DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P.O. BOX 309
MADISON WI 53701-0309

(608) 266-8922
FAX: (608) 266-1096
www.dhfs.state.wi.us

Tommy G. Thompson
Governor

Joe Leean
Secretary

State of Wisconsin

Department of Health and Family Services

March 6, 2000

Mr. Ken Czaplewski
St. Rose Residence, Inc.
3801 North 88 Street
Milwaukee, WI 53222

Dear Mr.Czaplewski:

Thank you for contacting the Division of Health Care Financing (DHCF) regarding your questions about the letter you received concerning prior authorization of therapy services for children residing in your CCIs.

For the past several years DHCF staff have held a number of meetings and had conversations with representatives of CCIs, therapy providers, the Wisconsin Association of Family and Children Agencies (WAFCA) and the Department of Public Instruction (DPI). DHCF staff also visited several CCIs to observe services provided and to discuss Medicaid reimbursement and prior authorization issues with their staff and therapy providers. The DHCF agreed to review the issues raised and share the results of that review with CCIs and their providers. The letter you received was to inform you of those results.

The intent of the previous letter was to clarify for you and your therapy provider(s) that Prior Authorization (PA) requests for CCI residents will be adjudicated consistent with the guidelines applied to requests for therapy services to all children throughout the state. In the past there have been issues about the submission of the Individual Educational Plan (IEP) and the treatment plan developed by staff of the CCI. Prior Authorization requests must include sufficient information to assure that the review criteria are met. DHCF is requiring that your therapy providers submit the IEP and the facility treatment plan. Similar documentation is required of providers for all other therapy requests for children.

It was anticipated that there would be limited impact of this clarification, since only three (3) of the approximate fifty-two (52) licensed CCIs currently submit prior authorization requests for therapy services. However, in response to concerns that have been raised the DHCF has extended the date of this notice to May 1, 2000.

Services previously approved through the PA process will continue to be effective until the end date as stated on the PA. Therapy providers may continue to submit prior

authorization requests for therapy services to children residing in CCIs. If the PA request is determined to meet the review criteria of medically necessary as defined in Wisconsin Administrative Code HFS 101.03(96m) and all other applicable criteria listed in HFS 107 the PA request will be approved and may be reimbursed by the Wisconsin Medicaid Program (WMAP).

If you or your therapy provider have other questions or concerns please contact Barbara Evans, at the Bureau of Health Care Program Integrity at (608) 261-7783 or by writing to her at P.O. Box 309, Madison, WI 53701-0309.

Sincerely,

Alan S. White, Director
Bureau of Health Care Program Integrity
Division of Health Care Financing

Cc: Jean Fahl
Team Rehab
9450 N. 107th Street
Milwaukee, WI 53224-1106

State of Wisconsin
Department of Health and Family Services

Tommy G. Thompson, Governor
Joe Leean, Secretary

March 21, 2000

Beth Grossmeyer
Lad Lake Inc.
Dousman, WI 53118

Dear Ms. Grossmeyer:

Thank you for your letter to Governor Thompson regarding Medicaid coverage of therapy services for children in Child Caring Institutions (CCIs). Your concerns were forwarded to the Department of Health and Family Services, the agency that administers Wisconsin Medicaid.

The letters from Peggy Bartels and Alan White that you referenced were the result of considerable discussion and communication with CCI administrators and therapy providers. Those discussions revealed that 3 of the 52 licensed CCIs in the state were providing therapy services through contractual arrangements with community providers. Their letters did not indicate that Medicaid would no longer pay for therapy services provided to those residents, but that approval of those services would be based on the same standards used to review requests for all other children in the Medicaid program. Those standards are required to assure coordination of services, to avoid duplication of services, and to determine if the skills of a therapist are necessary.

At the request of Representative Steven Foti, Medicaid staff met with therapy providers to discuss the prior authorization process and assess the impact of applying the statewide standard to CCI-related services. At that meeting, Medicaid staff agreed to delay the effective date of the January 24, 2000, letter to May 2000, to provide the CCIs additional transition time.

Thank you, again, for your inquiry.

Sincerely,

Richard W. Lorang
Deputy Secretary

cc: Governor Tommy G. Thompson

ST. ROSE
RESIDENCE
INCORPORATED
3801 NORTH 88TH STREET
MILWAUKEE, WISCONSIN 53222
(414) 466-9450
FAX (414) 466-0730

LICENSED RESIDENTIAL TREATMENT CENTER • DAY EDUCATION/TREATMENT SERVICES • CERTIFIED OUTPATIENT CLINIC

March 1, 2000

Representative Steven M. Foti
Wisconsin State Assembly
P.O. Box 8952
Madison, Wisconsin 53708

Dear Representive Foti:

I am very concerned about the recent decision by the Division of Health Care Financing to categorically eliminate prior authorizations for Occupational Therapy and Speech and Language Services for children and adolescents in child caring institutions.

It appears that the Division of Health Care Financing suggests that these services should be part of the cost and rate structure of the child caring institution.

The problem with that solution is that we are only allowed by the State to charge one rate to all purchasers and counties. Not all of our residents are in need of these services. Generally, about 70% of our residents are prescribed Occupational Therapy and 25% are prescribed Speech and Language services.

As you can see, if we incorporated these services into our rate structure, the rate for residents who would not need these services would be inflated. I do not believe this is a good business decision, to charge residents for services that are not needed. I believe the current system is the most equitable and fair.

The Division of Health Care Financing seems to have an agenda to reduce their costs even if it impacts negatively on children in care. I think this is wrong and poor public policy.

Thank you for your concern.

Sincerely,

Kenneth Czaplewski
President

KC:gc

Tommy G. Thompson
Governor

Joe Leean
Secretary

DIVISION OF HEALTH CARE FINANCING

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State of Wisconsin

Department of Health and Family Services

March 3, 2000

The Honorable Steven M. Foti
Wisconsin State Assembly
P.O. Box 8952
Madison, WI 53708

Dear Representative Foti:

Thank you for facilitating the meeting with you and your staff, Representative Vrakas's staff, your constituents and staff of the Division of Health Care Financing. We appreciate the leadership and direction you provided in attempting to resolve the issues and concerns raised.

At the meeting DHCF agreed to: (1) extend until May 1, 2000 the application of adjudication notice, (2) review criteria for therapy PAs submitted for children residing in CCIs which is currently applied to all therapy requests for children, (3) investigate the possibility of CCIs obtaining School Based Services reimbursement and (4) develop additional information to assist the therapy providers submitting prior authorization services for the CCI children.

We have already notified the CCI administrators of the extension and have begun to work toward meeting our other commitments. We will keep you apprised of further discussions on the issues as seems appropriate.

If we can be of further assistance to you please feel free to contact me at (608) 266-7436. Thank you, again for your efforts and understanding.

Sincerely,

Alan White, Director
Bureau of Health Care Program Integrity

Cc: John Kiesow
Kevin Lewis
Peggy Bartels

Tommy G. Thompson
Governor

Joe Leean
Secretary

DIVISION OF HEALTH CARE FINANCING

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State of Wisconsin

Department of Health and Family Services

April 14 2000

The Honorable Steven M. Foti
Wisconsin State Assembly
P.O. Box 8952
Madison WI 53708

Dear Representative Foti:

As a follow-up to our March meeting in your office, we wanted to give you an update on our activities.

As we agreed at the meeting, we have developed and attached to this letter a copy of the informational sheet developed to assist therapy providers for recipients residing in CCI's.

As we also agreed, and indicated to you in a previous letter, the involved CCIs and their therapy provider organizations were notified immediately following our meeting of the agreement to extend the application of adjudication notice until May 1, 2000. As we have stated previously, and re-stated in our attached cover letter to therapy providers, these requirements are the same requirements that apply to therapy providers submitting Prior Authorization requests for all children between the ages of 3 – 21.

In addition, as we agreed, Department of Health & Family Services (DHFS) staff are exploring CCI funding mechanisms as a part of the DHFS Biennial Budget proposal.

We believe that we have fulfilled all of the commitments made during the meeting in your office. However, we will continue to work with state therapy providers on this and other issues to ensure that Medicaid recipients receive medially necessary services in a timely and cost-efficient manner.

Thank you again, for your facilitation in helping us address the concerns of the parties involved. If we can be of further assistance to you please feel free to contact me at (608) 266-7436.

Sincerely,

Alan White, Director
Bureau of Health Care Program Integrity

cc: John Kiesow
Kevin Lewis
Peggy Bartels

Tommy G. Thompson
Governor

Joe Leean
Secretary

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State of Wisconsin

Department of Health and Family Services

April 14, 2000

Jean Fahl
Team Rehab, Inc
9450 N. 107th Street
Milwaukee, WI 53224-1106

Dear Ms. Fahl:

As agreed at the meeting with Representative Foti enclosed is a copy of the documentation requirements to be submitted with Prior Authorization Requests for Medicaid recipients residing in Child Caring Institutions (CCI). These are documentation requirements that are required of other Medicaid providers for children throughout the state.

The Prior Authorization Request Form and the Prior Authorization Therapy Attachment are required for therapy requests submitted for all Medicaid recipients. The Individualized Education Program (IEP) is required for all therapy requests submitted for recipients between the ages of three (3) and twenty-one (21). The facility treatment plan including the goals and objectives of other service areas are required for recipients in other residential settings such as Intermediate Care Facilities.

If you have further questions regarding documentation requirements please feel free to contact Barbara Evans at (608) 261-7783 or by writing to her at 1 West Wilson Street, PO Box 309, Madison, WI 53701-0309.

