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

[redacted]

APPEAL NO. 15F-08633

PETITIONER,

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 05 Citrus
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice and agreement, an administrative hearing convened before Hearing Officer Patricia C. Antonucci on December 9, 2015 at 1:00 p.m. All parties and witnesses appeared via teleconference.

APPEARANCES

For the Petitioner: [redacted] Petitioner's mother

For the Respondent: Sheila Broderick, Registered Nurse Specialist,
Agency for Health Care Administration

STATEMENT OF THE ISSUE

At issue is a decision by Respondent, the Agency for Health Care Administration (AHCA), through its contracted health plan, Ped-I-Care, to reduce Petitioner's previously authorized Occupational Therapy (OT) service from three, 60-minute sessions per week to three, 45-minute sessions per week. Respondent bears the burden of proving, by a preponderance of the evidence, that this proposed reduction is proper.

PRELIMINARY STATEMENT

This matter was originally scheduled to convene on two prior occasions, but was continued and reset by agreement of the parties, to allow for exchange and review of proposed documentary evidence. Although Petitioner did not have all evidence packets in front of her when the final hearing convened, Petitioner opted to proceed with hearing, noting that she had copies of the same documentation within her own files.

At hearing on December 9, 2015, the minor Petitioner was not present, but was represented by her mother, [redacted] Additional testimony on Petitioner's behalf was provided by [redacted] Petitioner's Occupational Therapist, and [redacted], Petitioner's Speech Therapist. The Respondent was represented by Sheila Broderick, RN Specialist and Fair Hearing Liaison with AHCA. Respondent presented several witnesses from Ped-I-Care: John Nackashi, Ph.D., M.D., Medical Director; Justin Breton, OT Consultant; Holly Estep, Assistant Director of Utilization Management; and Laura Monday, Utilization Management Manager.

Petitioner's Exhibits 1, 2, and 3, and Respondent's Exhibits 1 through 9, inclusive, were accepted into evidence. Administrative Notice was taken of pertinent legal authority, including relevant portions of the Florida Medicaid Therapy Services Coverage and Limitations Handbook (August 2013).

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 an 8-year old female, born November 22, 2007. At all times relevant to this proceeding, Petitioner has been eligible for and receiving Medicaid.

2. Petitioner has several diagnoses, including [redacted]

3. The Petitioner's scores on standardized assessments show improvement since Petitioner began receiving OT in September of 2013, but still reflect low percentiles of development. Per Petitioner's therapist, Petitioner has yet to plateau and continues to progress.

4. The Petitioner attends school, and receives assistance from a classroom aide; however, the aide is assigned to Petitioner's entire class, and does not provide individual assistance to Petitioner, beyond walking her to the bathroom every 30 minutes in accordance with a toileting schedule.

5. Prior to the action at issue, from approximately November of 2013 through October of 2015, Petitioner was authorized to receive three, hour-long sessions of OT service per week via her provider, O. T. 4 Kids.

6. On or about September 11, 2015, O. T. 4 Kids submitted to Ped-I-Care a request on behalf of the Petitioner to continue OT services of three hours per week, for the certification period spanning September 11, 2015 through March 8, 2016. Petitioner's OT Plan of Care was included along with this request.

7. On or about September 14, 2015, Ped-I-Care received the request and supporting documentation, and conducted a medical necessity review. Intake notes from Ped-I-Care's reviewing nurse note that Petitioner has a weak grasp, cannot write, is showing increased stimming behaviors and emotional sensitivity, difficulty sleeping ("likely indicative of poor self-regulation/modulation"), poor oral motor control and poor

sensory awareness. She is noted as unable to manipulate buttons or fasteners and to be working on potty training. Petitioner's request for OT was then forwarded to the medical director, as it exceeded "nurse approvable limits (greater than 2hr/wk for age)."

