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

[redacted]

PETITIONER,

APPEAL NO. 14F-02512

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 17 Broward
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing telephonically on May 12, 2014, at 3:15 p.m.

APPEARANCES

For the Petitioner: [redacted]
Petitioner

For the Respondent: Ken Hamblin
Area 10 Medicaid Fair Hearing Coordinator
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 Jazzy Elite 14 Power Wheelchair.

PRELIMINARY STATEMENT

[redacted] the petitioner ("petitioner"), appeared on his own behalf. [redacted], the petitioner's caregiver, appeared as a witness on behalf of the petitioner.

Ken Hamblin, Field Office 10 Medicaid Fair Hearing Coordinator for the Agency for Health Care Administration (sometimes hereinafter referred to as the "respondent", "AHCA" or the "Agency"), appeared on behalf of the Agency. The following individuals from Sunshine Health appeared as witness on behalf of the Agency for Health Care Administration: Jeff Martorana, M.D., Chief Medical Officer; and Donna Laber, R.N., Manager of Grievance and Appeals. The following individuals from Sunshine Health were present solely for the purpose of observation: Paula Daley, Grievance and Appeals Coordinator; and Carolyn Janvier, also a Grievance and Appeals Coordinator.

The respondent introduced respondent's Exhibits "1" through "5", inclusive, at the hearing, all of which were accepted into evidence and marked accordingly. Petitioner introduced no evidence.

FINDINGS OF FACT

1. The petitioner is an adult male. He resides in Broward County, Florida.

2. The petitioner has a history of cancer and multiple sclerosis. The petitioner can no longer walk independently and requires the assistance of a wheelchair for ambulation.

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

4. The petitioner is enrolled in Sunshine Health. Sunshine Health is a health maintenance organization ("HMO") contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in Broward County.

5. UniVita is the durable medical equipment ("DME") vendor for Sunshine Health.

6. On or about October 14, 2013 [redacted] received a prescription dated October 10, 2013 from the petitioner's physician, [redacted] M.D., for a "Pride Jazzy Select standard power wheelchair. Upon investigation, it was later discovered that the prescription incorrectly combined the names of two Jazzy models. The manufacturer offers a Jazzy Select Elite model and a Jazzy Elite 14 model.

7. On or about October 23, 2013, [redacted] received a brand specific script for the Pride Jazzy Elite 14. The petitioner's doctor did not check the box on the script indicating "Do Not Substitute", nor did the request include any documentation explaining the medical necessity of the brand specific power wheelchair.

8. On or about October 28, 2013 [redacted] attempted to deliver a Jazzy Select power wheelchair to the petitioner. The petitioner refused deliver stating he would only accept a Jazzy Elite 14.

9. The Jazzy Elite 14 is not on the list of formulary power wheelchairs at Sunshine Health.

10. Sunshine Health must preauthorize any request for a non-formulary or brand specific power wheelchair.

11. Pursuant to the petitioner's request, on or about October 29, 2013, [redacted] submitted a request for authorization of the Jazzy Elite 14 to Sunshine Health.

12. The Sunshine Health Medical Director reviewed the preauthorization request upon its receipt from UniVita. The Sunshine Health Medical Director concluded there was not sufficient information to justify the brand specific wheelchair for petitioner.

13. The last medical notes provided in conjunction with the petitioner's request for a power wheelchair were from his primary care physician. The medical notes did not include an evaluation by a therapist or a seating and equipment assessment.

14. Sunshine Health sent a denial letter to the petitioner dated November 4, 2013. The letter provides the following explanation for the denial

> There is not sufficient information to justify the requested wheelchair for this member. The last medical notes provided is [*sic*] from the MD and there is no evaluation provided by a therapist to include a seating / equipment assessment. It is unclear if the requested w/c will have the ability to be adapted to meet the long term needs of the member as continued decline would be expected due to the nature of his disease process. There is no indication that the requested w/c would provide optimal positioning and pressure relief or that the member has tried the requested w/c and that he displays the cognitive, problem solving, awareness or visual perceptual ability to be safe with the device or that his home is accessible and that they would have the ability to transport the device as necessary. The request for a wheelchair is therefore denied.

15. The petitioner filed a grievance with Sunshine Health regarding the denial of the brand specific power wheelchair. Sunshine Health acknowledged receipt of the grievance in a letter to the petitioner dated March 10, 2014.

16. Sunshine Health rendered a decision to the petitioner's grievance in a letter dated March 12, 2014. The letter, in relevant part, states as follows

> ...Review of clinical records does not support the medical necessity of the brand specific wheelchair Jazzy Elite 14 over the standard power wheelchair available from our contracted vendor. There is no documentation of a comprehensive evaluation by a therapist to justify the brand specific device over the chair offered to you. Therefore the request for the Jazzy Elite wheelchair is denied.

17. Petitioner testified that the Jazzy Elite 14 has a higher ground clearance than the Jazzy Select, which will make it easier for him to maneuver the wheelchair

outside so he can work in his garden and go to and from the community pool where he gets his exercise.

