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

[redacted]

PETITIONER,

APPEAL NO. 14F-09519

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 20 Collier
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in this matter telephonically on December 23, 2014, at 10:40 a.m.

APPEARANCES

For the Petitioner: [redacted]
Petitioner's Mother

For the Respondent: Pat Brooks
Program Administrator
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether the decision of the Agency for Health Care Administration to deny the petitioner's request for a pulse oximeter, disposable pulse oximeter probes, and adult wipes.

PRELIMINARY STATEMENT

[redacted] the petitioner's mother, appeared on behalf of the petitioner, [redacted] ("petitioner"), who was not present. Ms. [redacted] may sometimes hereinafter be referred to as the petitioner's "representative".

Pat Brooks, Program Administration at the Region 8 Office of the Agency for Health Care Administration, appeared on behalf of the Agency for Health Care Administration (sometimes hereinafter referred to as "AHCA" or the "Agency"). The following individuals appeared as witnesses on behalf of the Agency: Marc Kaprow, D.O., Long Term Care Plan Medical Director of United Healthcare; and Christian Laos, Senior Compliance Analyst with United Healthcare.

During the hearing, the respondent introduced Exhibits "1" through "8", inclusive, all of which were accepted into evidence and marked accordingly. The hearing record in this matter was left open until the close of business on December 30, 2014 for the respondent to provide more legible copies of screen-prints contained in its proposed evidence packet. The information was not provided by the respondent.

FINDINGS OF FACT

1. The petitioner is a 26-year-old male.

2. The petitioner is a medically fragile individual. He is ventilator dependent and oxygen dependent.

3. Petitioner was eligible to receive Medicaid benefits at all times relevant to these proceedings.

4. The petitioner is an enrolled member of United Healthcare. United Healthcare is a health maintenance organization ("HMO") contracted by the Agency for

Health Care Administration to provide services to certain Medicaid eligible recipients in Florida.

5. The petitioner's effective date of enrollment with United Healthcare was October 1, 2013.

6. The petitioner is presently enrolled in and receiving services through the Long Term Care Waiver. He was enrolled in a different waiver prior to his transition to United Healthcare. The Long Term Care Waiver is the result of a consolidation of six previous waivers. As a result of the consolidation, some recipients formerly enrolled in different waivers received enhanced benefits while others experienced a decrease in services.

7. On or about October 13, 2014, the petitioner's provider requested prior authorization for a pulse oximeter, four disposable pulse oximeter probes, and 12 cases of adult moist wipes per month. One case of adult moist wipes consists of 48 wipes.

8. In a denial notice dated October 20, 2014, United Healthcare denied the petitioner's request for a pulse oximeter and disposable pulse oximeter probes. The notice explains that the long-term care health plan does not cover the supplies.

9. In a different denial notice also dated October 20, 2014, United Healthcare advised the petitioner that it would cover four packs per month of adult moist wipes. Four packs per month is the equivalent of 192 wipes.

10. The petitioner has been ventilator dependent for 16 years. During that time, the petitioner has always had a pulse oximeter by his bedside.

11. A pulse oximeter is a non-invasive piece of medical equipment that looks at oxygen saturation in the blood.

12. A pulse oximeter does not measure the amount of oxygen in the blood but rather the average percentage of red blood cells that are oxygenated.

13. The petitioner's mother testified that she and the petitioner's nurses use the pulse oximeter as an early warning system to monitor the petitioner for secretions and desaturation. They have been using a pulse oximeter in the care of the petitioner for at least 16 years.

14. The doctor appearing for the Agency testified that providing care for an individual whose respiratory status so unstable as to require 24 hour monitoring of oxygenation is beyond the scope of the Long Term Care Waiver. The doctor explained there are available alternatives which more closely coincide with the level of care that the petitioner requires, such as nursing home care. He set forth the Agency's position that an individual's choice to not pursue alternatives does not create medical necessity for items that would otherwise not be covered under the Program.

15. The doctor testifying for the Agency explained that the petitioner's request for a pulse oximeter and disposable pulse oximeter probes was not denied due to a lack of medical necessity but rather because reimbursement for the monthly rental of a pulse oximeter is only available for newborns and children under six years of age pursuant to the Agency's Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook.

16. The doctor testifying for the Agency explained that the purpose of adult disposable wipes is not for cleaning an individual after a bowel movement, but rather to prepare the area for the application of a barrier cream or other agent that helps prevent or minimize skin breakdown.

17. The doctor testifying for the Agency stated that toilet paper and disposable wash clothes are the appropriate items to clean an individual after a bowel movement.

18. The doctor testifying for the Agency explained that based on the number of adult moist wipes requested by the petitioner, if the wipes were used properly, there would be enough wipes to prepare the petitioner's area for the application of a barrier cream or spray after 10 bowel movements daily. He explained that there is no indication that the petitioner suffers from chronic diarrhea or other condition that would cause him to have that many bowel movements.

CONCLUSIONS OF LAW

19. By agreement between the Agency for Health Care Administration and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to § 120.80, Fla. Stat.

20. The Florida Medicaid Program is authorized by Chapter 409, Fla. Stat., and Chapter 59G, Florida Administrative Code. The Program is administered by AHCA. All goods and services requested under the Florida Medicaid Program must be shown to be medically necessary in order to be approved.

21. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

22. The respondent is proposing a reduction in the petitioner's services. Therefore, in accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof is assigned to the respondent.

23. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

24. Section 409.905, Fla. Stat. 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...
> (4) HOME HEALTH CARE SERVICES.--The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home...
> (a) The agency shall require prior authorization of home health services....
> (c) The agency may not pay for home health services unless the services are medically necessary ...

25. Under § 1915(c) of the Social Security Act (42 USC § 1396n(c)), a state may obtain a Medicaid waiver that allows the state to include in the state's Medicaid program the cost of home or community-based services (other than room and board) provided to individuals who otherwise would require care in a hospital, nursing facility, or intermediate care facility.

26. Home or community-based services include personal care services, habilitation services, and other services that are "cost effective and necessary to avoid institutionalization." See 42 CFR § 180.

27. 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.

28. 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 enrolled in managed care plans, as a condition of Medicaid eligibility, to pay the Medicaid program a share of the premium of $10 per month.

29. No evidence was presented to demonstrate that Petitioner may opt-out of managed care for her Long-Term Care needs.

30. 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 Healthcare.

31. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Chapter 59G-4. In accordance with the above Statute, the Handbook states on page 1-27

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.
>
> Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

32. Pages 1-28 of the Florida Medicaid Provider General Handbook provide a list of HMO covered services. These services include durable medical equipment.

33. Page 1-30 of the Florida Medicaid Provider General Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service." However, an HMO may choose to offer more services than the Medicaid State Plan. If an HMO chooses to offer additional services, it must do so consistently and in accordance with the provisions set forth in its Member Handbook.

34. The argument of the Agency's witness that the refusal of an individual to pursue an alternate course of care such as institutionalization does not create medical necessity for an otherwise uncovered item is unpersuasive. The intent of the Long Term Care Program is to provide cost-effective alternatives to institutionalization. Petitioner in the present case has received care in the family home for an extended period of time

and that care has been successful. Therefore, the petitioner's request must be reviewed to determine if the items requested are medically necessary.

35. Although the terms medically necessary and medical necessity are often used interchangeably and may be used in a variety of contexts, their definition for Florida Medicaid purposes is contained in the Florida Administrative Code. Fla. Admin. Code R. 59G-1.010 states:

> (166) "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) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
> (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.

36. Section 409.913, Fla. Stat. governs the oversight of the integrity of the Florida Medicaid Program. Section (1)(d) sets forth the "medical necessity or medically necessary" standards, and states in pertinent part as follows

> "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice....
>
> Section (1)(d) goes on the further state:
>
> ...For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

37. Section (1)(d) highlights that the Agency makes the final decision regarding whether or not a requested service is medically necessary; however, the hearing officer is the final decision making authority for the Agency. See § 120.80, Fla. Stat.

38. The United Healthcare Community Plan Health and Home Connection Enrollee Handbook in the Section entitled "Medical Equipment and Supplies", on Page 21, explains that the Plan will approve: "Disposable supplies essential to adequately care for the needs of the enrollee. These supplies enable the enrollee to perform activities of daily living or to stabilize or monitor a health condition..."

39. The petitioner's representative offered credible testimony explaining that a pulse oximeter has been used to monitor the petitioner's respiratory status for at least 16 years and is an indispensible piece of durable medical equipment in the petitioner's care.

40. Pursuant to the testimony and evidence presented at the hearing, the hearing officer concludes that the pulse oximeter is medically necessary for petitioner.

41. In accordance with the durable medical equipment provision set forth in the United Healthcare Enrollee Handbook, the petitioner is entitled to the approval of the pulse oximeter.

42. The respondent has not met its burden of proof with regard to the denial of the pulse oximeter.

43. With regard to the proposed reduction in the amount of adult moist wipes approved for the petitioner from 12 cases to four cases per month, the respondent's witness provided credible testimony that such wipes are to be used to prepare an area for the application of a barrier cream or other agent to assist with the prevention of skin breakdown and not for cleaning an individual after a bowel movement. Based on the petitioner's current medical circumstances, four cases per month should be sufficient to meet the petitioner's needs. More economical alternatives, such as disposable wash cloths, are available for cleaning the petitioner after a bowel movement. Accordingly, the respondent has met its burden of proof with regard to the reduction of adult moist wipes.

44. The respondent has met its burden of proof with regard to the reduction of adult moist wipes.

45. In rendering this decision, the undersigned hearing officer considered all of the testimony and documentary evidence presented during the hearing process and reviewed all conditions of "medical necessity" set forth in the Florida Administrative Code and the rules governing the Florida Medicaid program.

DECISION

The petitioner's appeal is hereby GRANTED with respect to the pulse oximeter. The Agency is directed to continue providing the petitioner with his pulse oximeter.

The petitioner's appeal is hereby DENIED with respect to the proposed reduction of adult moist wipes. The Agency is directed to continue providing the petitioner with the reduced amount of wipes and to work with the petitioner's representative to provide the petitioner with more cost-effective supplies such as disposable wash cloths.

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 6th day of February, 2015,

in Tallahassee, Florida.

Peter J. Tsamis
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Dietra Cole, Area 8, AHCA Field Office Manager