8. Via Notice of Action dated September 16, 2015, Ped-I-Care notified Petitioner of its intent to reduce her weekly OT. Said Notice stated, in pertinent part:

> Children's Medical Services Managed Care Plan (Ped-I-Care Title XIX Program) has reviewed your request for Occupational Therapy (OT)…. After our review, this service has been:
> REDUCED to 3 times a week for 45 minutes for 6 months as of October 1, 2015.
> We made our decision because:
>
> We determined that your requested services are not **medically necessary** because the services do not meet the reason(s) checked below: (See Rule 59G-1.010)
> × Must be able to be 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.
> …
> Progress toward new skills will require daily exposure and repetition. Documentation shows a strong family participation and practice of the Home Education Program. This will help improve member's growth towards functional outcomes. The member is now receiving support from a personal care assistant (PCA) in school to facilitate progress and meet individual needs. The PCA can take a leadership role in implementation of handwriting curriculum at school. Some goals are educationally-relevant and should be worked on by the educators and caregivers. The child's condition is ongoing and considered chronic. Ped-I-Care guidelines recommend moderate therapy for chronic conditions which is defined as up to 9 units (1 unit equals 15 minutes) per week.
>
> PR Principal Reason – Denial: 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 documentation provided.

9. Via facsimile cover sheet sent to Petitioner's OT provider and physician, Ped-I-Care noted:

> Member has been receiving intensive therapy for more than 12 months with this provider, and continues to work on goals that are developmental in nature. Acquisition of new skills will require daily exposure and repetition due to member's medical condition and global developmental delays…. [long term goals] #7 and #12 are educationally-relevant abilities that should be emphasized by the educators and caregivers, not clinical OT. However, we recognize the need for ongoing therapy due to member's age and positive response to intervention. For these reasons, an authorization for up to 9 units a week is provided, which reflects that maximum amount of therapy for chronic conditions based on established therapy guidelines (please refer to the Ped-I-Care XIX Provider Manual). Thank you.

10. Via letter dated September 18, 2015, [redacted] Petitioner's OT at O. T. 4 Kids, requested reconsideration of the proposed reduction. [redacted] noted, in part:

> … [Petitioner] is currently participating in intensive sensory and therapeutic home programs in addition to therapy services to address sensory processing issues and developmental delays….These programs are recommend[ed] in addition to, not in place of, intensive therapy services.
>
> Although [Petitioner's] condition is considered "chronic" she is making steady and significant therapeutic gains with intensive therapy services including improved gross motor and fine motor skills, increased independence with daily living skills including grooming, dressing, and toileting. However, she continues to demonstrate global developmental delays and [it] is medically necessary that [she] continue to receive intensive therapy services to address all areas of need so that she will continue to make progress towards functional independence. Reduction of services at this time may result in regression.
>
> The medical necessity guidelines according to EPSDT standards require appropriate level of service not just minimal services because a child with a chronic condition cannot be expected to progress with limited intervention. Our request is appropriate to meet this level of service.

11. Via Notice of Appeal Determination dated October 12, 2015, Ped-I-Sure upheld its decision to reduce Petitioner's weekly OT.

12. On or about October 12, 2015, Petitioner requested a hearing to challenge this reduction.

13. At hearing, [redacted] reviewed Petitioner's Plan of Care, her evaluations, and her progress [redacted] is a licensed occupational therapist, who obtained her Master's in OT from the University of Florida. She is trained in sensory processing disorders, Handwriting without Tears, Interactive Metronome, and other treatment modalities. Ms. Messier has worked primarily in pediatric OT since 2008, and has experience with neurodevelopmental delays. It is [redacted] opinion that at this point in Petitioner's development, mere practice and repetition via a home program and in school will not lead to improvement in handwriting or activities of daily living-based goals, as Petitioner lacks the fundamental spatial and body awareness to know such basics as top/bottom/left/right orientation, and does not have the grasp strength or motor skills to hold a pencil. As such, hand-over-hand assistance will not be sufficient is to meet her therapy goals. The Petitioner does not currently have bilateral skills/motor planning to facilitate non-OT intervention, and still requires sensory system regulation by a skilled OT provider.

