11c

PRIOR AUTHORIZATION GUIDELINES MANUAL

CATEGORY OF SERVICE	PROVIDER TYPE(S) AFFECTED	GUIDELINE EFFECTIVE DATE
Personal Care	86, including 86 with 44	07/01/95 02/28/95 03/04/94 01/01/94

PROCEDURE/SERVICE

W9900 (TOS 1) Personal Care Worker (Employed by Personal Care-Only Agency)
W9902 (TOS 1) Personal Care Travel Time (PC/TT)
W9903 (TOS 1) Personal Care Worker (Employed by Dually Certified Home Health/Personal Care Agency)

MEDICAL POLICY STATEMENT

1. The rule provisions from the following citations must be considered in adjudicating every prior authorization received:

   Wisconsin Administrative Code HSS 107.02(3)(a) through (I) provides the Department with authority to require prior authorization for covered services, procedures for prior authorization documentation, and departmental review criteria used to authorize coverage and reimbursement.

   In addition, Wisconsin Administrative Code HSS 106.02(9)(a) through (g) requires providers to prepare and maintain medical and financial recordkeeping and documentation for all services provided recipients, and to provide such recordkeeping and documentation as requested by the Department in order to determine WMAP coverage and reimbursement.

   Effective Date: 03/04/94 **Reference:** 94-B-3-21 (03/04/94)
   ML94-0364 (03/09/94)

2. 49.45(42) Personal Care Services. Personal care services under s. 49.46(2)(b)6.j. provided to an individual are reimbursable under Medical Assistance only if all of the following conditions are met:

   a. The provider of the personal care services receives prior authorization from the department for all personal care services that are provided to the individual in excess of 50 hours in a calendar year.

   b. The individual is not eligible to receive home health aide services under Medicare, as defined in sub. (3)(L)1.b.

   Effective Date: 07/01/95 **Reference:** s. 49.45(42) Wis. Statutes

CONSIDERATIONS/DISPOSITIONS OF PA REQUEST

Adjudication:
An EDS analyst must adjudicate all personal care prior authorization (PA) requests , including new, renewal, and amendments (including updates), in accordance with the procedures described below.

The signature date on the Home Care Update form submitted with a PA/RF or PA Amendment form may be no earlier than 90 days prior to the ICN date. If the signature date is more than 90 days prior to the ICN date, the provider must submit a new Home Care Update form, which must be signed no earlier than 90 days prior to the ICN date.

e. Physician orders must be submitted with:

- All requests to initiate care (submitted with PA/RF);
- All requests to continue care (submitted with PA/RF or PA Amendment form) when physician orders in the recipient's file are not valid for the start date on the new request; and
- All requests to amend a PA (submitted with PA Amendment form) when physician orders in the recipient's file are not valid for the start date on the amendment request or the physician orders have changed.

2. Verify that forms are completed per instructions as indicated below:

a. ***PA/RF:*** Refer to Attachment 1 for a sample form and completion instructions. For personal care services, the quantity at Element 18 is a weekly quantity, as described below.

Quantity of Personal Care Services
Personal care providers must now request personal care services as a weekly total on the prior authorization request form (PA/RF), rather than as services per day, days per week. For example, if the physician orders three hours of personal care three days per week, the provider will request nine hours of personal care per week on the PA/RF. Travel time is to be requested as a weekly total in parenthesis beneath the personal care hours. For example: (three hours/week travel time).

b. ***Prior Authorization Amendment:*** Refer to Attachment 2 for a sample form and completion instructions.

c. ***Home Care Assessment Form:*** Refer to Attachment 3 for a sample form and completion instructions.

d. ***Home Care Update Form:*** Refer to Attachment 4 for a sample form and completion instructions.

e. *Physician Orders:* Orders cover the *start date* of a PA or PA amendment.
The orders may be dated no more than one year prior to the requested start date and must cover the start date. The signature date on the physician orders may be 15 months prior to the ICN date, as long as the physician order was for a specified period of time that is no longer than 12 months and includes the requested start of care date.

"When signed and dated physician orders are required and verbal orders are not attached, the date the signed Plan of Care (HCFA 485) was received by the agency (entered at Element 25) may be accepted as the signature date for the orders. Unless verbal orders authorize an earlier date, the wirtten orders are in effect on the signature date in Element 27 or the receipt date in Element 25, whichever is earlier."

Effective Date: 06/06/95 **Reference:** 95-B-6-20/ML95-0969

Refer to Attachment 5 for detailed physician order instructions.

3. Complete the Calculation Worksheet per instructions on the worksheet. Refer requests when directed by the Calculation Worksheet at Attachment 6.

If Calculation Worksheet does not allow approval of the weekly quantity requested, the request must be referred to a State Nurse Consultant.

IMPORTANT: THE CALCULATION WORKSHEET IS CONFIDENTIAL AND MUST NOT BE SENT TO THE PROVIDER, RECIPIENT, OR ANY PERSON OUTSIDE OF THE BUREAU OF HEALTH CARE FINANCING, NOR THE CONTENTS DIVULGED TO ANY PERSON OUTSIDE OF THE BUREAU OF HEALTH CARE FINANCING.

Information regarding the Calculation Worksheet may only given to BHCF staff after confirming that the person is a BHCF staff person. For phone inquiries, this means that EDS staff must obtain the callers name and telephone number, verify the person is employed by BHCF, and return the call.

4. When the Calculation Worksheet allows approval of personal care services, refer to the Approval/Referral Chart at Attachment 7 for authority to approve. Refer requests to consultants when directed by the Approval/Referral Chart at Attachment 7.

5. When the Approval/Referral Chart allows approval of personal care services, establish the duration or deny in accordance with the Duration of Personal Care Approval Chart at Attachment 8.

6. Figure quantity of personal care hours as follows:

   a. Total each procedure code separately.

   b. Count the actual number of days granted by subtracting the Julian start (grant) date from the Julian end (expiration) date and adding one more day.

   c. Divide the total number of days granted by 7 to determine the number of weeks. If the answer is not a whole number, round up to the next whole number.

   d. Multiply the number of hours approved per week per personal care procedure code by the number of weeks. The result is the total number of hours approved.

   e. Effective 02/28/95, when Home Health or Personal Care services are requested at a frequency of daily (7 days/week), calculations of the visits requested can be based on 365 days in the year (366 days for leap years). This change applies only to services requested at 7 days/week.

Reference: 95-B-2-173/ML95-0329
Amendment (02/27/95)

If the PA/RF gives the hours as X hours per day, X days per week, rather than total hours per week, multiply the hours per day times the days per week to arrive at the total hours per week. The amount requested under W9900 or W9903 must agree with the number entered at 15.1-a of the Home Care Assessment form.

If the PA/RF indicates both personal care hours and travel time hours under the personal care procedure, the amount requested under W9902 must agree with the total of numbers entered at 15.1-a and 15.1-b of the Home Care Assessment form.

7. Any correctly completed prior authorization that cannot be approved through the above process must be referred to a State Nurse Consultant.

8. When the State Nurse Consultant returns adjudicated PAs to EDS, accept the adjudication of the State Nurse Consultant and figure the quantity of personal care services per 6 when:

   a. A determination is indicated by an "x" or check mark in a box by one of the following statements: "Approved", "Modified - Reason:", "Denied - Reason", or "Return - Reason";

      If no action is indicated and EDS is not authorized to approve the request, return the PA to the State Nurse Consultant to complete.

   b. A written reason is entered to explain one of the following actions: Modified, Denied, Return. If no reason is indicated, return the PA to the State Nurse Consultant to complete. Reasons entered by State Nurse Consultants do not have to be indicated by reason action code numbers. EDS staff may contact the State Nurse Consultant for clarification in assigning reason action codes.

   c. The identity of the State Nurse Consultant must be indicated by one of the following in order for EDS to accept the adjudication and finalize the prior authorization: State Nurse Consultant's full signature, State Nurse Consultant's initials, or State Nurse Consultant's assigned identification code.

   If the date of the adjudication is not entered by the State Nurse Consultant, EDS staff will enter the date the PA was received back at EDS from the State.

Special Considerations:

1. Providers may submit personal care prior authorization requests no earlier than 90 days prior to the requested start (grant) date. Requests submitted earlier must be returned to providers for submission at a later date.

2. If a personal care service is not rounded to the nearest 2 hour increment on the request, round the quantity to the nearest 2 hour increment using standard rounding procedures.

3. Do not authorize personal care services for nursing home or inpatient hospital recipients, or for recipients on leave from a nursing home or inpatient hospital.

4. Although RN supervision (W9906, W9044) is required at least every 60 days, this does not need to be prior authorized. EDS should cross out any requests for these two procedure codes on the PCW PA/RF and write "RN supervision does not belong on PCW PA/RF."

5. If the provider is requesting backdating of the request, a justification for this action must be included in the request. Providers are given the requirements in Section VIII of the Part A Handbook. Adjudication must be in accordance with BHCF memorandum B-12-76, dated 12/13/93, at Attachment 9.

6. If the provider is requesting backdating of the request, the physician's order must apply to all dates of service on and after the requested start/grant date and prior to the ICN date. The orders may be dated no more than one year prior to the requested start date and must cover the start date. The signature date on the physician orders may be 15 months prior to the ICN date, as long as the physician order was for a specified period of time that is no longer than 12 months and includes the requested start of care date.

7. Reasonable travel time, if so indicated on the request, does not require a physician's prescription. Reasonable travel time is generally considered to be one hour per trip to the residence, but may vary according to individual factors. EDS does not need to review for reasonable travel time as long as the request is approvable according to the PA guidelines. If the PA is not approvable, the State Nurse Consultant will consider reasonable travel time when reviewing the request.

8. The personal care worker may not be the recipient's spouse or the parent of a minor recipient (under age 18). Return the request to the provider if the request identifies that either of these are employed as the personal care worker.

9. When a request for prior authorization or an amendment request is received and is incomplete, return the request to the provider, noting the omitted/erroneous item(s). Check for **all** required information before returning a request to the provider in order to reduce the number of times a request is returned.

10. If the quantity of hours requested on the PA/RF, excluding travel time, is greater than the quantity of hours on the physician orders, return the request to the provider for correction.

BHCF Clarification of EDS Questions/Additional Directives

1. Q: When photocopying for administrative hearings or Katie Beckett program, do we also copy the calculation worksheet?

   A: No. Do not photocopy the calculation worksheet for administrative hearings or Katie Beckett. If Katie Beckett staff, or any other non-BHCF staff have questions about the adjudication, refer the person to a State nurse consultant.

2. Q: What is proper procedure when hours/week on face of prior authorization and total at 15.1 and 2 do not match, i.e., math error? We are currently sending to state per Ann Pooler.

   A: Providers were informed in the Assessment instructions at Attachment 6 of MAPB-093-025-L, dated 11/08/93, that:

   - 15.1(a) must match the hours on the requesting provider's PA/RF for either procedure code W9900 or W9903, including PRN hours;
   - 15.1(b) must match the travel hours requested on the PA/RF; and
   - 15.1(d) must equal the home health aide visits requested on the PA/RF times the hours indicated (four hours per visit and three hours per subsequent visit), plus home health aide visits paid by other payers.

   If hours indicated on the PA/RF or Assessment form are not indicated in hour or half-hours units, round to the nearest half-hour unit according to standard rounding guidelines.

