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OFFICE OF APPEAL HEARINGS
DEPT OF CHILDREN & FAMILIES

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

APPEAL NO. 14F-02622

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 Dade
UNIT: AHCA

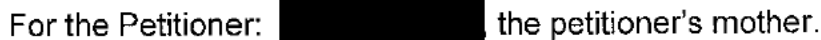
RESPONDENT.

_______________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on May 6, 2014, at 11:30 a.m., with all parties appearing telephonically.

APPEARANCES

For the Petitioner:  the petitioner's mother.

For the Respondent: Luis Davila, senior program specialist, Agency For Health Care Administration (AHCA).

STATEMENT OF ISSUE

At issue is the Agency action of March 14, 2014 to deny/reduce the request for occupational therapy for four units, three times a week for twenty six weeks which covers the certification period of February 25, 2014 to August 23, 2014. The Agency approved four units, one time a week for twenty six weeks. The petitioner has the burden of proof.

PRELIMINARY STATEMENT

Present as a witness for the petitioner was [redacted] therapist.

Present as a witness for the respondent was Dr. Darlene Calhoun, physician Reviewer, eQHealth Solutions.

The hearing was left open for fourteen additional days in order for the petitioner to submit additional information. The hearing was left open for fourteen more additional days, for a total of twenty eight days, in order for the respondent to provide a response. The petitioner did not submit additional information during the above noted time allotted.

FINDINGS OF FACT

1. The petitioner is sixteen years of age and has been diagnosed with cerebral palsy and is a quadriplegic which requires the evaluation of services as provided through the Agency for Health Care Administration's (AHCA) Medicaid State Plan. The petitioner's condition(s) is further outlined in Respondent Composite Exhibit 1. AHCA will be further addressed as the "Agency".

2. eQHealth Solutions has been authorized to make Prior [service] Authorization Process decisions for the Agency. The Prior Authorization Process was completed for the petitioner by eQHealth Solutions. The request for service was for occupational therapy. The first review for this case was completed by an occupational therapist from eQHealth Solutions. A board certified pediatrician is the consultant reviewer for eQHealth Solutions who also reviewed this request. eQHealth Solutions determined on March 14, 2014, that the petitioner's request for four units, three times a week for occupational therapy (OT) was denied/reduced for the period of February 25, 2014

through August 23, 2014. eQHealth Solutions approved four units, one time a week for the certification period. One unit is equal to fifteen minutes of the therapy service. This request by the petitioner's provider is an initial request for OT services.

3. eQHealth Solutions mailed a notice to the petitioner and the petitioner's provider on February 24, 2014 indicating that, "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 the documentation provided." eQHealth also provided clinical rational for the decision:

> The patient is a 16 year old with cerebral palsy. Occupational therapy is being requested for passive range of motion. This can be done at home with home exercise program and caregivers. Based on the patient's deficits and needs, 4 units 1 time a week are approved. The additional requested units are not approved as they have been deemed excessive.

4. A reconsideration was request by the petitioner's provider, but eQHealth Solutions upheld the first decision for this case and sent the petitioner and provider a notice advising of this on March 21, 2014.

5. The petitioner's provider has included information as part of the provider's request for the OT service for the petitioner. This information was reviewed and evaluated by eQHealth Solutions and is included in Respondent Composite Exhibit 1. This information shows both long term and short term goals. As this is the first request for the OT service with Medicaid-eQHealth Solutions; no previous results were noted. This report also indicated the petitioner has deficits in activities in daily living; adaptive skills and fine motor skills. With the fine motor; the petitioner is able to grasp and release a one inch cube; a tennis ball; crayon/pencil and with assistance; one inch

diameter peg and marker; smooth voluntary release of large objects and controlled smooth release of all objects; is unable to grasp and release buttons and paper clips.

6. The respondent's witness indicated that the reviewing therapist from eQHealth Solutions also provided the following explanation: "The documentation indicates that the recipient is receiving maintenance therapy services. The therapy method used to address theses deficit areas may be taught to the caregiver via home program training and does not require the ongoing intervention from a skilled therapist. The caregiver may then continue these therapeutic techniques with the recipient on an ongoing basis." The respondent's witness reiterated what was said in the Agency notice noted above as the reasons why the amount of the service request (4 units, 3 times a week) was denied. She also indicated that the information as provided in the reconsideration process from the petitioner's provider did not show any new information.

7. The respondent witness also indicated that the provisions of the EPSDT Program were considered for this decision.

CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat § 409.285. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

9. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code § 65-2.056.

10. In accordance with Fla. Admin. Code § 65-2.060 (1), the burden of proof was assigned to the petitioner.

11. Fla. Admin. Code 59G-1.010 states in part:

(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;
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...

12. The Therapy Services Coverage and Limitations Handbook pages 2-4; 2-9 and 2-10 (August 2013) set forth the process for therapy services including speech therapy and state in part:

All requests for prior authorization must be submitted to the Medicaid QIO via its web-based internet system.

