is sought meets the legal definition of “medically necessary.” In prior authorization cases the burden is on the person requesting the PA to demonstrate the medical need for the services. Wis. Admin. Code §DHS 107.02(3)(d)6; see also Wis. Admin. Code, §DHS 106.02(9)(e)1. As an MA-certified provider, providers who request the MA program to reimburse for their services are required, by law, to completely and accurately complete the prior authorizations which they submit. Not every medical provider can submit a PA to the MA program to request reimbursement. Only those providers who have been certified to provide MA-reimbursable services are allowed to submit a PA. One of the reasons these medical providers are “certified” is to assure they are kept up to date on changes in the MA program and the prior authorization process. MA-certified providers are expected to know the rules and policies controlling the prior authorization process and the completion of the prior authorization forms.

In this case the OIG modified the PA request because it determined that the level of PT requested was not medically necessary. Essentially the OIG is stating that the provider did not document how the requested PT is necessary to supervise petitioner’s gross motor activities weekly, did not document how his neuromuscular system changes on a weekly basis, and did not show why his home exercise program (HEP) requires changing on a weekly basis. The OIG found that the provider did not document a measurement of petitioner’s impairment(s) to establish a baseline to show that PT was necessary or that there was measured progress. The provider listed petitioner’s impairments as hypotonia, muscle weakness, poor motor coordination, decreased body awareness and motor planning, poor attention to task, poor balance, delayed communication skills, inconsistent eye contact, decreased ability to follow adult direction, and overall significant delays with his gross motor skills.

The long term goals for petitioner were listed in the PA request as:

- 1) being safe and independent with mobility throughout his environment including surface changes, dynamic surfaces, and stair navigation without falling (Baseline=per parent report petitioner falls very frequently throughout the day, has poor control with dynamic surfaces, is inconsistent with surface changes, and requires hand held assistance to walk up/down stairs) and
- 2) petitioner will be independent with all transfers (Baseline= lifted in/out of tub and car).

See [Exhibit 3](#), Plan of Care dated 4/9/13.

The short term goals at that time were to 1) demonstrate increased safety awareness in unfamiliar settings as demonstrated by less need for assistance as reported by his mother (Baseline=in unfamiliar settings he falls more often and mother reports he needs more help than would be expected for his age); 2) consistently step up a 6 inch high step independently in all settings (Baseline=Shows ability to do so, however if he is too focused on the step he prefers to use his hands; 3) Will step up 2 steps into family home using the wall for support and without hand held assist (Baseline=requires hand held assist); 4) will demonstrate improved balance and motor coordination as demonstrated by his ability to purposefully kick a ball forward or kick down a block tower (Baseline= minimal interest in kicking, has been able to do so accidentally); 5) will demonstrate improved strength as noted by his ability to jump clearing both feet from the floor with 2 hands held (Baseline=unable, unsure of interest level in this activity); 6) will tolerate assisted tricycle riding with pedal attachments for 200 feet and make attempts to pedal demonstrating improved strength, coordination, and motor planning (Baseline= tolerate for approximately 45 feet and does make attempts to pedal). Id.

Petitioner's mother, who clearly wants the best for her child, testified at hearing, as well as petitioner's physician and ABA therapist. The physician testified to the improvement she has seen with the petitioner over the course of the past year in terms of his walking and core stability. The ABA therapist testified to her in-home play-based behavioral therapy that did not involve any PT services. His mother attempted to show that measurements were taken for her son's impairments, and indeed there were objective measurements made in August 2012 and in December 2012. This, however, was not done with respect to his status at the time of the PA request here. While I certainly understand that a mother would know when her child is doing better and, in this case, falling less, it is not the kind of information that works for MA reimbursement by a MA certified provider. This also relates to how his function might be affected by his maturation, motivation and behavioral therapies, which do not require the skills of a PT therapist. There is also still a lack of explanation as to why the HEP is not enough, or what is changing weekly with petitioner that would require a medically necessary weekly PT program.

Based upon the preponderance of the evidence in this record, I conclude that the provider has not justified the level of services requested. This is not to diminish the challenges petitioner faces and I do not doubt that petitioner benefits from the PT; however, under the documentation I have, it does support the level of therapy requested. I agree with the OIG that the 6 visits appear the most appropriate course under these MA rules with the documentation provided. The private PT provider can always submit a new or amended PA if the modified visits are not sufficient and has the documentation to support the request.

I add, assuming petitioner finds this decision unfair, that it is the long-standing position of the Division of Hearings & Appeals that the Division's hearing examiners lack the authority to render a decision on equitable arguments. See, Wisconsin Socialist Workers 1976 Campaign Committee v. McCann, 433 F.Supp. 540, 545 (E.D. Wis.1977). This office must limit its review to the law as set forth in statutes, federal regulations, and administrative code provisions.

### **CONCLUSIONS OF LAW**

The OIG correctly modified petitioner's PA request for PT.

**THEREFORE, it is**

**ORDERED**

That the petition for review herein be 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 14th day of October, 2013

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\sKelly Cochrane  
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 October 14, 2013.

Division of Health Care Access And Accountability