Sincerely,

Alan S. White, Director
Bureau of Health Care Program Integrity

Cc: Ken Czaplewski
St. Rose Residence, Inc
3801 North 88 Street
Milwaukee, WI 53222

Dennis Neuenfeldt
Lad Lake
P.O. Box 158
Dousman, WI 53118

John G.Guay
St. Aemilian-Lakeside, Inc
8901 West Capitol Drive
Milwaukee, WI 53222-1798

ST. ROSE
RESIDENCE
INCORPORATED
3801 NORTH 88TH STREET
MILWAUKEE, WISCONSIN 53222
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February 29, 2000

Re: Speech and Occupational Therapy Services for Mentally Ill Children and Adolescents

To Whom It May Concern:

I have thirty years of experience in the field of child and adolescent psychiatry. I am Clinical Professor of Psychiatry at the Medical College of Wisconsin and Director of Child Adolescent Psychiatry at the Medical College. I have been a consultant at St. Rose Residence for thirty years.

I am concerned about lack of funding for what I consider absolutely essential services for disturbed adolescent and child patients. We may be glib and articulate as adults, however, children are in the state of becoming and their primary mode of communicating is through action. This is developmentally normal and is taught in any child development course. It is well known that children and adolescents, though they may have some speech, communicate primarily through acting in one of four ways:

1. They act up because they don't have the means at their disposal of communicating thoughts and feelings as we adults do.

2. They experiment with new behavior.

3. They test limits through their actions.

4. They act out conflict.

While emotionally unbalanced adults may regress or may have not progressed to a more verbal world, the need for action as a form of self-expression is synonymous with childhood and adolescence.

A principal concern with these disturbed children and adolescence is that they have most often been raised in an environment in which people have not attempted to help them control themselves, let alone develop ways of appropriate mastery of anger, assertion etc. for whatever reason the adults have not been sensitive to these developmental needs. Consequently, the use of occupational therapy and speech and language therapy are the cornerstones of our work. It is so critically essential that the Joint Commission on Accreditation of Hospital makes the use of

speech and language therapy and occupational therapy essential for accreditation for any treatment facility.

I do consider the withholding of funding for treatment for these children and adolescents in the area of occupational therapy and speech and language therapy to amount to child neglect and would not hesitate to report this to State and Federal agencies in this context.

All of the girls at St. Rose carry a psychiatric diagnosis. All psychiatric problems are medical. Occupational therapy and Speech/Language therapy are medically necessary for the treatment of these medical disorders.

Anthony D. Meyer, M.D.
Child Psychiatrist

ADM:gc

Mount Mary College

2900 North
Menomonee River
Parkway
Milwaukee, WI
53222-4545

(414) 258-4810

March 1, 2000

Mr. Allan White
Director, Bureau of Health Care
Program Integrity
Madison, Wisconsin 53701

Dear Mr. White,

I am writing in support of occupational therapy programming at facilities as St. Rose Residence and St. Aemilian's-Lakeside in Milwaukee and Lad Lake in Dousman.

I have worked as an occupational therapist for over thirty years and value the psychosocial occupational therapy programming provided by the therapists at these facilities. I have visited all three centers in my role as an occupational therapy student fieldwork supervisor. The high quality of therapy provided at these centers is an excellent model for students and the therapists have been supportive of student learning.

Occupational therapy treatment at these centers has been geared to individual children. Following evaluation, goals are set to help children develop or improve their skills and learn new ways to interact effectively in their environment in areas of work, play and self care. At the above centers, the occupational therapists have worked as team members using their skills to help the children return to the community. The therapists have worked effectively with children with a variety of disorders and provided excellent psychosoical intervention.

I strongly support the need for occupational therapy services at St. Rose Residence, St. Aemilian-Lakeside and Lad Lake. The occupational therapists are skilled in meeting the needs of the children at these centers. Mount Mary College values the therapist's skills and the excellent therapy provided at these centers is a model for our students.

Thank you for your time and support of occupational therapy and the residents at these centers.

Sincerely yours,

Diana Bartels

Diana Bartels, MS, OTR
Associate Professor
Occupational Therapy

State of Wisconsin
Department of Health and Family Services

Tommy G. Thompson, Governor
Joe Leean, Secretary

April 28, 2000

Jean Fahl
Director of Operations
Team Rehab, Inc.
9450 N. 107th Street, Suite B
Milwaukee, WI 53224

Dear Ms. Fahl:

Thank you for your letter regarding Medicaid coverage for occupational therapy (OT), physical therapy (PT), and speech therapy (ST) services for children residing in Child Caring Institutions (CCIs).

As we previously explained in a letter to you and in the meeting with Representative Steven Foti, Medicaid coverage for OT, PT and ST services for children residing in CCIs has not ceased. As we indicated, Prior Authorization (PA) therapy requests for residents in CCIs will be adjudicated in the same manner as requests for therapy services to all children throughout the state.

For the past several years, Division of Health Care Financing (DHCF) staff have held a number of meetings and conversations with representatives of CCIs, therapy providers, the Wisconsin Association of Family and Children Agencies (WAFCA), and the Department of Public Instruction (DPI). DHCF staff also visited several CCIs to observe services provided and to discuss Medicaid reimbursement and PA issues with their staff and therapy providers. As we stated at that time, Medicaid's professional consultants are required by Wisconsin Administrative Code to consider 12 review criteria as outlined in HFS 107.03(3)(e) when adjudicating PA requests. Our intent to apply these criteria consistently across all therapy requests was conveyed in our correspondence and meetings addressing these issues.

Therapy providers may continue to submit PA requests for therapy services to children residing in CCIs. However, realizing the difficulty that a few providers are having in understanding the above criteria, we will closely review each PA submitted for residents of these CCIs, and will continue to provide technical assistance to the providers in preparing and submitting their requests. If a PA request is determined to meet the review criteria of medically necessary, as defined in Wisconsin Administrative Code HFS 101.03(96m) and all other applicable criteria listed in HFS 107, the PA request will be approved and may be reimbursed by the Wisconsin Medicaid program. Currently we are not aware of any provision in statute or administrative code that would authorize us to treat PAs submitted for children in

these CCIs any differently than we would treat a PA submitted for any other child in the state. It is not our intention to deprive individuals of medically necessary services, rather it is a part of our mission to ensure that those services are provided in a cost-effective and cost-appropriate manner.

Thank you, again, for allowing us to address your concern about services to the children of Wisconsin.

Sincerely,

Joe Leean
Secretary

cc: Governor Tommy G. Thompson
Senator Brian Burke
Senator Peggy A. Rosenzweig
Representative Steven Foti
Representative David Cullen
Representative Daniel Vrakas
Representative Peter Block
Representative Mark Gundrum
Peggy L. Bartels, Administrator, DHCF
Susan Dreyfus, Administrator, DCFS
Barbara Evans, DHCF/BHCPI
Martha Rasmus, CEO, Mental Health Association of Milwaukee County
Dennis Nuenfeldt, Treatment Director, Lad Lake
Ken Czaplewski, Administrator, St. Rose Residence
John Guay, Administrator, St. Aemilian-Lakeside
Richard MacNally, Administrator, Oconomowoc Developmental Training Center
Claudia Meyer
Beth Grossmeyer
Georgia Meyer

State of Wisconsin
Department of Health and Family Services

Tommy G. Thompson, Governor
Joe Leean, Secretary

April 28, 2000

Claudia Meyer
c/o St. Rose Residence
3801 N. 88th Street
Milwaukee, WI 53222

Dear Ms. Meyer:

Thank you for your letter to Governor Thompson regarding Medicaid coverage of therapy services for children in Child Caring Institutions (CCIs). Your concerns were forwarded to the Department of Health and Family Services, the agency that administers Wisconsin Medicaid.

The letter from the Division of Health Care Financing that you referenced was the result of considerable discussion and communication with CCI administrators and therapy providers. This letter did not indicate that Medicaid would no longer pay for therapy services provided to those residents, but that approval of those services would be based on the same standards used to review requests for all other children in the Medicaid program. Those standards are required to assure coordination of services, to avoid duplication of services and to determine if the skills of a therapist are necessary.

At the request of Representative Steven Foti, Medicaid staff met with therapy providers to discuss the prior authorization process and assess the impact of applying the statewide standard to CCI-related services. At that meeting, Medicaid staff agreed to delay the effective date of the January 24, 2000, letter to May 2000 to provide CCIs additional transition time.

Since that time, Medicaid staff have agreed to review each prior authorization request on an individual basis rather than establishing a blanket implementation date. You will soon be receiving a letter from the Wisconsin Medicaid program regarding this change.

Thank you, again, for your inquiry.

Sincerely,

John Kiesow
Executive Assistant

cc: Governor Tommy G. Thompson

May 1, 2000

Representative Foti

Statements have been made in the correspondence that has been exchanged between the Department of Health Care Financing and parties interested in the issue of Medicaid recipients in Wisconsin Child Care Institutions receiving Occupational and Speech therapy services reimbursed by the Medicaid program that have suggested that the providers in the CCIs have received preferential treatment in adjudication and authorization for the provision of occupational and speech therapy services for their patients. We do not feel that the recipients in CCIs have been treated preferentially or equitably in comparison with their age related peers receiving medically based services in the schools.

The School Based Benefit was established to financially assist the public schools in meeting the medical needs of Medicaid recipients attending school. Surely the intent of the benefit was not to preclude or make it more difficult for the Medicaid recipient children requiring medical attention through residential placement in CCIs to obtain the same services. The CCIs treat children who have been unable to function in traditional school settings because of their psychiatric, emotional and/or behavioral disorders and who require physician directed occupational and/or speech therapy services to assist them in their treatment programs.