14. Per [redacted] when Petitioner arrives for an OT session, she is "low-end lethargic," and begins by stimming/hitting herself in her face. [redacted] starts the OT session by getting Petitioner alert and engaged, addressing her body via deep pressure touch protocol in preparation for working on other skills, such as toileting, posture, grasp strengthening, gross motor, bilateral integration, motor planning, and vestibular systems. If Petitioner is not prepared at a foundational level for skill training, she is unable to fully engage and benefit from skill practice. As such, it is [redacted]

opinion that educators and a general classroom aide will not be able to implement the OT curriculum utilized in intensive OT sessions, and cannot take the place of skilled OT intervention.

15. Over the course of Petitioner's weekly OT, she works on each program within her Plan of Care. [redacted] does not know what would be cut from the program, were Petitioner reduced from 60-minute sessions to 45-minute sessions, but believes Petitioner would regress if this were to occur. This is particularly true given that Petitioner has already regressed, following hospitalization and surgery in June of 2015, during which she could not attend OT. Following hospitalization [redacted] noted a regression in toileting, and increased balance issues. While Petitioner is regaining these skills, she is still not where she was prior to hospital admission. Although the aide at school takes Petitioner to the bathroom on a schedule, so as to avoid accidents, this does not assist in self-regulation. Petitioner still lacks the body awareness to know when she has to go to the bathroom, and the aide does not assist in teaching Petitioner how to move her body onto/off of the toilet, or to unfasten and/or reposition her clothes, as needed. Petitioner is still progressing toward independence in this regard.

16. Petitioner's Speech Language Pathologist, [redacted], also works with the Petitioner relative to the motor planning aspect of her dyspraxia [redacted] has noticed that Petitioner responds positively to OT, which has assisted in the development of gestures and queueing, related to oral-motor processing and planning for speech. Prior to OT, Petitioner could not manage simple sign language, because she couldn't motor plan her body to accomplish signing. Now, she is integrating motor planning and her speech is developing, as well. She can follow along with gesture systems which

she could not before, due to lack of coordinatio [redacted] works closely with Ms. [redacted] in providing interdisciplinary therapies to the Petitioner. It is [redacted] position that under EPSDT, Petitioner requires intensive, one-on-one services, and that reducing OT would be detrimental to development of her gross and fine motor skills, and sensory growth.

17. It is Ped-I-Care's position that the generally accepted standard of care for OT is intensive therapy (2-3 hours per week) for younger children, followed by transition to maintenance therapy (1-2 hours per week) in combination with a home program and school attendance. [redacted] who has 33 years of experience in pediatrics and has been Ped-I-Care's Medical Director since 2003, the intervention model guidelines utilized by Ped-I-Care recommend this coaching-based approach, combining therapy sessions with home and educational programs [redacted] Statement of Matters, "Three hours a week of OT is not indicated in the treatment of [Petitioner's] developmental disability. A total package of OT, speech therapy, home educational program and school is recommended and meets best practices."

18. [redacted] Ped-I-Care's OT Consultant, is a licensed Occupational Therapist, who has been practicing since 1995, and working in Florida, primarily in pediatric OT, since 1999. He graduated from McGill University, which is accredited in OT. It is Mr. [redacted] opinion that the Petitioner needs skilled interventions and observation, mainly to relay and teach interventions to caregivers for daily implementation. His recommendation for OT at 45-minute sessions is based on Petitioner's diagnoses and age, and the need to improve performance. However, he believes that the best practice is family-centered intervention, and testified that the proposed reduction is based on

generally accepted practice to reduce OT intensity as child ages and is exposed to additional supports, i.e., interventions in school and a comprehensive home program. Per [redacted] Petitioner's progress is steady but slow, which suggests the skilled intervention needs to continue, but that daily interventions must be provided at home and in the natural environment. Petitioner has met some of her goals, continues to work on others, and is still developing goals that were initiated when OT began in 2013. Mr. [redacted] does not believe that any of the interventions in Petitioner's plan of care are inappropriate, and agrees that they are geared toward meeting Petitioner's needs. Per [redacted] three, 45-minute sessions of OT per week is still considered intensive therapy.

