STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[redacted]

APPEAL NO. 14F-00520

PETITIONER,

VS.

CASE NO.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 09 OSCEOLA
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, a hearing in the above-styled matter convened on March 6, 2014 in Kissimmee, Florida. All parties appeared in person.

STATEMENT OF ISSUE

At issue is whether Respondent's denial of petitioner's request for Durable Medical Equipment (DME) was proper.

PRELIMINARY STATEMENT

On January 15, 2013, petitioner's representative requested a hearing to challenge AHCA's denial. The petitioner was present for hearing, and was represented by his parents, [redacted] [redacted] Assistive Technology Professional with Browning's Pharmacy & Health Care was present as a witness for the

petitioner. [redacted], petitioner's physical therapist, appeared by phone and was presented as a witness for the petitioner.

Doretha Rouse, Registered Nurse Specialist, represented the respondent. Respondent presented one witness by phone, Ellyn Theophilopolous, M.D., physician reviewer with eQHealth Solutions.

Respondent's composite exhibit 1 was entered into evidence. Administrative Notice was taken of the DME and Medical Supply Coverage and Limitations Handbook (DME Handbook), Florida Administrative Code Rule 59G-4.070, and the cases contained in respondent's Early Periodic Screening Diagnosis and Treatment Memorandum.

FINDINGS OF FACT

Based upon the oral and documentary evidence presented at the final hearing, and on the entire record of this proceeding, the following Findings of Fact are made:

1. Petitioner is a 10 year old male diagnosed with cerebral palsy. He is non-verbal, non-ambulatory and wholly dependent on others for care. He is cognizant of his surroundings. He communicates with eye gaze and will not initiate conversations, but he will communicate by head movement and sound to answer yes or no questions.

2. He currently has a motorized wheelchair that he has outgrown. He is capable and competent at using the wheelchair to navigate. He can shift his weight slightly, but he can lose posture control and fall out of his wheelchair.

3. In order to obtain authorization for DME, a Medicaid recipient's DME provider must submit a request for the DME to AHCA. Following that submission, AHCA's prior authorization (PA) reviewer, eQHealth Solutions, reviews the medical necessity of the

requested DME, pursuant to the requirements and limitations of the Florida Medicaid Program. Based upon that review, AHCA determines whether the recipient's request will be approved or denied.

4. eQ Health Solutions denied the request for the customized wheelchair via letter dated December 23, 2013. The letter stated that the denial was because the request was in excess of the patients' needs. The clinical rationale given in the denial letter sent to the providers was as follows:

> The patient is a 10 year old with cerebral palsy and the request is for a custom wheelchair; however, the request for power center mounted elevating leg rests, standing leg rests, power standing system, and power elevating seat are excessive and components for standing are not covered. The requested DME is not approved.

5. Petitioner requested reconsideration. Upon a second review, the original decision was upheld and notice of the decision was sent by letter dated January 29, 2014.

6. The eQ Health physician reviewer indicated that she did take the Early Periodic Screening, Diagnosis and Treatment rule into account when she reviewed this case.

7. It is undisputed that Petitioner requires a new wheelchair. The Agency disputes certain add-ons to the wheelchair that would be required components for standing. Specifically, the Agency's position, which was repeated by the physician reviewer during the hearing, is that standing components (elevating leg rests, standing leg rests, power standing system, and power elevating seat) are not covered by the Medicaid program and there are no exceptions to this rule.

8. The physician reviewer indicated that the service was not covered by the Medicaid program. Medical necessity was not the primary reason for the denial.

9. Petitioner's position is that the standing components are medically necessary in order to build mass and bone density in his legs, alleviate pressure points from sitting all day, alleviate discomfort due to his dislocated hips, as well as potentially alleviate his respiratory issues by permitting him to alter his positioning.

10. Petitioner is capable of learning how to use the components, as he currently uses the motorized wheelchair without issue. His providers believe that he will use the standing components independently, resulting in stronger legs and less need for physical therapy. Independent ability to stand will mean more time standing, and thus more strength building, than if he was required to rely on others to place him in a non-powered standing unit.

11. Further, Petitioner asserts that standing components will allow petitioner to become more independent with his activities of daily living because he will be able to reach higher places in his surroundings. The increased independence and strength will also contribute to petitioner's emotional well-being.

12. The Agency suggested that another Medicaid program may cover the requested equipment. It also suggested that alternative equipment is available, although those alternatives may not be practical solutions.

CONCLUSIONS OF LAW

13. By agreement between AHCA and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction to conduct this hearing pursuant to Florida Statutes Chapter 120.

