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

APPEAL NO. 09F-06954

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 06 Pinellas
UNIT: HMO

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, a telephonic administrative hearing was convened before the undersigned hearing officer on December 1, 2009, at 1:44 p.m. The petitioner was not present. She was represented by her legal guardian,

The respondent was represented by Linda Thompson, human services program specialist, Patricia Cobb, registered nurse specialist and Hazel Greenburg, program administrator for the Bureau of Managed Care. Witnesses for the respondent from WellCare Incorporated were Geoff Petrie, director of regulatory affairs; Vincent Kuntz, M.D., senior medical director, and Valda John, project analyst.

ISSUE

The petitioner is appealing the respondent's action to deny the petitioner a continuous glucose monitoring device.

FINDINGS OF FACT

1. The petitioner is a Medicaid eligible nine year old child. The petitioner has juvenile type 1 diabetes. The petitioner's glucose levels change rapidly. She has no hyperglycemic or hypoglycemic awareness. She requires constant monitoring of her blood glucose levels. The monitoring is done by pricking her finger with a lancet, putting a drop of blood on a test strip and then placing the strip into a meter that displays your blood sugar level. This is done several times a day. This traditional glucose monitoring system has been approved and paid for by Medicaid.

2. Most Medicaid recipients are required to get services through managed care known as Health Maintenance Organizations (HMOs). The respondent contracts the managed care provider. The Bureau of Managed Health Care is responsible for the approval and monitoring of all Medicaid HMO contracts in the state. One of the contracted managed care providers is WellCare Incorporated. The WellCare Incorporated division that manages Medicaid services is HealthEase.

3. The petitioner believes that her blood sugar levels need to be monitored constantly. It is not uncommon for the petitioner to experience extreme low blood sugar at night. The guardian reports that this is a life-threatening condition if they did not become aware of these lows. The petitioner requested a continuous glucose monitoring device and supplies from HealthEase Incorporated. This device is different then the one she is currently using. This device allows for continuous monitoring of blood sugar.

4. The device and supplies were requested using the Centers for Medicare & Medicaid Services' standardized coding system for describing and identifying health care equipment and supplies in health care transactions. The coding system is the Healthcare Common Procedure Coding System (HCPCS). The codes were indicated as:

> A9276 Sensor; Invasive disposable, for use with interstitial continuous glucose monitoring system, one unit= one day supply
> A9277 Transmitter: External, for use with interstitial continuous glucose monitoring system
> A9278 Receiver: External, for use with interstitial continuous glucose monitoring system.

5. The petitioner filed numerous grievances and appeals pursuant to HealthEase's grievance and appeal procedure. On September 10, 2009, the medical director with the Appeals Committee reviewed the petitioner's request for appeal. The medical director's decision was to uphold the denial that the requested continuous glucose monitoring system was not a covered service. On September 10, 2009, HealthEase sent the petitioner a final determination letter. The rational was that the requested continuous glucose monitoring system was not covered under the Florida Medicaid durable medical equipment fee schedule. On October 9, 2009, the petitioner requested an appeal hearing.

CONCLUSIONS OF LAW

By agreement between the Agency for Health Care Administration and the Department of Families and Children, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing

pursuant to Chapter 120.80 F.S. The hearing officer's jurisdiction is to determine if the respondent followed the rules of the Program.

The petitioner's position is that the State should provide the continuous glucose monitoring system. The petitioner noted that the requested device is not experimental and was prescribed by the petitioner's treating physician. The petitioner argued that the lack of the codes appearing on the respondent's fee schedule and pre-approved list is insufficient reason to deny coverage. The petitioner understands that the Juvenile Diabetes Research Foundation has issued a Position Statement regarding the glucose monitoring system that calls for coverage by all insurance. The petitioner further believes that there is a statute requiring insurance companies to cover durable medical equipment that is medically necessary, therefore it is logical that the State Medicaid must also cover all medically necessary durable medical equipment. The respondent's position is the requested continuous glucose monitoring system was not listed under the Florida Medicaid durable medical equipment (DME) fee schedule and as such is not a covered service pursuant to Florida Administrative Code.

Florida Administrative Code 59.G-1.010, "Definitions", states for medical necessity:

> (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.

The Florida Administrative Code at 59G-1.010 "Definitions" defines prior authorization:

(226) "Prior authorization" means the approval by the Medicaid office for a Medicaid provider, or by a prepaid health plan for its affiliated providers, to deliver Medicaid covered medical or allied care, goods, or services in advance of the delivery of the care, goods, or services.

The Florida Administrative Code at 59G-4.070 states in part:

(1) This rule applies to all durable medical equipment and supply providers enrolled in the Medicaid program.
(2) All durable medical equipment and medical supply providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook, July 2008, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which is incorporated by reference in Rule 59G-4.001, F.A.C...