   EDS staff are directed to amend 15.1 (a) or (b) on the Assessment form to match the PA/RF when the information submitted by the provider does not match as requested. However, if 15.1(a) matches the PA/RF, but 15.1(b) indicates travel time and the hours at 15.2 are approvable, and travel time is missing from the PA/RF, EDS may write travel time hours on the PA/RF and add those hours to the total quantity granted on the PA/RF.

However, since providers were given faulty information in the MAPB, EDS is directed to accept home health or combined personal care/home health requests that do not include the HCFA 486 until revisions to the home health manual are sent to providers with the correct information. If a request is submitted without a HCFA 486 and the nurse consultant needs additional information to adjudicate the request, the nurse consultant may request it on an individual basis.

Effective Date: 02/01/94 **Reference:** 94-B-1-159 (01/20/94)
ML93-1391 (02/01/94)

BHCF Clarification of EDS Questions/Additional Directives

1. Q: There is a current PCW PA on file and a different provider submits another one. Neither PA references the other. How should EDS handle the subsequent PA?

   R: Effective 02/28/95, EDS is to no longer return Home Health or Personal Care PA if another provider has a current PA for the same recipient. Instead, EDS should send these requests to BHCF Nurse Consultants.

   Reference: 95-B-2-174/ML95-0330
   Amendment (02/27/95)

2. Q: When assessment forms are submitted for skilled nursing, home health aid, amendments or in lieu of the 486 form, is EDS to monitor the completeness of all fields on the assessment form?

   R: Yes. EDS is to return incomplete assessment forms with the appropriate return message.

3. Q: When a provider submits an incomplete instruction form, how is EDS to handle?

   R: EDS is to return incomplete instruction forms to providers with the appropriate return message.

4. Q: When a 485 form is submitted and the provider and/or MA number is missing or blank, how should EDS handle?

   R: EDS is to return the form to providers with the appropriate return message.

5. Q: Providers continue to use the draft copies of assessment forms. Should EDS continue to accept these?

   R: No. Providers have had ample time to obtain and begin to use the correct forms, therefore ED is to return the draft forms to providers with an appropriate return message. (However, EDS is to accept computer print-out forms.)

6. Q: Are there any providers whose PA requests are to be directly referred to the BHCF?

   R: PA guidelines are developed by the BHCF with the intent that all PAs, providers and recipients are adjudicated equally. In the event a sensitive issue arises, special handling procedures will be communicated to EDS via BHCF sign-off (i.e., 94-B-1-159) or the BHCF Medical Audit Section Chief (currently Pat Sheehan) or Supervisor (currently Marilyn Howe) will provide written notification to EDS' Prior Authorization Manager (currently Joan Landgraf). With either of these BHCF communications, EDS is to follow the instructions provided.

7. Q: How is EDS to 'round' hours?

   R: EDS is round up total hours (not each detail)

8. Q: In situations where the physician has signed the Physician's Plan of Care (PPOC), does not date it, but there is a date STAMP on line 25 (of the document - where the nurse is to sign), is EDS to accept this?

   R: Yes. Medicare accepts the date stamp, therefore we will also.

9. Q: How should EDS handle PCW PAs that merely state days/weeks, and no hours?

   R: Hours are required, therefore EDS is to return the request with the appropriate return message code.

10. Q: Is EDS to request clarification of a certification period on PCW orders?

    R: No. PCW orders (certification periods) are valid for one (1) year.

11. Q: If Part 11.2 of the assessment form is not checked, should EDS return?

    R: Follow guidelines directions as presented in sign-off.

12. Q: What should EDS do with an amendment for PA that is at the BHCF?

    R: If the PA file out-card states "Out to Consultant", EDS is to expedite BHCF notification by telephoning the Consultant to inform her/him that an amendment has been received. If the Consultant still has the PA file, EDS is to refer the amendment to the BHCF Consultant. If the PA file is in transit back to EDS, EDS is to return the file and amendment to the Consultant upon receipt. If the PA out-card states "Out to Penny Bahr", EDS is to telephone Paul Mickey and ask that he check the Appeal Pending file. If the PA files is at the BHCF (in the Appeal Pending file), EDS is to ask that the PA file be returned to EDS in order that the amendment may be adjudicated. For informational purposes only, EDS is to staple a note to the front of the PA file folder that an appeal is evidently forthcoming.

13. Q: Do PAs for Respiratory Care request HSA and RC attachments?

    R: If the Respiratory Care Handbook states they are required, then they are required.

14. Q: Is travel time allowable for Independent Nurses?

    R: No travel time is allowed for Independent Nurses?

15. Q: Independent Nurses have asked how they are to handle situations where they were approved a 12-hour shift, but work more than 12 hours because the next shift nurse is unavailable (e.g., snowstorm, sickness, etc.)?

    R: EDS is to inform the Nurse that though situations exceeding approved work shifts should be rare, they (the Nurse) should submit an amendment and explain the circumstance.

16. Q: Can a PCW be allowed any time to accompany a recipient to swim therapy?

    R: No, not to swim therapy, but they can for doctor or OT/PT/ST. In addition, they can go do grocery shopping, but they can't to accompany the recipient to do the shopping.

17. Q: In situations where the provider is requesting hours to accompany the recipient to an MD appointment, is EDS to add-on the time for the approved one-time appointment to the weekly total at 15.1 on the assessment worksheet?

PERSONAL CARE PA GUIDELINES
ATTACHMENT 9

DURATION OF PERSONAL CARE CHART

Provider Type	Signature Credentials on Physician Orders	Approval Duration
86	R.N. - Verbal orders from physician are submitted, signed and dated by R.N. Verbal orders must state the name of the physician who ordered the service.	5 weeks
86	M.D. or D.O. - Written orders from physician are submitted, signed and dated by M.D. or D.O.	53 weeks
86	M.D. or D.O.- Provider submits signed physician orders with amendment or copy of approved PA/RF. previously approved for 5 weeks, in order to have PA extended to total of 53 weeks. Written orders, signed and dated by M.D. or D.O. are also submitted. ICN date is equal to or prior to the expiration date on the approved PA.	Amend approved PA to add 48 weeks for total of 53 weeks approved
86	Provider submits signed physician orders with amendment or copy of PA/RF, previously approved for 5 weeks, in order to have PA extended to total of 53 weeks. However, ICN date is after the expiration date on the approved PA.	Return to provider to submit with a new PA/RF.
dual 44/86	R.N. - Verbal orders from physician are submitted, signed and dated by R.N. Verbal orders must state the name of the physician who ordered the service.	53 weeks
dual 44/86	M.D. or D.O. - Written orders from physician are submitted, signed and dated by M.D. or D.O.	53 weeks

PERSONAL CARE PA GUIDELINES
ATTACHMENT 6

CALCULATION WORKSHEET

CALCULATION WORKSHEET FOR HOME CARE ASSESSMENT - CONFIDENTIAL - FOR INTERNAL USE ONLY

Complete with information submitted on the Medical Assistance Home Care Assessment (ADLS form)

Recipient MA # _____

PA # _____

Total Hours Entered at 15.2 (a) _____

Number of Days per week entered at 15.2 (b) _____

Total Hours that Worksheet Will Allow (Where "Approve" is circled) _____

Signature of Analyst Reviewer _____ Date _____

Signature of Nurse Consultant Reviewer _____ Date _____

CIRCLE THE WORD "APPROVE" AT THE POINT SERVICES ARE AUTHORIZED.

A. Activity of Daily Living - Section 10:

In this section, one and only one box must be checked on the ADLS form. If no box is checked, a comment is required and the request must be referred to a State Nurse Consultant. If a box is checked, ignore all comments. If no box is checked and no comment entered, or if multiple boxes are checked, return the request to the provider to complete.

- ☐ 10.1 Dressing - Mark if box 2, 3, or 4 is checked.
- ☐ 10.2 Grooming - Mark if box 2, 3, or 4 is checked.
- ☐ 10.3 Bathing - Mark if box 3, 4, or 5 is checked.
- ☐ 10.4 Eating - Mark if box 3, 4, 5 or 6 is checked.

  For all forms, also check the level of eating.

  Eating is: O Light -Mark if box 0, 1, 2 or 3 is checked; or

  O Heavy - Mark if box 4, 5 or 6 is checked.
- ☐ 10.5 Transfers - Mark if box 2, 3, or 4 is checked.
- ☐ 10.6 Mobility - Mark if box 2, 3, or 4 is checked.
- ☐ 10.7 Positioning - Mark if box 2 or 3 is checked.
- ☐ 10.8 Toileting - Mark if box 1, 2, 3, 4, or 5 is checked.

Count the number of boxes checked under 10.1-10.8, enter total here _____, then check the ADL rating.

ADL Rating:
- ☐ Low (1-3 ADLS checked)
- ☐ Medium (4-6 ADLS checked)
- ☐ High (7-8 ADLS checked)

If no ADL rating (0 ADLs), refer to State Nurse Consultant.

Proceed to Section B.

PERSONAL CARE PA GUIDELINES
ATTACHMENT 6

CALCULATION WORKSHEET

B. Challenging Behavior - Section 9.1 and 9.2:

In this section, one or more box must be checked under 9.2 if box 5 is checked under 9.1. If a box is checked, ignore the comments. If a box is required and not checked, but a comment is entered, refer the request to a State Nurse Consultant. If a box is required and not checked, and no comment is entered, return the request to the provider to complete.

☐ Yes - Check Yes if box 5 is checked under 9.1 and any one box (1-7) is checked under 9.2.

If box 5 under 9.1 is checked, but no box under 9.2 is checked refer to State Nurse Consultant.

If Yes for Challenging Behavior:

If Hours at 15.2 (a) are	*And Days at 15.2 (b) are*	*And ADLs are*	*Take this action:*
Equal to or greater than 1	1, 2, 3, 4, 5, 6, or 7	0	Refer to State Nurse Consultant
Equal to or less than 70	1, 2, 3, 4, 5, 6, or 7	Low, Medium or High	Approve
Greater than 70, but equal to or less than 84	6 or 7	Low, Medium or High	Approve
Greater than 70, but equal to or less than 84	1, 2, 3, 4,or 5	Low, Medium or High	Refer to State Nurse Consultant
Greater than 84, but equal to or less than 98	7	Low, Medium or High	Approve
Greater than 84, but equal to or less than 98	1, 2, 3, 4, 5, or 6	Low, Medium or High	Refer to State Nurse Consultant
Greater than 98	1, 2, 3, 4, 5, 6, or 7	Low, Medium or High	Refer to State Nurse Consultant

☐ No - Check No if box 0, 1, 2, 3, 4, or N are checked. Then proceed to Section C.

If no box is checked, but a comment is entered, refer to State Nurse Consultant.

C. Medically Oriented Tasks - Section 11:

Complete this section is the recipient does not have challenging behavior under B - Challenging Behavior. If Yes is answered under this section, do not complete D - Behavior.

SEIZURES

☐ Yes - (Seizures) Check Yes if: box 11.1 is checked, and both A and B are answered yes, and 11.2 is checked.

If Hours at 15.2 (a) are	*And Days at 15.2 (b) are*	*Take this action:*
Equal to or less than 112	1, 2, 3, 4, 5, 6, or 7	Approve
Greater than 112	1, 2, 3, 4, 5, 6, or 7	Refer to State Nurse Consultant

☐ No - Check no if: box 11.1 is not checked, or
11.1 is checked, but B is answered No, or
11.2 is not checked.

