

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

**FILED**

JUN 29 2015

OFFICE OF APPEAL HEARINGS  
DEPT OF CHILDREN & FAMILIES

  
PETITIONER,

vs.

APPEAL NO. 14F-08498

AGENCY FOR HEALTH CARE ADMINISTRATION  
CIRCUIT: 12 SARASOTA  
UNIT: AHCA

AND


UNITED HEALTHCARE COMMUNITY PLAN

RESPONDENTS.  
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**FINAL ORDER**

Pursuant to notice and interim orders, a hearing in the above-styled matter convened at approximately 11:00 a.m. on April 29, 2015 before Hearing Officer Patricia C. Antonucci. All parties and witnesses appeared via teleconference.

**APPEARANCES**

For Petitioner:  Petitioner

For Respondent, Agency for Health Care Administration: Donald Freeman, Esq.

For Respondent, United Healthcare Community Plan: Paul Norman, Esq.

**STATEMENT OF ISSUE**

At issue is the action taken by Respondents, the Agency for Health Care Administration (AHCA) and United Healthcare Community Plan (United), to deny

Petitioner's request for a new power wheelchair. Petitioner bears the burden of proof, by a preponderance of the evidence, to show that said denial was improper.

**PRELIMINARY STATEMENT**

Prior to hearing, this matter convened for telephonic status conferences, pre-hearing orders were issued by the undersigned, and communication between the parties was encouraged. Petitioner was initially represented by an emeritus attorney; however, said representative withdrew before final hearing.

Petitioner appeared on her own behalf, and also presented one, additional witness: [REDACTED], Petitioner's physical therapist. Petitioner's Exhibits 1 through 4, inclusive, were accepted into evidence. Donald Freeman, Esq. represented Respondent AHCA, presenting one witness: Pat Brooks, Program Administrator, AHCA Field Office 8. Paul Norman, Esq. represented Respondent United, presenting two witnesses from the health plan: Marc Kaprow, D.O., Long Term Medical Care Director, and Susan Frishman, Senior Compliance Analyst. Ms. Frishman exited the hearing prior to its conclusion

Rick Zimmer, Hearing Officer with the Office of Appeal Hearings, and Kevin Dewar, Esq., AHCA Assistant General Counsel, observed. Petitioner's Exhibits 1 through 4, inclusive, and Respondent's Exhibits 1 through 8, inclusive, were entered into evidence. All pertinent legal authority was Administratively Noticed.

After proceeding to hearing and securing testimony from both sides, the hearing officer held the record open, directing Respondent to submit additional documentation referenced at hearing, which was not previously filed or provided to Petitioner.

Petitioner was also provided opportunity to submit additional information. Both sides

were given deadlines by which to file supplements, and secondary deadlines by which to file their response(s) to same. As of the date of this Order, no additional documentation has been received.

### 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 Medicaid-enrolled, 78-year-old female, born [REDACTED]. She has been enrolled with United Healthcare Community Plan as her managed care provider, since September 1, 2013. She has a medical history inclusive of polio, is diagnosed with peripheral neuropathy, has spinal deformities/scoliosis, is quadriparetic, and exhibits decreased range of motion. She uses a wheelchair to mobilize, and has increased difficulty with transfers.
2. The Petitioner used manual wheelchairs for approximately 26 years of her life, and has since utilized power chairs (over 30 years). In 2012-2013, when her Medicare-funded chair ceased working, Petitioner researched power chairs currently on the market. Her Physical Therapist (PT) and physician completed measurements/specifications; met with vendors, and placed the order for a Boulder wheelchair.
3. Around June of 2013, Petitioner received the Medicaid-funded, Boulder power wheelchair (group 4). Petitioner was unhappy with the Boulder from the date of delivery, and contacted both AHCA and the manufacturer on several occasions in an attempt to remedy her concerns.
4. Petitioner's PT notes that the Boulder chair was not made according to

her PT specifications, despite the fact that she provided measurements to the manufacturer multiple times. Per the PT, the Bounder is at least one inch too high, the arms at least two inches too high, and the back too high to support Petitioner's use. The chair makes for difficult transfers, and is either missing brakes or has brakes that do not consistently function. As a result, the chair does not meet Petitioner's needs.

