



STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[REDACTED]
[REDACTED]
[REDACTED]

DECISION

HMO/157678

PRELIMINARY RECITALS

Pursuant to a petition filed May 13, 2014, under Wis. Stat. § 49.45(5)(a), and Wis. Admin. Code § HA 3.03, to review a decision by the Division of Health Care Access and Accountability in regard to Medical Assistance, a hearing was held on August 12, 2014, at Milwaukee, Wisconsin.

The issue for determination is whether iCare correctly modified Petitioner's request for Personal Care Worker (PCW) hours to one hour per day.

NOTE: At Petitioner's request, the record was held open to obtain medical records from an emergency room visit. Petitioner submitted the records on August 15, 2014. They have been marked as Exhibit 4 and entered into the record.

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: Meri DeGarmo, Nurse Consultant
iCare
1555 N. Rivercenter Drive
Suite 206
Milwaukee, WI 53212

ADMINISTRATIVE LAW JUDGE:

Mayumi M. Ishii
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner is a resident of Milwaukee County.
2. On October 15, 2013, Preferred Home Healthcare submitted a prior authorization request to iCare for personal care services, in the amount of 1620 units (405 hours), for the 26 week period of October 27, 2013 to April 24, 2014. (Exhibit 2, attachment 1, pg. 32) This works out to be a request for about 15.58 hours per week or 2.23 hour per day.
3. The October 15, 2013 prior authorization request was based upon a personal care screening tool (PCST) completed by Preferred Home Healthcare on September 12, 2013. (Exhibit 2, attachment 1, pgs. 35-40)
4. iCare approved 2.5 hours per week of personal care, pending an independent assessment. ([REDACTED])
5. iCare contracted with ANS Home Health (ANS) to conduct an independent assessment of Petitioner's needs and on January 10, 2014, ANS went to the Petitioner's home and completed another PCST. (Exhibit 2, attachment 1, pgs. 20-30)
6. At that time the Petitioner reported to ANS staff that she had chronic pain, but was able to complete activities of daily living independently. (Id.; testimony of Petitioner)
7. On February 13, 2014, iCare sent the Petitioner a letter indicating that effective February 28, 2014, she would no longer be receiving Personal Care Services. (Exhibit 2, attachment 1, pgs. 15-17)
8. The decision to deny/end personal care services was based upon the January 10, 2014 PCST completed by ANS. ([REDACTED])
9. On February 26, 2014, police took the Petitioner to the hospital for complaints of alcohol intoxication and possible drug overdose; Petitioner was reported to have said that she did not want to live anymore. (Exhibit 4)
10. On March 5, 2014, the Petitioner filed a grievance with iCare. (Exhibit 2, attachment 1, pg. 13)
11. On March 31, 2014, the iCare grievance committee determined that it was appropriate to approve one hour per day of personal care services. iCare sent Petitioner a notice of the committee's decision on that same date. (Exhibit 2, attachment 1, pgs. i-iii; Exhibit 2, attachment 3)
12. The Petitioner filed an appeal that was received by the Division of Hearings and Appeals on May 13, 2015. (Exhibit 1)

DISCUSSION

Under the discretion allowed by *Wis. Stat.*, §49.45(9), the Department of Health Services (DHS) requires MA (Medical Assistance) recipients to participate in HMOs. *Wis. Admin. 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. Admin. 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. Admin. Code*, §DHS 104.05(3) which states that HMO enrollees shall obtain services "paid for by MA" from the HMO's providers. The department must contract with the HMO concerning the specifics of the plan and coverage. *Wis. Admin. 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 DHS 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 DHS's denial within 45 days. *Wis. Stat.*, §49.45(5), *Wis. Admin. Code*, § DHS 104.01(5)(a)3.

When determining whether to approve any service, the HMO, as with the Division of Health Care Access and Accountability (DHCAA), 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)

For any prior authorization request to be approved, the Medicaid recipient must show that the requested service satisfies the generic prior authorization criteria listed above. At their core, those criteria include the requirement that the service be medically necessary. *Id.*

In determining how many hours of personal care services an individual is allowed, a service provider, in this case, Preferred Home Health and ANS Home Health, completes a personal care screening tool (PCST). A link to the blank form can be found in the on-line provider handbook located on the Forward Health website: <https://www.forwardhealth.wi.gov/WIPortal>, under topic number 3165.

The responses are then cross-references with the Personal Care Activity Time Allocation Table, which is a guideline showing the maximum allowable time for each activity. *On-Line Provider Handbook Topic #3165*. This chart can also be found at the aforementioned website. A copy of the table was also attached to Exhibit 2, attachment 2).

In general seven activities of daily living (ADLs) are reviewed: 1) Bathing, 2) Dressing, 3) Grooming, 4) Eating, 5) Mobility, 6) Toileting, and 7) Transfers. In addition, Medically Oriented Tasks (MOTs), such as are also examined.

In the case at hand, [REDACTED] does not dispute the fact that she told ANS Home Health staff that she could safely complete all of the aforementioned activities of daily living, despite her chronic pain. However, [REDACTED] testified that she exaggerated her abilities when speaking to ANS Home Health staff and that on her worst days, she needs assistance with bathing, dressing, grooming, mobility and transfers. The Petitioner also asserts that after her emergency room visit in February 2014, the discharging physician indicated that she required medication assistance, because she was hospitalized for a suicide attempt in which she attempted to overdose on her medications.

Exhibit 4 does confirm that the Petitioner was taken to the emergency room for alcohol intoxication, drug overdose and suicidal ideation, but it does not contain a physician's order for medication assistance. It further indicates that when asked by hospital staff, the Petitioner denied abusing her medications, even though the number of pills left in the bottles indicated that she took more medication than prescribed.

Looking at the record, it is clear that the Petitioner is not a reliable self-reporter and that, in the future, any PCST should be completed with her family or personal care worker present and that her medical records should also be reviewed, to verify the accuracy of the information in the PCST.

At this time, the only other medical documentation in the record are some physician's notes from a doctor's appointed on September 26, 2014, which indicates that at that time, despite her osteoarthritis, the Petitioner had full range of motion in both of her upper extremities and lower extremities and that her strength was good. (Exhibit 2, attachment 1, pgs. 55-56) That same record also indicates that the Petitioner was advised to exercise, with no limitations. (*Id.*)

The September 26, 2014 physician's notes contradict the assertions made in the original request for prior authorization of PCW services submitted by Preferred Home Healthcare. Further, those physician's notes support the grievance committee's determination that the Petitioner does not generally need personal care worker services, but might need help on occasion. As such, the grievance committee's determination that one hour of services per day is allowable for acute episodes of pain, will not be changed.

The Petitioner indicated that she will be having surgery in October and will need further assistance while she recovers. If that is the case, Petitioner can have Community Home Health Care complete a new PCST and submit a new prior authorization request for additional services.

CONCLUSIONS OF LAW

iCare correctly modified the Petitioner's request for personal care service hours to 1 hour per day.

THEREFORE, it is ORDERED

That the petition 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 11th day of September, 2014

\sMayumi M. Ishii
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 September 11, 2014.

iCare
Division of Health Care Access and Accountability