



STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of



DECISION

FCP/165147

PRELIMINARY RECITALS

Pursuant to a petition filed April 02, 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 April 21, 2015, at Waukesha, Wisconsin.

The issue for determination is whether the agency properly denied the Petitioner’s request for massage therapy.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:



Respondent:

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

By: Julie Doll

Community Care Inc.
205 Bishops Way
Brookfield, WI 53005

ADMINISTRATIVE LAW JUDGE:

Debra Bursinger
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # ) is a resident of Waukesha County. Petitioner is enrolled in the FC program.
2. Petitioner’s primary diagnoses include quadriplegic cerebral palsy, scoliosis and left hip dislocation. She also has contractures in both hand and chronic pain issues in all joints. She has

painful edema in her feet. She experiences chronic pain from her medical conditions. She uses a power wheelchair for mobility and an adaptive back/seating system. A lift is used for all transfers. She has poor trunk control/support. Petitioner is dependent on a caregiver for all activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Petitioner takes narcotic analgesics for chronic pain.

3. On November 6, 2014, the Petitioner made a request to her FC agency for massage therapy.
4. On November 13, 2014, the agency issued a Notice of Action to the Petitioner informing her that it was denying her request for massage therapy.
5. The Petitioner received skilled therapy services through [REDACTED] from July through December, 2014. As part of the therapy, she received deep tissue massage. When the Petitioner was discharged from therapy in December, 2014, Petitioner's caregiver received instruction regarding a home exercise program. The caregiver is not a trained or certified therapist. The agency increased the Petitioner's PCW hours to accommodate the home exercise program.
6. Petitioner currently pays privately for deep tissue massage therapy once/week for 1 ½ hours. Petitioner gets pain relief from the therapy.
7. On January 14, 2014, the agency did a home visit. The Petitioner again requested message therapy. The agency used the Resource Allocation Decision (RAD) tool in assessing the Petitioner's request. On January 16, 2015, the agency denied the Petitioner's request.
8. The agency's appeal committee reviewed the agency's determination. On March 18, 2015, the MCO upheld the agency determination. On March 20, 2015, the agency issued a notice to the Petitioner informing her of the agency's determination.
9. Petitioner's identified long-term care outcome includes remaining as independent as possible and living in her own apartment.
10. On April 2, 2015, the Petitioner filed an appeal with the Division of Hearings and Appeals.

DISCUSSION

The Family Care Program (FCP), which is supervised by the Department of Health and Family Services, is designed to provide appropriate long-term care services for elderly or disabled adults. Medicaid Eligibility Handbook (MEH), §29.1. It is authorized under Wisconsin Statutes, §46.286, and is described comprehensively in the Wisconsin Administrative Code at Chapter DHS 10. The program is operated and administered in each county by a Care Management Organization (CMO), which in this case is Community Care, Inc. Though FCP enrollees are full partners in the assessment of needs and strengths and in the development of care plans those plans are subject to the general requirements and limitations outlined for the program, including the requirement that a service be cost-effective compared to alternative services or supports that could meet the same needs and achieve similar outcomes. Wis. Admin. Code, §§ DHS 10.44(2)(e) & (f). Medical assistance and its subprograms are meant to provide only basic and necessary health care.

The state code language on the scope of permissible services for the FC reads as follows:

DHS 10.41 Family care services. ...

(2) SERVICES. 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, Stat., the long-term support 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.

Note: The services that typically will be required to be available include adaptive aids; adult day care; assessment and case planning; case management; communication aids and interpreter services; counseling and therapeutic resources; daily living skills training; day services and treatment; home health services; home modification; home delivered and congregate meal services; nursing services; nursing home services, including care in an intermediate care facility for the mentally retarded or in an institution for mental diseases; personal care services; personal emergency response system services; prevocational services; protective payment and guardianship services; residential services in an RCAC, CBRF or AFH; respite care; durable medical equipment and specialized medical supplies; outpatient speech; physical and occupational therapy; supported employment; supportive home care; transportation services; mental health and alcohol or other drug abuse services; and community support program services.

In the FCP, a case management organization (CMO) must develop an Individual Service Plan (ISP) in partnership with the client. Wis. Admin. Code, §DHS 10.44(2)(f). The ISP must reasonably and effectively address all of the client's long-term needs and outcomes to assist the client to be as self-reliant and autonomous as possible, but nevertheless must be cost effective. While the client has input, the CMO does not have to provide all services the client desires if there are less expensive alternatives to achieve the same results. Wis. Admin. Code, §DHS 10.44(2)(f); DHS booklet, Being a Full Partner in Family Care, page 9.

When determining whether medical assistance regulations require the CMO to provide a specific service, the CMO must consider, among other things, the medical necessity of the service, the appropriateness of the service, the cost of the service, the extent to which less expensive alternative services are available, and whether the service is an effective and appropriate use of available services. Wis. Adm. Code § HFS 107.02(3)(e)1.,2.,3.,6. and 7. "Medically necessary" means a medical assistance service under ch. HFS 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.