5. Petitioner's PT does not have a copy of the measurements she submitted for the Bounder, as these were taken when the PT was working under a former employer. AHCA was unsure whether the Agency maintained a copy of the measurements/order form, and was not certain what its position would be regarding repair or replacement of Medicaid-funded durable medical equipment (DME) authorized to a certain set of specifications but not manufactured accordingly.

6. Petitioner and her PT do not believe the incorrect measurements of the Bounder chair can be remedied by adjustment, as the pertinent parts do not appear adjustable. Petitioner also states that the battery for the chair drains quickly, that the chair does not maneuver over transitional thresholds in indoor flooring, and that the brakes do not engage when she releases the hand control, as intended. On more than one occasion, Petitioner was unable to engage the brakes when utilizing a van lift and accompanying ramp. She states that while other power chairs gradually slow down and permit redirection before braking, the Bounder does not slow or steer well, has abrupt transitions, and does not stop when the hand control is released. For this reason, Petitioner is unable to

use the chair with a van lift, and thus has great difficulty finding transportation to and from medical appointments.

7. Petitioner's PT was trained at New York University, graduating in 1972. She practiced physical therapy in New York for 25 years, and has been licensed in Florida for 17 years. It is her professional opinion, having worked with Petitioner for over five years, that Petitioner is still capable of managing a power wheelchair. The PT notes that Petitioner's conditions are degenerative, and testified to observing a decrease in Petitioner's ability to transfer into and out of the chair, and increased exhaustion and joint pain/stiffness from working with a chair that does not meet her needs. However, she also specified that Petitioner retains sufficient hand control to engage and benefit from a properly responsive chair.

8. On or about September 8, 2014, Petitioner submitted a request to AHCA, via its contracted provider, United. In the form of a letter to United's Executive Director, Petitioner requested provision of a new power wheelchair. There is no evidence that an order form, measurements, or model number accompanied this request, or that Petitioner requested replacement of individual chair components.

9. By letter dated September 10, 2014, United notified Petitioner of its decision to deny her request. Said letter stated, in pertinent part:

We used the following criteria to make our decision: Florida Medicaid DME and Medical Supply Services Coverage and Limitations Handbook, Version 1.0, p 2-95.

The specific reason for our decision: You asked for a new electric wheelchair. Medicaid covered an electric wheelchair for you within the past 5 years. You are not eligible for a new wheelchair until your current

chair is 5 years old. The health plan will cover maintenance of your chair. The health plan will not replace your chair until it is at least 5 years old.

10. Respondent, United, maintains that the decision to deny was based on a strict benefit limitation, as set forth in the DME Handbook. As such, no medical necessity review occurred.

11. AHCA, in contrast, posits that the five-year benefit limitation may not *prohibit* replacement of a wheelchair, if the chair cannot be adjusted/fixed to meet the consumer's needs.

12. Per testimony from both Petitioner and United's expert witness, Dr. Marc Kaprow, a basic evaluation of the Bounder's brakes and battery was conducted on April 1, 2015. Prior evaluations were attempted, but as the battery would not hold a charge, the vendor could not assess the functionality of the chair until April 2015.

13. No one present at hearing was in attendance for the April 1, 2015 evaluation. Petitioner's former attorney and his paralegal were present, met with the evaluator. However, Petitioner was not provided with a copy of a resultant report, and neither AHCA nor United submitted documentation regarding the evaluation into evidence, or supplemented the record with same, despite being so instructed.

