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

[redacted]

APPEAL NO. 15F-01885

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 02 Leon
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on April 17, 2015 at 11:07am.

APPEARANCES

For the Petitioner: [redacted] daughter

For the Respondent: Cindy Henline, Medicaid Health Care Program Analyst

STATEMENT OF ISSUE

Petitioner's issue is whether the Agency properly denied a request for home modifications (ramps, door widening, and tub to shower modification) and hours of assistance.

PRELIMINARY STATEMENT

Present as a witness for the petitioner was [redacted] son-in-law. The petitioner submitted a photo of the tub which was entered as Petitioner Exhibit 1. The

petitioner also submitted two written statements prior to hearing which were entered as Petitioner Exhibit 2.

The Agency for Health Care Administration (AHCA) is responsible for administering Florida's Medicaid Program. AHCA contracts with Health Maintenance Organizations (HMOs) to provide pre-paid, comprehensive, cost-effective medical services to enrolled Medicaid recipients. Respondent witnesses were Dr. Marc Kaprow, Medical Director, and Susan Frishman, Senior Compliance Analyst, both with United Healthcare.

The respondent presented evidence prior to hearing. The evidence labeled Evidence Part 1-AHCA evidence was entered as Respondent Exhibit 1. Evidence Part 2-United Healthcare evidence, was entered as Respondent Exhibit 2. During the hearing two documents were distributed to the petitioner and the undersigned by the respondent. The first document (policies) was entered as Respondent Exhibit 3. The second document (letter dated April 16, 2015) was entered as Respondent Exhibit 4.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. The petitioner is eligible for Medicaid under the Long-term Care Waiver Program. United Healthcare is the HMO assigned to provide services to petitioner.

2. United Healthcare received requests for multiple home modifications which included ramps, interior and exterior, widening of doorways, and conversion of a tub to a shower on March 1, 2014.

3. United Healthcare denied the requests on December 1, 2014 as the home modifications were for a place where the member is not currently residing.

4. United Healthcare reviewed the request and issued a notice on April 16, 2015. This notice shows the modification of entry to the home, modification of steps inside the home, and widening of doorways are now approved.

5. United Healthcare identified the conversion of a tub to a shower as the remaining issue. United Healthcare confirmed the conversion of a tub to a shower is an adaptation service allowed within the contract with the Agency. The petitioner confirmed this is the sole remaining issue of the hearing.

6. The petitioner fell in September 2013 and broke her hip. She moved into Centre Point Health and Rehab. The petitioner was able to walk with a walker until February 2014 when she developed a bedsore on her foot.

7. The petitioner's mobility is presently limited to a wheelchair. She is able to stand and transfer with assistance. However, she currently is unable to toilet, bathe or groom independently.

8. The petitioner requested that Medicaid convert her tub to a shower because of her mobility issues. The tub, as shown in Petitioner's Exhibit 1, has a step up which the petitioner is unable to navigate.

9. The petitioner has sensitive skin and is concerned a bed bath may cause development of bed sores. There are additional concerns of the bed bath providing the same level of cleanliness as a shower. The petitioner believes the conversion is necessary so she may continue to take showers as she does in the facility.

10. The petitioner has a history of being combative in the facility. The family believes this is due to being in the facility instead of home with family.

11. The petitioner believes the only reason facility staff are present when she is bathed is due to facility policy that all residents must have a staff member present when being bathed.

12. Dr. Kaprow explained most members living at home wheelchair or bed bound with a high risk of falling are given bed baths using special medical wipes which require limited rinsing as well as no rinse shampoos. Members have used these for years with no consequence.

13. The petitioner's concern regarding bed baths and bed sores was addressed by Dr. Kaprow. He explained that bed sores are also known as pressure ulcers. These are most commonly found on the posterior of an individual who is bed or wheelchair bound. The use of a shower over a bed bath will not change the possibility of bed sores occurring.

14. Dr. Kaprow testified the tub to shower modification did not meet the criteria for "medical necessity" as defined in Fla. Admin. Code § 59G-1.010(166). This rule requires the service furnished to meet five conditions to be considered medically necessary. Dr. Kaprow discussed the conditions that must be met. Through analysis of the petitioner's current needs, conditions one, two and four were not met according to Dr. Kaprow.

15. The first condition of the rule was reviewed and found not to be met. This condition questions if the service (home modification) is necessary to protect life or prevent significant illness or significant disability. Dr. Kaprow explained because the

petitioner is unable to transfer herself from a wheelchair to a shower chair independently and is combative, it was determined this modification would not enhance her safety, but actually add a risk of her falling while in the bathroom on a hard surface.

