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

[redacted]

APPEAL NO. 15F-09525

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 10 Polk
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on January 19, 2016, at 12:40 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 respondent prove by a preponderance of the evidence that it correctly terminated the petitioner's Prescribed Pediatric Extended Care ("PPEC") Services?

PRELIMINARY STATEMENT

[redacted] the petitioner's mother, appeared on behalf of the petitioner, Ethan Burgos-Bonilla ("petitioner"), who was not present. Ms. Bonilla 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. Rakesh Mittal, M.D., Physician Reviewer with eQHealth Solutions, appeared as a witness on behalf of the Agency.

The respondent introduced Exhibits "1" through "6", inclusive, at the hearing, all of which were accepted into evidence and marked accordingly. The petitioner did not introduce any exhibits.

At the request of the respondent, the hearing officer took administrative notice of the following:

- Section 409.905, Florida Statutes.
- Florida Administrative Code Rules 59G-1.001, 59G-1.010, and 59G-4.260.
- The Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook, September 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 a 10-month old male with a history of [redacted]

2. Petitioner was eligible to receive Medicaid services at all times relevant to this proceeding.

3. The petitioner's medical history is remarkable for the following: [redacted] The petitioner also has a history of behavioral problems.

4. [redacted]

5. The petitioner has a ventriculoperitoneal shunt ("V-P shunt" or "ventricular shunt"). The shunt drains fluid from the ventricle to the general cavity of the abdomen.

6. The petitioner does not have any complications associated with his V-P shunt.

7. The petitioner is prescribed [redacted] and [redacted] but is not prescribed anti-seizure medication. Both the [redacted] and [redacted] are given orally. The petitioner receives his evening dose of [redacted] while at PPEC but takes no other medications there while attending.

8. Although the petitioner is diagnosed with [redacted], his PPEC records do not indicate any recent seizure activity.

9. The petitioner is ambulatory and on a regular diet. He can communicate verbally but has a limited vocabulary.

10. The petitioner has no recent emergency room visits or hospitalizations.

11. The petitioner has not had any recent changes in his medications. His medication regimen is not complex.

12. The petitioner was previously enrolled in a traditional daycare setting but was asked to leave due to his behavioral problems.

13. The child to teacher ratio in a traditional daycare can be as high as 25:1, whereas the child to center personnel ratio at a PPEC is generally 3:1.

14. The petitioner lives in the family home with his mother and one sibling. The petitioner's father was allegedly responsible for his injuries and is incarcerated in another state.

15. The petitioner's mother works in the retail industry. Her work hours and days vary.

16. The petitioner's mother has no physical limitations which limit her ability to provide care to the petitioner.

17. A PPEC is a non-residential center that serves three or more medically dependent or technologically dependent recipients under the age of 21 who require short, long-term, or intermittent medical care due to medically-complex conditions. A PPEC offers services that meet the recipients' physiological, developmental, nutritional, and social needs.

18. The petitioner was approved to receive PPEC Services Monday through Saturday for up to and including 12 hours per day in the prior certification period.

19. On November 2, 2015, the petitioner's PPEC provider submitted a prior authorization request to eQHealth Solutions for PPEC services to be provided for up to 12 hours per day, Monday through Saturday, for the certification period November 14, 2015 through May 11, 2016. PPEC services are normally certified for six-month periods.

20. eQHealth Solutions is the Quality Improvement Organization contracted by the Agency for Health Care Administration to review requests by Medicaid recipients in the State of Florida for PPEC Services.

21. eQHealth Solutions is delegated the responsibility of determining whether a requested service is medically necessary under the terms of the Florida Medicaid Program. eQHealth Solutions has the authority to present a case and act as a witness for the Agency for Health Care Administration.

22. A request for PPEC Services is submitted directly to eQHealth Solutions by a petitioner's PPEC provider. Once eQHealth Solutions receives the information, it completes a prior authorization review – it reviews the written request to determine if the services requested are medically necessary.

