



STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[REDACTED]

DECISION

MPA/156102

PRELIMINARY RECITALS

Pursuant to a petition filed March 13, 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 22, 2014, at Racine, Wisconsin.

The issue for determination is whether the Department correctly modified a prior authorization request for physical therapy from an evaluation and two visits per week for 26 weeks to an evaluation and 12 visits in 26 weeks.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:

[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:

David D. Fleming
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner is a resident of Racine County.
2. A prior authorization (PA) request seeking Wisconsin Medicaid program payment for physical therapy (PT) for Petitioner was filed with the Medicaid program on or about December 18, 2013. The request was for 52 sessions at a frequency of twice per week at a cost of \$28,294.20. The PA requested Medicaid payment for an evaluation, therapeutic exercises, gait training and neuromuscular reeducation.

3. The PA noted Finding # 2 was approved in part – the evaluation was approved as, ultimately, were 12 PT sessions for the 26 weeks.
4. Petitioner is 3 years old (04/21/2011). He lives in the community with his parents. His diagnoses as noted on the first page of the PA are muscle weakness and lack of coordination but the documentation also indicates diagnoses of congenital sucrose-isomaltase deficiency and congenital kyphosis. He also has the hypotonia, global muscle weakness especially in his legs and trunk muscles. He is unable to jump. He can go up and down the stairs using the railing. He walks and runs independently. He was fitted with a thoraco-lumbar-sacral-orthosis (Essentially a body jacket used for a variety of diagnoses, e.g., including post-operative protection, scoliosis, vertebral fractures, etc.) in late December 2013 and wears it more than 20 hours per day. Per the provider, while he is mobile, Petitioner is not at an age-appropriate level. Petitioner's parents do not have him enrolled in a birth to three program and because of his diagnoses do not want him in school until age 5 - 6.

DISCUSSION

When determining whether to approve therapy, the Department 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).

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 a Petitioner's burden to demonstrate that s/he qualified for the requested continued services 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. It is not enough to demonstrate a benefit; rather, all of the tests cited above must be met.

Both parties submitted fairly length written responses. See Exhibits 3 (Department) and 4 (Medical Support). They need not be reproduced in detail here. Briefly, the provider states that Petitioner is at the 2nd percentile on the Peabody Motor development Scale-II. Petitioner's provider notes that it provided PT at a frequency of twice per week from the time of the filing of this PA to the date of the filing for the hearing and points to the progress made. It is insistent that the skills of a private therapist are the reason for this. I note that the hearing process is to make a determination as to whether or not the decision made by the Department was the correct decision at the time it was made. Some documentation postdates the denial and appeal, e.g., the prescription from Petitioner's doctor dated March 31, 2014 (part of Exhibit # 4).

In a nutshell and in plain layman terms, the Department agrees that Petitioner has issues that require PT but maintains that strength, coordination and balance are developed and improved by practice and that this is achieved by repetition at home through play and parent supervised activity, e.g., repetitive going up and down stairs.

In essence, there are two different views or models for providing physical therapy presented by the parties. The provider maintains that intensive hands on therapy by a professional is necessary to establish, hone and maintain a particular movement so as to achieve, in this case, improved strength and coordination. The Department maintains that the skills of the professional are needed to establish a regimen of exercise to achieve certain goals but that it is the work done outside of therapy that achieves progress (and in this case perhaps with some affect from maturation).

I note again that Medicaid is a basic program meant to provide essential services, not every service that a person might or does benefit from. As such it is the Department model that is most appropriate and cost effective here. Twelve sessions of PT were authorized for the purpose of management of the home program by the provider. Depending on circumstances, the provider could always submit a prior authorization for additional session. While the provider has elected to provide more than authorized this does not mean that the parent have to pay for the services:

(c) Prior authorization of services. When a service must be authorized by the department in order to be covered, the recipient may not be held liable by the certified provider unless the prior authorization was denied by the department and the recipient was informed of the recipient's personal liability before provision of the service. In that case the recipient may request a fair hearing. Negligence on the part of the certified provider in the prior authorization process shall not result in recipient liability.

Wis. Admin. Code, DHS, §104.01(12)(c).

NOTE: Petitioner should be aware that Petitioner's provider will not receive a copy of this Decision. Petitioner's family may provide a copy to the provider.

CONCLUSIONS OF LAW

That the evidence does not demonstrate that the Department incorrectly approved a modified course of physical therapy for Petitioner.

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, 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 10th day of June, 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 June 10, 2014.

Division of Health Care Access and Accountability