



FH

**STATE OF WISCONSIN
Division of Hearings and Appeals**

In the Matter of

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

DECISION

MPA/160437

PRELIMINARY RECITALS

Pursuant to a petition filed September 04, 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 May 14, 2015, at Kenosha, Wisconsin.

The issue for determination is whether evidence has been submitted that is sufficient to demonstrate that sufficient to demonstrate that the Medicaid program should provide payment for a hip orthosis.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Respondent:

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

By: Mary Chucka

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 Kenosha County.
2. A prior authorization request (PA), dated June 23, 2014, was filed by [REDACTED] seeking payment for a hip abduction orthosis at a cost of \$2581.00. The PA indicates that it is a SWASH [sitting, walking, standing hip] hip orthotic that was prescribed.

3. Petitioner is 12 years of age ([REDACTED]). She suffered a traumatic brain injury in a motor vehicle accident. She has tight hip abductors and spasticity. She walks with a scissors gait and narrow base of support.
4. This PA was denied. The reasons for the denial were that the provider had not demonstrated that the request met standards necessary for approval.

DISCUSSION

The DHS may only reimburse providers for medically necessary and appropriate health care services and equipment listed in Wis. Stat. §§ 49.46(2) and 49.47(6)(a), as implemented by Wis. Admin. Code, Ch. DHS 107. Some services and equipment require submission and approval of a written prior authorization request by the provider. Some services and equipment are never covered. Occupational therapy is a service that requires approval of a request for prior authorization. *See, generally, Wis. Admin. Code, § DHS 107.17.* A PA is required after 35 lifetime OT sessions. *Wis. Admin. Code, § DHS, 107.17(2)(a).*

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.

The Department's position is detailed in the September 30, 2014 letter contained in the record as Exhibit # 3. I am not reproducing the letter here but, in brief, as I understand it, the documentation submitted with the PA does not indicate a problem with range of motion so the requested orthotic is not warranted for ROM. Indeed, the provider indicated that Petitioner participates in other activities, walking, standing, biking, swimming and horseback riding and receives Botox injections. These all provide range of motion exercise. The Department also notes that an attachment to Petitioner's gait trainer is a less expensive alternative to prevent scissoring. Finally, Petitioner's physician indicates that the SWASH will prevent deformity but the rationale for that statement is not apparent. Additional information was submitted to the Department just prior to the last hearing date but the Department did not find that it changed the analysis here.

I am sustaining the denial. There are two broad reasons. First, there are no detailed countervailing medical arguments to the positions asserted by the Department in letter of September 30, 2014. Range of motion is not documented to be an issue, 'scissoring' can be improved via less expensive options and the evidence is not convincing as to deformity prevention. Second, there have been a number of reschedules in this case and so much time has passed that it is not clear that Petitioner has not changed physically to a point where the SWASH is still what Petitioner might need to address deficits. A new PA may certainly be submitted but I suggest that Petitioner's father give copies of the Department letters to Petitioner's providers and any future PA be more comprehensive and reasoned.

CONCLUSIONS OF LAW

That the available evidence is not sufficient to demonstrate that the requested hip orthotic meets standards required for Medicaid payment.

THEREFORE, it is

ORDERED

That this appeal is dismissed.

REQUEST FOR A REHEARING

You may request a rehearing if you think this decision is based on a serious mistake in the facts or the law or if you have found new evidence that would change the decision. Your request must be **received within 20 days after the date of this decision**. Late requests cannot be granted.

Send your request for rehearing in writing to the Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400 **and** to those identified in this decision as "PARTIES IN INTEREST." Your rehearing request must explain what mistake the Administrative Law Judge made and

why it is important or you must describe your new evidence and explain why you did not have it at your first hearing. If your request does not explain these things, it will be denied.

The process for requesting a rehearing may be found at Wis. Stat. § 227.49. A copy of the statutes may be found online or 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 filed with the Court **and** served either personally or by certified mail on the Secretary of the Department of Health Services, 1 West Wilson Street, Room 651, Madison, Wisconsin 53703, **and** on those identified in this decision as “PARTIES IN INTEREST” **no more than 30 days after the date of this decision** or 30 days after a denial of a timely rehearing (if you request one).

The process for Circuit Court Appeals may be found at Wis. Stat. §§ 227.52 and 227.53. A copy of the statutes may be found online or at your local library or courthouse.

Given under my hand at the City of Milwaukee,
Wisconsin, this 5th day of June, 2015

\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 5, 2015.

Division of Health Care Access and Accountability