Durable Medical Equipment/ Medical Supply Services Coverage and Limitations Handbook (June 2008) page 2-3 sets forth the services limited to recipients under 21 Years of age:

> Many durable medical equipment (DME) items and services are limited to recipients under 21 years of age. To determine whether a service is available to all recipients or limited to recipients under age 21 years of age, refer to the DME and Medical Supply Services Provider Fee Schedules and the service specific requirements described in this handbook...The fee schedules are incorporated by reference in 59G-4.071, Florida Administrative Code...

Durable Medical Equipment/ Medical Supply Services Coverage and Limitations Handbook (June 2008) page 2-16 sets forth prior authorization and states in relevant part:

> DME Items and Services Requiring Prior Authorization (PA)
>
> Durable medical equipment services or items that require prior authorization
> (PA) are indicated on the DME Fee and Medical Supply Services Provider Schedules with a "PA" designation. DME services or items that require PA include the following...
> • **DME items that do not have an assigned procedure code(s) listed on the fee schedules and are requested using the miscellaneous DME procedure code; and miscellaneous DME, which may include items such as external insulin pumps and custom cranial remolding devices; and**...

Durable Medical Equipment/ Medical Supply Services Coverage and Limitations Handbook (June 2008) page 2-18 thru 2-19 sets forth documentation for prior authorization and states in relevant part:

> For all DME services and DME items requiring prior authorization (PA), at a minimum, item specific documentation along with the following documentation must be submitted to the appropriate office with the authorization request form:
> • A statement clarifying why the recipient's current equipment no longer meets his current needs; and

• Full description of the item(s) requested; and
• Manufacturer's name and address; and
• Model; and
• Serial number or item number for non-custom manufactured item(s); and
• A listing of all parts, components, attachments, or special features of the requested durable medical equipment; and
• A statement clarifying whether the requested equipment or component is new, used or refurbished; and
• A statement clarifying whether the requested equipment is to be purchased, rented, or purchased as a rent-to-purchase item (if the requested equipment is a rental or rent-to-purchase item, the total quantity of monthly rental units must be identified on the authorization request form); and
• Documentation regarding the length of time (number of months or years) the requested item will be medically necessary to meet the recipient's current needs; and
• DME provider's sales invoice, which must include the following information:
(1) A list of custom and non-custom components that are described by HCPCS procedure codes that are listed on the current DME and Medical Supply Services Provider Fee Schedules and the scheduled fee for each component;
(2) The invoice subtotal;
(3) A list of the remaining components not listed on the DME and Medical Supply Services Provider Fee Schedules and the provider's requested price for each individual component; and
(4) The invoice total, excluding all shipping and handling fees; and
• Description of the current items or equipment being used or currently owned by the recipient of the same or similar type requested, indicating whether the equipment is rented or was purchased specifically for the recipient, the age of the equipment; and whether and when the recipient's equipment was purchased by Medicaid; and
• A signed and dated prescription or Certificate of Medical Necessity (CMN) specifying the type of durable medical equipment prescribed from the recipient's treating physician or the treating physician's prescribing ARNP or physician assistant, with the Florida professional license number; and...
• If a more costly device or component is being recommended over a less costly alternative, the therapist evaluator and the provider must clearly justify why the less costly alternative will not appropriately meet the recipient's needs; and...
• Diagnosis code(s), using the most current version of the International Classification of Diseases, Clinical Modification (ICD-9-CM), that is pertinent to the recipient's need for the item or service being requested; and

- Documentation that a sufficient amount of space is available in the recipient's home to ensure safe and effective use and storage of the equipment; and
- Product information that is required for items purchased by Medicaid.

The codes that were used to request the continuous glucose monitoring device were the codes that are listed in the HCPCS procedure codes and are not listed the Florida DME fee schedule. The respondent's position is that this is fatal and thus can not be authorized regardless of medical necessity. However, the handbook sets forth a procedure for requesting item(s) that are not listed on the fee schedule and created a fee schedule code for miscellaneous. The code that should be used in this case would be the miscellaneous code. The DME and Medical Supply Services Fee Schedule for All Medicaid Recipients, Effective January 2009 lists the following fee schedule codes "A9900 Miscellaneous DME Supply, Accessory, and/or Service Component of Another HCPCS Code" and "E1399 Miscellaneous, Durable Medical Equipment". That code requires that there be a finding of medical necessity with documentation as established in the handbook on pages 2-18 through 2-19. There does not appear to be a policy that requires all DME requests to have a specific code related to a specific item. By the creation of a miscellaneous category, the opposite seems to be true.

If the petitioner had used the fee code of "miscellaneous", then the respondent should have proceeded with a medical necessity analysis. However, this opportunity does not seem to have been allowed. After repeated attempts by the providers to use codes not listed on the DME fee schedule, the respondent should have suggested to the provider that the provider use the miscellaneous

code for prior authorization. Therefore, the hearing officer remands the case back to the respondent to consider the requested continuous glucose monitoring device using a miscellaneous code of possibly E1399 and to complete a determination of medical necessity.

DECISION

This appeal is remanded back to the respondent.

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 agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 10th day of January, 2010,

in Tallahassee, Florida.

Linda Jo Nicholson

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