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

[redacted]

APPEAL NO. 14F-04331

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 June 19, 2014, at 1:30 p.m., with all parties participating telephonically.

APPEARANCES

For the Petitioner: [redacted], 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 16, 2014 to deny/reduce the request for speech therapy of four units, three times a week for the period of April 12, 2014 to October 8, 2014. The Agency approved four units, two times per week of the therapy for the above certification period. The respondent has the burden of proof.

PRELIMINARY STATEMENT

Present as a witness for the respondent was Dr. Darlene Calhoun, physician reviewer, eQHealth Solutions. Present as an interpreter was Boris Rodriguez.

FINDINGS OF FACT

1. The petitioner is four years of age and has been diagnosed with mixed expressive and receptive language delay and developmental delay 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. A speech therapist and a board certified pediatrician were the consultant reviewers for eQHealth Solutions. The request for service was for speech therapy. eQHealth Solutions determined on April 16, 2014, that the petitioner's request for four units, three time a week for speech therapy was reduced/denied for the period of April 12, 2014 through October 8, 2014. eQHealth Solutions approved four units, two times a week for the certification period. One speech therapy unit is 15 minutes.

3. eQHealth Solutions mailed a notice to the petitioner and the petitioner's provider on April 16, 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 3 year old with a mild receptive and expressive language delay who may benefit from continued speech therapy; however, the request is excessive based on the severity of delay with the progress made with 5 short term goals met. 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 are deemed excessive.

4. The petitioner's provider requested a reconsideration of the above decision. eQHealth Solutions upheld the original decision and mailed the petitioner a notice advising of the decision on May 1, 2014.

5. As part of a Speech-Language reevaluation and plan of care submitted by the petitioner's provider, and according to the Preschool Language Scale-5th Edition, which is a standardized test, provided to the petitioner in April 2014; the petitioner tests scores were a 74 in auditory comprehension; 70 for expressive communication and 70 in total language. Additionally, the petitioner scored an 81 under expressive "one word" vocabulary test and a 69 under receptive "one word" picture test. The score of 85 is considered "normal". Also as part of measuring standardized tests; the respondent representative explained that "100" is a medium score and standard deviations from that score, either plus or minus is 15 points. Normal as noted above is measured between 85 and 115. Scores measured between 70 through 84 are considered as mild (deficits). Scores between 55 through 69 are considered as moderate and scores less that 54 are considered severe.

6. As part of the petitioner's provider's request for reconsideration review; the petitioner's provider/speech therapist also listed on a "report"; that the petitioner's;

"Standard scores clearly place [redacted] as moderately to severely delayed in expressive language skills" and "assessment results and clinical observations clearly state that receptive and expressive language delays are moderately to severe delay." The respondent witness explained that the above comment is inaccurate to the petitioner's actual delay, as no standardized score for the petitioner measured in the severe range and in fact measured in the mild range, except for under the receptive test score which measured in the moderate range. The hearing officer accepts the respondent's witness explanation as noted above as more credible.

7. The physician reviewer reiterated the above noted Agency notice. The physician reviewer indicated that based on the above, the petitioner's has made progress over the last year, by meeting his goals. She indicated that the petitioner has mostly mild expressive delay and moderate expressive deficits. Additionally the petitioner has mild articulation deficits. Based on the receptive language deficits which are mostly mild deficits and as per the petitioner's standard scores; the petitioner is making progress, thus the Agency has correctly determined that the petitioner has the medically necessary need for 4 units 2 times a week of speech therapy.

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

CONCLUSIONS OF LAW

9. 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.

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

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

12. 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.
>
> (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…

13. 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.

14. 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.

15. 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."

16. As shown in the Findings of Fact, the Agency, through eQHealth Solutions denied the petitioner's request for speech therapy of four units, three time a week and approved four units, two times a week for the period of April 12, 2014 to October 8, 2014, based on: "Submitted information does not support the medical necessity for

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

requested frequency and/or duration. Therapy services are approved for partial length of service requested, based on the documentation provided."

17. The petitioner's representative argued that the petitioner cannot express himself. She argued that the petitioner is unable to speak and will "throw" himself on the floor in frustration. She argued that when the Agency made the changes to decrease the service rate of the speech therapy; the petitioner's improvement rate also decreased. She argued that he had improved considerably in the last school period and needs to continue at that rate. She also argued that she disagrees with the respondent's evaluation that the petitioner has mild deficits as she as a mother believes the petitioner has severe deficits.

18. The respondent witness argued that based on the petitioner's standard test scores; his progress as shown in meeting his goals and his mostly mild to some moderate deficits that cause delay; four units two times a week of speech therapy have been approved. Additionally she argued that 4 units 3 times a week of speech therapy is in excess of the petitioner's needs; thus the eQHealth Solution decision to approve the petitioner for 4 units of speech therapy, 2 times a week is the correct medically necessary decision for this case. She additionally argued that the petitioner's provider was incorrectly evaluating the petitioner's test scores, as no test score was within the severe range of deficits for the petitioner.

19. For the case at hand, the hearing officer notes that the petitioner had made progress, especially with meeting his goals. Additionally, as the petitioner has mostly mild deficits and some moderate deficits, the hearing officer agrees with the

respondent's arguments especially that the amount of speech therapy approved is the correct medically necessary amount and the amount as requested is in excess of the petitioner's needs.

20. 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 deny/reduce the petitioner's request for the additional speech therapy of four units, three times a week, but approve four units two times a week for the certification period of April 12, 2014 through October 8, 2014, due to: "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..." is correct, as the respondent has met its 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 11th day of August, 2014,

in Tallahassee, Florida.

Robert Akel

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