



STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[REDACTED]
[REDACTED]
[REDACTED]

DECISION

MPA/154813

PRELIMINARY RECITALS

Pursuant to a petition filed January 16, 2014, 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 April 01, 2014, at Milwaukee, Wisconsin.

The issue for determination is whether a prior authorization request for a power wheel chair was correctly denied.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:

[REDACTED]
[REDACTED]
[REDACTED]

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, Wisconsin 53703

By: Mary Chucka, OTR

Division of Health Care Access and Accountability
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 Milwaukee County.
2. A prior authorization request (PA), dated November 29, 2013, was filed by Homestead Independence, Inc. It sought Medicaid program payment for a power wheelchair and various components and the total cost was noted to be \$18,402.50. The PA was, however, confusing in that it actually listed 2

power wheelchairs – a Quantum Q6 and a Bounder Plus. Documentation submitted with the PA opined that Petitioner did not qualify for the Bounder Plus and, in essence, indicated that funds equivalent to the cost of the Quantum Q6 were sought from the Medicaid program and that other funds would be sought to add to the Medicaid payment to permit purchase of the Bounder Plus.

3. Petitioner is a participant in the IRIS (Include, Respect, I Self direct) program.
4. Petitioner is diagnosed with Limb-girdle Muscular Dystrophy. His heart has compromised capacity and Petitioner is on a heart transplant list. He has lost his ability to ambulate.
5. This PA was denied because the PA did not follow standards necessary for consideration and Medicaid payment.

DISCUSSION

Power wheelchairs are a type of durable medical equipment that must be authorized by the Division of Health Care Access and Accountability before the medical assistance program will pay for it. *See Wis. Admin. Code § DHS 107.24*. When determining whether to approve any prior authorization, the Department of Health Services must consider the generic prior authorization review criteria listed at *Wis. Admin. Code, § DHS 107.02(3)(e)*. Those criteria are:

(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.

The Wisconsin Administrative Code does define the term ‘medical necessity’. It is a service that:

“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. HFS 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 Petitioner's burden to demonstrate that he qualified for the requested occupational therapy 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.

Here it became apparent during the course of the first scheduled hearing that the provider was seeking funding from the Medicaid program equivalent to the cost of the lower cost Quantum Q6 wheelchair and that Petitioner was told by a representative of the IRIS program that the IRIS program would cover the cost difference between the Quantum Q6 and the wheelchair Petitioner was really seeking – the Bounder Plus. The initial hearing was adjourned to see if coordination between fee for service Medicaid and the IRIS program really worked or was permitted as contemplated by this PA. Petitioner permitted me to contact the Department to learn more about this. The hearing was reconvened and the Department representative participated in the second hearing.

The Department reported that it had no request from IRIS for a power wheelchair for Petitioner – there is Department input on such purchase and funding. Further, the following Medicaid program law and policy is relevant here:

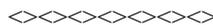
(2) CONTENT. (a) In the preparation of claims, the provider shall use, as applicable, diagnosis, place of service, type of service, procedure codes and other information specified by the department under s. DHS 108.02 (4) for identifying services billed on the claim. The department shall inform affected providers of the name and source of the designated diagnosis and procedure codes.

(b) Claims shall be submitted in accordance with the claims submission requirements, claim forms instructions and coding information provided by the department.

(c) Whether submitted directly by the provider, by the provider's billing service or by another agent of the provider, the truthfulness, completeness, timeliness and accuracy of any claim are the sole responsibility of the provider.

(d) Every claim submitted shall be signed by the provider or by the provider's authorized agent, certifying to the accuracy and completeness of the claim and that services billed on the claim are consistent with the requirements of chs. DHS 101 to 108 and the department's instructions issued under s. DHS 108.02 (4). For claims submitted by electronic media or electronic transmission, the provider agreement under sub. (1)(c) substitutes for the signature required by this paragraph for each claims submission.

Wis. Admin. Code, §DHS 106.03(2).



Wheelchairs and Accessories

Rental of manual wheelchairs after 60 days requires PA. The PA request must indicate that the need is of short-term duration. Rental of a wheelchair may be approved for a time period.

The following guidelines are used for requesting PA for a non-nursing home manual wheelchair and a non-nursing home power\motorized wheelchair:

- Document the specific brand and type with the components.
- Have a physician prescription.
- Documents the following (be as specific as possible):
 - Medical necessity.
 - Therapist evaluation and justification (if available).
 - Independent use or description of abilities.
 - Caregiver involvement.
 - Accessibility of the home (e.g., ramps, door ways, bathroom, halls, kitchen).
 - Means of transporting the wheelchair.
 - Specific activity involvement.

Provider handbooks, durable medical equipment, wheelchairs and wheelchair accessories at:
<https://www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Display/tabid/152/Default.aspx>

The bottom line is that a PA must specify the exact item for which fee for service Medicaid is sought. The ability of Wisconsin Medicaid to pay the difference between other insurance coverage and actual cost is quite limited.

Petitioner was advised to have his provider of choice resubmit a PA for the exact chair sought by and for Petitioner with the appropriate documentation.

CONCLUSIONS OF LAW

That the Medicaid program cannot provide funding for a power wheelchair for Petitioner in the manner requested here.

THEREFORE, it is

ORDERED

That this case 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 7th day of May, 2014

\sDavid D. Fleming
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 7, 2014.

Division of Health Care Access and Accountability