14. Dr. Kaprow, D.O., is United's long-term medical care director. He is a board certified in internal medicine and hospice/palliative care, and has worked with the aged and disabled community in Florida for at least 10 years. It is his position that before United will authorize a new wheelchair or adjustments to

Petitioner's current chair, he would need to see an evaluation of Petitioner's ability to manage the chair and a comparison of the measurements submitted when the Bounder was ordered versus the measurements of the product, as delivered.

15. United's witness also clarified its position regarding the five year benefit limitation. Per the witness, Petitioner's chair is considered a custom chair, and the "base unit" of this chair type (class 4 power wheelchair) has a five-year limitation. While United *does* make exceptions with regard to the benefit limitations for specific components (e.g., headrest, arms, seat, etc.), and will provide certain components more frequently than set forth in the limitation schedule, United states there is no express exception to the five-year limit with regard to the wheelchair/base unit, itself. Although United's witness referenced contract provisions in support of this policy, the contract was not filed prior to hearing, nor was it provided as a supplement to the record.

16. Petitioner's PT testified that Petitioner has never been formally evaluated in the Bounder wheelchair, to determine whether it was properly manufactured and/or whether it can be adjusted to meet her needs. It is the PT's opinion that such evaluation should be conducted as soon as practicable.

#### **PRINCIPLES OF LAW AND ANALYSIS**

17. 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.

18. 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.

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

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

21. The burden of proof in the instant case belongs to Petitioner, and the standard of proof is preponderance of the evidence. (See Fla. Admin. Code R. 65-2.060(1).)

22. 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.

23. 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. History.—s. 6, ch. 2011-134; s. 4, ch. 2014-57.

24. No evidence was presented to demonstrate that Petitioner may opt-out of managed care for her medical needs.



25. 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 United.

26. As of the date of this Final Order, there is no Medicaid Long-Term Care Handbook currently promulgated by rule. As such, the undersigned must review United's determinations in conjunction with the July 2010 Durable Medical Equipment/Medical Supply Services Coverage and Limitations Handbook (DME Handbook), as promulgated by Fla. Admin. Code R. 59G-4.070.

27. Page 2-17 of the DME Handbook sets forth the requirements for requesting prior authorization (PA) of a power wheelchair, noting:

PA requests for custom manual and custom power-operated wheelchairs (K0009 and K0014) must be submitted on either the Custom Wheelchair Evaluation, AHCA-Med Serv Form 015, July 2007, or another document that contains the same information as the form. The Custom Wheelchair Evaluation, AHCA-Med Serv Form 015, July 2007, is incorporated by reference in 59G-4.070, F.A.C.

More detailed and additional requirements are noted on page 2-18.

28. There is no evidence that any type of form or measurements/specifications were submitted along with Petitioner's 2014 request, or that she requested (from United) replacement of specific, problematic components.

29. With regard to benefit limitations, page 2-95 of the Handbook states:

Medicaid will reimburse a powered mobility device, such as the vehicle described in HCPCS procedure code for a POV.

Since Medicaid may fund and maintain only one mobility device within the

maximum limit period, the recipient is not eligible for more than one power operated vehicle (POV) or wheelchair (standard or customized) within the same five-year maximum limit period.

Note: See the DME and Medical Supply Services Provider Fee Schedules for the maximum limits. The fee schedules are available on the Medicaid fiscal agent's Web site at [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select Public Information for Providers, then Provider Support, and then Fee Schedules.

30. The referenced fee schedule, The Florida Medicaid Durable Medical Equipment and Medical Supply Services Provider Fee Schedule for All Medicaid Recipients (July 2014), has been promulgated into law and incorporated by reference at Fla. Admin. Code R. 59G-4.071. As Dr. Kaprow noted, the fee schedule includes benefit limitations for complete chairs, as well as for individual components.

