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

[redacted]

APPEAL NO. 14F-06718

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 05 Marion
UNIT: HMO

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice and agreement, this matter convened for telephonic hearing on August 29, 2014 at 10:34 a.m. and reconvened for additional evidence on October 13, 2014, at 8:30 a.m.

APPEARANCES

For the Petitioner: [redacted], Petitioner

For the Respondent: Carol Meszlenyi
Agency for Health Care Administration

STATEMENT OF THE ISSUE

Whether Respondent, the Agency for Healthcare Administration (AHCA) was correct in eliminating petitioner's receipt of Ensure, a nutritional supplement. In addition, petitioner requests that he be enrolled in a different HMO if his request for Ensure is not upheld.

PRELIMINARY STATEMENT

Prior the matter convening for hearing on October 31, 2014, it had convened on August 29, 2014. The record was held open until November 7, 2014 for petitioner to provide additional evidence.

Petitioner appeared and represented himself. He offered no other witnesses. Petitioner offered two exhibits which were accepted and marked into evidence as petitioner's Exhibits 1 and 2.

Respondent Agency for Health Care Administration (respondent or agency) was represented by Carol Meszlenyi, Medical and Health Care analyst for the agency. Sonia Pastor, Grievance and Appeals officer; and Dr. Barbara Crowley, Chief Medical Officer/Medical Director, both from Clear health Alliance (CHA), petitioner's HMO, testified on behalf of respondent. Respondent offered four exhibits, which were accepted into evidence and marked as respondent's Exhibits 1 through 4. Administrative notice was taken of 59G-1.010 and the contract between the agency and CHA.

FINDINGS OF FACT

Based on 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. The Petitioner is a 60-year old male, born [redacted]. He resides alone in his own home. He was diagnosed with HIV in 1985 and, in addition, has COPD.

2. Prior to becoming a member of CHA program, petitioner previously received care from the Florida Department of Health through the Medipass program. Through this Waiver, he received a nutritional supplement, Ensure.

3. Petitioner was transitioned to CHA May 1, 2014 as a result of mandatory, statewide movement to managed care. His previously authorized services were continued, pending a new assessment and Plan of Care CHA.

4. CHN continues the current services a patient receives without prior authorization for 60 days upon enrollment while evaluating the patient's needs. At that time prior authorization for services is needed.

5. On May 7, 2014, petitioner's Primary Care Physician (PCP), Dr. [redacted] filed a request for pre-authorization of services, including a prescription for a nutritional supplement, Ensure. CHA denied the request for Ensure as not being medically necessary.

6. This request is considered a request for continuation of care.

7. Petitioner's medical assessment does not indicate that he has any barriers to eating and digestion, although he did report some weight loss at his regular medical exam on September 9, 2013. His then PCP prescribed one time per day. He does eat regular meals.

8. CHN does provide nutritional and dietary counseling to members, but will not approve nutritional supplements unless that is the member's only source of nutrition or the member has barriers to eating and digestion.

CONCLUSIONS OF LAW

9. 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.

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

11. This is a Final Order, pursuant to § 120.569 and § 120.57, Fla. Stat.

12. This hearing was held as a de novo proceeding, in accordance with Fla. Admin. Code R. 65-2.056.

13. The burden of proof for the denial of the nutritional supplements belongs to respondent.

14. The standard of proof in an administrative hearing is preponderance of the evidence. (See Fla. Admin. Code R. 65-2.060(1).)

15. Florida Statutes § 409.98 addresses mandatory Medicaid services under the Long Term Care plans of managed care agencies:

> Long-term care plans shall, at a minimum, cover the following:
> (1) Nursing facility care.
> (2) Services provided in assisted living facilities.
> (3) Hospice.
> (4) Adult day care.
> (5) Medical equipment and supplies, including incontinence supplies.
> ...
> (15) Nutritional assessment and risk reduction.

16. With regard to managed care, per Fla. Stat. § 409.965

> All Medicaid recipients shall receive covered services through the statewide managed care program, except...The following Medicaid recipients are exempt from participation in the statewide managed care program:
> (1) Women who are eligible only for family planning services.
> (2) Women who are eligible only for breast and cervical cancer services.
> (3) Persons who are eligible for emergency Medicaid for aliens.

