



STATE OF WISCONSIN  
Division of Hearings and Appeals

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In the Matter of

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

DECISION

FCP/163756

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**PRELIMINARY RECITALS**

Pursuant to a petition filed February 04, 2015, under Wis. Admin. Code § DHS 10.55, to review a decision by the Community Care Inc. in regard to Medical Assistance, a hearing was held on June 09, 2015, at Sheboygan, Wisconsin.

The issue for determination is whether Community Care, Inc. (Community Care) correctly denied supportive home care services for Petitioner, for the period of August 9, 2014 through September 24, 2014.

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: Heather Neuman, Family Care Supervisor  
Community Care Inc.  
205 Bishops Way  
Brookfield, WI 53005

**ADMINISTRATIVE LAW JUDGE:**

Mayumi M. Ishii  
Division of Hearings and Appeals

**FINDINGS OF FACT**

1. Petitioner is a resident of Sheboygan County.

2. Petitioner suffers from Parkinson's disease and requires assistance with walking at all times. (Exhibit 3)
3. Petitioner also suffers from GERD, swallowing issues, a hernia, coronary artery disease, high blood pressure, arthritis, osteoporosis and back pain / degenerative joint disease of the spine. (Exhibit 3)
4. Petitioner requires assistance with all activities of daily living and all instrumental activities of daily living. (Exhibit 3)
5. Petitioner was previously approved to receive 10-10.5 hours of supportive home care services per day. Her husband provided informal supports during the remaining 14 hours per day. (Exhibits 2-3)
6. Petitioner's husband had a stroke on August 9, 2014 and went into a hospital. He did not return home until September 24, 2014. (Testimony of [REDACTED], petitioner's son and authorized rep.)
7. On August 14, 2014, [REDACTED] contacted Community Care to let them know about his father's stroke. (Testimony of [REDACTED]; Ms. Julia Johnson, Family Care Case Manager; Exhibits 2 and 9)
8. On August 21, 2014, September 23, 2014 and again on September 26, 2014, [REDACTED] contacted Community Care, asking for placement options and expressing concerns about his mother's need for assistance. (Exhibit 9)
9. After returning home from his hospitalization / rehabilitation on September 24, 2014, Petitioner's husband was no longer able to care for her, so Community Care increased the Petitioner's supportive home care services to 22.5 hours per week. (Testimony of [REDACTED] and Ms. Julia Johnson)
10. On September 26, 2014, Community Care completed a Resource Allocation Tool (RAD tool) and concluded that the most cost-effective means of meeting the Petitioner's desired outcomes was to continue Supportive Home Care Services at home, with an increase in time for overnight hours. (Exhibit 5)
11. On September 26, 2014, Community Care completed another RAD and again concluded that it would be most cost-effective to keep the Petitioner at home, with an increase in Supportive Home Care Services for overnight hours. (Exhibit 6)
12. Petitioner paid, out-of-pocket, for additional supportive home care services that she needed while her husband was in the hospital / rehabilitation facility. (Testimony of [REDACTED]; Exhibits 10 and 11)
13. On October 1, 2014, Petitioner requested reimbursement/coverage for the cost of the additional supportive home care services needed while Petitioner's husband was in the hospital/rehabilitation. (Exhibit 8)
14. October 14, 2014, Community Care completed a RAD and concluded that it would have been more cost-effective for the Petitioner to go into an adult family home, rather than receive an increase in supportive home care services, during her husband's hospitalization. (Exhibit 8)
15. On October 14, 2014, Community Care sent the Petitioner a Notice of Action, advising her that her request for reimbursement was denied, as not being cost-effective and because she did not receive prior authorization for those services. (Exhibit 8)
16. On an unspecified date the Petitioner filed an appeal with Community Care's Grievance and Appeal Committee. (Exhibit 1)

17. On December 22, 2014, the Grievance and Appeal Committee upheld the denial, stating that the Petitioner could not be reimbursed for the services, because she did not receive prior authorization for the services. (Exhibit 1)
18. The Petitioner filed an appeal that was received by the Division of Hearings and Appeals on February 4, 2015. (Exhibit 1)

### DISCUSSION

The Family Care Program is a subprogram of Wisconsin's Medical Assistance (MA) program and is intended to allow families to arrange for long-term community-based health care and support services for older or impaired family members without resort to institutionalization, *Wis. Stats.* §46.286; *Wis. Admin. Code* §DHS 10.11. It is, in short, a long-term care benefit for the elderly, people with physical disabilities and those with developmental disabilities. *Medicaid Eligibility Handbook (MEH)*, §29.1.

