

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

FILED

AUG 29 2014

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES



APPEAL NO. 14F-03295

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 August 7, 2014, at 1:30 p.m., in Doral, Florida.

APPEARANCES

For the Petitioner:  the petitioner's mother.

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

STATEMENT OF ISSUE

At issue is the Agency action of April 2, 2014 to deny/reduce the request for occupational therapy (OT) of four units, three times a week for twenty six weeks which covers the certification period of March 10, 2014 to September 5, 2014. The Agency approved four units, two times a week for twenty six weeks. The respondent has the burden of proof.

PRELIMINARY STATEMENT

Present as a witness for the respondent was Dr. Rakesh Mittal, physician Reviewer, eQHealth Solutions. Present as an interpreter was Boris Rodriguez.

A continuance was granted on behalf of the respondent and the petitioner for a hearing previously scheduled on June 12, 2014.

FINDINGS OF FACT

1. The petitioner is fourteen years of age and has been diagnosed with developmental delay and scoliosis, 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 April 2, 2014, that the petitioner's request for four units, three times a week for occupational therapy (OT) was denied/reduced for the period of March 10, 2014 through September 5, 2014. eQHealth Solutions approved four units, two times a week for the certification period. One unit is equal to fifteen minutes of the therapy service.

3. eQHealth Solutions mailed a notice to the petitioner and the petitioner's provider on April 2, 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:

The patient is a 14 year old with PDD and developmental delay who may benefit from continued occupational therapy addressing fine motor, gross motor and cognitive skills; however, the request is excessive based on the progress made over the years of therapy and the potential for progress. Intensive therapy is no longer warranted. Based on the patient's deficits and needs, 4 units 2 times a week are approved. The additional requested units are not approved as they have been deemed excessive.

4. No reconsideration request was requested for this case.

5. In an Occupational Therapy Evaluation report for the petitioner dated February 15, 2014, as presented as part of Respondent Composite Exhibit 1, indicates: "Freddy continues with delay in all areas." This report indicates that the petitioner has made minimal to moderate progress. It also indicates that the petitioner has not met any of his goals. The respondent witness indicated that based on this information and that the petitioner has received years of OT service; the Agency action to reduce the petitioner's OT service is the correct medically necessary decision.

~~6. The petitioner submitted into evidence, Petitioner Exhibit 1, which contains~~
copies of a lab report; an interpretation; and a doctor's prescription for the petitioner. This report indicates the petitioner may have a genetic disorder but needs more testing. This information was not reviewed by the Agency and the respondent witness indicated that he saw no related reason to review it.

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 respondent.

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 occupational 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, you¹ 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.

14. Fla. Stat. § 409.913 addresses "Oversight of the integrity of the Medicaid program," with (1)(d) describing "medical necessity or medically necessary" standards

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

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 April 2, 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, two times a week, which covers the certification period of March 10, 2014 to September 5, 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 based on the petitioner making minimal to moderate progress; he should receive an increase in OT service, not a decrease. She argued that the petitioner needs help with his muscle tone. She also argued that the petitioner has made progress with the help of OT service. She argued that she provides the petitioner with therapy herself, but some of the therapy can only be provided by a professional therapist.

17. The respondent representative argued that based on the petitioner making minimal to moderate progress; not meeting his goals; the petitioner's caretaker duty to also provide the therapy; and the length of time the petitioner has received therapy; the reduction in OT therapy is the correct medically necessary decision. He also argued that the Agency is approving the petitioner for the OT services and not denying it altogether.

18. For the case at hand, based on the evidence presented such as the petitioner not meeting his goals; making minimum to moderate progress and the years of receiving OT service; and only making minimum to moderate progress; 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 for four units three times a week and approve four units, two times a week for the certification period of March 10, 2014 to September 5, 2014, is correct. The respondent has 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 29th day of August, 2014,
in Tallahassee, Florida.

Robert Akel
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