17. Fla. Stat. § 409.972 adds to the list of those exempt, noting:

(1) The following Medicaid-eligible persons are exempt from mandatory managed care enrollment required by s. 409.965, and may voluntarily choose to participate in the managed medical assistance program:
(a) Medicaid recipients who have other creditable health care coverage, excluding Medicare.
(b) Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice or mental health treatment facilities as defined by s. 394.455(32).
(c) Persons eligible for refugee assistance.
(d) Medicaid recipients who are residents of a developmental disability center, including Sunland Center in Marianna and Tacachale in Gainesville.
(e) Medicaid recipients enrolled in the home and community based services waiver pursuant to chapter 393, and Medicaid recipients waiting for waiver services.
(f) Medicaid recipients residing in a group home facility licensed under chapter 393.
(g) Children receiving services in a prescribed pediatric extended care center.
(2) Persons eligible for Medicaid but exempt from mandatory participation who do not choose to enroll in managed care shall be served in the Medicaid fee-for-service program as provided under part III of this chapter.
(3) The agency shall seek federal approval to require Medicaid recipients managed care plans, as a condition of Medicaid eligibility, to pay the Medicaid program a share of the premium of $10 per month.

18. No evidence was presented to demonstrate that petitioner may opt-out of managed care for his Long-Term Care needs.

19. Section 409.978, Florida Statutes, provides that the "Agency shall administer the long-term care managed care program," through the Department of Elder Affairs and through a managed care model. Fla. Stat. § 409.981(1), authorizes AHCA to bid for and utilize provider service networks to achieve this goal. In the instant case, the provider network/HMO is CHN.

20. Review of appropriate Handbooks that govern the provision of Medicaid demonstrates that the July 2010 Durable Medical Equipment/Medical Supply Services Coverage and Limitations Handbook (DME Handbook) is currently promulgated by rule, via Fla. Admin. Code R. 59G-4.070. As such, the undersigned must review CHN's

determinations in conjunction with the DME Handbook and general provisions of medical necessity.

21. 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. ...
>
> (b) 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.

22. In addition to these requirements, the DME Handbook (handbook) provides additional criteria for medical supplies, defined on page 1-2 as "medically-necessary medical or surgical items that are consumable, expendable, disposable, or non-durable and appropriate for use in the recipient's home." Nutritional supplements and home-delivered meals fall under the category of consumable medical supplies.

23. Per page 2-10 of the Handbook states, in part:

> All documentation of medical necessity must include the type of medical equipment, services or consumable goods ordered, including the type, quantity, frequency and length of the need ordered or prescribed.

24. Although Petitioner does have a prescription for the nutritional supplements, that prescription is not controlling. There is no evidence to show that the nutritional supplement is necessary to alleviate illness or disability ((166)(a)(1)), that it is individualized to Petitioner's needs ((166)(a)(2)), that it is consistent with medically accepted standards for provision of dietary supplements ((166)(a)(3)), that it is safely furnished and its purpose cannot be met more effectively by some other good or service ((166)(a)(4)), or that the supplement is for medical purposes, as opposed to dietary convenience ((166)(a)(4)).

25. Absent such documentation, respondent was correct to deny continuation of nutritional supplements.

26. With respect to the request to change HMO providers, petitioner's request was contingent upon the hearing officer's decision in this matter and therefore no evidence on that issue was taken. At hearing petitioner was advised of the steps he can take to change providers and that if his request is not granted he has the right to separately appeal that denial.

DECISION

Petitioner's appeal is DENIED. Respondent's denial of Petitioner's request for nutritional supplements is hereby affirmed. His request to change HMO providers is premature and he may pursue that request at this time if he so desires.

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 2nd day of January, 2015,

in Tallahassee, Florida.

Nancy Hutchinson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal_Hearings@dcf.state.fl.us

Copies Furnished To: [redacted] Petitioner
Marilyn Schlott, Area 3, AHCA Field Office Manager
Beverly Smith, Esq.
Bureau of Managed Health Care AHCA