Physical therapy, including massage therapy, is a Medicaid covered service and a service that is included in the FC benefit package. See Wis. Admin. Code § DHS 107.16(1)(d)6.e.; ForwardHealth FC Handbook, Topics #4717 and 2535. The ForwardHealth handbook indicates that physical therapy is included in the FC benefit package and is covered for all settings except inpatient facilities or when provided by a physician.

See

<https://www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Display/tabid/152/Default.aspx?ia=1&p=4&sa=&s=2&c=61&nt=Services+Included+and+Not+Included+in+Family+Care+and+Family+Care+Partnership+Benefit+Packages;>

and

<https://www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Display/tabid/152/Default.aspx?ia=1&p=4&sa=&s=2&c=61&nt=Medicaid+Services+Included+in+the+Family+Care+Benefit+Package.>

In this case, the CMO used the Resource Allocation Decision (RAD) Tool to make its decision. The RAD process involves input from inter-disciplinary team members and the participant to make decisions regarding a participant's request for services.

The CMO denied the Petitioner's request for massage therapy finding that she does not need the service to support her outcome and that her outcome is already being supporting in another way. Specifically, the agency asserts that the home exercise program that was developed by the physical therapist and taught to the Petitioner's caregiver includes massage therapy and that this is sufficient to support the Petitioner's outcome. The CMO also asserts that massage therapy is part of the benefit package only if it is administered within a traditional therapy setting such as a PT agency and is not part of the package if done in the home. The agency also notes that it approved additional time in the Petitioner's service plan to allow the caregiver to provide the therapy. In addition, the agency testified that the physical therapist believed he had maximized the Petitioner's massage therapy service and that it was appropriate to have maintenance therapy done by a caregiver at home. Further, the agency determined that there is scientific evidence that benefits of massage therapy are limited.

The Petitioner and her caregiver testified at the hearing. The caregiver testified that she was provided only 10 minutes of instruction by the physical therapist. She testified that she is not otherwise trained or certified to provide massage therapy and is not comfortable providing such therapy to the Petitioner. She noted at the hearing that the Petitioner has complex medical conditions and that she is afraid of injuring the Petitioner or doing the therapy in a way that will not benefit the Petitioner. The caregiver also testified that she does not feel full body massage is a part of a caregiver's job duties.

The Petitioner testified that massage therapy should be done by a trained and certified massage therapist for her to get the proper benefit and to be sure it is done properly. She noted that the regulations and the CMO's own clinical guidelines state that massage therapy should only be used with a licensed massage

therapist. She testified that massage decreases her pain and her need for pain medications for several days after the massage. The decreased pain and usage of pain meds help her to meet her outcome to remain independent in her home.

I conclude that the CMO has not met its burden to demonstrate that it properly denied this service to the Petitioner. The agency presented no evidence with regard to the type and amount of training provided by the physical therapist to the caregiver and did not present the home exercise plan that was developed. The regulations at Wis. Admin. Code § DHS 107.16(1)(a) indicate that therapy should be done by a trained therapist and the CMO's own clinical guidelines state explicitly that massage therapy should only be used with a licensed massage therapist. It is acceptable for a therapist to develop a home exercise program to be done by caregivers at home but the agency presented no evidence of the home exercise plan in this case and how it is an acceptable alternative for the Petitioner to meet her outcomes. Specifically, the agency's testimony regarding the therapist's conclusions are all hearsay. No reports from the therapist or progress notes were presented to support the testimony.

In addition, the agency presented no evidence to support its assertion that massage therapy is only covered when performed in a clinical setting. The regulations and policies cited above suggest that it is part of the benefit package and covered in all settings except inpatient hospital.

Finally, with regard to the benefits of massage therapy, it is a service that is specifically covered under the regulations. The Medicaid agency has already determined that it is an acceptable and covered treatment for certain individuals and the CMO may not deny services that are specified as part of the FC benefit package based on an argument that they are experimental or of overall limited benefit. It may deny such a service asserting that it is not medically necessary for a specific individual but may not deny the service asserting that it is of overall limited benefit, as the CMO did here.

The CMO does not dispute that massage therapy helps to reduce the Petitioner's chronic pain and contractures.

The Petitioner has demonstrated that her complex medical conditions make massage therapy a medically necessary service. She has cerebral palsy, contractures and chronic pain in all joints. Massage therapy helps to reduce her pain and reliance on pain medications and therefore helps to support her outcome to remain independent in her apartment for as long as possible. The agency did not present evidence that is sufficient to demonstrate that a home exercise program by an untrained caregiver is an acceptable alternative to massage therapy by a trained physical therapist. Therefore, I conclude that the Petitioner is eligible to receive the requested massage therapy by a physical therapist once/week.

CONCLUSIONS OF LAW

Petitioner is eligible to receive massage therapy once/week by a trained physical therapist.

THEREFORE, it is

ORDERED

That the matter is remanded to the agency to take all administrative steps necessary to rescind its denial of the requested massage therapy and to allow the request massage therapy for the Petitioner once/week retroactive to the date of the Petitioner's request. These actions shall be completed within 10 days of the date 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 24th day of June, 2015

\sDebra Bursinger
Administrative Law Judge
Division of Hearings and Appeals



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The preceding decision was sent to the following parties on June 24, 2015.

Community Care Inc.
Office of Family Care Expansion