



STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

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

DECISION

MPA/154343

PRELIMINARY RECITALS

Pursuant to a petition filed December 19, 2013, under Wis. Stat. § 49.45(5), and Wis. Admin. Code § HA 3.03(1), to review a decision by the Office of the Inspector General (OIG) in regard to Medical Assistance (MA), a telephonic hearing was held on January 28, 2014, at Kenosha, Wisconsin.

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, Room 651
Madison, Wisconsin 53703

By: Pamela J. 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 Kenosha County and is certified for MA.

2. Petitioner is 4 years old and lives at home with her family. She is diagnosed with spina bifida, muscle weakness, and gait abnormality.
3. On September 5, 2013 the petitioner's private PT provider (TTT) submitted a PA request (PA# [REDACTED]) for petitioner to receive private PT twice weekly for 13 weeks. That PA was returned to the provider requesting further information to support the medical necessity of the requested services. The provider responded and also clarified that the request was for PT 1x/week for 26 weeks.
4. On November 12, 2013 the OIG issued a notice to petitioner indicating that it was modifying the PA request to 6 dates of service because it did not find the level of PT requested to be medically necessary.

DISCUSSION

Physical Therapy (PT) is covered by MA under DHS §107.16 of the Wisconsin Administrative Code. 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. Adm. Code, DHS §§107.02(3)(d) and §106.02(9)(e)1.

In this case the OIG modified the PA request because it determined that the *level* of PT requested was not medically necessary. The OIG’s position was that TTT did not provide objective measures of petitioner’s impairments to show a baseline or progress, and that the petitioner’s home exercise program (HEP) and PT at school (1x/wk) provide interventions to prevent, identify and treat her disability, and maintain her skills through routine and repetitive participation.

As to the measure of a baseline and progress, the agency is asking for the kinds of measurements one can get through manual muscle testing (MMT) and other like testing. Specifically, the agency argues that the provider has not documented that PT services are necessary to treat a weakened isolated muscle group condition nor documented that it is medically necessary to change the petitioner’s HEP on a weekly basis. The agency’s basis for this is founded upon the rules about when a PA will be approved, which state in relevant part:

e) *Extension of therapy services.* Extension of therapy services shall not be approved beyond the 35-day per spell of illness prior authorization threshold in any of the following circumstances:

1. The recipient has shown no progress toward meeting or maintaining established and measurable treatment goals over a 6-month period, or the recipient has shown no ability within 6 months to carry over abilities gained from treatment in a facility to the recipient's home;...

Wis. Adm. Code §DHS 107.16(3)(e)1(emphasis added). The agency also cites Wis. Adm. Code, DHS §101.03(96m)6, 7, 8 and 9, cited above.

Indeed, I must agree with the agency’s decision here. The TTT’s baselines for muscle strength are suggested, as one example, as “decreased strength”. With all due respect to the treating therapist’s determination that petitioner’s functional measurements show baselines for muscle strength, it cannot be determined from their information what the muscle strength is, or what muscle(s) needs strengthening, or

what an improvements were made in her muscle strength. This is why a baseline quantitative assessment is performed and subsequent assessments on the same or similar basis are necessary to demonstrate “progress”. This also would serve to show how *this* PT provider is benefitting petitioner, when she receives PT services at school, even if the service appears different. Without clinical information to identify petitioner’s gains or losses, the PA request is not supported. And while the provider argues that measuring baselines for such a young child is difficult, or even impossible, I do not see other providers having similar issues on a regular basis across the State, especially when this petitioner is consistently described as bright and motivated.

Finally, petitioner’s mother, who is an excellent advocate for her daughter, anecdotally described progress and regression for her. However, that still does not provide us with *measurable* limitations. Petitioner is essentially at the mercy of the provider who is required to justify the requested services.

Based upon my review of the record in this case, I must agree with the OIG’s decision to modify the PA. The basic assertion of the OIG has been the lack of evidence that would justify the medical need for continued PT services in a clinical/aquatic setting as requested. I agree that that information has not been presented. Therefore, I must conclude the requested PT in this case is not covered by the MA program. The OIG was therefore unable to approve the requested service.

I note for petitioner’s benefit that this is not a bar to submitting another PA request for PT or amending the current PA. The requesting provider will need to provide the basic documentation to support another request, however.

While petitioner may believe this to be unfair, 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 constitutional or 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 agency correctly modified petitioner’s PA request for PT.

THEREFORE, it is

ORDERED

That the petition for review herein 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, Room 651, 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 6th day of February, 2014

\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 February 6, 2014.

Division of Health Care Access and Accountability