The table below illustrates the different requirements that Medicaid providers in the CCIs and Medicaid providers reimbursed through School Based Benefits are held to for reimbursement of therapy services. The table includes comparison of the prior authorization review process, the documentation requirements and the interpretation of "medical necessity."

Please contact me at 414-355-7157 with any questions or concerns.

Sincerely,

Jean M. Fahl

CHILD CARE INSTITUTIONS	SCHOOL BASED BENEFIT
1. **Prior Authorization required**- sent to DHCF reviewers (with all documentation listed below) for adjudication. 2. **Documentation to be submitted to DHCF with Medicaid Prior Authorization Requests:** • Prior authorization request form (PA/RF) • Prior authorization therapy attachment (PA/TA). This is a form that includes the following information: • Recipient History and Therapy History. A summary of the recipient's history of placement in residential programs including dates; services provided; treatment interventions and results/outcomes of interventions. • Evaluation. A complete and comprehensive therapy evaluation of the recipient including a baseline for established limitations. The reviewing consultant may request photocopies of the evaluation form(s) or score sheet(s). • Progress. The goals and interventions must identify specific, measurable change in the recipient's skills that are related to the established limitations and baselines. Progress must be solely related to the interventions of the therapist. • Plan of Care. Documentation must include specific, measurable, objective goals related to established limitations and baselines and ongoing coordination of services with other service/care providers.	**No prior authorization required**—no review process per Wisconsin Medicaid Provider Handbook Part X School Based Services.

3. **Additional required documents:** • Individualized Educational Plan (IEP). • Facility treatment plan with goals and objectives of other services such as social work, nursing, psychotherapy, recreational therapy, etc. • The daily, weekly and monthly schedule of the resident's programs.	
4. **Medical Necessity:** • Physician' s order required with review and recertification of Plan of Care every 90 days. • required to meet the definition stated in the Wisconsin Administrative code HSS 101.03 (96m). (Conditions have not been defined specifically for CCI recipients).	**Medical Necessity:** Physician's order required annually. Required to meet the definition stated in the Wisconsin Administrative code HSS 101.03 (96m). Per the Wisconsin Medicaid Provider Handbook Part X SBS the service is considered medically necessary when the service meets the following conditions: • identifies, treats, manages, or addresses a medical problem, or a mental, emotional or physical disability; • is identifies in a school district's or CESA's Individualized Educational; Program (IEP) or Individualized Family Service Program (IFSP) for the child; • is necessary for a child to benefit from special education; and • is referred or prescribed by a physician.

Tommy G. Thompson
Governor

Joe Leean
Secretary

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State of Wisconsin

Department of Health and Family Services

April 14, 2000

Jean Fahl
Team Rehab, Inc
9450 N. 107th Street
Milwaukee, WI 53224-1106

Dear Ms. Fahl:

As agreed at the meeting with Representative Foti enclosed is a copy of the documentation requirements to be submitted with Prior Authorization Requests for Medicaid recipients residing in Child Caring Institutions (CCI). These are documentation requirements that are required of other Medicaid providers for children throughout the state.

The Prior Authorization Request Form and the Prior Authorization Therapy Attachment are required for therapy requests submitted for all Medicaid recipients. The Individualized Education Program (IEP) is required for all therapy requests submitted for recipients between the ages of three (3) and twenty-one (21). The facility treatment plan including the goals and objectives of other service areas are required for recipients in other residential settings such as Intermediate Care Facilities.

If you have further questions regarding documentation requirements please feel free to contact Barbara Evans at (608) 261-7783 or by writing to her at 1 West Wilson Street, PO Box 309, Madison, WI 53701-0309.

Sincerely,

Alan S. White, Director
Bureau of Health Care Program Integrity

Cc: Ken Czaplewski
St.Rose Residence, Inc
3801 North 88 Street
Milwaukee, WI 53222

Dennis Neuenfeldt
Lad Lake
P.O. Box 158
Dousman, WI 53118

John G.Guay
St. Aemilian-Lakeside, Inc
8901 West Capitol Drive
Milwaukee, WI 53222-1798

Documentation to be submitted with Medicaid Prior Authorization Requests for Recipients in CCI's.

1. **Prior Authorization Request Form (PA/RF)**

2. **Prior Authorization Therapy Attachment (PA/TA)**
   Documentation on the PA/TA (or attached documents) must support the requested service is medically necessary according to HFS 101.03(96m), within the professional scope and standards of practice, require the skills of a therapist to implement the procedure, and is not duplicative of other services provided to the recipient.

   The PA/TA includes headings to outline the required information. Providers may either write on the form or attach a report with the required information. The PA/TA subheadings and documentation expectations are described below.

   - Recipient History and Therapy History.

   A summary of the recipient's history of placement in residential programs including dates; services provided; treatment interventions and results/outcomes of interventions

   - Evaluation.

   A complete and comprehensive therapy evaluation of the recipient including a baseline for established limitations. Photocopies of the evaluation form(s) or score sheet(s) may be submitted by the provider or requested by the reviewing consultant.

   - Progress

   The goals and interventions must identify specific, measurable change in the recipient's skills that are related to the established limitations and baselines. Progress must be solely related to the interventions of the therapist.

   - Plan of Care

   Documentation must include specific, measurable, objective goals related to established limitations and baselines and ongoing coordination of services with other service/care providers.

3. **Required Documents**

The following documents must be attached to the PA.

- Individualized Education Plan (IEP) or a written statement as to why there is no IEP. (If you have difficulty obtaining IEPs contact Mr. Elliot Wymann at the Department of Public Instruction.)

Documentation to be submitted with Medicaid Prior Authorization Requests for Recipients in CCI's.

1. **Prior Authorization Request Form (PA/RF)**

2. **Prior Authorization Therapy Attachment (PA/TA)**
Documentation on the PA/TA (or attached documents) must support the requested service is medically necessary according to HFS 101.03(96m), within the professional scope and standards of practice, require the skills of a therapist to implement the procedure, and is not duplicative of other services provided to the recipient.

The PA/TA includes headings to outline the required information. Providers may either write on the form or attach a report with the required information. The PA/TA subheadings and documentation expectations are described below.

- Recipient History and Therapy History.

A summary of the recipient's history of placement in residential programs including dates; services provided; treatment interventions and results/outcomes of interventions

- Evaluation.

A complete and comprehensive therapy evaluation of the recipient including a baseline for established limitations. Photocopies of the evaluation form(s) or score sheet(s) may be submitted by the provider or requested by the reviewing consultant.

- Progress

The goals and interventions must identify specific, measurable change in the recipient's skills that are related to the established limitations and baselines. Progress must be solely related to the interventions of the therapist.

- Plan of Care

Documentation must include specific, measurable, objective goals related to established limitations and baselines and ongoing coordination of services with other service/care providers.

3. **Required Documents**
The following documents must be attached to the PA.

- Individualized Education Plan (IEP) or a written statement as to why there is no IEP. (If you have difficulty obtaining IEPs contact Mr. Elliot Wymann at the Department of Public Instruction.)

- The treatment plan from the facility with goals and objectives of other services such as social work, nursing, psychotherapy, recreational therapy, etc.

- The schedule of the resident's programs (daily, weekly or monthly).

Documentation of services requested through the PA process is unique to the needs of the individual recipient for whom the request is made. For this reason, we have included the following list of questions the providing therapist may wish review before submitting their PA request.

1). Have I described in sufficient detail how my skills as a therapist are required to assist the recipient in meeting his/her treatment goals? For example: If the child has a diagnosis of conduct disorder what information is identified, based on the therapy evaluation, that was not previously identified or addressed in the facility plan.

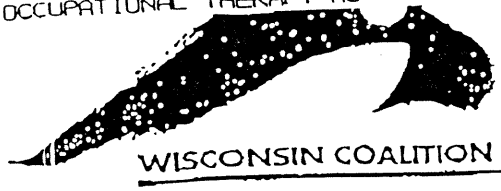
2). Have I described why the skills of a therapist are needed to implement the procedures and/or treatment interventions? For example, if the recipient is significantly delayed or impaired in a functional area does my documentation that this delay or deficit is due to a medical condition. If so have I shown that the therapy intervention is required to prevent, identify or treat the cause or is of proven medical value or usefulness in relation to that cause?

3). Have I clearly defined the functional outcomes to be achieved and the specific deficits it relates to an identified condition/diagnosis? Are the functional outcomes, as well as the underlying limitations, objectively measured in the initial evaluation and subsequent progress reports?

4). Have I described adequately how the interventions employed are treatment and not educational in nature?

5). Have I described in sufficient detail the treatment history and the potential for progress as it relates to the identified deficit, esp. when there is a long history of interventions addressing the same areas of need? Am I able to document improvement in the identified deficit which is carried over to circumstances other than the therapy session group and directly attributable to the therapy interventions?

6). Have I described how the therapy interventions and treatment goals differ from and are not duplicative of those of other service providers?



WISCONSIN COALITION FOR ADVOCACY

THE PROTECTION AND ADVOCACY SYSTEM FOR PEOPLE WITH DISABILITIES

June 5, 2000

Mr. Michael Kruley
Regional Manager
Department of Health and Human Services
Office of Civil Rights
Region V
233 Michigan Av., Ste. 240
Chicago, IL 60601

Dear Mr. Kruley:

We are making this complaint against the State of Wisconsin and the Department of Health and Family Services (DHFS) concerning systematic denial and/or delay in receipt of benefits to eligible medicaid recipients. We believe that these denials constitute a pattern or practice of discrimination against people with disabilities in violation of Title XIX of the Social Security Act, 42 U.S.C. §1396, *et seq.*, Title II of the Americans with Disabilities Act, 42 U.S.C. §§12132, *et seq.*, and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §794, *et seq.* We request that you investigate these allegations.