Continue review for Other Medically Oriented Tasks.

PERSONAL CARE PA GUIDELINES
ATTACHMENT 6

CALCULATION WORKSHEET

OTHER MEDICALLY ORIENTED TASKS

In this section, no boxes are required. If a box is checked and a comment is entered, refer the request to a State Nurse Consultant. If a box is checked and no comment entered, proceed with the following.

☐ Yes - Check Yes if:
any box 11.3 through 11.10 is checked.

If Yes for Other Medically Oriented Tasks and Low ADL Rating at A:

If Hours at 15.2 (a) are	*And Days at 15.2 (b) are*	*Take this action:*
Equal to or less than 30	1, 2, 3, 4, 5, 6, or 7	Approve
Greater than 30, but equal to or less than 36	6 or 7	Approve
Greater than 30, but equal to or less than 36	1, 2, 3, 4,or 5	Refer to State Nurse Consultant
Greater than 36, but equal to or less than 42	7	Approve
Greater than 36, but equal to or less than 42	1, 2, 3, 4, 5, or 6	Refer to State Nurse Consultant
Greater than 42	1, 2, 3, 4, 5, 6, or 7	Refer to State Nurse Consultant

If Yes for Medically Oriented Tasks and Medium ADL Rating at A:

If Hours at 15.2 (a) are	*And Days at 15.2 (b) are*	*Take this action:*
Equal to or less than 40	1, 2, 3, 4, 5, 6, or 7	Approve
Greater than 40, but equal to or less than 48	6 or 7	Approve
Greater than 40, but equal to or less than 48	1, 2, 3, 4,or 5	Refer to State Nurse Consultant
Greater than 48, but equal to or less than 56	7	Approve
Greater than 48, but equal to or less than 56	1, 2, 3, 4, 5, or 6	Refer to State Nurse Consultant
Greater than 56	1, 2, 3, 4, 5, 6, or 7	Refer to State Nurse Consultant

If Yes for Medically Oriented Tasks and High ADL Rating at A:

If Hours at 15.2 (a) are	*And Days at 15.2 (b) are*	*Take this action:*
Equal to or less than 72.5	1, 2, 3, 4, 5, 6, or 7	Approve
Greater than 72.5, but equal to or less than 87	6 or 7	Approve
Greater than 72.5, but equal to or less than 87	1, 2, 3, 4,or 5	Refer to State Nurse Consultant
Greater than 87, but equal to or less than 101.5	7	Approve
Greater than 87, but equal to or less than 101.5	1, 2, 3, 4, 5, or 6	Refer to State Nurse Consultant
Greater than 101.5	1, 2, 3, 4, 5, 6, or 7	Refer to State Nurse Consultant

☐ No - If no medically oriented tasks are checked, go to D - Behavior.

PERSONAL CARE PA GUIDELINES
ATTACHMENT 6

CALCULATION WORKSHEET

D. **Behavior - Section 9.1:**

In this section, one and only one box must be checked on the ADLS form. If no box is checked, a comment is required and the request must be referred to a State Nurse Consultant. If a box is checked, ignore all comments. If no box is checked and no comment entered, or if multiple boxes are checked, return the request to the provider to complete.

☐ Yes - Mark if 9.1, box 2, 3, or 4 is checked.

If YES for Behavior and Low ADL Rating at A:

If Hours at 15.2 (a) are	*And Days at 15.2 (b) are*	*Take this action:*
Equal to or less than 15	1, 2, 3, 4, 5, 6, or 7	Approve
Greater than 15, but equal to or less than 18	6 or 7	Approve
Greater than 15, but equal to or less than 18	1, 2, 3, 4,or 5	Refer to State Nurse Consultant
Greater than 18, but equal to or less than 21	7	Approve
Greater than 18, but equal to or less than 21	1, 2, 3, 4, 5, or 6	Refer to State Nurse Consultant
Greater than 21	1, 2, 3, 4, 5, 6, or 7	Refer to State Nurse Consultant

If Yes for Behavior and Medium ADL Rating at A:

If Hours at 15.2 (a) are	*And Days at 15.2 (b) are*	*Take this action:*
Equal to or less than 27.5	1, 2, 3, 4, 5, 6, or 7	Approve
Greater than 27.5, but equal to or less than 33	6 or 7	Approve
Greater than 27.5, but equal to or less than 33	1, 2, 3, 4,or 5	Refer to State Nurse Consultant
Greater than 33, but equal to or less than 38.5	7	Approve
Greater than 33, but equal to or less than 38.5	1, 2, 3, 4, 5, or 6	Refer to State Nurse Consultant
Greater than 38.5	1, 2, 3, 4, 5, 6, or 7	Refer to State Nurse Consultant

If Yes for Behavior, High ADL Rating at A, and Light Eating Rating at A. 10.4:

If Hours at 15.2 (a) are	*And Days at 15.2 (b) are*	*Take this action:*
Equal to or less than 37.5	1, 2, 3, 4, 5, 6, or 7	Approve
Greater than 37.5, but equal to or less than 45	6 or 7	Approve
Greater than 37.5, but equal to or less than 45	1, 2, 3, 4,or 5	Refer to State Nurse Consultant
Greater than 45, but equal to or less than 52.5	7	Approve
Greater than 45, but equal to or less than 52.5	1, 2, 3, 4, 5, or 6	Refer to State Nurse Consultant
Greater than 52.5	1, 2, 3, 4 5, 6, or 7	Refer to State Nurse Consultant

PERSONAL CARE PA GUIDELINES
ATTACHMENT 6

CALCULATION WORKSHEET

If Yes for Behavior, High ADL Rating at A, and Heavy Eating Rating at A.10.4:

If Hours at 15.2 (a) are	*And Days at 15.2 (b) are*	*Take this action:*
Equal to or less than 42.5	1, 2, 3, 4, 5, 6, or 7	Approve
Greater than 42.5, but equal to or less than 51	6 or 7	Approve
Greater than 42.5, but equal to or less than 51	1, 2, 3, 4, or 5	Refer to State Nurse Consultant
Greater than 51, but equal to or less than 59.5	7	Approve
Greater than 51, but equal to or less than 59.5	1, 2, 3, 4, 5, or 6	Refer to State Nurse Consultant
Greater than 59.5	1, 2, 3, 4, 5, 6, or 7	Refer to State Nurse Consultant

☐ No - If no behavior is identified above, go to E - ADLS Only.

E. Activity of Daily Living Only - No Challenging Behavior at B, No Medically Oriented Tasks at C, and No Behavior at D

Refer to A - Activity of Daily Living for the ADL rating and approve as follows:

For Low ADL Rating at A, With No Challenging Behavior, No Behavior, No Medically Oriented Tasks:

If Hours at 15.2 (a) are	*And Days at 15.2 (b) are*	*Take this action:*
Equal to or less than 12.5	1, 2, 3, 4, 5, 6, or 7	Approve
Greater than 12.5, but equal to or less than 15	6 or 7	Approve
Greater than 12.5, but equal to or less than 15	1, 2, 3, 4, or 5	Refer to State Nurse Consultant
Greater than 15, but equal to or less than 17.5	7	Approve
Greater than 15, but equal to or less than 17.5	1, 2, 3, 4, 5, or 6	Refer to State Nurse Consultant
Greater than 17.5	1, 2, 3, 4, 5, 6, or 7	Refer to State Nurse Consultant

For Medium ADL Rating at A, With No Challenging Behavior, No Behavior, No Medically Oriented Tasks:

If Hours at 15.2 (a) are	*And Days at 15.2 (b) are*	*Take this action:*
Equal to or less than 22.5	1, 2, 3, 4, 5, 6, or 7	Approve
Greater than 22.5, but equal to or less than 27	6 or 7	Approve
Greater than 22.5, but equal to or less than 27	1, 2, 3, 4, or 5	Refer to State Nurse Consultant
Greater than 27, but equal to or less than 31.5	7	Approve
Greater than 27, but equal to or less than 31.5	1, 2, 3, 4, 5, or 6	Refer to State Nurse Consultant
Greater than 31.5	1, 2, 3, 4, 5, 6, or 7	Refer to State Nurse Consultant

PERSONAL CARE PA GUIDELINES
ATTACHMENT 6

CALCULATION WORKSHEET

For High ADL Rating at A and Light Eating at A, 10.4, With No Challenging Behavior, No Behavior, No Medically Ordered Tasks:

If Hours at 15.2 (a) are	*And Days at 15.2 (b) are*	*Take this action:*
Equal to or less than 30	1, 2, 3, 4, 5, 6, or 7	Approve
Greater than 30, but equal to or less than 36	6 or 7	Approve
Greater than 30, but equal to or less than 36	1, 2, 3, 4,or 5	Refer to State Nurse Consultant
Greater than 36, but equal to or less than 42	7	Approve
Greater than 36, but equal to or less than 42	1, 2, 3, 4, 5, or 6	Refer to State Nurse Consultant
Greater than 42	1, 2, 3, 4, 5, 6, or 7	Refer to State Nurse Consultant

For High ADL Rating at A and Heavy Eating at A, 10.4, With No Challenging Behavior, No Behavior, No Medically Ordered Tasks:

If Hours at 15.2 (a) are	*And Days at 15.2 (b) are*	*Take this action:*
Equal to or less than 40	1, 2, 3, 4, 5, 6, or 7	Approve
Greater than 40, but equal to or less than 48	6 or 7	Approve
Greater than 40, but equal to or less than 48	1, 2, 3, 4,or 5	Refer to State Nurse Consultant
Greater than 48, but equal to or less than 56	7	Approve
Greater than 48, but equal to or less than 56	1, 2, 3, 4, 5, or 6	Refer to State Nurse Consultant
Greater than 56	1, 2, 3, 4, 5, 6, or 7	Refer to State Nurse Consultant

FOR SECTIONS 9, 10, AND 11, IF NO BOXES ARE CHECKED AND THE "COMMENT" LINES CONTAIN WRITING, OR IF ANY RESPONSE IS NOT CLEAR, REFER TO THE STATE NURSE CONSULTANT TO CONFIRM/DETERMINE THE APPROPRIATE CHOICE.

If the request cannot be approved, refer to the State Nurse Consultant.

PERSONAL CARE REQUESTS RECORDS
Attachment 7

Recipient Last Name _____ Provider _____

Date _____ Sign/Initials _____ PA # or Amendment #: _____

Change in Home Care Assessment?
Γ No Γ Yes Ψ
If yes, record changes on Calculation Worksheet (Parts A through Part E), then record changes in hours below:

Change in Hours Requested or Allowable? (Hours need not be entered if unchanged)
Γ No Γ Yes Ψ
Total Hours Requested [at 15.2(a)]: _____

Comments: Number of Days/Week [at 15.2(b)]: _____

# of Hours/Week Worksheet Allows: _____

Total Hours Requested if Case-Shared: _____

Recipient Last Name _____ Provider _____

Date _____ Sign/Initials _____ PA # or Amendment #: _____

Change in Home Care Assessment?
Γ No Γ Yes Ψ
If yes, record changes on Calculation Worksheet (Parts A through Part E), then record changes in hours below:

Change in Hours Requested or Allowable? (Hours need not be entered if unchanged)
Γ No Γ Yes Ψ
Total Hours Requested [at 15.2(a)]: _____

Comments: Number of Days/Week [at 15.2(b)]: _____

# of Hours/Week Worksheet Allows: _____

Total Hours Requested if Case-Shared: _____

Recipient Last Name _____ Provider _____

Date _____ Sign/Initials _____ PA # or Amendment #: _____

physician within 20 working days following the recipient's admission for care. The written plan of care shall include, in addition to the medication and treatment orders:

a. Measurable time–specific goals;

b. Methods for delivering needed care, and an indication of which, if any, professional disciplines are responsible for delivering the care;

c. Provision for care coordination by an RN when more than one nurse is necessary to staff the recipient's case;

d. Identification of all other parties providing care to the recipient and the responsibilities of each party for that care; and

e. A description of functional capabilities, mental status, dietary needs and allergies.

