



STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[REDACTED]
[REDACTED]
[REDACTED]

DECISION

MPA/159239

PRELIMINARY RECITALS

Pursuant to a petition filed July 21, 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, now known as the Office of Inspector General (OIG) in regard to Medical Assistance (MA), a telephonic hearing was held on August 14, 2014. The record was held open for 14 days to allow petitioner the opportunity to submit medical documentation to the Administrative Law Judge (ALJ). Nothing was received within that time.

The issue for determination is whether the OIG correctly denied payment for a computed tomography (CT) for petitioner.

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: written submittal of Robert Derendinger
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 Racine County.

2. On June 13, 2014 Dr. Richard █████ submitted a prior authorization (PA) request for petitioner's CT completed on October 10, 2013.
3. On June 13, 2014 MedSolutions returned the PA to Dr. █████'s office requesting clinical information to support the PA request. No information was received by MedSolutions from Dr. █████.
4. On June 16, 2014 the Department of Health Services issued a notice to petitioner advising her that the PA request was denied because the documentation submitted by the provider did not support the medical necessity of the service.

DISCUSSION

Physician-prescribed diagnostic services can be covered by MA, if they are consistent with good medical practice. Wis. Admin Code §§DHS 107.06(1) and 107.25. The OIG has made payment of CT scans subject to prior authorization (PA), in an effort to determine if they are being ordered consistent with good medical practice. This PA requirement was announced to providers in an *MA Update*, #2010-92, issued to all providers in October, 2010.

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;

...

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

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. DHS §107.02(3)(d)6, Wis. Admin. Code; see also, DHS §106.02(9)(e)1, Wis. Admin. Code.

As an MA-certified provider, providers who request the MA program to reimburse for their services are required, by law, to completely and accurately complete the prior authorizations which they submit. Not every medical provider can submit a PA to the MA program to request reimbursement. Only those providers who have been certified to provide MA-reimbursable services are allowed to submit a PA. One of the reasons these medical providers are “certified” is to assure they are kept up to date on changes in the MA program and the prior authorization process. MA-certified providers are expected to know the rules and policies controlling the prior authorization process and the completion of the prior authorization forms.

The instant prior authorization request was denied because the provider did not provide any clinical information to support the request. There was nothing provided with the PA, and nothing in response to the direct request for that information. Given the lack of evidence that the OIG’s agent had to work with at the time of decision, that denial decision was correct. The record was held open in this matter to allow petitioner the opportunity to get the clinical information from her provider. Again, nothing was provided. Because no information is available to review whether or not the CT was ordered consistent with good medical practice and in conformance with national clinical guidelines for such imaging, the denial will be upheld.

I add, assuming petitioner finds this decision unfair, that 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 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 OIG correctly denied petitioner’s PA request for CT because the PA request did not support the medical necessity of the PA request.

THEREFORE, it is

ORDERED

The petition for review herein be and the same is hereby 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 9th day of September, 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 September 9, 2014.

Division of Health Care Access and Accountability