23. The petitioner's request was reviewed by an eQHealth Solutions Physician Reviewer on November 5, 2015. The Physician Reviewer determined on-going PPEC services were not medically necessary; however, the Physician Reviewer did approve 90-days of services to allow time to transition the petitioner out of PPEC.

24. The Physician Reviewer provided the following approval rationale for the decision:

> The patient is a 10 year old with a history of [redacted] appear to be well-controlled with no reported [redacted] The patient is ambulatory and verbal. The patient has behavioral issues. The clinical information provided does not support the medical necessity of the requested services; however, 3 months will be approved to allow time to transition the patient out of PPEC.

25. The Physician Reviewer also supplied the following clinical rationale for the decision:

> The clinical information provided does not support the medical necessity of the requested services. The patient does not appear to require skilled nursing. The remainder of the requested services are denied.

26. The evidence does not indicate the petitioner requested an internal review of the eQHealth Solutions decision. This case proceeded directly to the administrative hearing process.

27. The Agency for Health Care Administration administratively approved the continuation of petitioner's PPEC Services pending the resolution of this appeal.

28. The respondent's witness testified that Prescribed Pediatric Extended Care is designed for children that are medically complex and who require skilled nursing care. He testified PPEC services are generally for children who require ventilators for breathing assistance, apnea monitors, or gastrostomy tubes ("G-tubes"). He explained PPEC services may also be approved for children who have frequent seizures, such as five or six seizures per hour. The respondent's witness testified that the petitioner in the present case does not have a complex medication regimen and does not require skilled nursing services. Although the petitioner requires monitoring for behavioral problems, PPEC services may not be approved to monitor an individual for behavioral problems. He explained that, although the petitioner has a ventricular shunt, the shunt is operating properly and there are no complications associated with it. He further explained that any care provider may be trained to observe for symptoms associated with a malfunctioning shunt and call for emergency assistance if he or she observes such symptoms and that PPEC services may not be approved solely for the monitoring of a ventricular shunt.

CONCLUSIONS OF LAW

29. 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 Fla. Stat. § 120.80.

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

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

32. The respondent in the present case is proposing to terminate previously approved services. Therefore, in accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof is assigned to the respondent.

33. 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.).

34. 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…

35. 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.

. . .

(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.

36. 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.

37. 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).

38. 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.

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 Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook, September 2013 ("PPEC Handbook") is promulgated into law by Florida Administrative Code Rule 59G-4.260.

42. Page 2-1 of the PPEC Handbook lists the requirements for receiving PPEC services. Page 2-1 states:

To receive reimbursement for PPEC services, a recipient must meet all of the following criteria:

- Be Medicaid eligible
- Diagnosed with a medically-complex or medically fragile condition as defined in Rule 59G-1.010, F.A.C.
- Be under the age of 21 years
- Be medically stable and not present significant risk to other children or personnel at the center
- Require short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care due to a medically complex condition.

43. Fla. Admin Code R.59G-1.010 defines "medically complex" and "medically fragile" as follows:

(164) "Medically complex" means that a person has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention.

(165) "Medically fragile" means an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, e.g., requires total parenteral nutrition (TPN), is ventilator dependant, or is dependent on a heightened level of medical supervision to sustain life, and without such services is likely to expire without warning.

44. The testimony and documentary evidence in the instant matter fail to establish the medical necessity of PPEC services for the petitioner. The petitioner is not on a complex medication regimen, nor does he require the provision of skilled nursing services. The petitioner's level of illness does not reach the level of "medically complex" or "medically fragile," as defined in the Florida Administrative Code.

45. After carefully reviewing the EPSDT and medical necessity requirements set forth above, the hearing officer concludes the respondent has met its burden of proof, by the greater weight of the evidence, in terminating petitioner's PPEC services.

DECISION

Based upon the foregoing, the petitioner's appeal is DENIED and the decision of the Agency for Health Care Administration is AFFIRMED.

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 11 day of February, 2016, in Tallahassee, Florida.

Peter J. Tsamis

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