4. The written plan of care shall be reviewed, signed and dated by the recipient's physician as often as required by the recipient's condition but at least every 62 days. The RN shall promptly notify the physician of any change in the recipient's condition that suggests a need to modify the plan of care.

5. Drugs and treatment shall be administered by the RN or LPN only as ordered by the recipient's physician or his or her designee. The nurse shall immediately record and sign oral orders and shall obtain the physician's countersignature within 10 working days.

6. Supervision of an LPN by an RN or physician shall be performed according to the requirements under ss. N 6.03 and 6.04 and the results of supervisory activities shall be documented and communicated to the LPN.

(c) *Prior authorization.* 1. Prior authorization requirements under sub. (3) apply to services provided by an independent nurse.

2. A request for prior authorization of part–time, intermittent care performed by an LPN shall include the name and license number of the registered nurse supervising the LPN.

(d) *Other limitations.* 1. Each independent RN or LPN shall document the care and services provided. Documentation required under par. (b) of the unavailability of a home health agency shall include names of agencies contacted, dates of contact and any other pertinent information.

2. Discharge of a recipient from nursing care under this subsection shall be made in accordance with s. HFS 105.19 (9).

3. The limitations under sub. (4) apply.

4. Registered nurse supervision of an LPN is not separately reimbursable.

(e) *Non–covered services.* The following services are not covered services under this subsection:

1. Services listed in sub. (5);

2. Private duty nursing services under s. HFS 107.12; and

3. Any service that fails to meet the recipient's medical needs or places the recipient at risk for a negative treatment outcome.

History: Cr. Register, February, 1986, No. 362, eff. 3–1–86; r. and recr. Register, April, 1988, No. 388, eff. 7–1–88; am. (3) (d) and (e), cr. (3) (f), Register, December, 1988, No. 396, eff. 1–1–89; emerg. r. and recr. eff. 7–1–92; r. and recr. Register, February, 1993, No. 446, eff. 3–1–93; emerg. cr. (3) (ag), eff. 1–1–94.

HFS 107.112 Personal care services. (1) COVERED SERVICES. (a) Personal care services are medically oriented activities related to assisting a recipient with activities of daily living necessary to maintain the recipient in his or her place of residence in the community. These services shall be provided upon written orders of a physician by a provider certified under s. HFS 105.17 and by a personal care worker employed by the provider or under contract to the provider who is supervised by a registered nurse according to a written plan of care. The personal care worker shall be assigned by the supervising registered nurse to specific recipients to do specific tasks for those recipients for which the personal care worker has been trained. The personal care worker's training for these specific tasks shall be assured by the supervising registered nurse. The personal care worker is limited to performing only those tasks and services as assigned for each recipient and for which he or she has been specifically trained.

(b) Covered personal care services are:

1. Assistance with bathing;

2. Assistance with getting in and out of bed;

3. Teeth, mouth, denture and hair care;

4. Assistance with mobility and ambulation including use of walker, cane or crutches;

5. Changing the recipient's bed and laundering the bed linens and the recipient's personal clothing;

6. Skin care excluding wound care;

7. Care of eyeglasses and hearing aids;

8. Assistance with dressing and undressing;

9. Toileting, including use and care of bedpan, urinal, commode or toilet;

10. Light cleaning in essential areas of the home used during personal care service activities;

11. Meal preparation, food purchasing and meal serving;

12. Simple transfers including bed to chair or wheelchair and reverse; and

13. Accompanying the recipient to obtain medical diagnosis and treatment.

(2) SERVICES REQUIRING PRIOR AUTHORIZATION. (a) Prior authorization is required for personal care services in excess of 250 hours per calendar year.

(b) Prior authorization is required under par. (a) for specific services listed in s. HFS 107.11 (2). Services listed in s. HFS 107.11 (2) (b) are covered personal care services, regardless of the recipient's age, only when:

1. Safely delegated to a personal care worker by a registered nurse;

2. The personal care worker is trained and supervised by the provider to provide the tasks; and

3. The recipient, parent or responsible person is permitted to participate in the training and supervision of the personal care worker.

(3) OTHER LIMITATIONS. (a) Personal care services shall be performed under the supervision of a registered nurse by a personal care worker who meets the requirements of s. HFS 105.17 (3) and who is employed by or is under contract to a provider certified under s. HFS 105.17.

(b) Services shall be performed according to a written plan of care for the recipient developed by a registered nurse for purposes of providing necessary and appropriate services, allowing appropriate assignment of a personal care worker and setting standards for personal care activities, giving full consideration to the recipient's preferences for service arrangements and choice of personal care workers. The plan shall be based on the registered nurse's visit to the recipient's home and shall include:

1. Review and interpretation of the physician's orders;

2. Frequency and anticipated duration of service;

3. Evaluation of the recipient's needs and preferences; and

4. Assessment of the recipient's social and physical environment, including family involvement, living conditions, the recipient's level of functioning and any pertinent cultural factors such as language.

(c) Review of the plan of care, evaluation of the recipient's condition and supervisory review of the personal care worker shall be made by a registered nurse at least every 60 days. The review shall include a visit to the recipient's home, review of the personal care worker's daily written record and discussion with the physician of any necessary changes in the plan of care.

(d) Reimbursement for registered nurse supervisory visits is limited to one visit per month.

(c) No more than one–third of the time spent by a personal care worker may be in performing housekeeping activities.

(4) NON–COVERED SERVICES. The following services are not covered services:

(a) Personal care services provided in a hospital or a nursing home or in a community–based residential facility, as defined in s. 50.01 (1), Stats., with more than 20 beds;

(b) Homemaking services and cleaning of areas not used during personal care service activities, unless directly related to the care of the person and essential to the recipient's health;

(c) Personal care services not documented in the plan of care;

(d) Personal care services provided by a responsible relative under s. 49.90, Stats.;

(e) Personal care services provided in excess of 250 hours per calendar year without prior authorization;

(f) Services other than those listed in subs. (1) (b) and (2) (b);

(g) Skilled nursing services, including:

1. Insertion and sterile irrigation of catheters;

2. Giving of injections;

3. Application of dressings involving prescription medication and use of aseptic techniques; and

4. Administration of medicine that is not usually self–administered; and

(h) Therapy services.

History: Cr. Register, April, 1988, No. 388, eff. 7–1–88; renum. (2) to be (2) (a), cr. (2) (b), am. (3) (e), Register, December, 1988, No. 396, eff. 1–1–89; r. and recr. (2) (b), r. (3) (f), am. (4) (f), Register, February, 1993, No. 446, eff. 3–1–93; emerg. am. (2) (a), (4) (e), eff. 1–1–94.

HFS 107.113 Respiratory care for ventilator–assisted recipients. (1) COVERED SERVICES. Services, medical supplies and equipment necessary to provide life support for a recipient who has been hospitalized for at least 30 consecutive days for his or her respiratory condition and who is dependent on a ventilator for at least 6 hours per day shall be covered services when these services are provided to the recipient in the recipient's home. A recipient receiving these services is one who, if the services were not available in the home, would require them as an inpatient in a hospital or a skilled nursing facility, has adequate social support to be treated at home and desires to be cared for at home, and is one for whom respiratory care can safely be provided in the home. Respiratory care shall be provided as required under ss. HFS 105.16 and 105.19 and according to a written plan of care under sub. (2) signed by the recipient's physician for a recipient who lives in a residence that is not a hospital or a skilled nursing facility. Respiratory care includes:

(a) Airway management, consisting of:

1. Tracheostomy care: all available types of tracheostomy tubes, stoma care, changing a tracheostomy tube, and emergency procedures for tracheostomy care including accidental extubation;

2. Tracheal suctioning technique; and

3. Airway humidification;

(b) Oxygen therapy: operation of oxygen systems and auxiliary oxygen delivery devices;

(c) Respiratory assessment, including but not limited to monitoring of breath sounds, patient color, chest excursion, secretions and vital signs;

(d) Ventilator management, as follows:

1. Operation of positive pressure ventilator by means of tracheostomy to include, but not limited to, different modes of ventilation, types of alarms and responding to alarms, troubleshooting ventilator dysfunction, operation and assembly of ventilator circuit, that is, the delivery system, and proper cleaning and disinfection of equipment;

2. Operation of a manual resuscitator; and

3. Emergency assessment and management including cardiopulmonary resuscitation (CPR);

(e) The following modes of ventilatory support:

1. Positive pressure ventilation by means of a nasal mask or mouthpiece;

2. Continuous positive airway pressure (CPAP) by means of a tracheostomy tube or mask;

3. Negative pressure ventilation — iron lung, chest shell or pulmowrap;

4. Rocking beds;

5. Pneumobelts; and

6. Diaphragm pacing;

(f) Operation and interpretation of monitoring devices:

1. Cardio–respiratory monitoring;

2. Pulse oximetry; and

3. Capnography;

(g) Knowledge of and skills in weaning from the ventilator;

(h) Adjunctive techniques:

1. Chest physiotherapy; and

2. Aerosolized medications; and

(i) Case coordination activities performed by the registered nurse designated in the plan of care as case coordinator. These activities include coordination of health care services provided to the recipient at home and coordination of these services with any other health or social service providers serving the recipient.

(2) PLAN OF CARE. A recipient's written plan of care shall be based on the orders of a physician, a visit to the recipient's home by the registered nurse and consultation with the family and other household members. The plan of care established by a home health agency or independent provider for a recipient to be discharged from a hospital shall consider the hospital's discharge plan for the recipient. The written plan of care shall be reviewed, signed and dated by the recipient's physician and renewed at least every 62 days and whenever the recipient's condition changes. Telephone orders shall be documented in writing and signed by the physician within 10 working days. The written physician's plan of care shall include:

(a) Physician orders for treatments provided by the necessary disciplines specifying the amount and frequency of treatment;

(b) Medications, including route, dose and frequency;

(c) Principal diagnosis, surgical procedures and other pertinent diagnosis;

(d) Nutritional requirements;

(e) Necessary durable medical equipment and disposable medical supplies;

(f) Ventilator settings and parameters;

(g) Procedures to follow in the event of accidental extubation;

(h) Identification of back–ups in the event scheduled personnel are unable to attend the case;

(i) The name of the registered nurse designated as the recipient's case coordinator;

(j) A plan for medical emergency, to include:

1. Description of back–up personnel needed;

2. Provision for reliable, 24–hour a day, 7 days a week emergency service for repair and delivery of equipment; and

3. Specification of an emergency power source; and

(k) A plan to move the recipient to safety in the event of fire, flood, tornado warning or other severe weather, or any other condition which threatens the recipient's immediate environment.

