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

[redacted]

APPEAL NO. 14F-02291

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 Dade
UNIT: AHCA

RESPONDENT.

_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on April 22, 2014, at 11:30 a.m., with all parties appearing telephonically.

APPEARANCES

For the Petitioner: [redacted], the petitioner's mother.

For the Respondent: Luis Davila, senior program specialist, Agency For Health Care Administration (AHCA).

STATEMENT OF ISSUE

At issue is the Agency action of February 24, 2014 to deny/reduce the request for occupational therapy for four units, three times a week for twenty six weeks which covers the certification period of February 21, 2014 to August 19, 2014. The Agency approved four units, one time a week for twenty six weeks. The petitioner has the burden of proof.

PRELIMINARY STATEMENT

Present as a witness for the respondent was Dr. Darlene Calhoun, physician Reviewer, eQHealth Solutions.

FINDINGS OF FACT

1. The petitioner is eleven years of age and has been diagnosed with developmental delay, autism, and is visually impaired (legally blind) which requires the evaluation of services as provided through the Agency for Health Care Administration's (AHCA) Medicaid State Plan. The petitioner's condition(s) is further outlined in Respondent Composite Exhibit 1. AHCA will be further addressed as the "Agency".

2. eQHealth Solutions has been authorized to make Prior (service) Authorization Process decisions for the Agency. The Prior Authorization Process was completed for the petitioner by eQHealth Solutions. The request for service was for occupational therapy. The first review for this case was completed by an occupational therapist from eQHealth Solutions. A board certified pediatrician is the consultant reviewer for eQHealth Solutions who also reviewed this request. eQHealth Solutions determined on February 24, 2014, that the petitioner's request for four units, three times a week for occupational therapy (OT) was denied/reduced for the period of February 21, 2014 through August 19, 2014. eQHealth Solutions approved four units, one time a week for the certification period. One unit is equal to fifteen minutes of the therapy service. This request by the petitioner's provider is a request for an increase in OT services.

3. eQHealth Solutions mailed a notice to the petitioner and the petitioner's provider on February 24, 2014 indicating that, "Submitted information does not support

the medical necessity for requested frequency and/or duration. Therapy services are approved for partial length of service requested, based on the documentation provided." eQHealth also provided clinical rational for the decision:

> This is a ten year old with developmental delay and low vision in both eyes. Therapy is needed to improve fine motor, visual motor, visual perception, coordination, strength, endurance, and social skills. However, the patient is functioning at an average level for age, in several of the areas targeted and has demonstrated progress. All requested units are not approved as they are deemed excessive.

4. No reconsideration request was requested for this case.

5. The petitioner's provider has included information as part of the provider's request for the OT service for the petitioner. This information was reviewed and evaluated by eQHealth Solutions and is included in Respondent Composite Exhibit 1. This information shows the petitioner has met with various degrees of efficiency his previously established goals. The information shows the petitioner has made moderate progress for four previously established goals and has made moderate progress for two new goals. This report also indicated the petitioner scored a 91 under visual motor; scored 59 under visual motor perception; and scored 67 under visual motor coordination. A score of 85 is considered within the normal range for standardized tests. The report indicates the petitioner did not have deficits under visual motor and that under "fine motor"; no testing evaluation results were provided by the petitioner's provider.

6. The respondent's witness reiterated what was said in the Agency notice noted above as the reasons why the increase in service request was denied. She indicated

also that the information as provided by the petitioner's provider was more of a request for "maintenance therapy" and not as a request for intensive therapy.

7. The respondent witness also indicated that the provisions of the EPSDT Program were considered for this decision.

CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat § 409.285. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

9. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code § 65-2.056.

10. In accordance with Fla. Admin. Code § 65-2.060 (1), the burden of proof was assigned to the petitioner.

11. Fla. Admin. Code 59G-1.010 states in part:

> (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;
> 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...

12. The Therapy Services Coverage and Limitations Handbook pages 2-4; 2-9 and 2-10 (August 2013) set forth the process for therapy services including speech therapy and state in part:

All requests for prior authorization must be submitted to the Medicaid QIO via its web-based internet system.

At a minimum, each prior authorization request must include all of the following:

• Recipient's name, address, date of birth, and Medicaid ID number;

• Therapy provider's Medicaid provider number, name and address;

• Procedure code(s), with modifier(s) if applicable, matching the services reflected in the plan of care;

• Units of service requested;

• Summary of the recipient's current health status, including diagnosis(es);

• Planned dates and times of service;

• Ordering provider's Medicaid provider number, National Provider Identifier, or Florida Medical License number, name, and address;

• The complete evaluation and plan of care, reviewed, signed and dated by the primary care provider, ARNP or PA designee, or designated physician specialist;

• Patient condition summaries that substantiate medical necessity and the need for requested services, such as a hospital discharge summary (if services are being requested as a hospital discharge summary (if services

are being requested as a result of a hospitalization), physician or nurse progress notes, or history and physical;

• A copy of the documentation demonstrating the recipient has been examined or received medical consultation by the ordering or attending physician before initiating services and every 180 days thereafter.

...The QIO may use a national standardized set of criteria, approved by the Agency for Health Care Administration (AHCA), as a guide to establish medical necessity for prior authorization of therapy services at the first review level. If services cannot be approved by the first level reviewer, the QIO's physician peer reviewer will determine medical necessity using his clinical judgment, acceptable standards of care, and AHCA's medical necessity definition.

• A prescription for the therapy services in accordance with the prescription requirements described in this chapter

The prescription should be as specific as possible, and must include:

• The recipient's diagnosis or diagnoses contributing to the need for therapy;

• Signature of the prescribing provider;

• Name, address and telephone number of the prescribing provider;

• Date of prescription;

• The specific type of evaluation or service requested

• For therapy services, the duration and frequency of the therapy treatment period; and

• The physician's MediPass authorization number, if applicable

Evaluations determine the recipient's level of function and competencies through therapeutic observation and standardized testing measures appropriate to the language, speech, or physical limitations and specific to the therapeutic services required.

Evaluation results should be used to develop baseline data to identify the need for early intervention for therapeutic services and to address the recipient's functional abilities, capabilities, and activity level deficits and limitations.

Tests should be:

• Standardized for a specific disorder identified; or

• Consist of a standardized caregiver report format; or

• Composed of professionally acceptable therapeutic observational techniques.

Age equivalent score reporting does not report a standard score and is not an acceptable evaluation test.

13. The State Medicaid Manual in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services section states in part:

5010. Overview
A. Early and Periodic Screening, Diagnostic and Treatment Benefit.-- Early and periodic screening, diagnostic and treatment services (EPSDT) is a required service under the Medicaid program for categorically needy individuals under age 21…

5110. Basic Requirements

OBRA 89 amended §§1902(a)(43) and 1905(a)(4)(B) and created §1905(r) of the Social Security Act (the Act) which set forth the basic requirements for the program. Under the EPSDT benefit, you[1] must provide for screening, vision, hearing and dental services at intervals which meet reasonable standards of medical and dental practice established after consultation with recognized medical and dental organizations involved in child health care. You must also provide for medically necessary screening, vision, hearing and dental services regardless of whether such services coincide with your established periodicity schedules for these services. Additionally, the Act requires that any service which you are permitted to cover under Medicaid that is necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be provided to EPSDT participants regardless of whether the service or item is otherwise included in your Medicaid plan.

[1] "You" in this manual context refers to the state Medicaid agency.

14. Fla. Stat. § 409.913 addresses "Oversight of the integrity of the Medicaid program," with (1)(d) describing "medical necessity or medically necessary" standards and saying in relevant part: "For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity."

15. As shown in the Findings of fact, on February 24, 2014, eQHealth Solutions denied/reduced the petitioner's request for occupational therapy for four units, three times a week for twenty six weeks. The petitioner was approved four units, one time a week, which covers the certification period of February 21, 2014 to August 19, 2014. The reason for the denial of the requested services was based on, "Submitted information does not support the medical necessity for requested frequency and/or duration. Therapy services are approved for partial length of service requested, based on the documentation provided."

16. The petitioner's representative argued that the petitioner has deficits that cause the petitioner to be in need of more occupational therapy. She argued that the petitioner needs more OT as he is not making as much progress as he used to make.

17. The respondent witness argued that based on the petitioner's making progress with most of his goals; his normal to near normal test scores; and the addressing of the petitioner's visual concerns, eQHealth Solutions' decision to approve the petitioner for 4 unit of occupational therapy, 1 time a week is the correct medically necessary decision for this case. She also argued that she understands the petitioner's representative's concerns regarding the OT services, but regards the information as

submitted by the petitioner's provider as more of a request for "maintenance therapy" than as a request for intensive therapy.

18. For the case at hand, the hearing officer acknowledges the petitioner's representative's concerns, but based on the evidence presented such as the petitioner's progress and his standardized tests scores; this hearing official finds that the amount of occupational therapy approved by the Agency is the correct medically necessary amount for the petitioner.

19. After considering the evidence, the Fla. Admin. Code Rule and all of the appropriate authorities set forth in the findings above, the hearing officer concludes that the Agency action to reduce/deny the petitioner's request and approve four units, one time a week for the certification period of February 21, 2014 to August 19, 2014, is correct. The petitioner has not met his burden of proof.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED and the Agency action affirmed.

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 20th day of May, 2014,

in Tallahassee, Florida.

Robert Akel

Robert Akel
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
Rhea Gray, Area 11, AHCA Field Office Manager