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-07553

CASE NO.

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on November 16, 2015, at 10:40 a.m.

APPEARANCES

For the Petitioner: [redacted]
Attorney-in-Fact

For the Respondent: Oscar Quintero
Program Operations Administrator
Agency for Health Care Administration

STATEMENT OF ISSUE

Did the respondent prove by a preponderance of the evidence that it correctly reduced the petitioner's monthly supply of 30' x 36' underpads from three cases (60 per case) to two cases (60 per case) and correctly terminated approval of the petitioner's dimethicone cream?

PRELIMINARY STATEMENT

[redacted] the petitioner's son and attorney-in-fact, appeared on behalf of the petitioner, [redacted] ("petitioner"). The petitioner was not present.

Oscar Quintero, Program Operations Administrator with 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: Mary Colburn, M.D., Long-Term Care Medical Director for Amerigroup; and Carlene Brock, L.P.N., Quality Operations Nurse with Amerigroup.

The petitioner introduced Exhibits "1" through "9", inclusive, at the hearing, which were accepted into evidence and marked accordingly. The respondent introduced Exhibits "1" through "7", inclusive, at the hearing, which were accepted into evidence and marked accordingly. The hearing record in this matter was left open until the close of business on November 20, 2015 in order for the respondent to provide a copy of the Amerigroup Long-Term Care Member Handbook along with the relevant portions of the contract between the Agency for Health Care Administration and Amerigroup regarding the Long-Term Care program. Once received, this information was accepted into evidence and marked as respondent's Exhibit "8". The hearing record was then closed.

FINDINGS OF FACT

1. The petitioner is an 84-year-old female. She resides in [redacted] Florida.

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

3. Petitioner is enrolled in Amerigroup. Amerigroup 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.

4. The petitioner is diagnosed with the following: [redacted]

5. The petitioner is incontinent of both bowel and bladder.

6. The petitioner was previously approved to receive three cases (60 per case) of 30' x 36' underpads and one bottle (32 oz.) of dimethicone cream per month.

7. In a Notice of Action dated July 22, 2015, Amerigroup informed petitioner it was reducing her monthly supply of underpads from three cases to two cases, and that it was terminating her receipt of the remedy skin repair cream dimethicone. The Notice states these changes were to become effective August 1, 2015.

8. The Notice of Action states in part:

X We determined your requested services are **not medically necessary** because the services do not meet the reason(s) checked below: *(See Rule 59G-1.010)*

X Must be furnished in a manner not primarily intended for the convenience of the recipient, caretaker or provider....

9. At the petitioner's request, Amerigroup completed an internal review of its decision, called a Level 1 Appeal, to reduce the petitioner's underpads and terminate her receipt of the skin repair cream.

10. In a letter dated August 11, 2015, Amerigroup the informed petitioner it was upholding its original decision to reduce her monthly supply of underpads and terminate approval of the skin repair cream.

11. On or about September 9, 2015, Amerigroup received a request from the petitioner's son and attorney-in-fact asking for a continuation of benefits pending the resolution of a Medicaid Fair Hearing. Amerigroup approved continuation of benefits for the petitioner's incontinence supplies on September 24, 2015.

12. In September, 30' x 30' underpads were sent to the petitioner because the petitioner's durable medical equipment and supplies provider discontinued the 30' x 36' underpads. With the petitioner's approval, Amerigroup secured another durable medical equipment and supplies provider for the petitioner who was able to supply the petitioner with the 30' x 36' underpads from that point forward. However, Amerigroup maintained its position that it would reduce the supply of petitioner's underpads from three cases to two cases per month (60 per case) for a total of 120 underpads per month.

13. The petitioner is approved to receive briefs in addition to underpads. Briefs are adult diapers that have tape on the sides whereas underpads are designed to lay flat on the bed and absorb any waste not contained in the diaper.

14. The petitioner receives three cases of 72 high-absorbency briefs per month for a total of 216 briefs. Amerigroup has not proposed a reduction in the amount of briefs that the petitioner receives monthly.

15. Amerigroup has determined the petitioner requires between six to eight diaper changes daily. 216 briefs per month is equal to approximately seven briefs per day.