(3) PRIOR AUTHORIZATION. (a) All services covered under sub. (1) and all home health services under s. HFS 107.11 provided to a recipient receiving respiratory care shall be authorized prior to the time the services are rendered. Prior authorization shall be renewed every 12 calendar months if the respiratory care under this section is still needed. The prior authorization request shall

DHA-15 (R10/97)

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]
Madison, WI 53703

DECISION

MPA-13/39653

PRELIMINARY RECITALS

Pursuant to a petition filed April 16, 1999, under Wis. Stat. § 49.45(5), to review a decision by the Division of Health Care Financing in regard to Medical Assistance (MA), a hearing was held on May 19, 1999, at Madison, Wisconsin.

The issue for determination is whether the Division correctly modified and reduced the petitioner's Prior Authorization Request for personal care worker (PCW) services.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:
Petitioner:

[redacted]
Madison, WI 53703

Department of Health and Family Services
Division of Health Care Financing
1 West Wilson Street, Room 250
P.O. Box 309
Madison, WI 53707-0309
By: Jeanne Siroky, Nurse Consultant

EXAMINER:
Kenneth D. Duren, Attorney
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner [redacted] is a 13 year-old resident of Dane County; she receives MA.

2. Petitioner's diagnosed conditions are: Down's Syndrome; hypotonia; myopia; arthritis; and incontinence. She needs "hands on assistance" to complete all activities of daily living. She needs intermittent cueing or supervision when transferring, needs assistance with stairs/home ramp, and she is ambulatory with the assist of a walker.

3. The petitioner attends school on a daily basis, where her care needs are met by school-based services and providers.

4. On or about February 23, 1999, the petitioner's personal care fee-for-service provider requested Prior Authorization from the Division for the cost of reimbursement of 59.5 hours per week of personal care worker (PCW) services.

5. The Division modified the request and reduced the approved PCW services from the requested 59.5 to 31.5 hours per week based upon the Home Care Assessment Form submitted with the provider documentation. The Division concluded that the amount of time requested was not medically necessary.

6. The petitioner filed an appeal with the Division on April 16, 1999.

7. The petitioner requires, at present an average of 8.5 hours per day of assistance with her personal care needs from a personal care worker to complete her morning and evening personal care regimen and meals, exclusive of any home housekeeping services other than some meal preparation. See, Exhibits #1 & #2.

DISCUSSION

The Division may only reimburse providers for medically necessary and appropriate health care services and equipment listed in Wis. Stat. §§ 49.46(2) and 49.47(6)(a), as implemented by Wis. Admin. Code § HFS 107.02(3). Some services and equipment are covered only when listed guidelines are met. Some services and equipment are covered if a prior authorization request is submitted and approved by the Division in advance of receiving the service. Some services are covered only as modified by the Division for medical necessity or other reasons. Finally, some services and equipment are never covered by the MA program.

Personal care worker (PCW) services are an MA-covered service, subject to prior authorization when they exceed 250 hours per year. Wis. Admin. Code § HFS 107.112(2). Prior authorization is given if the request satisfies the generic prior authorization criteria (such as "medical necessity") found at Wis. Admin. Code § HFS 107.02(3)(e). Part of this generic criteria is that the requested services be "reasonable" and "medically necessary", as that term is defined by the MA Program. See, Wis. Admin. Code § HFS 101.03(96m). Personal care services not documented in the assessment plan are not covered services. Wis. Admin. Code § HFS 107.112(4)(c).

The Division assigns a professional consultant to review each and every Prior Authorization (PA) Request to ascertain whether the service is covered by MA. The burden of proof is on the person requesting the prior authorization to demonstrate the need for the PA. Wis. Admin. Code § HFS 107.02(3)(d)6; see also, Wis. Admin. Code § HFS 106.02(9)(e)1.

The petitioner's PCW provider appeared at the hearing and testified that she was seeking approval of a pattern of PCW services which consisted of an hour-and-a- half (1.5) in each weekday early morning before [redacted] goes to school to assist her in preparing for school and breakfast; six hours (6.0) each evening from after school until bedtime, and 8.5 hours per day, as needed on Saturdays and Sundays. The provider requested 59.5 hours per week, based on a 8.5 hour per day average. Apparently, she included one hour per week-day for as needed services, though she does not explicitly state this.

The provider, Nancy Anderson, R.N. of Community Living Alliance (CLA), testified that she premised the request on the "thumbnail" sketch of the services to be provided to [redacted], attached as Exhibit #1, and came to 8.5 hours per day of services. She also performed an analysis using what she understood to be the "Minnesota" method of computing PCW services, and under that analysis concluded that [redacted] needed 9.38 hours per day of PCW *exclusive* of any housekeeping services, plus 4.4 hours of housekeeping services. See, Exhibit #2. Anderson testified that she completed the required Home Care Assessment Form to the best of her ability, and that she does not know and cannot ascertain how the Division tallied the services on the HCAF to arrive at 31.5 hours per week as sufficient for [redacted] She

asserted that the Division had not been using this method of review in recent years, and that nurse consultants had changed. She indicated that children like [redacted] have extensive needs and require some flexibility in the hours of service provided. She stressed that her agency had a good reputation with the Division for only providing the services that were needed, and only billing for the services provided, regardless of the authorized upper limits. Anderson alleged that the Division's method for computing the level of PCW services based upon its variant upon the Minnesota" style system arising from the HCAF was a complete mystery, and that the Division guards the formulae like a "secret".

Anderson testified that [redacted] moves extremely slowly with her walker, and that she requires toileting assistance up to 8 times per day. She testified that on days when [redacted] is in school, she is soiled when she returns home because no one provides the needed toileting assist regularly at school. This necessitates an immediate sponge bath when [redacted] gets home from school each day, in addition to the regular bath each night prior to bed. Anderson testified that the PCW does not even provide any housekeeping services under the proposed plan of care (other than some meal preparation). Rather, she notes that all the PCW care is for the preparation of Stephanie's toilet, hygienic care, dressing, exercises, ROM drills, and breakfast in the morning, and undressing, bathing, shampooing, dressing, hygienic care, lotion application, nail cleaning, ROM exercises and speech & language therapy, as well as dinner and snack preparation.

Mrs. [redacted] testified that she suffers from hemiparesis in her left side resulting from an automobile accident, and that she has significant limits as to her ability to perform caregiver tasks for and with [redacted].

The Division produced a Summary on May 5, 1999, in which the Consultant asserts merely that [redacted] receives the maximum number of hours of PCW that she can receive under the review process as indicated by her home care assessment form. Nurse Siroky notes only that she concludes that while it is clear that [redacted] requires considerable assistance in completion of her personal cares, that she does not see the clinical documentation for deviation from the number of hours determined available by EDS, the Department's fiscal agent.

I agree with the petitioner here. The Department has done a poor job of providing meaningful guideposts to ascertain the appropriate hours of personal care needed for [redacted]. See, Summary, pp.1-2. With all due respect to the so-called "decision tree" premised on the "Minnesota" system of determining home health care hours, I cannot determine that the decision here functions in anything but an arbitrary and unreasonable manner. The Department's analysis lacks data analysis or any explanation of how "points" or hours of PCW care are determined under the decision tree. The Summary is long on conclusory language but short on meaningful data or analysis of data. Recipients and providers deserve, and reviewing fair hearing officers require, a much better explanation of how this process results in a reasoned amount of hours. It maybe that the "Minnesota" model will result in a fair and reasonable determination model for such decision. Other decisions made by the Department have rested on such point systems or mechanisms, and been found valid. This case file, however, is bereft of any real explanation of how the decision was actually made.

I conclude that the petitioner has met her burden of proof to demonstrate that 59.5 hours per week are medically necessary to meet her personal care needs, and that the Department has failed to rebut this case. The Division's denial is reversed.

CONCLUSIONS OF LAW

That the petitioner is entitled to prior authorization for 59.5 hours per week of personal care worker (PCW) services; the Division's modification action must be reversed.

NOW, THEREFORE, It is ORDERED

That the petitioner's provider is directed to submit a copy of the claim for payment of 59.5 hours per week of PCW services to EDS-Federal, Inc. together with a copy of this Decision. IT IS FURTHER ORDERED, that EDS-Federal, Inc. is directed to pay the petitioner's claims for PCW services up to 59.5 hours per week, under PA Request #9950881.

REQUEST FOR A NEW HEARING

This is a final fair hearing decision. If you think this decision is based on a serious mistake in the facts or the law, you may request a new hearing. You may also ask for a new hearing if you have found new evidence that would change the decision. To ask for a new hearing, send a written request to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707-7875.

Send a copy of your request to the other people named in this decision as "PARTIES IN INTEREST."

Your request must explain what mistake the examiner made and why it is important or you must describe your new evidence and tell why you did not have it at your first hearing. If you do not explain these things, your request will have to be denied.

Your request for a new hearing must be received no later than twenty (20) days after the date of this decision. Late requests cannot be granted. The process for asking for a new hearing is in sec. 227.49 of the state statutes. A copy of the statutes can found at your local library or courthouse.

APPEAL TO COURT

You may also appeal this decision to Circuit Court in the county where you live. Appeals must be filed no more than thirty (30) days after the date of this hearing decision (or 30 days after a denial of rehearing, if you ask for one).

Appeals concerning Medical Assistance (MA) must be served on the Wisconsin Department of Health and Family Services, as respondent, P.O. Box 7850, Madison, WI 53707-7850.

The appeal must also be served on the other "PARTIES IN INTEREST" named in this decision. The process for Court appeals is in sec. 227.53 of the statutes.

THIS IS A CERTIFIED COPY OF THE
FINDINGS AND DECISION AS APPEARS
ON RECORD AND FILED IN
THE OFFICE OF THE DIVISION OF
HEARINGS AND APPEALS IN
MADISON, WISCONSIN

Given under my hand at the City of Madison, Wisconsin, this 4th day of June, 1999.

Kenneth D. Duren, Attorney
Division of Hearings and Appeals
524/

cc: F. Center, Dane Co. DHS
Division Of Health Care Financing - Appeals Coordinator
Judy Zitske, BLTS
Susan Wood, DHFS
EDS-Federal Corporation

DHA-15 (R10/97)

JUN 15 1999

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]
McFarland, WI 53558

DECISION

MPA-13/39830

PRELIMINARY RECITALS

Pursuant to a petition filed May 3, 1999, under Wis. Stat. § 49.45(5), to review a decision by the Division of Health Care Financing in regards to the modification of a Prior Authorization (PA) Request for personal care worker (PCW) services under the Medical Assistance (MA) Program, a hearing was held on May 26, 1999 at Madison, Wisconsin. At the request of the Division of Health Care Financing, the record was held open for 17 days for the submission of additional information.

The issue for determination is whether petitioner is eligible for payment by the MA program for personal care worker (PCW) services as requested.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:
[redacted]
McFarland, WI 53558

Represented by:
[redacted]
Same Address

Department of Health and Family Services
Division of Health Care Financing
1 West Wilson Street, Room 250
P.O. Box 309
Madison, WI 53707-0309
By: Kerry Cantwell, R.N., Nurse Consultant
Jeanne Siroky, R.N., Nurse Consultant

EXAMINER:
Kenneth D. Duren, Attorney
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner ([redacted]) is a resident of Dane County; she is 88 years old and is certified for MA. She alternates the uses of a cane, a walker, and a wheelchair to ambulate; she has the following physical conditions: cerebrovascular disease, atrial fibrillation, degenerative joint disease, insulin dependent diabetes, hypertension, stress incontinence, and general dizziness. She is alert and oriented, has no visual impairments, is fully cooperative, and generally needs hands on assistance with her activities of daily living (ADLS).