An individual, who meets the functional and financial requirements for Family Care, participates in Family Care by enrolling with a Care Management Organization (CMO) / Managed Care Organization (MCO), which, in turn, works with the participant and his/her family to develop an individualized plan of care. *See Wis. Stats.* §46.286(1) and *Wis. Admin. Code* §DHS 10.41. The CMO / MCO, in this case Community Care, implements the plan by contracting with one or more service providers.

Wis. Admin. Code DHS 10.41(2) states that:

Services provided under the family care benefit shall be determined through individual assessment of enrollee needs and values and detailed in an individual service plan unique to each enrollee. As appropriate to its target population and as specified in the department's contract, each CMO shall have available at least the services and support items covered under the home and community-based waivers under 42 USC 1396n (c) and ss. 46.275, 46.277 and 46.278, Stats., the long-term support community options program under s. 46.27, Stats., and specified services and support items under the state's plan for medical assistance. In addition, a CMO may provide other services that substitute for or augment the specified services if these services are cost-effective and meet the needs of enrollees as identified through the individual assessment and service plan.

*Emphasis added*

The aforementioned administrative code further notes that personal care and supportive home care services are among the services that typically will be required to be available. *Id.*

It is a well-established principle that a moving party generally has the burden of proof, especially in administrative proceedings. *State v. Hanson*, 295 N.W.2d 209, 98 Wis. 2d 80 (Wis. App. 1980). In a case involving the reduction of services, the agency bears the burden to prove it correctly reduced the services. In cases involving the request for new or additional services, the Petitioner bears the burden of proof.

In the case at hand, it is undisputed that Petitioner needed additional assistance with personal care / supportive home care tasks when her husband went into the hospital unexpectedly on August 9, 2014. Petitioner's family contacted Petitioner's provider and asked them to meet that additional need. Until Community Care completed a RAD on September 26, 2014, approving an increase in services to 22.5 hours per day, the Petitioner was being billed for those additional services. The Petitioner's family would like coverage/reimbursement for the additional supportive home care services that she needed between August 9, 2014 and September 25, 2014.

It is the position of Community Care that it would have been more cost-effective to put the Petitioner in an Adult Family Home (AFH). Strictly in terms of dollars, it might have been cheaper to put the Petitioner in an AFH. The AFH cost \$172.29 per day for residential respite care, but supportive home care services were billed at \$20 to \$23 per hour. (See Exhibits 10, 11 and 12) However, the RADs completed in September 2014, determined that the most appropriate and cost-effective means of meeting the Petitioner's needs and desired outcomes would be to keep the Petitioner at home; allow her to continue with her current supportive home care provider and increase her supportive home care services, to include time for overnight cares. As such, Community Care cannot now claim that placement in an AFH would have been the more appropriate, cost-effective option.

Community Care also asserts that it cannot reimburse the Petitioner for the cost of the additional supportive home care services she received during her husband's unexpected hospitalization, because Petitioner did not receive prior authorization for the services. At the hearing, Community Care could not cite the specific law or policy to which it referred. In Exhibit 1, the Grievance and Appeal committee cited to Wis. Admin. Code §DHS 10.44(2)-(3) as authority for its proposition, but there is no language in those code provisions that supports the claim that a request for services must have prior authorization.