The Wisconsin Coalition for Advocacy is the designated protection and advocacy agency for people with disabilities in Wisconsin pursuant to 42 USC §§6041-6043; 42 USC §§10801-10841; 42 U.S.C. §794(e) and Sec. 51.62, Wis. Stats. WCA engages in systems as well as individual advocacy and representation. We are concerned about Wisconsin's practices and policies in the administration of medicaid programs that discriminate against people with disabilities. We are making this complaint on behalf of all people with disabilities and their families who are medicaid eligible and are being denied access to services by Wisconsin through the DHFS.

Wisconsin requires medicaid-eligible recipients to receive prior authorization for certain services, including speech therapy, physical therapy, occupational therapy, durable medical equipment, personal care and home health care. Through the use of prior authorizations, Wisconsin has improperly delayed, decreased and denied services to medicaid-eligible recipients. These actions include:

- sharp reductions or modifications in the amount of service,
- long delays of crucial services while approval is pending, often due to returns for more information being sent again and again to providers,
- denials for those seeking approval of therapies that will not result in "progress",

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but rather prevent regression or deterioration, and denial of therapies provided in the community in preference to school-based services.

When services are approved, recipients often find that the number of times a therapy is to be provided has been sharply reduced. For example, a recipient's physical therapy authorized for 12 weeks is reduced from 3 times a week to 1 time a month. Because the person is still approved for 12 weeks of service, the DHFS does not record this as a denial, nor does it keep records on reduction of services. Families of children with disabilities and providers spend needless time appealing denials of needed therapies. For example, one family reports successfully appealing three denials of therapy for their child with disabilities. This child was improperly denied physical therapy and twice denied occupational therapy. The family appealed these denials and they were overturned. The delays this child experienced and the lack of continuity in receipt of service may negatively affect his development. This family fears future denials.

The prior authorization process, as implemented by DHFS, delays delivery of services with cumbersome, repetitive paperwork. Prior authorizations are granted for short periods of time, typically 8-12 weeks. Each time the therapy needs a new prior authorization approval, recipients and service providers are asked the same questions that delay receipt of services for months at a time. Providers report that prior authorization forms are returned to them again and again with the same questions, then the process begins all over again once the approval period finishes. DHFS claims that PA's are acted upon within 10 working days to 12 weeks, with an average of 4-8 weeks. However, this is the length of time for each *event*, or each time a PA is returned to a provider with more questions. The actual length of time from submission of the PA to approval can be many months.

Recipients are denied services that are deemed to be for "maintenance." These therapies often prevent regression and thus are medically necessary. Also, by approving therapies for brief periods of time (8-12 weeks), it is difficult to measure and document progress to justify further approvals.

Some families have a preference for therapies for their children to be provided at home or in the community, rather than at school. Wisconsin has been denying these community services in violation of these families' right to choice of provider. Wisconsin has a financial interest in approving therapies provided in school over therapies provided in the community. School-based Services Medicaid billing brings in federal medicaid dollars to the general fund, while billing Community-based Services cost the state and state percentage of medicaid dollars.

We are concerned that Wisconsin's children with disabilities are not properly receiving the medicaid services for which they are eligible. Wisconsin is using prior authorization authority to improperly deny and delay medicaid services to children with disabilities. We ask you to investigate. Because the majority of over 225,000 prior authorizations

submitted annually are drug-related requests, the records, as DHFS has reported them, are not a useful response to service-related concerns. Also, because DHFS considers a P'A "approved" even if substantive changes are made that sharply reduce service, the high "approval" rate they claim is misleading. Please contact us to discuss this complaint. We look forward to working with you.

Sincerely,

Jodi Hanna
Attorney

Lynn Breedlove
Executive Director

16 N. Carroll Street suite 400
Madison, WI 53703
1-608-267-0214
FAX 1-608-267-0368

Proposed Legislative Audit on DHFS Medicaid Prior Authorization Practices Regarding Therapies for Children with Special Health Care Needs

Over the past 2-3 years there has been increasing concern among disability groups regarding the number of parents with children with severe disabilities and the providers who serve them who have had negative experiences in their efforts to obtain Medicaid Funded Therapies, Durable Medical Equipment and Home Health/Personal Care Services. There is an emerging consensus view among parents, providers and disability groups around the state that **the Division of Health Care Finance (DHFS) is misusing its prior authorization authority to inappropriately ratchet down the level of Medicaid spending in this area of services.**

This issue goes beyond how many requests for services are actually denied, how many denials are appealed, and the final outcome of those appeals. More and more parents and providers have become discouraged by this cumbersome, bureaucratic process leading to an overall "chilling effect" on the number of Medicaid-eligible families who even seek needed services, as well as, the number providers willing to navigate this process in order to provide services to these children and families.

Organizations such as the Wisconsin Council for Advocacy (WCA), the ARC-WI and the Wisconsin Council for Developmental Disabilities (WCDD) individual providers and provider groups WOTA, WPTA have attempted to have their questions answered and concerns resolved through ongoing direct inquiry, multiple meetings and interactions with DHFS officials. This has not led to a clearer understanding of the problem, nor has it diminished the concerns of parents and providers statewide. **While DHFS has reported improvements in their processing, providers and families have not experienced the system as improved in any significant capacity.**

Consequently, the SURVIVAL Coalition of 25+ statewide disability organizations is calling on the Legislature to undertake an audit of DHFS practices in the area of prior authorization and adjudication of therapy services for children with special needs. We understand that The Senate Committee on Health, Utilities, Veteran's and Military Affairs has requested a legislative audit for similar issues of Personal Care Services. **We would like the Audit Committee to support this request and include a logical expansion of the Personal Care Audit of DHFS to include the following issues related to Therapy Services:**

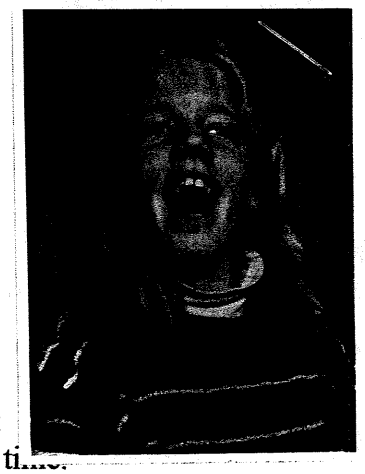
Suggested areas for inquiry:

1) If prior authorizations for therapy services (Physical Therapy-PT, Occupational Therapy-OT, and Speech Language Pathology-SLP) for a group of children with similar ages and diagnoses were compared prior to 1996 and in 1999 would there be a significant increase in the number of denials for services? Modifications for services? Decrease in length of services? Number of returns (for more information) on a Prior Authorization (PA) for the same services? Is this change supported by newly published legislation, administrative rule and or consumer/provider publications that clarify the change, its rationale and appropriateness for Medicaid consumers/providers?

2) Does the Prior Authorization Process require cumbersome, repetitive paperwork that delays delivery of services? Are the questions asked by reviewers needed to be asked repeatedly and in an ever-expanding way in order to justify services for medically needy, disabled children who have an obvious need for these interventions? How can children, with these ongoing needs, be expected to demonstrate measureable changes for ongoing authorization in brief periods of services authorized (8-12 weeks)? Is this process a more costly, inefficient and ineffective way of managing dollars and services?

Log of Meetings /Technical Support Between DCHF, CCI's, and Providers

Date:	Meeting /Contact:	Responses:
Summer 1997	Phone contacts regarding speech denials	Statements that guidelines/policy would be out shortly.
Fall 1997	Start of request for IEP's	
June 1998	Meeting in Madison with DCHF Attendees: Linda Hall, Ken Czaplewski Dennis Nuenfeldt, Cindy Eisenman, Claudia Meyer, Beth Grossmeyer, Jean Fahl, Linda Stegemeyer, Mary Chucka, Theresa Lindner, Barb Evans, Alan White, Mary Louise Wrisbecki, and several other members of DCHF.	Summary of meeting and guidelines to be out within two weeks. Never received. Invitation extended to visit CCI's and observe treatment.
September, 1998	DCHF visits St. Aemillian-Lakeside and St. Rose.	Stated guidelines and summary of visit would be received within two weeks. Not received to date.
December 1997 to Present	Comments on bottoms of prior authorizations indicating increase in information needed to adjudicate PA and change in guidelines which the DHCF would provide shortly.	Increasing demands on therapist for information not related to medical or therapy information regarding client. Longer adjudication time periods. No clear guidelines other than comments about medical necessity . No changes in code directing therapy treatment practices.
July, 1999	Phone call to Barb Evans regarding Length of time to adjudicate three PA's.	Phone call not returned.
July 29, 1999	Letter to Mary Chucka as follow-up to three OT denials received. Had verbally requested review of the PA's as adjudication had taken 6 months.	Denials were reversed.
September 9, 1999	Fair Hearing over adjudication delay	Hearing officer indicated that the DHCF had 20 days in which to respond to a PA request after which a failure to act appeal could be submitted.
February 1, 2000	Letter from DHCF indicating that therapy services in CCI's would no longer be reimbursed.	Two delays in implementation.
March 1, 2000	Meeting in Rep. Foti's office between providers and DHCF.	Agreement to provide guidelines.
April 14, 2000	Guidelines received	Reiterated information as has been communicated on PA's.