2. On March 30, 1999, the petitioner's personal care fee-for-service provider requested Prior Authorization from the Division for the cost of reimbursement of 49 hours per week of personal care worker (PCW) services.

3. On or about April 2, 1999, the Division modified the request and reduced the approved PCW services from the requested 49 to 31.5 hours per week based upon the Home Care Assessment Form submitted with the provider documentation. The Division concluded that the amount of time requested was not medically necessary based upon the use of the so-called "Minnesota Model Home Health Assessment Tool".

4. The petitioner filed an appeal with the Division on May 3, 1999.

5. The Division of Health Care Financing did not produce a copy of the "tool" as it was applied to determine the petitioner's request at the hearing; the record was held for the Division Consultant to provide the "tool" to the examiner and the petitioner. Subsequently, on or about June 7, 1999, the Division submitted the "tool" to DHA requesting that it be kept confidential as providers throughout the state had not been provided the tool in order to avoid excessive and fraudulent requests and to apparently obtain objective information upon which to accurately assess individual PA Request for PCW services. This submission was returned and not accepted by DHA because a copy was not provided to the petitioner and/or her provider, and the DHCF was given 7 days to re-submit the "tool" and provide a copy to the petitioner, or to submit no further information.

6. On June 11, 1999, the Division's Nurse Consultant advised the examiner that the DHCF would choose not to submit the assessment "tool" in this case.

7. The petitioner requires, at present an average of 7 hours per day of assistance with her personal care needs from a personal care worker to complete her morning and evening personal care regimen(i.e., bathing, showering, toileting, dressing and personal hygiene), transfers, range of motion exercises, meal preparation, laundry, and cleaning. See, Exhibits #1 & #2.

DISCUSSION

The Division may only reimburse providers for medically necessary and appropriate health care services and equipment listed in Wis. Stat. §§ 49.46(2) and 49.47(6)(a), as implemented by Wis. Admin. Code § HFS 107.02(3). Some services and equipment are covered only when listed guidelines are met. Some services and equipment are covered if a prior authorization request is submitted and approved by the Division in advance of receiving the service. Some services are covered only as modified by the Division for medical necessity or other reasons. Finally, some services and equipment are never covered by the MA program.

Personal care worker (PCW) services are an MA-covered service, subject to prior authorization when they exceed 250 hours per year. Wis. Admin. Code § HFS 107.112(2). Prior authorization is given if the request satisfies the generic prior authorization criteria (such as "medical necessity") found at Wis. Admin. Code § HFS 107.02(3)(e). Part of this generic criteria is that the requested services be "reasonable" and "medically necessary", as that term is defined by the MA Program. See, Wis. Admin. Code § HFS 101.03(96m). Personal care services not documented in the assessment plan are not covered services. Wis. Admin. Code § HFS 107.112(4)(c).

The Division assigns a professional consultant to review each and every Prior Authorization (PA) Request to ascertain whether the service is covered by MA. The burden of proof is on the person requesting the prior authorization to demonstrate the need for the PA. Wis. Admin. Code § HFS 107.02(3)(d)6; see also. Wis. Admin. Code § HFS 106.02(9)(e)1.

The petitioner's PCW provider appeared at the hearing and testified that she was seeking approval of a pattern of PCW services, as described in Finding #7, above, and as demonstrated in Exhibits #1 & #2. The provider requested 49 hours per week, based on a 7 hour per day average.

The provider, Nancy Anderson, R.N. of Community Living Alliance (CLA), testified that she premised the request on the "thumbnail" sketch of the services to be provided to [redacted], attached as Exhibit #2, and came to 7 hours per day of services. She also performed an analysis using what she understood to be the "Minnesota" method of computing PCW services, and under that analysis concluded that [redacted] needed 7.9 hours per day of PCW services. See, Exhibit #1: Anderson testified that she completed the required Home Care Assessment Form to the best of her ability, and that she does not know and cannot ascertain how the Division tallied the services on the HCAF to arrive at 31.5 hours per week as sufficient for [redacted]. She asserted that the Division had not been using this method of review in recent years, and that nurse consultants had changed. She indicated that elderly disabled people like [redacted] have extensive needs and require some flexibility in the hours of service provided. She stressed that her agency had a good reputation with the Division for only providing the services that were needed, and only billing for the services provided, regardless of the authorized upper limits. Anderson alleged that the Division's method for computing the level of PCW services based upon its variant upon the "Minnesota" style system arising from the HCAF was a complete mystery, and that the Division guards the formula like a "secret".

The Division produced a Summary on May 13, 1999, in which the Consultant asserts merely that [redacted] receives the maximum number of hours of PCW that she can receive under the review process as indicated by her home care assessment form. Nurse Cantwell notes only that she concludes that while it is clear that [redacted] requires considerable assistance in completion of her personal cares, that she does not see the clinical documentation for deviation from the number of hours determined available by EDS, the Department's fiscal agent.

I agree with the petitioner here. The Department has done a poor job of providing meaningful guideposts to ascertain the appropriate hours of personal care needed for [redacted]. See, Summary, pp.1-2. With all due respect to the so-called "decision tree" premised on the "Minnesota" system of determining home health care hours, i.e., the "tool", I cannot determine that the decision here functions in anything but an arbitrary and unreasonable manner. The Department's analysis lacks data analysis or any explanation of how "points" or hours of PCW care are determined under the decision tree. The Summary is long on conclusory language but short on meaningful data or analysis of data. Recipients and providers deserve, and reviewing fair hearing officers require, a much better explanation of how this process results in a reasoned amount of hours. It may be that the "Minnesota" model will result in a fair and reasonable determination model for such decision. Other decisions made by the Department have rested on such point systems or mechanisms, and been found valid. This case file, however, is bereft of any real explanation of how the decision was actually made.

This examiner offered the Department ample opportunity to explain and demonstrate the calculations used in the "tool", by holding the record open. The Division Consultant has failed to produce a copy of the "tool" document used here, or even a blank copy of the tool and formula. Rather, the Division has indicated that there are few PCW cases that go to appeal, and that, implicitly if not explicitly, the "tool" is at present more useful if undisclosed to providers at large. This approach is wholly insufficient to demonstrate that the PA Request was correctly determined. It is also poor public policy.

I conclude that the petitioner has met her burden of proof to demonstrate that 49 hours per week are medically necessary to meet her personal care needs, and that the Department has failed to rebut this case. The Division's denial is reversed.

CONCLUSIONS OF LAW

That the petitioner is entitled to prior authorization for 49 hours per week of personal care worker (PCW) services; the Division's modification action must be reversed.

NOW, THEREFORE, it is ORDERED

That the petitioner's provider is directed to submit a copy of the claim for payment of 49 hours per week of PCW services to EDS-Federal, Inc. together with a copy of this Decision. IT IS FURTHER ORDERED, that EDS-Federal, Inc., is directed to pay the petitioner's claims for PCW services up to 49 hours per week, under PA Request #9951193.

REQUEST FOR A NEW HEARING

This is a final fair hearing decision. If you think this decision is based on a serious mistake in the facts or the law, you may request a new hearing. You may also ask for a new hearing if you have found new evidence that would change the decision. To ask for a new hearing, send a written request to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707-7875.

Send a copy of your request to the other people named in this decision as "PARTIES IN INTEREST."

Your request must explain what mistake the examiner made and why it is important or you must describe your new evidence and tell why you did not have it at your first hearing. If you do not explain these things, your request will have to be denied.

Your request for a new hearing must be received no later than twenty (20) days after the date of this decision. Late requests cannot be granted. The process for asking for a new hearing is in sec. 227.49 of the state statutes. A copy of the statutes can found at your local library or courthouse.

APPEAL TO COURT

You may also appeal this decision to Circuit Court in the county where you live. Appeals must be filed no more than thirty (30) days after the date of this hearing decision (or 30 days after a denial of rehearing, if you ask for one).

Appeals concerning Medical Assistance (MA) must be served on the Wisconsin Department of Health and Family Services, as respondent, P.O. Box 7850, Madison, WI 53707-7850.

The appeal must also be served on the other "PARTIES IN INTEREST" named in this decision. The process for Court appeals is in sec. 227.53 of the statutes.

Given under my hand at the City of Madison, Wisconsin, this 14th day of June, 1999.

/Kenneth D Duren

Kenneth D. Duren, Attorney
Division of Hearings and Appeals
611/

cc: EDS Federal Corporation
Division Of Health Care Financing - Appeals Coordinator
Judy Zitske, BLTS
Susan Wood, DHFS
Nancy Anderson, R.N., CLA, 1310 Mendota Street, Madison, WI 53558
F. Genter, Dane County DHS

8/30/00 **Wisconsin Personal Services Alternatives, Inc. (WPSA)**

MAPC Audit Survey of County and County Subcontractor Agencies.

Preface: As of 8/30/00, Independence First of Milwaukee (an independent living center) has an out of court settlement agreement with DHFS for $54,382. This is the only MAPC only agency to settle a financial audit from DHFS known to WPSA. The major recoupment issues in the Independence First audit were travel and in/out time documentation. Of the 25 counties or agencies reported in the press as having financial audits, WPSA has identified 15 counties or county contractors, who received out of the audit process settlement offers and conducted a survey from 7/27 – 8/21/00.

Survey Participants: 15

10 Counties: Ashland, Barron, Brown, Dane, Grant, Kewaunee, Manitowoc, Price, Rock, Vernon

1 Independent Living Center – Society's Assets, Inc.

4 Home Health Agencies – Aurora Community Services, Bay Area Home Health, Gunderson Lutheran, Lifenet.

Survey Findings of Major Recoupment Issues of 14 Participants

#1 issue: In/out time documentation = 14
#2 issue: MD order documentation = 11
#3 issue: Travel time documentation = 6
(7 county/agencies do not bill travel time, 2 county/agencies met settlement agreement for travel, but not audit criteria.)

Individual Audit Results:

Ashland County: Date of on-site audit 6/99, period of audit 1996-6/30/98. Draft preliminary findings 8/00, response date 8/27/00.Received an extension.

Total Recoupment amount:	**$255,665**
Settlement:	
Issues #1 In/out:	**$195,237**
#2 MD orders:	**$ 47,023**
#3 Other documentation:	**$ 7,067**

Comments: Auditors did not complete the on-site audit but took records to a local copy store and copied parts of records, returned records to Ashland County and left town.

Barron County: Date of on-site audit 5/99, period of audit 1/96-6/30/98. Draft and preliminary findings 8/00, response date 8/25/00.

Total Recoupment amount:	**$207,571**	
Settlement:	**$2,332**	**Accepted 8/25/00**
Issues #1 In/out:	**$204,222**	
#2 Other documentation:	**$ 2,560**	**- have not finished findings review**

Comments: was told at time of audit they had exceptional documentation.

Brown County: Date of on-site audit 1999.

Total Recoupment amount:	**$1,100,000**	**Learned this in the press**
Settlement:	**$4,464**	**Accepted 8/11/00**
Issues #1 In/out:		**They were told this was their major issue.**

Comments: Brown County was offered a settlement in year 2000. As of 8/9/00 they had not received a draft preliminary letter or findings.