19. [redacted] disagrees with the plan to reduce OT, at this time, noting that Petitioner has yet to plateau, and is thus not ready for mere maintenance therapy. She is still progressing, such that reduction is premature and may prohibit Petitioner from reaching her potential. In [redacted] opinion, the Petitioner will be ready for reduced OT once she achieves her therapy goals and gains independence, or if she does plateau, such that maintenance is appropriate. However, so long as Petitioner is progressing, [redacted] believes she needs to continue with three hours of OT per week, to obtain foundational skills that will allow for the type of practice and repetition that can be accomplished through home programs and in school.

CONCLUSIONS OF LAW

20. By agreement between AHCA and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction to conduct this hearing pursuant to Florida Statutes Chapter 120.

21. Legal authority governing the Florida Medicaid Program is found in Fla. Stat., Chapter 409, and in Chapter 59G of the Florida Administrative Code. Respondent, AHCA, administers the Medicaid Program.

22. The Florida Medicaid Therapy Services Coverage and Limitations Handbook, August 2013 ("The Handbook") has been incorporated, by reference, into Fla. Admin. Code 59G-4.320(2).

23. This is a Final Order, pursuant to § 120.569 and § 120.57, Fla. Stat.

24. This hearing was held as a *de novo* proceeding, in accordance with Fla. Admin. Code R. 65-2.056.

25. The burden of proof in the instant case is assigned to the Respondent, who seeks to reduce a previously authorized service. The standard of proof in an administrative hearing is preponderance of the evidence. (See Fla. Admin. Code R. 65-2.060(1).)

26. Fla. Stat. § 409.905 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.…

(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.—The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

27. The Handbook describes the services covered under the Florida Medicaid Home Health Services Program, including OT.

28. Page 1-3 of The Handbook defines Occupational Therapy as follows:

> Occupational therapy is the provision of services that address the developmental or functional needs of a child related to the performance of self-help skills; adaptive behavior; and sensory, motor and postural development.
>
> Occupational therapy services include evaluation and treatment to prevent or correct physical and emotional deficits, minimize the disabling effect of these deficits, maintain a level of function, acquire a skill set or restore a skill set. Examples are perceptual motor activities, exercises to enhance functional performance, kinetic movement activities, guidance in the use of adaptive equipment and other techniques related to improving motor development.

29. Similarly, per Fla. Stat. § 468.203(4):

> "Occupational therapy" means the use of purposeful activity or interventions to achieve functional outcomes.
> (a) For the purposes of this subsection:
> 1. "Achieving functional outcomes" means to maximize the independence and the maintenance of health of any individual who is limited by a physical injury or illness, a cognitive impairment, a psychosocial dysfunction, a mental illness, a developmental or a learning disability, or an adverse environmental condition.
> 2. "Assessment" means the use of skilled observation or the administration and interpretation of standardized or nonstandardized tests and measurements to identify areas for occupational therapy services.
> (b) Occupational therapy services include, but are not limited to:
> 1. The assessment, treatment, and education of or consultation with the individual, family, or other persons.
> 2. Interventions directed toward developing daily living skills, work readiness or work performance, play skills or leisure capacities, or enhancing educational performance skills.

> 3. Providing for the development of: sensory-motor, perceptual, or neuromuscular functioning; range of motion; or emotional, motivational, cognitive, or psychosocial components of performance.
> (emphasis added)

30. Consistent with the law, Ped-I-Care performs service authorization reviews under the Prior Authorization Program for certain Medicaid recipients in the state of Florida. Once Ped-I-Care receives an OT service request, its medical personnel conduct file reviews to determine the medical necessity of requested services, pursuant to the authorization requirements and limitations of the Florida Medicaid Program.

31. Florida Administrative Code Rule 59G-1.010(166) defines medical necessity, as follows:

> "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. …
>
> (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.

32. As the Petitioner is under 21, a broader definition of medically necessary applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) requirements. The undersigned must, therefore, consider both EPSDT and standard Medical Necessity requirements when developing a decision.

33. EPSDT augments the Medical Necessity definition contained in the Florida Administrative Code via the additional requirement that all services determined by the agency to be medically necessary for the *treatment, correction, or amelioration* of problems be addressed by the appropriate services.

34. United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in Moore v. Reese, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, (which involved a dispute over private duty nursing):

> (1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.
> (2) A state Medicaid plan must include "reasonable standards … for determining eligibility for and the extent of medical assistance" … and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.
> (3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."
> (4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."
> (5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to

> provide medically unnecessary, albeit desirable, EPSDT services. However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."
> (6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and my present its own evidence of medical necessity in disputes between the state and Medicaid patients (citations omitted).

35. In terms of being specific and individualized, in keeping with Fla. Admin. Code R. 59G-1.010(166)(2), Petitioner's POC is based upon her therapist's evaluation, via standardized tests *and* professional observation of the petitioner, such that said POC is "an individualized and specific written program…designed to meet the medical, health and rehabilitative needs of the recipient." (See page 2-11 of the Handbook).

36. Fla. Admin. Code R. 59G-1.010(166)(2) also bears the requirement that any provided service not be in excess of the patient's needs. Although the Respondent suggests that provision of three hours per week of OT is excessive, nothing within the OT definitions or relevant legal authority excludes the treatment which Petitioner's provider recommends, nor does Ped-I-Care deny that such protocols are consistent with the provision of OT. Indeed, Respondent previously authorized O. T. 4 Kids' treatment protocol, at the frequency requested. Ped-I-Care now contends that this frequency is too intensive, as Petitioner has aged, and "best practice" suggests reduction of intensity to moderate OT based upon her age and developmental delays.

37. Similarly, with regard to Fla. Admin. Code R. 59G-1.010(166)(3)'s requirement that a service be consistent with generally accepted professional medical standards as determined by the Medicaid program, Ped-I-Care suggests that moderate OT is appropriate for Petitioner's diagnoses and that 9 units per week (which it defines as

moderate) is "the maximum amount of therapy for chronic conditions based on established therapy guidelines." Ped-I-Care's approach seems slightly inconsistent in this regard, as it suggests moderate or maintenance therapy is appropriate, but then contends that 45-minutes per week is still considered intensive. The fact that the recommendation of service relies, in part, upon Petitioner's diagnosis and age, is itself, inconsistent with the case-by-case review required under EPSDT.

38. With regard to Fla. Admin. Code R. 59G-1.010(166)(1), ST services were initially approved to treat and ameliorate the developmental delay and resultant deficits which Petitioner's situation present. Respondent contends that Petitioner can continue to progress with a reduced frequency of skilled OT, while Petitioner argues that without three weekly hours, Petitioner risks regression.

39. The undersigned finds that, absent competent and substantial evidence to the contrary, continuation of three weekly OT hours is appropriate until such time as Petitioner's deficits are ameliorated and prolonged progress (beyond the fundamental level) is maintained. (Fla. Admin. Code. R. 59G-1.010(166)(1). This is particularly important given that Petitioner has experienced some regression due to hospitalization, and must be given opportunity to regain skills previously obtained, as she continues to progress in her overall development.

40. After examining all testimony and evidence, it is determined that Petitioner requires OT to address the effects of her developmental delays on activities of daily living and communication. These needs and the therapeutic plan for addressing same substantiate the provision of OT at 60-minute sessions, three times per week, through a treatment protocol that address all of Petitioner's deficits.

41. When jointly considering the requirements of both ESPDT and Medical Necessity, along with a review of the totality of the evidence and legal authority, Respondent has not met its burden of proof to show that reduction of OT is appropriate, at this time.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, 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 05 day of February, 2016, in Tallahassee, Florida.

Patricia C. Antonucci
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
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