August 28, 2000

Re: Funding for the Medical Assistance Program

Dear Senator Lazich:

I am one of your constituents and am in need of your understanding and support regarding the state of the Wisconsin Medical Assistance program at this current ti...

My daughter, Chelsey, has the most severe form of cerebral palsy, spastic quadraparesis. Chelsey is non-ambulatory and considered non-verbal. Chelsey essentially requires total assistance in doing even the simplest of tasks. She needs someone to feed her, change her diaper, bath her, clothe her, study, play, etc.

Our hope is that Chelsey can one day achieve her highest level of potential, whatever that may be, through aggressive therapy and hard work. Chelsey has the desire, initiative and positive attitude needed to maximum her skills. The rather high "hurdle" in this process is not Chelsey's desire, but is the Medical Assistance prior authorization process for securing this much needed therapy.

To say that trying to accomplish this is a taxing and arduous undertaking is an understatement. It hasn't always been this way. To my knowledge, there has been no new legislation or administrative rule that would empower the Bureau of HealthCare Financing to significantly reduce services for children such as Chelsey.

My belief is that the only factor that has changed is their desire and efforts to cut costs by whittling away at these types of services.

A typical situation for us, and Chelsey's therapists, is having to justify on a much too frequent basis, every three months, why Chelsey requires ongoing therapy. Their contention usually revloves around the fact that Chelsey has not made significant enough improvements regarding some of her goals. The reimbursement for these services have slowly been whittled away over the last few years.

I truly believe that the goal of those that administer this program is to make this process so cumbersome, time-consuming and frustrating, that the average parent will say, "I don't have it in me to keep this up. I, and my spouse, work full time jobs and we simple don't have the time, stamina and energy to continue to fight for what is right – the continuing progress of our child."

I am asking that you continue to familiarize yourself with the problems of reimbursement for health care for children with special needs and offer a watchful eye over the Bureau of Health Care Financing.

Chris Lundquist

[redacted]

August 30th, 2,000

Dear Members of the Wisconsin Legislative Audit Committee,

At the age of 10 months, my daughter Lindsay suffered a traumatic brain injury as the result of complications from surgery. 5 days later she woke up from a coma and was blind and very physically disabled. For the past 7 ½ years, Lindsay has received physical, occupational, and speech therapies. During that time, Lindsay has made many strides. Not nearly as many as a "normal" child would, but my child that screamed in pain for months on end following her coma, is now a happy, contented child that attends 3rd grade with her many caring friends, uses a computer to communicate, uses an adaptive toilet, participates in Brownies, loves to swim and go horseback riding, attends birthday parties, made her 1st Communion this past year, and is the joy of her parent's life.

Lindsay still has many challenges in her life. The brain injury that she suffered has left her muscles extremely tight and rigid. Because of her tightness, Lindsay is frequently unable to sleep at night, it is difficult for her to move to use her communication device, and she often has trouble just sitting in her wheelchair comfortably. Her physicians and I are constantly trying new treatments and medications in an effort to reduce her muscle tone. If left unchecked, the high muscle tone pulls her body into abnormal patterns which will eventually result in contractures, dislocated hips, and a curved spine. Our hope is that with therapy intervention, we can avoid those conditions and the resulting surgeries. Although therapy isn't the only answer to treating Lindsay's high muscle tone, her physicians and I believe it is an essential part of her treatment.

My experience with the Wisconsin Medicaid Prior Authorization process for therapies has been very discouraging. Every three months Lindsay's therapists are required to submit a new request for prior authorization. This process usually takes several weeks and often involves additional questions (many of which were answered in the original documentation) and additional follow up letters by her therapist. All of her therapists are extremely frustrated and overwhelmed by the process. I can not say that the process is intentionally meant to discourage families from seeking these services and therapists from providing them, but that is exactly the result that it has had. I can't imagine a child that medically needs therapy more than Lindsay. Clearly her goals and situation are not going to change significantly every three months. It just doesn't make sense to me that this process needs to be repeated every three months for a child that is going to require long term care.

Recently Lindsay was denied Occupational Therapy services. I am in the process of preparing a letter indicating my reasons for appealing the denial. Unfortunately, I have very little faith that the appeal process is any more reasonable than the prior authorization process. And even if the denial were overturned, the request for services could be denied again in three short months.

Thank you for your support of a legislative audit of the Wisconsin Medicaid Prior Authorization process. I believe that the process is broken and an audit is necessary to determine why it is failing to provide services to the children that truly need them.

Sincerely,

Lori Murphy

August 31, 2000
Testimony before the Joint Audit Committee

Good morning. My name is Nancy Anderson. I am representing Wisconsin Personal Services Alternatives (WPSA), the personal care association. WPSA is very pleased that this committee has expressed its interest and concern for the prior authorization and audit process of community based Medical Assistance providers. WPSA has endeavored to work with Department staff for years at quarterly meetings on these issues and it is our hope that through this committee's intervention WPSA and other MA providers can find a way to improve our communication and cooperation with the Department to secure community based services for Wisconsin citizens.

As an organization, WPSA has been concerned for years about whether the procedure and process of prior authorization have been understood by providers and applied uniformly to MA recipients.

Through a Freedom of Information Request with other providers on Prior Authorization Guidelines WPSA has learned:

1. The personal care/homecare calculation for PA worksheet has been confidential to only employees of the Bureau of Health Care Finance and EDS staff.
2. The personal care/homecare calculation for PA worksheet has not been available at administrative hearings or the Katie Beckett program to administrative judges, recipients or providers. An appeal hearing administrative judge confirmed this as well at two hearings in June 1999.
3. The personalcare/homecare calculation sheet for PA ignores all comments on the assessment form to individualize a recipient's medical or functional status.
4. There are no housekeeping hours calculated on the worksheet raising the question, "Are housekeeping hours being allowed in the Prior Authorizations as prescribed by code?"
5. The WPSA interpretation of the doctor's order PA guidelines is that the doctor's order should be signed and dated or have a date stamp or returned to the provider.

WPSA has multiple concerns for the audit process such as:

- a lack of an audit tool,
- no clear concise expectations,
- no handbook until March 2000,
- no annual program reviews,
- being unable to interpret audit findings,
- ignoring the policy directives of previous department staff,
- understanding why some agencies were offered a settlement and some were not.

As a service to it's members, WPSA conducted a survey of 24 of 25 counties or agencies identified in the press as having financial audits that are still in business. WPSA also surveyed 4 of 5 agencies audited in 2000 waiting for results. These are the basic settlement findings of the survey.

- Five home health agencies are no longer in business (Cares R Us, Excel, J & A, Price County Home Health, Vida)
- One Independent Living Center, Independence First, negotiated an out-of-court settlement during the standard audit process.
- Fifteen entities (10 counties, 1 independent living center and 4 home health agencies) were offered out-of-audit process settlements. (See enclosed survey.)
- Four home health agencies were not offered a settlement but were processed through the standard audit process even though their audits were in the same timeframe as the settlement entities.
  - One is paying it's audit findings.
  - Three have submitted documentation to reduce their findings.

Audit findings of the 15 settlement counties or agencies:

#1 Issue	In/out time documentation	-	14
#2 Issue	Doctor order documentation	-	11
#3 Issue	Travel time documentation	-	6
	(7 did not bill travel, 2 did not meet audit criteria but met the settlement agreement)		

A complete survey of the 15 settlement counties and other agencies is enclosed.

Also enclosed is written testimony from an owner whose Home Health Agency in Milwaukee was audited and she requested her testimony be submitted.

Thank you for your time.

Nancy Anderson
WPSA Board and Legislative Committee
608/242-8335

WISCONSIN OCCUPATIONAL THERAPY ASSOCIATION

TESTIMONY BEFORE THE LEGISLATIVE AUDIT COMMITTEE
August 31, 2000

Good morning! My name is Jan Stevens, and I serve as the Co-Chair of the Reimbursement/Medical Assistance Committee Section of the Wisconsin Occupational Therapy Association (WOTA). WOTA is a professional membership trade association representing the interests of approximately 1800 member occupational therapists and occupational therapy assistants in Wisconsin, and we appreciate the opportunity to testify today before the Legislative Audit Committee. The Medical Assistance Committee of WOTA is about 20 years old.

We are here today to support an audit by the Legislative Audit Bureau of the Department of Health and Human Services/Program Integrity Section surrounding the policies, processes, procedures, interpretations, and rules of the Prior Authorization Program, as well as the manner in which provider audits are conducted.

Background:

The Medical Assistance Committee has worked with the Department of Health Care Financing and its OT consultants for many years. The purpose of the meetings have been:

- to be a conduit of information from the department to the OT community;
- to provide educational programs at the WOTA Annual Conference to keep the OT community abreast of current Medical Assistance Program updates; and
- to quantify and try to impact on current issues effecting providers and consumers;

Since 1996, Medicaid OT providers have experienced a significant increase in problems and number of denials associated with prior authorizations and requests for reimbursement. At that time, then president of WOTA, Karen Picus, sent a letter outlining the concerns of the OT community with the increase in denials to the head of the Medicaid department at that time, Kevin Piper. Ms. Picus indicated our willingness to work with the department to improve the reimbursement environment.

Our committee started collecting data from rehab agencies related to denials and processing problems for OT, Physical Therapy (PT), and Speech Therapy (ST). We collected data for two years in the following areas:

- Number of denials associated with each discipline;
- Number of days required by the department to process a prior authorization;
- Number of prior authorizations returned for further information; and

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WEB:www.wota.net Email:wota@execpc.com

- Number of approved prior authorizations and requests for reimbursement.