Dane County: Date of on-site audit 10/98, period of audit 1996-97. Draft preliminary findings 3/00, response date 8/11/00.

Total Recoupment amount:	**$2,467,690**	
Settlement:	**$194,335**	**Accepted 8/11/00**
Issues #1 In/out:	**$2,034,663**	
#2 Travel:	**$ 296,403**	
#3 Excess Services:	**$ 60,632**	**Travel hours billed with wrong code**
#4 Lack of Documentation:	**$ 30,172**	**Dane owes $6,700**
#5 MD Orders:	**$ 29,084**	**Dane owes $5,877**

Comments: Dane County feels it owes $30,000. It would like the ability to rebill the $60,000 in excess services in the correct billing code.

Grant County: Date of on-site audit 3/99, period of audit 1996-97. Draft preliminary findings 8/00, response date 8/25/00.

Total Recoupment amount:	**$181,755**	
Settlement:	**$23,674**	**Accepted 8/25/00**
Issues #1 In/out:	**8/9/00 unable to confirm amounts**	
#2 MD orders:	**issues surveyed 8/2/00**	

Comments: Unable to complete survey 8/9/00.

Kewaunee County: Date of on-site audit early 2000, period of audit 7/96-12/31/98. Draft preliminary findings 8/00, response date 8/25/00. Received an extension.

Total Recoupment amount:	**$610,383**	
Settlement:		
Issues #1 In/out:	**$517,400**	
#2 Non-covered Services:	**$ 69,845**	**Feels has records to justify service**
#3 Lack of Documentation:	**$ 19,000**	**Hasn't finished checking records**
#4 MD Orders:	**$ 2,592**	**All MD Orders in files**

Comments: hasn't completed records review, but of records reviewed has justification of services provided.

Manitowoc County: Date of on-site audit 4/99, period of audit 1/96-6/30/98. Draft preliminary findings 8/00, response date 8/25/00.

Total Recoupment amount:	**$839,794**	
Settlement:	**$3,174**	**Accepted 8/25/00**
Issues #1 In/out:	**$833,814**	

Comments: Has 5,900 in other documentation issues. Has not completed record review.

Price County: Desk audit only. Draft preliminary findings 8/00,response date 8/25/00

Total Recoupment amount:	**$6,180**	
Settlement:	**$3,147**	**Accepted 8/25/00**

Rock County: Date of on-site audit 2/99, period of audit 1996-97. Draft preliminary findings 8/00, response date 8/25/00. Received an extension.

Total Recoupment amount:	**$1,036,000**	
Settlement:	**Unknown**	**Preferred not to release amount**
Issues #1 In/out:	**95% of total**	**Preferred not to release amount**
#2 MD Orders:	**4% of total**	**Preferred not to release amount**

Comment: Issues audit done 7/31/00 by WPSA.

Vernon County: Date of on-site audit 1999, period of audit 1996-97. Draft preliminary findings 1/00, response date 8/11/00.

Total Recoupment amount:	**$789,468**	
Settlement:		**Declined 8/11/00**
Issues #1 In/out:	**$367,506**	
#2 MD Orders:	**$295,698**	**All MD orders in records, missing signature dates**
#3 Travel:	**$123,656**	
#4 Other:	**$ 2,500**	

Comments: Vernon County feels $2,500 is recoupable.

Society's Assets, Inc.: Date of on-site audit 9/98, period of audit 1996-97. Draft preliminary findings 8/00, response date 8/25/00. Received an extension.

Total Recoupment amount:	**$342,473**	
Settlement:		
Issues #1 Travel:	**$333,343**	**Feels can justify with its records**
#2 Misc.:	**$ 8,272**	**Hasn't completed record review**

Comment: Per telephone call to Lori Thornton DHFS 8/9/00 to question audit settlement since Society's Assets, Inc. rarely bills more than .5 hour per visit for travel. Jean Rumachik was told that the settlement offer on travel time was computed at .5 per day, but the settlement offer is .5/visit. Society's Assets, Inc. routinely does 2-3 visits per day with consumers. Since many counties/agencies do multiple visits/day, this raise the concern if any settlement offer involving travel time is accurate.

Service area: Racine, Kenosha, Walworth, some in Rock and Jefferson county.

Aurora Community Services: Date of on-site audit 11/98, period of audit 1/96-97. Draft preliminary findings 8/00, response date 8/25/00. Received an extension.

Total Recoupment amount:	**$2,825,983**	
Settlement:		
Issues #1 In/Out:	**$1,609,195**	
#2 MD orders:	**$1,190,603**	**Has MD orders on file, followed directions of EDS**
#3 Misc. other:	**$ 26,183**	**Hasn't completed record review**

Comment: Feels they followed directions given by EDS for program requirements and billing. The MD order issue is frequency of orders: yearly vs. every 60 days.

Service area: 14 counties – Barron, Burnett, Clark, Dunn, Eau Claire, Jackson, Pierce, Polk, Portage, Rusk, Sawyer, St. Croix, Taylor, Washburn, Trempealeau.

Bay Area Home Health: Date of desk audit request 10/99, period of audit 7/96-12/31/98. Draft preliminary findings 8/00, date of response 8/25/00. Received an extension.

Total Recoupment amount:	**$87,187**	
Settlement:		
Issues #1 In/Out:	**$46,835**	
#2 MD orders:	**$17,054**	**MD orders on file to justify service**
#3,4 Misc. documentation:	**$14,000**	**Has not completed record review**
#5 Travel:	**$ 4,191**	

Comments: No on-site audit. Received letter from DHFS-HCF to copy and send records within one month. Sent four boxes to DHFS 11/16/99 and had no calls or contact with auditors until received letter about draft preliminary findings 8/00.

Service area: Ashland, Bayfield and Iron.

Gunderson Lutheran: Date of on-site audit 10/98, period of audit 1996-97. Draft preliminary findings 8/00, response date 9/8/00 with extension.

Total Recoupment amount:	**$284,000**
Settlement:	
Issues #1 In/Out:	**$ 45,000**
#2 MD orders:	**$ 37,884**
#3 Travel:	**$ 8,678**

Comments: Has many other documentation issues but has not completed record review for comment.

Service area: La Crosse, Trempealeau, Monroe.

Lifenet: Date of desk audit 10/99, period of audit 1997-98. Draft preliminary findings 8/00, response date 8/25/00. Received an extension.

Total Recoupment amount:	**$143,874**	
Settlement:		
Issues #1 Travel:	**$ 28,928**	
#2 MD orders:	**$ 26,245**	**Has orders on file – wasn't asked to copy all of them for the desk audit**
#3 In/Out: unknown		**Knows has in/out but hasn't completed record review to know the amount.**

Comments: No on-site audit. Received a letter from DHFS 10/5/99 to copy records and send by 11/5/99. Delivered boxes to DHFS, but has had no communication with auditors until received draft preliminary findings.

Service Area: La Crosse, Monroe, Trempealeau, Jackson, Clark, Taylor, Chippewa, Eau Claire.

Prepared by: Nancy Anderson
WPSA Board Member & Legislative Committee
608-242-8335 ext. 128

FAX COVER SHEET

ANS Home Health Services, Inc.
4369 S. Howell Avenue
Suite 301
Milwaukee, WI 53207-5055

Phone number: (414) 481-9800
Fax number: (414) 481-9808

SEND TO Company name	From KIM MURPHY
Attention NANCY ANDERSON	Date August 30, 2000
Office location	Office location
Fax number 1-608-240-7060	Phone number

☐ Urgent ☐ Reply ASAP ☐ Please comment ☐ Please review ☐ For your information

Total pages, including cover: _____

COMMENTS

STATEMENT OF ANS HOME HEALTH SERVICES, INC.

ANS Home Health Services is a home health and staffing agency licensed by the State of Wisconsin to provide home health and personal care worker services in the greater Milwaukee area since 1995. Since it first became licensed ANS has served over 3,000 clients in their homes with needs ranging from assistance with activities of daily living through 24-hour intensive care. ANS services financially independent private pay clients and the poorest of clients on Title 19, giving each client the best quality care regardless of income source. In its short history as a licensed home care agency ANS routinely received and passed periodic auditing inspections conducted by representatives of the State of Wisconsin Department of Health and Family Services, Bureau of Quality Compliance. At no time during these routine audits did any representative of DHFS cite any instance of substandard care, improper care or improper servicing of clients by ANS or its employees. However, in the past 15 months, the Department has radically changed its enforcement protocols, policies and practices with regard to ANS predicated on one patently obvious change in ANS' operations - ANS chose to service Russian surnamed clients in the greater Milwaukee area. As a result of this expansion of services, ANS, its management, employees and clients have become the target of a most vituperative, vindictive and relentless enforcement effort by agents of the Department clearly designed to punish and potentially close the agency for its choice to service these clients.

During the latter part of 1998 and 1999 the members of the Milwaukee home health community were aware of DHFS' enforcement investigations which were launched into the practices of Excel, J&A, Cares R Us and Vida home health agencies, the four agencies which primarily serviced the Russian immigrant, Russian speaking and Russian surnamed clients in the Milwaukee community. These enforcement actions effectively shut down all four agencies leaving

a void of care providers for elderly and infirmed patients who legitimately needed and were entitled to Title 19 personal care worker services under the State Medicaid program. As a result of this void of service, ANS was contacted by physicians, social workers and patients inquiring as to whether these Russian surnamed individuals could receive services under ANS' direction and control. ANS had previously not serviced this community, but began the process of investigating whether it could secure the necessary bilingual employees and care providers to adequately serve the needs of this community. In a short period of time, ANS determined that it had or could acquire the resources to provide personal care worker services to the Russian community and slowly began the process of admitting Russian-based clients. In so doing, however, ANS was particularly cognizant of the fact that during DHFS' investigation of Cares R Us, J&A, Excel and Vida, there were allegations that those agencies serviced clients who were not Title 19 eligible and/or utilized care workers who were not properly qualified to service their clients. Hence, ANS staff and management carefully screened all new clients and care workers to ensure strict compliance with DHFS regulations and ANS internal policies for eligibility and qualifications under the Title 19 program. We were aware that many agencies refused to even consider servicing the Russian community because of the horror stories we heard about DHFS' enforcement action and intimidating investigating techniques used against Excel, J&A, Cares R Us and Vida. No one wanted to risk becoming the next targeted agency for shutdown by DHFS and many agencies simply shut their doors to these clients. ANS, however, confident in its excellent track record of compliance with its regulatory responsibilities and cognizant of its obligation to provide NON DISCRIMINATORY service to *all* members of the community, proceeded to begin to service the Russian-based community.

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ANS was soon to become aware that its confidence in the proposition that a quality agency providing quality services to the Russian community would be viewed differently by DHFS was entirely misplaced. ANS admitted its first Russian-based clients on or about October 1998. Slowly but surely, word of mouth spread within the community that a new home health agency, ANS, would admit Russian-based clients for personal care worker services and a steady of stream of patients and employees laid off from the other four agencies servicing those clients began to arrive at ANS. Mindful of the risks of overextending ANS' capacity or making mistakes in the intake process, ANS continued to carefully screen patient applicants and employee applicants before making any commitments to accepting them into the agency. During this process ANS regularly and routinely denied admission or employment to individuals who did not meet each and every criteria necessary for participation as an employee or beneficiary under the personal care worker regulations imposed by the State of Wisconsin. Those who passed the screening were assessed, admitted and ANS secured the appropriate prior authorizations and plans of care for services required by these clients.