18. Petitioner does not have a document substantiating the need for a power wheelchair that was written by an independent licensed physical therapist, occupational therapist or physiatrist.

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 petitioner in the present case is requesting a new service. Therefore, in accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof is assigned to the petitioner.

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. The Florida Medicaid program is authorized by Fla. Stat. ch 409 and Fla. Admin. Code R. 59G. The Medicaid program is administered by the respondent.

25. 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 ...

26. The Sunshine Health Member Handbook, on Page 16, explains as follows

> Sunshine covers home health services that are medically necessary. Home health services include home health visits (nurse and home health aide), private duty nursing and personal care services for children, therapy services medical supplies and durable medical equipment . Home healthcare does not include homemaker services, Meals on Wheels, companion, sitter or social services Sunshine Health follows the state Medicaid Home Health Services Coverage and Limitations Handbook.

27. The Florida Medicaid Home Health Services Coverage and Limitations Handbook March 2013 is incorporated by reference and promulgated into Rule by Chapter 59G-4.130, Florida Administrative Code.

28. The Florida Medicaid Home Health Services Coverage and Limitations Handbook, on Page 2-30, states as follows

> Home health agencies that provide DME must comply with the policies and procedures contained in this handbook and in the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook.

29. Section 409.912, Fla. Stat. states, in relevant parts:

> **Cost-effective purchasing of health care.**—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care ...
>
> (3) The agency may contract with health maintenance organizations certified pursuant to part I of chapter 641 for the provision of services to recipients. This subsection expires October 1, 2014.

30. 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.

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

32. 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."

33. In order for durable medical equipment and supplies to be approved, the equipment and supplies must not only be medically necessary but must also meet all

requirements set forth in the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook.

34. 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.

35. 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.

36. 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.

37. The Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook (July 2010) ("DME Handbook") is promulgated into rule by Fla. Admin. Code R. 59G-4.070. The Handbook describes the covered services, limitations, and exclusions associated with the acquisition and reimbursement of durable medical equipment and medical supplies obtained through the Medicaid program.

38. The DME Handbook sets forth the definition of durable medical equipment on Page 1-2. "Durable medical equipment (DME) is defined as medically-necessary equipment that can withstand repeated use, serves a medical purpose, and is appropriate for use in the recipient's home as determined by the Agency for Health Care Administration (AHCA)."

39. The DME Handbook provides the definition of a wheelchair on Page 2-91, where it states as follows: "A wheelchair is a seating device system mounted on wheels used to transport a non-ambulatory individual or an individual with severely limited mobility.

40. The DME Handbook, on Page 2-92, explains

> Prior authorization is required for all custom wheelchairs, power wheelchairs, power operated vehicles (POV), and modifications and custom upgrades. The following information must be submitted with the prior authorization request:
>
> Either the Medicaid Custom Wheelchair Evaluation form (Appendix A) or another document that contains the same information that is requested on the form; and
>
> Medical necessity documentation; and
>
> Written documentation describing the physical status of the recipient with regard to mobility, self-care status, strength, cognitive and physical abilities, coordination, and activity limitations; and
>
> ...
>
> What physical improvement(s) can be anticipated; and
>
> What physical deterioration may be prevented with the type of wheelchair and specific features requested; and
>
> ...
>
> Documentation of the recipient's home accessibility for the customized manual or motorized wheelchair requested...

41. The DME Handbook, on Page 2-96, states as follows

> All wheelchair evaluations for custom manual and power wheelchairs must be completed by a licensed physical therapist, occupational therapist, or physiatrist using either the Custom Wheelchair Evaluation, AHCA Med Serv Form 015, (Appendix A) or another document that contains the same information that is requested on the form.
>
> ...
>
> Documentation of home accessibility is required in a prior authorization

request for an extra-wide wheelchair, custom or non-custom power wheelchair or POV.

.42. In the present case, the petitioner's request for a non-formulary, brand specific power wheelchair was not accompanied by an evaluation by a licensed physical therapist, occupational therapist, or physiatrist, which was to include a seating and equipment assessment. From the information submitted, it is unclear if the requested wheelchair could be adapted to meet the long-term needs of the petitioner or if it would provide optimal positioning and pressure relief. There is no documentation confirming that the petitioner has the cognitive, problem solving, awareness or visual perceptual ability to be safe with the requested power wheelchair or that his home is accessible. For all of these reasons, Sunshine Health could not approve the non-formulary Jazzy Elite 14.

43. Based on the above, the Petitioner has not met his burden of proof that a Jazzy Elite 14 power wheelchair is medically necessary, or that he has met all of the Medicaid prior authorization requirements for the approval of the chair. Therefore, the hearing officer concludes that the Agency appropriately denied the Petitioner's request for a Jazzy Elite 14.

44. 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 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 petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 1st day of July, 2014,

in Tallahassee, Florida.

Peter J. Tsamis
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Ken Hamblin, Area 10, AHCA Program Operations Adminstrator