14. Legal authority governing the Florida Medicaid Program is found in Fla. Stat. Chapter 409, and in Chapter 59G of the Florida Administrative Code. Respondent, AHCA, administers the Medicaid Program.

15. The DME and Medical Supply Services Coverage and Limitations Handbook ("DME Handbook") has been incorporated, by reference, into Florida Administrative Code Rule 59G-4.070(2).

16. This is a Final Order, pursuant to Sections 120.569 and 120.57, Florida Statutes.

17. This hearing was held as a *de novo* proceeding, in accordance with Florida Administrative Code Rule 65-2.056.

18. The burden of proof was assigned to the Petitioner in accordance with Florida Administrative Code Rule 65-2060(1). The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Florida Administrative Code Rule 65-2.060(1).

19. Fla. Stat. § 409.905 addresses mandatory Medicaid services under the State Medicaid Plan:

> Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law....
>
> (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.—The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal care, private duty nursing, durable medical equipment, physical therapy,

> occupational therapy, speech therapy, respiratory therapy, and immunizations.

20. With regard to the need for DME, Section 409.906(10), Florida Statutes, states in relevant part, "The agency may authorize and pay for certain durable medical equipment and supplies provided to a Medicaid recipient as medically necessary."

21. Similarly, the Handbook defines the guidelines for DME on page 1-2, as follows:

> Durable medical equipment (DME) is defined as medically-necessary equipment that can withstand repeated use, serves a medical purpose, and is appropriate for use in the recipient's home as determined by the Agency for Health Care Administration (AHCA).

22. Consistent with the law, AHCA's agent, eQHealth, performs prior authorization reviews for Medicaid recipients in the state of Florida. Once eQHealth receives a DME request, its medical personnel conduct file reviews to determine the medical necessity of requested equipment, pursuant to the authorization requirements and limitations of the Florida Medicaid Program.

23. Page 2-97 of the DME Handbook lists items that are not covered under Medicaid. Specifically, it lists "powered wheelchair component for standing" as a non-covered item.

24. However, page 2-98 of the DME Handbook explains that exceptions to non-covered services and exclusions can be made for recipients under 21 years of age, such as the Petitioner. Such an exception can be made if the requested item corrects or ameliorates a defect, physical or mental illness, or a medical condition. Additionally, requests for exceptions must meet Florida Medicaid's definition of "medical necessity" and include the required prior authorization documentation (which is described on page

2-92 of the DME Handbook).

25. Florida Administrative Code Rule 59G-1.010(166) defines medical necessity, as follows:

> 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
>
> (a) Meet the following conditions:
>
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
>
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
>
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
>
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
>
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. ...
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

26. As the petitioner is under 21, a broader definition of medically necessary applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) requirements. The undersigned must, therefore, consider both EPSDT and Medical Necessity requirements (both cited, above) when developing a decision.

27. EPSDT augments the Medical Necessity definition contained in the Florida Administrative Code via the additional requirement that all services determined by the agency to be medically necessary for the *treatment, correction, or amelioration* of problems be addressed by the appropriate services.

28. United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in Moore v. Reese, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, (which involved a dispute over private duty nursing):

> (1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.
> (2) A state Medicaid plan must include "reasonable standards ... for determining eligibility for and the extent of medical assistance" ... and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.
> (3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."
> (4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."
> (5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to provide medically unnecessary, albeit desirable, EPSDT services. However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."
> (6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and my present its own evidence of medical necessity in disputes between the state and Medicaid patients (citations omitted).

29. The physician reviewer did not waver in her assertion that the requested standing components are not covered under the Medicaid program. Based on this information, the undersigned concludes that the Agency did not, in fact, take into account the

Petitioner's age and the broader definition of medical necessity under the EPSDT standards.

30. The Agency primarily denied the requested components due to the incorrect premise that they are not covered by Medicaid. The only comment regarding medical necessity that the Agency put forward was that there are other options available, which may be impractical, covered under the program. The Agency even advised the Petitioner about other programs which may have expanded services that may cover the requested components.

31. The undersigned is not making a decision based on whether the requested service was medically necessary. The Agency improperly denied the request because it claimed the service was not covered under the program.

32. After reviewing the totality of the evidence and legal authority, the undersigned remands this case back to the Agency for review of medical necessity and whether Petitioner's request could be approved as an exception to non-covered services as provided in the DME handbook.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Petitioner's appeal is hereby granted and remanded back to the Agency. The Agency is to make a new determination of the requested DME based on medical necessity, as the undersigned concludes the requested DME can be covered by Medicaid if the requirements are met.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 11th day of April, 2014, in Tallahassee, Florida.

Danielle Murray

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