Everything seemed to be going exactly according to plan. Yet, on July 27, 1999, ANS received a letter from Marlene T. Cruz, Chief of the Medicaid Audit and Review Section, Bureau of Health Care Program Integrity, State of Wisconsin Department Health and Family Services, notifying ANS that the Bureau would be conducting an audit at ANS' offices starting on August 10, 1999. ANS was informed that the auditors would arrive at 9:30 AM and be at ANS for approximately three weeks. Further, the alleged purpose of the audit was "to determine whether home health services provided to Medicaid recipients were documented and billed appropriately." Attached to the letter was a list of personal care worker recipients serviced by

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ANS. What was amazing was that of the names contained on the list, *over 80% of the names reflected some form of Russian surnamed individual* despite the fact that Russian clients composed only a minor percentage of ANS' total client base. The transparency of the audit sample was further revealed by ANS' examination of the list which revealed that certain individuals were included on the list because their first names appeared to have a Eastern European sound to them and that certain other individuals whose surnames could be interpreted as being potentially Russian were included on the list despite the fact that they had absolutely no connection with the Russian community. Additionally, prior to commencement of the on-site audit on August 10, 1999, the Department unilaterally changed the dates of the audit period with the clear design to capture additional client files of Russian clients who had been admitted to ANS during a period outside the previously stated audit limits. This was borne out during the commencement of the audit when those files were among the first requested by the DHFS auditors for examination.

The conduct of the auditors from the opening conference through the exit interview further bespoke the deliberate biased focus of the audit. Notwithstanding the written and oral lip service paid to the "routine" and "impartial" nature of the audit, it was very clear that the focus of the audit was the Russian-based clients. Client files of individuals determined to be non-Russian-based clients were either returned without review, rejected or only cursorily reviewed whereas client files of Russian-based clients were scanned, examined and questioned by the auditors in depth.

Concurrent with the on-site audit, and without notice to ANS, representatives DHFS commenced home visits to clients and employees of ANS as part of its ongoing investigation. ANS became aware of these home visits as a result of receiving numerous calls from terrified

employees and clients claiming that representatives of the Department were not only appearing unannounced at their doors but were actively engaged in actions which can only be characterized as an abuse of process and authority. ANS has documented written statements from clients and employees indicating that representatives of the Department threatened clients with criminal action, deportation and civil actions if the clients refuse to cooperate in the investigatory interview process. Other clients had family members threatened with obstruction of justice and immigration investigations. In at least one circumstance an individual who was acting as a translator for the State willfully misrepresented himself as being an employee of the Criminal Investigation Division of the Internal Revenue Service while in the company of nurse auditors of the Department of Health and Family Services when he in fact was neither an employee of the IRS nor the State of Wisconsin (but rather a contract individual). We have innumerable statements from family members who heard interpreters on the part of the State of Wisconsin willfully misquote and misrepresent client answers to the nurse auditors. These statements given to the translator in Russian by the clients were twisted in translation so as to provide incriminating statements where no such statement was ever made by the declarant. Threats were made to clients and employees of ANS that continued employment with ANS or patient servicing by ANS would result in potential criminal or civil actions against them and that they would be best advised to leave the agency. In other circumstances there were instances where the agents refused to allow the client and/or family member to close the door and decline the interview by physically obstructing the door until such time as admittance was gained, as well as numerous instances where clients indicated an unwillingness to continue to speak with the representatives of the Department and those wishes were not respected by the agents and the interrogation continued unabated.

These complaints became so numerous that ANS began taking statements from the individuals who were willing to tell their stories and in many circumstances signed statements detailing the allegations recited above. However, in many circumstances the abusive conduct of the agents so intimidated and harassed the clients that they were too petrified of the potential for personal or legal harm that they would not go on record unless subpoenaed in a legal action. Moreover, some clients indicated that the allegations and pressure of the home investigations by the agents (who indicated that they would return for further statements in the future) resulted in individuals requesting voluntary discharge from the agency rather than subject themselves to any further investigatory interviews. On behalf of ANS our legal counsel drafted a letter of protest to Alan White, Director of the Bureau of Health Care Program Integrity protesting these threats, intimidation and harassment of ANS clients and in support of their constitutional rights to be free from government interrogation in this manner. Mr. White responded to this letter by merely denying that any such conduct existed without making a single request for supporting documentation or investigation of the charges and complaints set forth in the agency's letter. It was patently obvious that Mr. White was going to serve as an apologist or engage in a whitewash of the allegations against his agents notwithstanding the documentary evidence which we were prepared to show him.

The desk audit and the home visits concluded by the beginning of September 1999 and a final report was compiled by BHCPI some seven months following the commencement of the audit detailing eight categories of alleged technical violations of the record keeping of the agency related to Russian clients. These matters have been timely and duly contested by ANS as of May 2000,

without a single response from the Department regarding the agency's rebuttal to the allegations to date.

However, in an apparent effort to pressure ANS into surrendering its due process rights to contest the audit/survey process initiated over one year ago, the Department has commenced a new round of investigation visits utilizing the same threatening, intimidating and harassment tactics designed to get clients of ANS to provide statements of improper conduct by ANS or admissions on the part of the clients themselves that they are not qualified to receive the benefits or do not receive the benefits of services provided by ANS for which ANS is billing the program. In short, the Department has been unsuccessful in its first efforts to find or secure incriminating evidence against ANS through its normal investigatory or its abusive process and is bound and determined to continue these actions until the Department secures such evidence lawfully or otherwise. Moreover since these audits began ANS has been compelled to provide third party certifications and assessments for needs for services for any renewal by a Russian-based client. This rule does *not* apply to any other client of the agency.

ANS further notes that other agencies which began to admit Russian clients following the demise of Cares R Us. J&A, Excel and Vida have also become the victims of the selective enforcement protocols of the Department of Health and Family Services. Several of those agencies have contacted ANS regarding the abusive tactics of the Department's investigatory agents and have reaffirmed that despite the fact that they service all different ethnic, religious, racial groupings in the Milwaukee community, the focus of the investigation has centered solely on Russian-based clientele. Their stories are similar, if not identical, to ANS's experience in this regard. Finally, those agencies that have chosen not to admit Russian-based clients have somehow

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been immune from the "routine audit/survey" process that has befallen ANS and the other agencies that admitted Russian speaking clients. It certainly is no surprise to ANS that these agencies were not similarly subject to the same scrutiny as was ANS. But is it not ironic that "routine" surveys only become "routine" when the agency admits Russian clients but the "routine" does not apply to agencies that do not admit Russian speaking clients? It is ANS's understanding that because this issue of selective enforcement has engendered legislative and potential judicial scrutiny, the Department has quickly, but belatedly, scrambled to send survey teams to other agencies who do not admit Russian clients to create an aura of "impartiality" of the "survey process." Notwithstanding this effort to cover up the selective enforcement protocol, nothing can remove the stain from the Department's prejudicial, biased and vindictive enforcement protocol against a group which has been openly characterized by representatives of the Department as "an investigation of a group of liars and thieves." No representative of the State of Wisconsin has any legal, moral or ethical authority to single out a group of clients based upon ethnic or national origin for selective enforcement because the Department believes that "those people" are dishonest. Further, the Department has no authority to conduct selective audits and surveys of agencies whose only "crime" is the legitimate service of that client group. ANS believes that those individuals within the Department and Bureau of Health Care Program Integrity who initiated and have perpetuated this selective enforcement program must be held accountable and that reparations should be made to those patients and families who have been harassed and intimidated, as well as those agencies that have been harmed by this process. ANS does not condone the conduct of any service provider or client who attempts to steal services from the state to which they are not entitled. However, after 15 months of investigation, intimidation and

harassment, the closure of four home health agencies and the extortion of civil penalties from others who refused to stand up to the State and litigate in support of the rights of this minority group, it is time for the legislature to put a halt to this discriminatory enforcement protocol and to ensure that the due process rights of all citizens of the State and the providers who service those citizens are respected and given the protection of the law.

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December 29, 1998

Representative Carol Kelso, Co-Chairperson
Joint Committee on Audit
Room 16 West Capitol
Madison, WI 53702

Senator Gary George, Co-Chairperson
Joint Committee on Audit
Room 118 South Capitol
Madison, WI 53702

Dear Representative Kelso:

I am writing to request that the Legislature's Joint Committee on Audit consider recommending an audit of the Department of Health and Family Services' Bureau of Health Care Finance. Specifically, a situation regarding the Bureau's practices with respect to prior authorizations for Medical Assistance therapy services for children with long-term disabilities has been brought to my attention. Because these questions persist, (it has been two years since I was first notified of these concerns), I feel the matter to be deserving of the Committee's scrutiny.

According to Mary Ann Maiers, Director of Medical Support Services in Racine, the Bureau is responsible for what she terms "unprecedented denials" of Medical Assistance authorization for physical, occupational and speech therapy for disabled children. These denials have most frequently been made on the basis of a "lack of medical necessity" due to the availability of these therapies in public schools.

Due to the number of complaints which were received on this issue, the Wisconsin Council on Developmental Disabilities conducted a one year investigation into the Medical Assistance program in regards to its authorizations for coverage of these therapy services. The results of that study are enclosed, along with Ms. Maiers' December 7th letter to me.

I have also enclosed the body of correspondence I have received from Ms. Maiers' on this subject over the past two years, which I hope you will find useful as background to this situation.

Please give this matter your serious and careful attention. I will look forward to hearing from you, and if there is any additional information you require, do not hesitate to contact me.

Sincerely,

Robert L. Turner

Robert L. Turner
STATE REPRESENTATIVE

RLT/nam
Enclosures

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August 16, 2000

Representative Carol Kelso, Co-Chairperson
Joint Committee on Audit
Room 16 West Capitol
Madison, WI 53702

Dear Representative Kelso:

As you may know, during the 1999 Session of the Legislature I had requested that an audit be performed of the Department of Health and Family Services' Bureau of Health Care Financing. Specifically, I had asked that the Bureau's prior authorization procedures for children with long-term disabilities be examined. A copy of my letter, dated December 29, 1998, is enclosed for your review.

In following up on my request just last week, I was surprised to learn from your office that a possible review of the prior authorization process is pending, and may be considered at a meeting of the Audit Committee scheduled for the end of this month. I was also informed that the prior authorization audit was being considered at the request of "other legislators," and that my original request, which was never formally acknowledged by you, was not among those at hand.

In the early months of 1999, subsequent to my letter, I had my staff contact your office on several occasions, and was informed by your staff that my request was not a priority. Frankly, I am troubled about the lack of professional courtesy that you have exhibited and am curious as to whether you routinely acknowledge other legislators' audit requests. If I had not followed up, would I have ever been informed about the Committee's plans for this audit?

Although I am encouraged to know that this problem may finally see a resolution, I am dismayed that it has taken this long for the problem to be recognized, especially given my letter to you at the end of 1998.

I look forward to hearing from you about your committee's protocols, as well as hearing some background on the other requests for the prior authorization audit and the status of the committee's plans to pursue it.

Thank you for your consideration.

Sincerely,

Robert L. Turner

Robert L. Turner
STATE REPRESENTATIVE

RLT/nam
Enclosure
Cc: Senator Gary George
Speaker Scott Jensen
Senator Charles Chvala
Representative Shirley Krug