At a minimum, each prior authorization request must include all of the following:

• Recipient's name, address, date of birth, and Medicaid ID number;

• Therapy provider's Medicaid provider number, name and address;

• Procedure code(s), with modifier(s) if applicable, matching the services reflected in the plan of care;

• Units of service requested;

• Summary of the recipient's current health status, including diagnosis(es);

• Planned dates and times of service;

• Ordering provider's Medicaid provider number, National Provider Identifier, or Florida Medical License number, name, and address;

• The complete evaluation and plan of care, reviewed, signed and dated by the primary care provider, ARNP or PA designee, or designated physician specialist;

• Patient condition summaries that substantiate medical necessity and the need for requested services, such as a hospital discharge summary (if services are being requested as a hospital discharge summary (if services are being requested as a result of a hospitalization), physician or nurse progress notes, or history and physical;

• A copy of the documentation demonstrating the recipient has been examined or received medical consultation by the ordering or attending physician before initiating services and every 180 days thereafter.

...The QIO may use a national standardized set of criteria, approved by the Agency for Health Care Administration (AHCA), as a guide to establish medical necessity for prior authorization of therapy services at the first review level. If services cannot be approved by the first level reviewer, the QIO's physician peer reviewer will determine medical necessity using his clinical judgment, acceptable standards of care, and AHCA's medical necessity definition.

• A prescription for the therapy services in accordance with the prescription requirements described in this chapter

The prescription should be as specific as possible, and must include:

• The recipient's diagnosis or diagnoses contributing to the need for therapy;

• Signature of the prescribing provider;

• Name, address and telephone number of the prescribing provider;

• Date of prescription;

• The specific type of evaluation or service requested

• For therapy services, the duration and frequency of the therapy treatment period; and

• The physician's MediPass authorization number, if applicable

Evaluations determine the recipient's level of function and competencies through therapeutic observation and standardized testing measures appropriate to the language, speech, or physical limitations and specific to the therapeutic services required.

Evaluation results should be used to develop baseline data to identify the need for early intervention for therapeutic services and to address the recipient's functional abilities, capabilities, and activity level deficits and limitations.

Tests should be:

• Standardized for a specific disorder identified; or

• Consist of a standardized caregiver report format; or

• Composed of professionally acceptable therapeutic observational techniques.

Age equivalent score reporting does not report a standard score and is not an acceptable evaluation test.

13. The State Medicaid Manual in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services section states in part:

5010. Overview
A. Early and Periodic Screening, Diagnostic and Treatment Benefit.-- Early and periodic screening, diagnostic and treatment services (EPSDT) is a required service under the Medicaid program for categorically needy individuals under age 21...
5110. Basic Requirements

> *OBRA 89 amended §§1902(a)(43) and 1905(a)(4)(B) and created §1905(r) of the Social Security Act (the Act) which set forth the basic requirements for the program. Under the EPSDT benefit, you[1] must provide for screening, vision, hearing and dental services at intervals which meet reasonable standards of medical and dental practice established after consultation with recognized medical and dental organizations involved in child health care. You must also provide for medically necessary screening, vision, hearing and dental services regardless of whether such services coincide with your established periodicity schedules for these services. Additionally, the Act requires that any service which you are permitted to cover under Medicaid that is necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be provided to EPSDT participants regardless of whether the service or item is otherwise included in your Medicaid plan.*

14. Fla. Stat. § 409.913 addresses "Oversight of the integrity of the Medicaid program," with (1)(d) describing "medical necessity or medically necessary" standards and saying in relevant part: "For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity."

15. As shown in the Findings of fact, on March 14, 2014, eQHealth Solutions denied/reduced the petitioner's request for occupational therapy for four units, three times a week for twenty six weeks, but approved four units, one time a week, which covers the certification period of February 25, 2014 to August 23, 2014, based on, "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 the documentation provided."

16. The petitioner's witness argued that the OT service is for more than just maintenance therapy for the petitioner. She indicated that the request for the therapy is

[1] "You" in this manual context refers to the state Medicaid agency.

that the petitioner needs weight bearing positioning and to prevent regression in areas such as his ability to use his hands. She indicated that the petitioner's mother provides home program for the petitioner along with the school caretakers of the petitioner, but the petitioner's caretakers cannot provide skilled therapy service as provided by the therapist professional.

17. The respondent witness argued that based on the petitioner's deficits; needs and the request for occupational therapy is being requested for passive range of motion; eQHealth Solution decision to approve the petitioner for 4 unit of occupational therapy, 1 time a week is the correct medically necessary decision for this case. She also argued that the OT for the petitioner can be provided through home care (by the petitioner's caretaker).

18. For the case at hand, the hearing officer acknowledges the petitioner's representative's concerns, but notes that the hearing was left open for additional information to be submitted and none was. The hearing officer thus agrees with the Agency decision; as based on the documentation presented which shows that the recipient is receiving maintenance therapy services and as the petitioner does not require the ongoing intervention from a skilled therapist for more than 4 units once a week; the amount of occupational therapy approved by the Agency is the correct medically necessary amount for the petitioner.

19. After considering the evidence, the Fla. Admin. Code Rule and all of the appropriate authorities set forth in the findings above, the hearing officer concludes that the Agency action to reduce/deny the petitioner's request and approve four units, one

time a week for the certification period of February 25, 2014 to August 23, 2014, is correct. The petitioner has not met his burden of proof.

DECISION

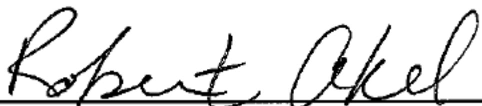
Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED and the Agency action affirmed.

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 17th day of June, 2014,

in Tallahassee, Florida.



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