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

[redacted]

PETITIONER,

Vs.

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

RESPONDENT.
_____/

APPEAL NO. 15F-07369

CASE NO.

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on October 1, 2015, at 10:50 a.m.

APPEARANCES

For the petitioner: [redacted]
Petitioner

For the Respondent: Linda Latson, R.N.
Registered Nurse Specialist/Fair Hearing Coordinator
Agency for Health Care Administration

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the Agency for Health Care Administration incorrectly denied his request for a power wheelchair?

PRELIMINARY STATEMENT

[redacted] the petitioner ("petitioner"), appeared on his own behalf. Linda Latson, R.N., Registered Nurse Specialist and Fair Hearing Coordinator for the Agency for Health Care Administration ("AHCA" or "Agency"), appeared on behalf of the Agency for Health Care Administration. The following individuals appeared as witnesses on behalf of the Agency: Vincent Pantone, M.D., Chief Medical Officer of Better Health; and Diana Anda, Grievance and Appeals Supervisor for Better Health.

The respondent introduced respondent's Exhibits "1" through "6", inclusive, at the hearing, all of which were accepted into evidence and marked accordingly. The hearing officer took administrative notice of the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook.

FINDINGS OF FACT

1. Petitioner is a 54-year-old male. He resides in [redacted] Florida.

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

3. Petitioner is enrolled in the Better Health Managed Medical Assistance plan. Better Health is a health maintenance organization ("HMO") contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in [redacted].

4. Petitioner's effective date of enrollment with Better Health was July 1, 2015.

5. On or about August 6, 2015, the petitioner's physician submitted a prior authorization request to Better Health for a power wheelchair for the petitioner.

6. In a Notice of Action dated August 8, 2015, Better Health notified the petitioner it was denying his request for a power wheelchair.

7. The Notice of Action explains, in part:

> ■ We determined that your requested services are not medically necessary because the services do not meet the reasons(s) checked below: *(See Rule 59G-1.010)*
>
> - ■ Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury, and not be in excess of the patient's needs.
> - ■ Must be furnished in a manner not primarily intended for convenience of the recipient, caretaker, or provider.

8. The Notice of Action goes on to state: "The facts that we used to make our decision are: You requested a power wheelchair. This was denied because your doctor doesn't state that you are unable to use a regular wheelchair, no mention that you are unable to use your arms, and doesn't mention that you are unable to walk or perform daily activities otherwise."

9. On or about August 27, 2015, the petitioner submitted a written request for an internal reconsideration of the denial to Better Health.

10. Better Health formally dismissed the internal appeal after receiving notice that the petitioner requested a Medicaid Fair Hearing.

11. The petitioner is diagnosed with [redacted] He ambulates with the assistance of a wheelchair.

12. The petitioner has a prescription for a motorized wheelchair dated August 27, 2015 from his primary care physician. The prescription states the petitioner is "unable to walk due to tremors and unable to wheel himself due to a torn rotator cuff."

13. The petitioner has used a power wheelchair since December 2004.

14. Petitioner's physician did not provide a wheelchair evaluation completed by a registered physical or occupational therapist or a certified physiatrist to Better Health. As of the date of the hearing in this matter, a wheelchair evaluation had not yet been completed.

CONCLUSIONS OF LAW

15. By agreement between the Agency for Health Care Administration and the Department of Children and Families, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to § 120.80, Fla. Stat.

16. The Florida Medicaid Program is authorized by Chapter 409, Fla. Stat., and Chapter 59G, Florida Administrative Code. The Program is administered by AHCA.

17. Goods and services requested under the Florida Medicaid Program must be shown to be medically necessary in order to be approved.

18. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

19. 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.

20. 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.).

21. Section 409.905, Fla. Stat. addresses mandatory Medicaid services under the State Medicaid Plan and explains as follows:

> 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 ...

22. The Florida Medicaid Home Health Services Coverage and Limitations Handbook October 2014 is incorporated by reference and promulgated into Rule by 59G-4.130, Florida Administrative Code.

23. The Florida Medicaid Home Health Services Coverage and Limitations Handbook, on Page 2-27, 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.

24. 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. The Handbook, on Page 1-27, states:

> 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.

25. Page 1-28 of the Florida Medicaid Provider General Handbook provides a list of HMO covered services. These services include durable medical equipment.

26. 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."

27. 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.

28. 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.

29. 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.

30. 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.

31. 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.

32. The DME 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.

33. 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)."

34. 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.

35. 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...

36. 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.

37. In the present case, the petitioner's physician did not provide a wheelchair evaluation completed by a registered physical or occupational therapist or a certified physiatrist to Better Health. Furthermore, as of the date of the hearing in this matter, a wheelchair evaluation had not yet been completed. Without this wheelchair evaluation, Better Health cannot approve the petitioner's request for a power wheelchair.

38. Pursuant to the above, the petitioner has not met his burden of proof that Better Health incorrectly denied his request for a power wheelchair.

39. Once a wheelchair evaluation is completed, the petitioner may resubmit his request for a power wheelchair, along with the evaluation, to Better Health.

40. 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 24 day of November, 2015,

in Tallahassee, Florida.

Peter J. Tsamis

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Copies Furnished To: [redacted] Petitioner
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