The data showed that there were considerable differences between the three therapies in the amount of returns, denials, etc. At that time, WOTA asked for a meeting with the supervisors of the OT consultants to address our concerns and share the collected data. A series of meeting were held to keep the dialogue of our concerns open. The department also conducted its own internal "audit" which in several ways validated our committee's data. It appeared clear that OT was being scrutinized more rigorously and denied more often than PT and ST. There was little or no explanation offered by the department on this matter.

Our next step was to meet with Secretary Leean to address our needs. Secretary Leean indicated that the denials OT was receiving were related to the fact that OT didn't meet the definition of "medical necessity." WOTA was able to increase Secretary Leean's understanding of the kinds of interventions OT might provide to consumers and he agreed that we do indeed meet the criteria of medical necessity. We concluded that there were too many departmental interpretations of the term "medical necessity" and that this uncertainty may lead to inappropriate denials for services.

As a result of the meeting with Secretary Leean, quarterly meetings were then established with the bureau chiefs within the department to include representatives of the three therapies. These meeting have been beneficial in both the information that was shared by the Medicaid department and also just being able to meet with bureau chiefs who have a greater capacity to take action than others we had met with previously. However, they have not been productive in addressing concerns, examples and questions posed at each meeting, i.e. it often takes up to six months or more to receive and answer.

We again decided to meet with Secretary Leean who referred us to Peggy Bartels, the Director of the Department of Health Care Financing. In August of 1999, we met with Peggy Bartels. The meeting was contentious from the start. We demonstrated our appreciation for the quarterly meetings with bureau chiefs, but indicated our ongoing frustration with the lack of action and delinquency in answering questions. Our agenda items for the Bartels meeting were:

- Seeking an administrative code change related to general supervision for OT and PT assistants;
- Obtaining ongoing regularly scheduled issuance of statistics related to prior authorization processes;
- Seeking ongoing opportunities for input in the Bureau's initiative to create a prior authorization checklist for better consistency with consultants;
- Revisiting the definition of medical necessity as it relates to the practice of rehabilitation;
- Seeking a more appropriate interpretation of the need to submit daily notes.

Concurrently, we included representatives from consumer advocacy groups to participate with the Bartels meeting. One such group, The Wisconsin Council on Developmental Disabilities (WCDD), presented results of a statewide survey, of parents of children with

developmental disabilities, that sought to determine the level of problems they were experiencing. Their findings confirmed that both consumers and providers were experiencing the same problems regarding prior authorization processes.

The Current Environment

Since that time, our quarterly meetings have had a more distinctly positive tone and level of responsiveness to our concerns. However, we contend that the department's actions vary dramatically from the informational exchange that occurs at the quarterly meetings. DHCF did develop a formal presentation on the prior authorization process and presented it across the state to various groups involved. The program has been well received; however in practice, problems with prior authorization have worsened. The department has taken steps to address WOTA's needs by reviewing *specific* prior authorizations, expanding the hours and number of EDS consultants, and demonstrating a willingness to setting up task groups. One current task group is charged with revising the prior authorization form to make it more provider-friendly. Prior authorization guidelines and examples that are clear to providers and that will not change with the hiring of new consultants would be of great benefit, especially to new providers. Our continued request for revised prior authorization guidelines has not been addressed.

Today however, prior authorization requests are requiring more demands for information and attachments; thereby, impacting on providers' documentation workload. Providers are placing patients on hold until the approval of a prior authorization. This did not occur in the past. For the most part, prior authorizations—although delayed—were entirely approved. The fact that a prior authorization was once overturned at fair hearing appears to have no impact on the reviewer when a new prior authorization is submitted. The same questions appear again.

Our continued areas of concern are:

- Continued requests for revised prior authorization guidelines (those currently sent to providers are dated 9/1/95).
- Significant delays In the processing of prior authorizations;
- Excessive requests for additional documentation;
- Significantly shorter number and duration of treatment sessions that do not follow the guidelines sent to providers;
- Provider education that clearly and consistently identifies what is needed for timely and accurate review of prior authorizations (i.e. a prior authorization in the revised *Wisconsin Provider Hand Book* dated 3/98, would not meet the approval criteria currently being used).

Furthermore, providers have no idea of the DHCF's definition of medical necessity as it relates to rehabilitation. Services that were approved three years ago are now being denied for lack of medical necessity. In addition, we are uncertain of the definition or interpretation of a "modified" prior authorization request versus an "approved" request.

Provider Audits:

Our final concern surrounds the matter in which the department conducts retroactive provider audits. We believe the department is applying unpublished guidelines and vague rules to deny payment (or seek recoupment) from providers in the areas of documentation and medical necessity. We hope that the Legislative Audit Committee will instruct the Legislative Audit Bureau to carefully determine the rules, policies and procedures for conducting provider audits when no threat of fraud and abuse has been identified. We suggest that current interpretations are being applied retroactively against providers who had no knowledge at the time that they may have been doing something wrong while there was a lack of published guidelines.

WOTA staff and members remain available to assist the Committee or the Bureau in exploring our concerns and issues. We wish to do everything we can to remain compliant with departmental instructions as long as they are concise, clear, current and meaningful. In this way, occupational therapists in the state of Wisconsin can best serve the needs of disabled and eligible Wisconsin consumers.

Respectfully,

Jan Stevens, OTR, Co-Chair
WOTA Reimbursement/Medicaid Committee

Michael Steinhauer, OTR, MPH, FAOTA,
WOTA Executive Director

Wisconsin
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February 10, 2000

To: Chairman Moen, Members of the Senate Health Committee
Members, Wisconsin State Senate
Members, Wisconsin State Assembly

From: Survival Coalition, Lynn Breedlove and Michael Blumenfeld, Co-Chairs

Subject: Personal Care Audits

The Survival Coalition, a group of advocacy organizations for people with disabilities very much appreciates the Senate Health Committee's holding a hearing on the issues surrounding the personal care audits and rates. This memo will concentrate on the audits.

At the hearing it was abundantly clear that there is an overzealous approach to the audits by DHFS and an attempt to limit personal care. It was most disheartening to hear DHFS staff say the audit requirements were clear while everyone else described a very confusing set of requirements and the impossible task of getting DHFS clarification and training on the requirements. In fact testimony suggested contradictory instructions from DHFS. It appears that at these types of hearings DHFS states one thing and everyone else states just the opposite.

It also appears that DHFS is most aggressive in its audit practices with small agencies getting paid very little for their work. At the hearing DHFS representatives interjected the word "fraud", but there is no fraud alleged with these audits.

Given all of this, the Survival Coalition has the following suggestions that hopefully will lead to more personal care agencies remaining in the service system.

- Ask the Legislative Audit Bureau to do a complete review and assessment of the policies, approaches and procedures of the DHFS personal care audits to determine if the policies were clear and if the personal care agencies should have been expected to understand the requirements that they have been audited against. It is absolutely necessary that independent auditors be permitted to do a complete assessment by reviewing source documents and interviewing all appropriate individuals. Until the Audit Bureau's review is completed, the personal care audits by DHFS should be suspended.

- Better yet is for DHFS to agree to suspend the personal care audits altogether, forward the newly developed personal care handbook to the appropriate Legislative Committee for review, public input and a determination that it is reasonable and is not Administrative Code developed without following proper procedures. After this is accomplished, DHFS should train all personal care agencies on the required procedures using the handbook. Future audits would then be based on the handbook requirements and procedures. This would eliminate the need for the Audit Bureau review, save time and money and begin to show support for the personal care program.

- Finally, the Survival Coalition would like to see DHFS be asked to help solve the problems with personal care through its leadership in supporting AB 630 and asking the Assembly Health Committee Chair to hold a hearing and bring AB 630 to the floor of the Assembly for a vote. DHFS also should be asked to show leadership in helping to solve the crisis of over 90 personal care agencies going out of business and of the lack of personal care workers.

- Gerry Born of the Arc-Wisconsin is the contact for the Survival Coalition on the personal care issue. Please contact him at 608-251-9272 with any questions or if the Survival Coalition can be of assistance in resolving the problems which the low rates and the DHFS audits have created concerning this very critical service for people with disabilities and their families.

Thank you for your concern for this matter and your assistance in solving this critical problem.

cc: Governor Thompson
Secretary Leean
Attorney Burt Wagner
Gerry Born

Medical Assistance Prior Authorization
Public Hearing Testimony

Presented by the Vernon County Department of Human Services
August 31, 2000

The Vernon County Department of Human Services became certified to provide personal care services in 1989. At that time, we were provided with a copy of the Administrative Code and the information required to apply for an MA provider number. We did subcontract this program with a local provider, Bethel Home & Services. Our agency started with only 5 consumers but this program has grown over the last 11 years. The number of consumers served on average has been 90 at any given time. We are currently the only personal care service agency in Vernon County.

In July of 1996, our personal care program was audited by the Bureau of Quality Compliance. At that time they randomly screened approximately 20 consumer records. The auditors looked closely at the documentation relating to direct client care as well as billing procedures. Their final verbal report indicated that there were no discrepancies found, and all questions had been fully answered. The auditors were extremely complimentary of the Human Services and Personal/Supportive Care supervisory staff. They described the established system of providing personal care services and the corresponding billing procedures as being excellent. They also reviewed the travel policy developed by Bethel Home & Services and they stated that it would meet their auditing requirements. As a result, we felt very confident that our program was meeting all State requirements.