16. The second condition of the rule was reviewed and found not to be met. This condition requires the service provided under Medicaid to be individualized, specific and consistent with symptoms or confirmed diagnosis, but not in excess of the patient's needs. Dr. Kaprow testified that this would be in excess of the patient's needs at this time due to her inability to stand and transfer independently.

17. The fourth condition of the rule was reviewed and found not to be met. This condition requires the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available. Dr. Kaprow testified the petitioner's inability to transfer independently adds a risk of falling during transfer. It is his experience that individuals with a higher risk of falling usually do receive bed baths as opposed to showers. Dr. Kaprow indicated that supplies for bed baths and homemaker training, particularly how to conduct a bed bath, are items approved under Medicaid.

18. The petitioner disagreed with the doctor's analysis and testimony regarding medical necessity. She does not believe his statements apply to her situation. It is expected the combative behavior will stop once she moves to the family home. The petitioner believes denying access to a shower by not converting the tub is not in her best interest. She believes by having access to a shower she will be able to participate in her bathing and become more independent.

19. The petitioner's doctor has offered to submit a statement explaining the medical necessity of converting the tub to a shower for the petitioner.

20. Dr. Kaprow explained Rule 59G-1.010 (166) (c) specifically discusses statements from providers prescribing or recommending a specific good or service, in itself does not make it meet the definition of medical necessity. In this case, a letter from the petitioner's doctor will not make the conversion meet the definition of medical necessity.

21. Dr. Kaprow did confirm should the petitioner's situation improve so that she may transfer independently and is no longer combative; the petitioner could request the modification again at that time.

CONCLUSIONS OF LAW

22. By agreement between the Agency for Health Care Administration (AHCA) 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.

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

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

25. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Florida Administrative Code Rule 65-2.060 (1).

26. Fla. Stat. § 409.978 provides that the "Agency shall administer the long-term care managed program." The Agency is required to do this through a managed

care model. *Id.* It does this by contracting with eligible plans to provide provider service networks. Section 409.981(1), Florida Statutes.

27. Federal Medicaid Regulations 42 C.F.R. § 438.210 "Coverage and authorization of services" states in relevant part:

> (a) Coverage. Each contract with an MCO, PIHP, or PAHP must do the following:
>
> (1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.
>
> (2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in §440.230.
>
> (3) Provide that the MCO, PIHP, or PAHP—
>
> (i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.
>
> (ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary;
>
> (iii) May place appropriate limits on a service—
>
> (A) On the basis of criteria applied under the State plan, such as medical necessity;
>
> ...
>
> (4) Specify what constitutes "medically necessary services" in a manner that—
>
> (i) Is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and
>
> (ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services related to the following:
>
> (A) The prevention, diagnosis, and treatment of health impairments.
>
> (B) The ability to achieve age-appropriate growth and development.
>
> (C) The ability to attain, maintain, or regain functional capacity.

28. Fla. Admin. Code § 59G-1.010 "Definitions" states in relevant 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; 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.

29. The Agency, through the HMO plan, will provide home modifications that are medically necessary in accordance with the rule above.

30. Petitioner's requests for modification of entry to the home, modification of steps inside the home, and widening of doorways were approved on April 16, 2015. The remaining modification requested is conversion of a tub to a shower. The petitioner maintained the conversion is necessary to allow her to continue taking showers as she does in the facility. The above controlling authority defines medical necessity criteria that must be met for Medicaid to pay for the service. The undersigned must determine if the conversion meets the definition requirements.

31. The first requirement listed in the authority indicates the service must be necessary to protect life and to prevent significant illness or significant disability. The concern expressed by the respondent was this conversion could actually cause a significant illness as the petitioner is presently combative at times and at risk for falls. In a bathroom all flooring surfaces are usually hard surfaces, which increases the risk of a serious injury occurring.

32. The fourth requirement listed in the authority indicates the service is reflective of the level of service that can be safely furnished, and there is no equally effective and more conservative or less costly treatment available. The respondent explained, in their opinion, the safer, but equally effective and less costly option which is a generally accepted standard is for the petitioner to receive bed baths. The undersigned acknowledges the petitioner's concerns regarding the bed bath option explained by the respondent. However, based on the only physician's testimony, the undersigned concludes the risk of falls and injury in petitioner's case, the requested service does not meet this criteria. There is a safer alternative that can be provided under Medicaid.

33. The undersigned reviewed the petitioner's testimony and statements, but finds no evidence to support her position that the shower conversion meets all five of the medical necessity criteria for payment under Medicaid. The undersigned concludes respondent appropriately denied the request as it does not meet medical necessity under the controlling Medicaid authorities. The undersigned notes, the respondent has indicated the request can be submitted again in the future should the petitioner's situation change.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is 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 8th day of May, 2015,

in Tallahassee, Florida.

Melissa Roedel

Melissa Roedel
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
Marshall Wallace, Area 2, AHCA Field Office Manager