31. In terms of exceptions to benefit limitations, United acknowledged that it will permit exceptions to time/year restrictions for components, but not for an entire wheelchair unit. The policy of waiving the limitation, or otherwise arranging for equipment that properly meets a consumer's needs, is consistent with provisions of the DME Handbook contained on (e.g.) pages 2-21, 2-24, and 2-27, which note:

[p. 2-21 Maximum Limit Exceptions] If it is medically necessary that the maximum limits must be exceeded, the additional services must:

- Be documented as medically necessary in the treating physician's progress notes; and
- Prescribed by an authorized prescriber; and
- Meet all DME service requirements; and
- Be authorized by the recipient's MediPass primary care provider, if the recipient is enrolled in MediPass.

Providers must consult with the staff at the recipient's area Medicaid office when submitting a request to exceed maximum limits.

[p. 2-24 Equipment Trade-Ins] When equipment purchased by Medicaid is no longer suitable for the recipient because of growth, development, or changes in the recipient's medical or physical condition, the Medicaid prior authorization request reviewer and the DME provider may negotiate a good faith trade-in of the recipient's current equipment.

A full description of the trade-in item, including the age, model, serial number, and the pro-rated trade-in amount must be clearly indicated on the purchase invoice for the new equipment.

[p. 2-27 Limitations for Replacement of Equipment] Medicaid may replace equipment when the recipient's medical necessity changes. The provider must submit the documentation required to justify the purchase of the replacement equipment.

Providers must contact the appropriate area Medicaid office if uncertain how to submit a request for a replacement item.

Providers are responsible for the repair or replacement of items damaged by the provider.  
(emphasis added)

32. Based upon United's stated policy, in conjunction with the above-cited legal authority, is clear that the time/year limitations on both components *and* entire wheelchair units is not absolute. Testimony from Petitioner's PT demonstrates that Petitioner's medical needs may, indeed, have changed, due to the degenerative nature of her ailments. As such that reevaluation of medical necessity for a new unit or new components would be proper. Regrettably, it does not appear that Respondents investigated these options and/or that counsel conferred with Petitioner (as she requested, subsequent to her attorney's withdrawal) to discuss her situation and assess her needs. Respondent's denial was based solely on

a benefit limitation; however, it is clear that said limitation is not without exceptions.

33. Ultimately, the burden of proof lies with Petitioner. While the undersigned accepts the testimony of both Petitioner and her PT that the Bounder chair is not meeting Petitioner's needs, absent a thorough evaluation of Petitioner's use of the chair, the undersigned is unable to determine that an entirely new unit is appropriate, as a medical necessity. Additionally, as Petitioner has not provided the documentation necessary for a prior authorization request (i.e., wheelchair forms, measurements, etc.), the undersigned must conclude that Petitioner has not met the preliminary requirements to obtaining a new chair.

34. Petitioner and Respondents are instructed to work together, in an effort to resolve Petitioner's concerns. Petitioner is encouraged to cooperate with Respondents, and Respondents are encouraged to speak directly with Petitioner and/or her caregivers and providers, to obtain a clear assessment of Petitioner's needs.

35. Petitioner has failed to meet the burden of proof required to demonstrate that Respondents' decision was incorrect. Should Petitioner submit additional requests for repair, replacement, or provision of a new chair, and receive denials of same, she will retain the right to appeal those, specific decisions.

**DECISION**

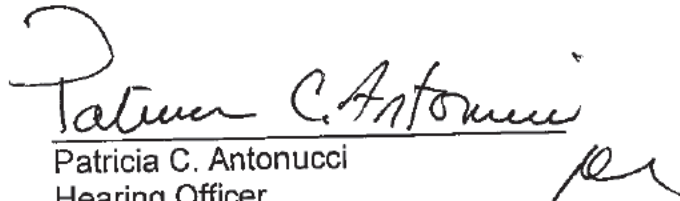
Based upon the foregoing Findings of Fact and Conclusions of Law, the Petitioner's appeal is hereby DENIED.

**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 agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.


DONE and ORDERED this 29<sup>th</sup> day of June, 2015,

in Tallahassee, Florida.



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