In January of 1999, our personal cares program was audited by the Bureau of Health Care Program Integrity. The five auditors spent four days at Bethel Home & Services reviewing case records, time sheets, personnel records, and various other documentation. They reviewed records for dates of service from January 1, 1996 through December 31, 1997. During this process they reviewed 117 cases. At the time of the exit interview, they informed us that we should receive a preliminary report within 2 to 3 months. On September 7, 1999, we received the preliminary finds of the audit that was completed the

previous January. At this time we were informed that our agency was overpaid in the amount of $789,468.03. We then informed the Division of Health Care Financing that we did not agree with their findings and we have been attempting to resolve this matter since.

Attached you will find a summary of our audit findings. You will note that one of the areas that we were sited on was the lack of M.D. orders. The total amount that the State has attempted to recoup is $295,698.09 for this one area. The main problem with our M.D. orders is that the physician signed the order, but he did not put a date by his signature. The date of the verbal order is on the form and the dates of service that are being ordered are also on the form. What is very interesting about this situation is that during 1996 and 1997 the prior authorization process required that the M.D. orders be submitted with the prior authorization request. If there was a problem with the M.D. orders then the prior authorization should not have been approved and it should have been returned to us for correction. What did happen is that the prior authorizations for these consumers were approved and we then provided the services and billed EDS accordingly. We were also then paid for these services, though now they are attempting to recoup these amounts. This process did change in 1998 when the Department decided that the M.D. orders did not have to be submitted with the prior authorization request. We were still required to have this information in the patient's medical record. Attached please find a copy of the Wisconsin Medicaid Update dated May 20, 1998, that informed providers of this change.

The Vernon County Department of Human Services is in the position that if we are required to submit $789,468.03 to the State it will have a large impact on Vernon County and its' residents. We would have to discontinue the program immediately because of the fiscal impact. Our concern would then be that the years 1998, 1999, and 2000 would also then be audited with similar results. This would mean that the consumers in Vernon County would no longer be able to access this service since we are the only provider. Older adults and people with disabilities will lose this service which has helped them to remain in the community where they want to be and where they belong. We currently have a waiting list for COP and COP-W/CIPII services. This waiting list is getting longer every day, so individuals who were only receiving personal care services would have to wait

until their name came up on the waiting list. This could be 6 months or longer. What are they to do in the meantime? Most of these individuals would be unwilling to consider institutional care, so they would remain at home without services. It is definitely a crisis waiting to happen. It would also have a large financial impact on our contract agency, Bethel Home & Services. Not only would they be obligated to refund payments to Vernon County, they would no longer be able to continue this program without the County's certification. They would be forced to lay off or reduce the hours worked for about 200 employees. This would also then have a large impact on the economy of Vernon County. We are a small rural county with a population of about 26,000 and this increase in the number of individuals unemployed would have a large impact.

Attached you will also find a copy of the recent findings from Vernon County's quality assurance technical compliance monitoring review for our COP-W, CIP II and COP programs. This review was conducted in 2000 but was for the year 1999. This document demonstrates that Vernon County is more than able to meet program requirements when we receive adequate direction and guidance. These reviews are completed by The Management Group through a contract with the Department of Health and Family Services. These reviews are conducted every two years and if there are any compliance issues, the local agency is able to submit a plan of correction to correct any problems.

Thank you for your time and consideration in this matter.

Submitted by:

Jean Klousia

Jean Klousia
Long Term Support Supervisor
Vernon County Department of Human Services

Attachments

10-Mar-99

Home Health Audit Findings Summary

VERNON COUNTY DEPARTMEN

43102700

Finding	Qty Allow	Qty Disallowed	MA Correct Pay	MA Paid	Recoupment
LACK OF DOCUMENTATION	71.00	71.00	$0.00	$784.56	$784.56
LACK OF M.D. ORDERS	26,240.00	26,240.00	$0.00	$295,698.09	$295,698.09
BILLING IN EXCESS OF SERVICES PROVIDED	1,647.50	165.00	$16,379.18	$18,202.13	$1,822.95
INCOMPLETE RECORD	46,393.50	31,450.85	$165,311.85	$532,818.10	$367,506.25
LACK OF DOCUMENTATION OF TRAVEL TIME	11,271.00	11,271.00	$0.00	$123,656.18	$123,656.18
TOTAL	85,623.00	69,197.85	$181,691.03	$971,159.06	$789,468.03

MAY 20, 1998

UPDATE 98-15

WISCONSIN MEDICAID UPDATE

TO:
HMOs and Other Managed Care Programs
Home Health Agencies
Personal Care Agencies

Prior Authorization Request Changes for Home Health and Personal Care Agencies

Changes made in response to provider suggestions

To respond to provider suggestions and to improve consumer services, Wisconsin Medicaid has made some changes to the prior authorization (PA) request requirements. The changes are intended to decrease the number of PA requests returned to providers for clerical errors.

Wisconsin Medicaid has changed some items on the HCFA forms 485, 486, and 487 from *required to optional* on PA requests. Providers may continue to complete these items, but Wisconsin Medicaid will no longer return PA requests due to incorrect or missing *optional* items.

Prior authorization (PA) request changes

Optional elements

Completion of the following are now *optional on PA requests*. While the following are optional on PA requests, Wisconsin Medicaid requires that the signatures be kept in the recipient's medical record. Wisconsin Medicaid will no longer return PA requests if the following elements are missing or incorrect:

Certification, licensing, and other Medicaid requirements *have not* changed

Providers must obtain written physician orders for home health services. Providers must maintain hard copies of dated, signed signatures and entries on file in the recipient's record as required by state and federal regulations. These prior authorization (PA) request changes do not eliminate the need for providers to comply with licensing, certification, or health insurance liability requirements (i.e., HFS 101-108 and HFS 133, Wis. Admin. Code, Federal Conditions of Participation, 42 CFR 484, etc.).

- Provider number on HCFA 485, 486, 487 (element 5).
- Provider number on PA/HHTA (element 7).
- RN or therapist signature* on HCFA 485 (element 23), 486 (element 21), 487 (element 11).
- RN or therapist signature* on verbal orders.
- RN/MD signature* on HCFA 485 (element 27) or personal care orders.

*Signatures must be obtained and kept in the patient's medical record as required by state and federal regulations (see the information in the box above).

Tommy G. Thompson
Governor

Joe Leean
Secretary

State of Wisconsin

Department of Health and Family Services

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August 7, 2000

Linda Nederlo, Director
Vernon County Department of Human Services
P.O. Box 823
Viroqua, WI 54665

Re: 2000 Quality Assurance Technical Compliance Monitoring Review for Vernon County

Dear Ms. Linda Nederlo:

This letter summarizes the findings of the Technical Compliance portion of the 2000 Quality Assurance Monitoring Review of Vernon County's COP-W, CIP II, and COP programs that was conducted by Peggy A. Sivesind of The Management Group, Inc. (TMG). This year's review involved eight record reviews. The review looked at technical compliance with waiver and COP program requirements.

The RESPECT Outcomes portion of the review will be conducted later in the year. The RESPECT Outcomes Monitoring will examine the program experience of the sample participants to determine the extent to which they are experiencing a set of 22 personal outcomes consistent with the consumer defined RESPECT values that guide the COP and waiver programs.

This letter summarizes the findings of the Technical Compliance review, describes any system issues identified during the review, and includes the following sections:

- Section One – Record Review Results
- Section Two – Discussion of Results
- Attachment – Summary of Compliance Issues and Potential Disallowances
- Attachment – Care Management Contact Chart for 2000 Sample

The preliminary findings have been presented to you, Jean Klousia-LTS Supervisor, and the care managers Shirley Johnson and Barbara Zeimet. If, upon review of the report, you or your staff have any questions about the content, please feel free to contact me. **No plan of correction is required for this report. If you have other comments on the report, please send them to the following address by September 7, 2000.**

Peggy A. Sivesind
The Management Group, Inc.
217 South Hamilton Street, Suite 200
Madison, WI 53703
(608) 255-6441

Section One – Record Review Results

The Technical Compliance review of participant records is conducted to ensure basic program requirements are met in the areas of financial and non-financial eligibility, service plan development and implementation, service standards and requirements, and billing. There is also a set of questions pertaining to participants residing in substitute care settings. There are 26 compliance questions in the CIP II/COP-W review and 21 compliance questions in the COP-only review. In addition to reviewing the records of CIP II/COP-W participants, one COP-only participant was included in the review. A summary of each of the compliance categories is presented in Table 1.

Table 1 – Record Review Categories	
Eligibility – Financial	*The MA Waiver Eligibility and Cost Sharing Worksheet/CARES screens were reviewed along with other documentation related to any cost share or spenddown obligations.*
Eligibility – Non-Financial	*The Functional Screens and Health Forms were reviewed for accuracy with compliance and documentation standards.*
Service Plan	*The service plans were reviewed for compliance with the following technical requirements: documentation of recipient rights, appropriateness of funding sources, documentation of service plan reviews, and consistency between the ISP and case notes. In addition, plans were reviewed to see if they met the minimum health and safety needs of the individual.*
Standards and Requirements	*The standards and requirements were reviewed for each Standard Program Category (SPC) service provided to a waiver program participant.*
Billing	*The case record and the (March 2, 2000) L-300 Report were reviewed for continuity*
Substitute Care	*For participants residing in substitute care, the case record was reviewed for documentation that actual room/board and care/supervision costs had been calculated, and that only allowable costs were billed to the waiver program.*

In addition, issues that occurred frequently or require management intervention are identified as system-wide issues. System-wide issues will require an additional response, as described in Section Two.

