



STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[REDACTED]
[REDACTED]
[REDACTED]

DECISION

HMO/155561

PRELIMINARY RECITALS

Pursuant to a petition filed February 12, 2014, under Wis. Stat. § 49.45(5)(a), and Wis. Admin. Code § HA 3.03, to review a decision by the Department of Health Services in regard to Medical Assistance (MA), a hearing was held on March 18, 2014, at Waukesha, Wisconsin.

The issue for determination is whether the requested surgery is medically necessary.

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: Dr. Tina Mason, Medical Director for Community Connect Health Plan

ADMINISTRATIVE LAW JUDGE:

Kelly Cochrane
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner is a resident of Waukesha County who receives MA. She is a member of the Community Connect Health Plan HMO.
2. On behalf of the petitioner, Dr. Christopher King of Waukesha Memorial Hospital requested prior authorization to perform back surgery on petitioner (spinal fusion).
3. On October 11, 2013, the HMO informed petitioner that the requested authorization was denied. Petitioner filed a grievance. On January 7, 2014 the Department of Health Services notified petitioner that it upheld the denial. Petitioner filed for this appeal.

DISCUSSION

Under the discretion allowed by Wis. Stat., §49.45(9), the 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. Wis. Adm. Code, §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 department or appeal to the Division of Hearings and Appeals. Just as with regular MA, when the department denies a grievance from an HMO recipient, the recipient can appeal the department's denial within 45 days. Wis. Stat., §49.45(5), Wis. Adm. Code, §DHS 104.01(5)(a)3. That is what occurred here.

MA services are covered if they are medically necessary. A service, such as the back surgery here, is medically necessary if it is 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)(a) and (b).

The best evidence before me is that the surgery cannot be approved because according to the medical professionals, this surgery is *not* of proven medical value or usefulness for someone such as petitioner who has degenerative disc disease and that it is not consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability when there is no showing of her having spinal instability. The agency did not find that the medical studies on this surgery show that this surgery is ultimately helpful for her condition, and that in fact, such surgery can produce no results or worsen her symptoms. Petitioner did submit additional documentation which was again reviewed post-hearing by Dr. Mason, who appeared at the hearing. Dr. Mason reviewed that evidence and again found that petitioner not provide any new evidence that would call that conclusion into question. I thus will uphold the denial.

CONCLUSIONS OF LAW

1. The preponderance of the evidence does not show that the requested surgery is medically necessary.
2. The HMO correctly denied the prior authorization request for petitioner.

THEREFORE, it is

ORDERED

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 21st day of April, 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 April 21, 2014.

Division of Health Care Access and Accountability