16. Briefs are considered the primary incontinence product for individuals who have incontinency issues.

17. The petitioner has a documented history of skin breakdown in the area between her lower back and upper thigh. The 30' x 36' underpad is the appropriate size to cover the area in which the petitioner has a history of skin breakdown. When she was receiving the 30' x 30' underpads, two underpads had to be used to cover the affected area.

18. Underpads help reduce the risk of skin breakdown.

19. It is the respondent's position that 120 underpads per month should be sufficient given the petitioner is also receiving 216 high-absorbency briefs per month. It is also the respondent's position that a moisturizer is not medically necessary for the petitioner.

20. The petitioner's representative testified that, because the petitioner is quadriplegic, she must be turned to one side and then the other in order to remove her soiled diaper. During this process, waste is left in her perineal area, lower back, and upper thigh. This waste consequently soils the underpad as the petitioner is being turned and necessitates the changing of the underpad each time petitioner is changed.

21. The petitioner's representative testified that, although the dimethicone is not a barrier cream, it helps to reduce the drying of the skin cause by the zinc oxide in the barrier cream and helps prevent skin breakdown and pressure sores. This testimony is consistent with the documentation provided by the petitioner's doctor and wound care nurse stating the dimethicone is medically necessary.

CONCLUSIONS OF LAW

22. 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.

23. 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.

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

25. The respondent in the present case is proposing to terminate, reduce, or change the petitioner's services. Therefore, in accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof is assigned to the respondent.

26. 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.).

27. 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.

28. Under § 1915(c) of the Social Security Act (42 USC § 1396n(c)), a state may obtain a Medicaid waiver that allows the state to include in the state's Medicaid program the cost of home or community-based services (other than room and board) provided to individuals who otherwise would require care in a hospital, nursing facility, or intermediate care facility.

29. Home or community-based services include personal care services, habilitation services, and other services that are "cost effective and necessary to avoid institutionalization." See 42 CFR § 440.180.

30. Section 409.978, Florida Statutes, provides that the "Agency shall administer the long-term care managed care program," through the Department of Elder Affairs and through a managed care model. Fla. Stat. § 409.981(1), authorizes AHCA to bid for and utilize provider service networks to achieve this goal. In the instant case, the provider network/HMO is Amerigroup.

31. 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 …

32. 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.

33. 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.

34. 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.

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

36. 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."

37. 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.

38. 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.

39. 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.

40. 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.

41. 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.

42. The DME Handbook, on Pages 2-48 and 2-49, sets forth the medical necessity, age, and documentation requirements for receiving disposable incontinence

briefs, diapers, protective underwear, pull-ons, liners, shields, guards, pads, and undergarments, along with the associated limitations for receiving such supplies. These requirements include documentation from the recipient's physician regarding the need for incontinence products.

43. The Contract between the Agency for Health Care Administration and Amerigroup governing the provision of Long-Term Care Services, AHCA Contract No. FP021, in Attachment II, Exhibit II-B, Effective 07/15/15, Section V, Page 14 of 116 – Covered Services, explains as follows:

> (14) Medical Equipment and Supplies --- Medical equipment and supplies, specified in the plan of care, include: (a) devices, controls or appliances that enable the enrollee to increase the ability to perform activities of daily living; (b) devices, controls or appliances that enable the enrollee to perceive, control or communicate the environment in which he or she lives; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment that is necessary to address enrollee functional limitations; (e) necessary medical supplies not available under the State Plan including consumable medical supplies such as adult disposable diapers. This service includes the durable medical equipment benefits available under the state plan service as well as expanded medical equipment and supplies coverage under this waiver. All items shall meet applicable standards of manufacture, design and installation. This service also includes repair of such items as well as replacement parts.

44. The Amerigroup Member Handbook, on Page 14, explains that medical equipment and supplies is a covered service. This service includes "Disposable diapers, gloves and other consumable medical supplies".

45. In the present case, the petitioner's representative presented credible testimony and evidence refuting the Agency's claim that 120 underpads per month are sufficient and documenting the need for both the additional 60 underpads per month

and the skin repair cream. The respondent has not demonstrated by a preponderance of the evidence that it correctly reduced the petitioner's monthly supply of underpads or correctly terminated the approval of the skin repair cream.

46. 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 GRANTED.

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 21 day of December, 2015, in Tallahassee, Florida.

Peter J. Tsamis

Peter J. Tsamis
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager