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

[redacted]

APPEAL NO. 15F-09253

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 06 Pasco
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on January 7, 2016, at 1:15 p.m.

APPEARANCES

For the Petitioner: [redacted]
Petitioner's mother

For the Respondent: Stephanie Lang, 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 respondent incorrectly denied his request for a custom cranial remolding helmet?

PRELIMINARY STATEMENT

[redacted] the petitioner's mother, appeared on behalf of the petitioner, [redacted] ("petitioner"), who was not present. [redacted] may sometimes hereinafter be referred to as the petitioner's "representative".

Stephanie Lang, R.N., Registered Nurse Specialist and Fair Hearing Coordinator 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: Erik Stumpf, M.D., Medical Director of Prestige Health Choice; Rachelle Narcisse, Grievance and Appeals Coordinator with Prestige Health Choice; and Sharon Burgher, Grievance and Appeals Coordinator for Prestige Health Choice.

The petitioner introduced Composite Exhibit 1, inclusive, at the hearing. The respondent introduced Exhibits "1" through "9", inclusive, at the hearing.

FINDINGS OF FACT

Based upon the oral and documentary evidence presented at the final hearing and on the entire proceeding, the following Findings of Fact are made:

1. The petitioner is an 11-month-old infant. His date of birth is [redacted]

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

3. Petitioner is enrolled in Prestige Health Choice ("Prestige"). Prestige is a health maintenance organization ("HMO") contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in Florida.

4. The petitioner is diagnosed with [redacted] of the [redacted]

5. On or about August 27, 2015, the petitioner's provider submitted a prior authorization request to Prestige Health choice for a [redacted] in the form of a [redacted] The letter accompanying the request states, in part:

> [redacted]
>
> The purpose of the [redacted] will be to address the [redacted] as repositioning efforts have failed to produce results. [Petitioner] has significant flattening of the left frontal and right occipital areas. [redacted]

6. In a Notice of Action dated September 17, 2015, Prestige Health Choice informed the petitioner it was denying his request for a [redacted]. The Notice states, in part:

> *We determined that your requested services are not medically necessary because the services do not meet the reason(s) below: (See Rule 59G-1.010)*
>
> *Must meet accepted medical standards and not be experimental or investigational.*

7. The Notice of Action goes on to state:

> The facts that we used to make our decision are: The request for a [redacted] is not approved as the supplied request does not comply with the requirements contained in the FL Medicaid DME Benefits and Limitations Handbook (p:2-48) which are as follows: Supporting documentation, at a minimum, must include: Clinical evidence, including measurements, indicating the infants current [redacted], taken from the following views: Superior; Frontal; Posterior; Right and left

lateral; and A statement from a treating orthopedic or [redacted]urgeon, stating that treatment using a [redacted]orthosis is recommended due to poor improvement in the infants CIS, after a documented six (6) months trial period of active counter positioning has been completed; and Six (6) months worth of documentation regarding daily counter positioning therapy.

8. The Prestige Health Choice Medical Director re-reviewed the petitioner's request on or about October 15, 2015 and upheld the denial.

9. The petitioner was informed of this denial in a Resolution of Appeal letter dated October 15, 2015. The letter explains, in part: "…the authorization request for a [redacted]s not approved as the supplied request continues to not comply with the requirements contained in the FL Medicaid DME Benefits and Limitations Handbook…."

10. Prestige Health Choice follows the Agency for Health Care Administration Medicaid guidelines for the approval of cranial orthotics.

11. The petitioner's [redacted]

CONCLUSIONS OF LAW

12. 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.

13. The Florida Medicaid Program is authorized by Chapter 409, Fla. Stat., and Chapter 59G, Florida Administrative Code. The Program is administered by the Agency for Health Care Administration.

14. All goods and services requested under the Florida Medicaid Program must be shown to be medically necessary in order to be approved.

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

16. The petitioner 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.

17. 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.).

18. 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 …

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

20. Rule 59G-4.130, Florida Administrative Code states in part:

> (2) All providers of home health services must be in compliance with provisions of the Florida Medicaid Home Health Services Coverage and Limitations Handbook, October 2014....

21. 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.

22. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Chapter 59G-5.020. 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.

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

24. 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.”

25. 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.

26. 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.

27. Since petitioner is under 21, a broader definition of medically necessary applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services

(EPDST) requirements. Section 409.905, Fla. Stat., Mandatory Medicaid Services defines Medicaid services for children to include:

> (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 provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

28. The 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:

> [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. (see (citations omitted)) (emphasis added).

29. Consistent with these requirements, the state is obligated to provide services to recipients under 21 years of age, but only to the extent such services are medically necessary. The definition of medical necessity for services provided under the EPSDT benefit is established by the state and the state is authorized to establish the amount, duration, and scope of such services.

30. 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.

31. 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.

32. 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.

33. The DME Handbook, on Page 2-48, describes a custom cranial remolding orthosis as "a non-invasive device used to correct the symmetry of an infant's skull."

34. The DME Handbook, also on Page 2-48, sets forth the eligibility and reimbursement requirements for a custom [redacted] It states as follows:

> Custom [redacted] require prior authorization (PA). PA requests must be submitted using the appropriate DME procedure code, to ensure proper routing for physician review.
>
> Custom [redacted] devices are covered by Medicaid when it is determined medically necessary to correct a moderate to severe [redacted] Supporting documentation, at a minimum, must include:
>
> - A prescription from an orthopedic or craniofacial surgeon; and

- Clinical evidence, including measurements, indicating the infant's current [redacted] and

- Current color photographs of the infant's head, taken from the following views:
  - Superior;
  - Frontal;
  - Posterior;
  - Right and left lateral; and

- A statement from a treating orthopedic or [redacted] stating that treatment using a [redacted] is recommended due to poor improvement in the infant's [redacted] after a documented six (6) month trial period of active counter positioning has been completed; and

- Six (6) month's worth of documentation regarding daily counter positioning therapy.

35. The AHCA rules definitively state that a custom [redacted] will be reimbursed by Medicaid only if the [redacted] is less than [redacted] In the present case, petitioner's [redacted] Therefore, Prestige Health Choice correctly denied the petitioner's request for the device.

36. 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.

37. This Order is not intended to state that the petitioner will not benefit from the use of a [redacted] only that he does not currently meet the Medicaid requirements for such a device.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, 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 02 day of February, 2016, in Tallahassee, Florida.

Peter J. Tsamis

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