The 2000 Technical Compliance review examined the records of seven CIP II/COP-W participants and one COP-only participant. The Record Review results are presented in Tables 2 (CIP II/COP-W) and 3 (COP-only). The results, including those findings with system-wide implications, are further described in the discussion in Section Two. Outstanding technical compliance issues, including those requiring a response, are detailed in Table 4 (Attachment).

The Record Review results (Tables 2 and 3) reflect the level of compliance with the program requirements described above. For each question a response of "Yes" means the compliance criteria was met, "No" means the compliance criteria was not met. After the records are reviewed,

the TMG field reviewer works with the county, whenever possible, to immediately rectify the compliance problem. Any compliance problems that were resolved during the monitoring visit have not been included in the summary of outstanding issues in Table 4. However, ***all compliance problems are*** *reflected in the Record Review results table. In other words, the number of "No" responses in the Record Review results tables may be greater than the number of outstanding issues identified in the attached summary table, because some issues were not able to be resolved and still require additional explanation, clarification, and/or documentation.*

Table 2

2000 Record Review Results

Vernon County

Sample size: 7

CIP2--COPW

	Yes	No	N/A	%NO of Applicable	'99 Statewide %NO of Appl
ELIGIBILITY -- FINANCIAL					
1 Medicaid eligibility confirmed timely.	6	0	1	0%	1%
2 Cost share payments made, documented; HSRS adjusted.	1	0	6	0%	48%
3 Spenddown obligation incurred and/or paid.	0	0	7	0%	50%
ELIGIBILITY -- NON-FINANCIAL					
4 Health Form/Functional Screen timeframes met.	7	0	0	0%	9%
SERVICE PLAN					
5 ISP reviewed every 6 months.	7	0	0	0%	7%
6 All services paid by the waiver were allowable.	7	0	0	0%	2%
7 Services listed on ISP within 6 months of receiving service.	7	0	0	0%	6%
DOCUMENTATION OF STANDARDS/REQUIREMENTS					
8 Care management exception documented.	0	0	7	0%	55%
9 Required care management contacts were made.	7	0	0	0%	29%
10 Missed contacts insignificant.	0	0	7	0%	20%
11 Case notation.	7	0	0	0%	4%
12 Waiver funding was explored.	2	0	5	0%	
13 Services conform to COP Guidelines 2.04.	1	0	6	0%	
14 SHC/Respite providers received training/certified.	5	0	2	0%	11%
15 MA Waiver service standards met.	1	0	6	0%	20%
BILLING					
16 Waiver program services billed to program.	7	0	0	0%	17%
17 All care management services billed to HSRS were provided.	7	0	0	0%	3%
18 Payments made to waiver allowable providers.	7	0	0	0%	0%
19 No services billed to waiver program while participant was in an institution.	0	0	7	0%	18%
20 No HSRS reporting problems based on CIP-II/COP-W L-300.	7	0	0	0%	26%
21 No HSRS reporting problems based on COP L-300.	3	0	4	0%	
22 COP variance requested, if needed?	0	0	7	0%	
SUBSTITUTE CARE ADDENDUM					
23 License/certificate for substitute care facility current.	1	0	6	0%	14%
24 Room and board costs and care/supervision costs calculated.	1	0	6	0%	26%
25 Only care/supervision costs charged to program.	1	0	6	0%	21%
26 RCAC documentation complete.	0	0	7	0%	0%

NOTE: "% NO of Applicable" is computed by dividing the number of "NO" responses by the sum of the "YES" + "NO" responses to each question..

Note: "99 statewide % NO of Appl" is based on 37 counties reviewed in 1999.

Table 3

2000 Record Review Results

Vernon County

COP 0NLY

Sample size: 1

	Yes	No	N/A	%NO of Applicable
ELIGIBILITY -- Financial				
1. Waiver financial eligibility was accurately determined?	1	0	0	0%
2. Was COP financial eligibility accurately determined?	1	0	0	0%
3. Documentation that cost share obligation has been met.	0	0	1	0%
ELIGIBILTY -- Non-Financial				
4. Waiver program level-of-care eligibility was accurately determined?	1	0	0	0%
5. Level-of-care eligibility for COP was accurately determined?	1	0	0	0%
6. Exemption from the MA Waiver Mandate was met?	0	0	1	0%
7. If applicable,an Estate Recovery Program Disclosure form is in the record.	1	0	0	0%
SERVICE PLAN				
8. Documentation for efforts to secure informal supports, Medicaid card, etc.	1	0	0	0%
9. Service(s) provided conform to COP Guidelines sec. 2.04	1	0	0	0%
10. Care manager reviewed ISP during face-to-face, evidenced by signature	1	0	0	0%
11. ISP has been reviewed during face-to-face at least every 6 months	1	0	0	0%
12. All services (case notes or billed to HSRS) were listed on ISP	1	0	0	0%
13. New Appl.: services did not begin more than 30 days prior to plan completion	1	0	0	0%
DOCUMENTATION OF SERVICE STANDARDS AND REQUIREMENTS				
14. Required care management contacts were made	1	0	0	0%
15. Documentation that an exception was granted and redocumented every 6 months	0	0	1	0%
16. Missed contacts were insignificant to participant's overall needs/care plan	0	0	1	0%
17. Original assessment has been completed and is in the participant's record.	1	0	0	0%
18. Documentation exists to verify a variance was obtained from ILTSC	0	0	1	0%
19. Documentation exists to verify a variance was obtained from BALTCR.	1	0	0	0%
BILLING				
20. All care management services billed to HSRS were provided	1	0	0	0%
21. Based on the L-300 Report, there were no HSRS billing/reporting problems	1	0	0	0%

NOTE: "% NO of Applicable" is computed by dividing the number of "NO" responses by the sum of the "YES" + "NO" responses to each question.

NOTE: There was no review of COP Only participants in 1999.

Section Two – Discussion

Vernon County Department of Human Services has achieved compliance in all the technical areas surrounding the CIP II/COP-W review. This year, a total of seven records were selected. The care managers did an exceptional job in every aspect. In all seven records, documentation was found to verify the financial and non-financial eligibility requirements were met. For the one participant reviewed who had a monthly cost share, there was documentation to indicate the participant had paid their cost share obligation and appropriate dollar amounts were listed on HSRS. The care managers did an excellent job of reviewing the service plans every six months and ensuring that all services and/or items provided to the participant were listed on the ISP. In addition, all services and/or items purchased with waiver funds were allowable.

The files were well organized and complete. All service standard requirements were met and documentation was easily accessible. The case notes were clear regarding when and with whom the various contacts occurred. For those participants who received supportive home care or respite, there was documentation to support the specific workers met the standards as outlined in DCS Memo 88-30. One of the cases reviewed involves a participant residing in a substitute care facility. All the appropriate documentation regarding room/board costs and licensing was available. Lastly, information was entered on HSRS correctly, including all institutional stay days.

In the one COP-only record reviewed, there were no technical compliance errors made. The care manager did a thorough job of ensuring all appropriate documentation was available and complete.

With regard to care management contacts, all of the required care management contacts were made. In fact, in some cases the amount of contacts exceeded the requirements. Please see the attached care management chart for more detail.

Because of the attention to detail and the competency of the care managers, there were no systems issues identified. I would like to commend Vernon County DHS and the long-term support care managers for their excellent work.

Table 4 (Attachment) – Summary of Compliance Issues and Potential Disallowances

Table 4 details the outstanding compliance issues identified by the review. However, table 4 is not included in this report because there are no outstanding compliance issues or potential disallowances pending.

I would like to extend my appreciation to you and your staff for their time and kind consideration. I enjoyed my visit to Vernon County and look forward to visiting with you again in the future.

Sincerely,

Peggy A. Sivesind

Peggy A. Sivesind
The Management Group, Inc.

cc: Irene Anderson, BALTCR
Susan Abbey, BALTCR
Jean Klousia, Supervisor Vernon County Department of Human Services
Kent Sprague, AAA, Western Region

Tommy G. Thompson
Governor

Joe Leean
Secretary

State of Wisconsin

Department of Health and Family Services

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March 20, 2000

Nancy Anderson, Wisconsin Personal Care Services Alternatives
Gerald Born, Executive Director, ARC Wisconsin
Lynn Breedlove, Executive Director, Wisconsin Coalition for Advocacy
Michael Steinhauer, Executive Director, Wisconsin Occupational Therapy Association

Dear Interested Parties:

This is in response to your request for information regarding Wisconsin Medicaid Program (WMAP) Prior Authorization. Although not included in this packet, the primary resource used by all consultants to determine approval, modification or denial of Prior Authorization requests is the Wisconsin Administrative Code. Interpretation and application of Wisconsin Administrative Code HFS 101-108 is further documented in the WMAP Provider handbooks and other Wisconsin Medicaid publications distributed to providers and recipients.

Per your request, enclosed are copies of Prior Authorization (PA) guidelines, tools and directives used by consultants when reviewing prior authorization requests. Included is a copy of the PA Guideline 121.001 for Personal Care, the Medical Assistance Home Care Assessment for PCW, the Personal Care PA Guideline Calculation Worksheet, directives to EDS regarding Personal Care PA guidelines dated January 20, 1994, March 4, 1994, June 3, 1994, February 24, 1995, and January 13, 1997, PA guidelines for Respiratory Care Services (RCS), Private Duty Nursing (PDN) and Home Health Aide (HHA) services. Therapy prior authorization guidelines are also included.

Prior Authorization guidelines for durable medical equipment (DME) are not included in this packet as there are over 100 such guidelines. Please let DHCF know if there are specific guidelines that you wish for particular pieces of equipment.

Sincerely,

Alan S. White, Director
Bureau of Health Care Program Integrity