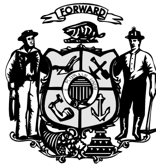

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STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

DECISION
Case #: HMO - 209818

PRELIMINARY RECITALS

Pursuant to a petition filed on August 11, 2023, under Wis. Stat. § 49.45(5)(a), and Wis. Admin. Code § HA 3.03, to review a decision by the Division of Medicaid Services regarding Medical Assistance (MA), a hearing was held on December 6, 2023, by telephone.

The issue for determination is whether the DMS correctly denied a prior authorization (PA) request submitted on Petitioner's behalf for implantation of a percutaneous peripheral nerve stimulator (PNS).

There appeared at that time the following persons:

PARTIES IN INTEREST:

Petitioner:

k

Petitioner's Representative:

Abdul Awyusuf
Spr Care
7225 Northland Dr. N
Ste 320
Brooklyn Park, MN 55430

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, WI 53703
By: Michelle Rocca
Division of Medicaid Services
PO Box 309
Madison, WI 53701-0309

ADMINISTRATIVE LAW JUDGE:

Nicole Bjork
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner is a resident of Winnebago County. Her diagnoses include cluneal neuropathy and back pain.

2. On May 11, 2023, Petitioner's provider submitted a PA request on Petitioner's behalf for implantation of a percutaneous peripheral nerve stimulator (PNS).

3. On May 23, 2023, [redacted] sent a letter to Petitioner and her provider notifying them that the PA request for the PNS had been denied. Petitioner appealed that denial to [redacted]'s internal panel.

4. On June 27, 2023, an appeals panel hearing was held. Petitioner's medical records were reviewed, which noted that previous interventions have included sacroiliac injections, paraspinal lumbar steroid injections, epidural steroid injections, diagnostic para lumbosacral lateral branch block, and a trigger point injection. Chiropractic therapy had provided some benefit in the past, but Petitioner was not in a structured physical therapy program at that time. Petitioner's most recent back exam showed full ROM with pain on extension and facet joint tenderness to palpation with positive facet loading maneuvers. An MRI on 8/15/2022 showed a widely patent central canal, no greater than mild-moderate neural foraminal stenosis, and no greater than mild degenerative disc disease. The panel voted to uphold the denial.

5. Petitioner then filed an appeal with the Division of Hearings and Appeals. Petitioner testified at hearing that her chronic pain affects her quality of life.

DISCUSSION

Under the discretion allowed by Wis. Stat. § 49.45(9), the agency now requires MA recipients to participate in HMOs. Wis. Adm. 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. Adm. Code § DHS 104.05(3). The criteria for approval by a managed care program contracted with the agency are the same as the general MA criteria. See Wis. Adm. Code, § DHS 104.05(3), which states that HMO enrollees shall obtain services "paid for by MA" from the HMO's providers. The agency must contract with the HMO concerning the specifics of the plan and coverage. See Wis. Adm. 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 or appeal to the Division of Hearings and Appeals. Just as with regular MA, when the agency denies a grievance from an HMO recipient, the recipient can appeal the agency's denial. Wis. Stat., § 49.45(5); Admin. Code, § DHS 104.01(5)(a)3. The petitioner has exercised those rights.

The issue in this case is whether or not the HMO was correct in denying Petitioner's PA request for a PNS. As explained in the notice of denial, agency's summary letter, and at hearing, the PA was denied because Petitioner did not meet the criteria for those services. Specifically, the HMO must determine whether the PA is medically necessary. Medically necessary is a term defined at Wis. Adm. Code § DHS 101.03(96m) and provides:

> **(96m)** "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.

For Petitioner, the issue really relates to #5 above. The HMO and DHS reviewed the medical literature for the requested service. The HMO's policy *"Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation: Policy Number: CS036.R: Effective Date: December 1, 2022,* was used in making the initial denial decision, and the updated version (*CS036.S, effective January 1, 2023)* in the subsequent appeal panel. The HMO found that the requested service was unproven and not medically necessary due to insufficient evidence of efficacy. The HMO referenced multiple research studies but determined that although some studies suggest "that PNS may be a promising treatment in the future, the small sample size, lack of randomization, lack of control groups, inclusion of observational studies, and short duration of follow-up in these numerous studies provide insufficient evidence to determine long-term safety and efficacy as compared to conventional treatment approaches for chronic low back pain." Id. Because they found that these studies had not fully addressed the potential long-term safety and efficacy or had adequately demonstrated that PNS had superiority over more established and conventional treatment approaches, the HMO denied the PA. The HMO's Chief Medical Officer testified as to the consideration of that policy as well as DHS's requirement that a service not be experimental in nature in denying the request. The agency's doctor also reviewed the HMO's determination and the medical literature on the service. See Exhibit 2. The agency noted that their review confirmed there was not enough published evidence to show that PNS is effective in the treatment of chronic back pain and therefore does not meet the definition of medical necessity; thus the agency had no basis with which to overturn the HMO's denial. Using evidence based and peer reviewed medical literature, which was reviewed by at least two physicians, the agency determined that the PNS has yet to be of proven benefit in the long term and is therefore still considered experimental.

Petitioner's representative testified that Petitioner has undergone multiple therapies and that there are no more effective or more conservative options available. Petitioner's representative argued that without access to a non-permanent PNS, Petitioner may advance to more invasive, expensive, and permanent treatment options like spinal cord stimulation or surgery, with the potential for significant risk. He also argued that there was a procedure code available for PNS. However, the agency's physician representative explained that procedure code (#64555) is an "umbrella" code that can cover several different technologies but does not guarantee coverage as a determination of medical necessity must still be made. The agency found no reason to change their determination of medical necessity for the PNS.

PNS is not specifically listed as a covered service by the MA program. Therefore, a medical provider must convince the agency through its professional medical staff that the service should be covered and meets the definition of medically necessary. That has not occurred here. In the end, PNS appears promising but the evidence is not there to support funding it through MA when it has yet to have proven medical usefulness as an established standard of care in the medical community. Accordingly, I must uphold the denial. If Petitioner develops better evidence, her provider can always submit a new PA request.

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. In other words, I cannot change the outcome based on a fairness argument.

CONCLUSIONS OF LAW

The Petitioner's HMO correctly denied petitioner's PA request for a PNS because it did not meet the criteria for medical necessity.

THEREFORE, it is ORDERED

The petition for review herein 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, 4822 Madison Yards Way, 5th Floor North, 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

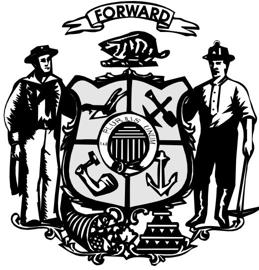
You may also appeal this decision to Circuit Court in the county where you live. Appeals must be filed with the Court **and** served either personally or by certified mail on the Secretary of the Department of Health Services, 1 West Wilson Street, Room 651, **and** on those identified in this decision 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 11th day of January, 2024

\s_________________________________
Nicole Bjork
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 January 11, 2024.

Division of Medicaid Services
sprcare@sprintpns.com