Post hearing, the agency submitted Exhibit 12, in which it attached a copy of Wis. Admin. Code DHS Chapter 107. However, that chapter describes services covered by fee-for-service Medicaid, not Family Care. Further, in the 2014 Family Care Programs Contract<sup>1</sup>, it states in Addendum X, paragraph B that, "MCOs will determine which services require prior authorization and use the member-centered planning process to define the service limitations, rather than using the requirements of Wis. Admin. Code § DHS 107." As such, Wis. Admin. Code DHS Chapter 107 doesn't really apply here.

Community Care has not provided a copy of any published policy manuals or guidelines showing that it requires prior authorization of supportive home care services in emergent situations. As such, its claim that it cannot cover the requested services without prior authorization is unsupported by the record.

Even if Chapter 107 did apply, the prior authorization requirement would likely be waived. Under topic #429 of the on-line provider handbook it states:

### **Emergency Services**

**In emergency situations, the PA requirement may be waived** for services that normally require PA. Emergency services are defined in DHS 101.03(52), Wis. Admin. Code, as "those services which are necessary to prevent the death or serious impairment of the health of the individual."

Reimbursement is not guaranteed for services that normally require PA that are provided in emergency situations. As with all covered services, emergency services must meet all program requirements, including medical necessity, to be reimbursed by Wisconsin Medicaid. For example, reimbursement is contingent on, but not limited to, eligibility of the member, the circumstances of the emergency, and the medical necessity of the services provided.

*Emphasis added*

An emergent situation arose, because the Petitioner's husband, who provided cares 14 hours per day, had a stroke and was suddenly unable to care for her. Given that Petitioner needs assistance with all activities of daily living, it is reasonable to conclude the Petitioner's family needed to make immediate arrangements for their mother's care in order to prevent serious impairment to her health.

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<sup>1</sup> The 2015 Family Care contract can be found on-line at: <http://mltc.wisconsin.gov/2014/>

Looking at Article VII of the 2014 Family Care Contract, it does state under paragraph B:

1. *Comprehensive Service Delivery System*

The MCO will provide members with high-quality long-term care and health care services that:

- a. Are from appropriate and qualified providers;
- b. Are fair and safe;
- c. Serve to maintain community connections, including integrated employment, and that are cost effective.

Services are delivered through a comprehensive interdisciplinary health and social services delivery system appropriate to the benefit package pursuant to this contract and any applicable state and federal regulations.

One must question whether it is “fair” to deny coverage of a service that is part of the benefit package and has been deemed a cost-effective means of achieving petitioner’s desired outcomes. This is particularly puzzling when one considers that the need for the additional services arose during an emergent / urgent situation in which the patient’s primary caregiver was unexpectedly hospitalized and the patient’s family contacted the MCO at least three times with concerns about the Petitioner’s need for care.

It should be noted that under Article VII, paragraph J of the 2014 Family Care Contract it states, “The MCO is responsible for items and services in the benefit package that are needed to support the member’s individual long term care outcomes. **The MCO and its providers are strictly prohibited from billing members for such services.**”

As such, Community Care is obligated, under the terms of the Family Care contract, to pay for services in the benefit package that support a member’s long term care outcomes.

After Petitioner’s husband returned from the hospital/rehabilitation and was deemed unable to care for the Petitioner, Community Care determined that a total of 22.5 hours per day of supportive home care services was needed and a cost-effective means of meeting the Petitioner’s long term care outcomes. As such, Community Care is obligated to pay for those services, during the time the Petitioner’s husband was in the hospital / rehabilitation, from August 8, 2014 through September 24, 2014.

**CONCLUSIONS OF LAW**

Community Care incorrectly denied supportive home care services for Petitioner, for the period of August 9, 2014 through September 25, 2014.

**THEREFORE, it is ORDERED**

That Community Care authorize reimbursement for supportive home care services, up to 22.5 hours per day, for the period of August 9, 2014 through September 25, 2014. Community Care shall take all steps necessary to complete this task within ten days of this decision.

**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 7th day of July, 2015.

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\sMayumi M. Ishii  
Administrative Law Judge  
Division of Hearings and Appeals



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The preceding decision was sent to the following parties on July 7, 2015.

Community Care Inc.  
Office of Family Care Expansion