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

APPEAL NO. 09F-07056

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION (AHCA)
CIRCUIT: 07 Volusia
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened telephonically before the undersigned hearing officer on December 10, 2009, at 1:39 p.m. The petitioner was represented by , paralegal with Testifying on behalf of the petitioner was his mother, his physical therapist, ; his nurse, and Controller with Medical Equipment. The Respondent was represented by Willis Melvin Jr, AHCA attorney. Jody Winter, physical therapist with AHCA and Sheila Broderick, registered nurse with AHCA testified on behalf of the Respondent.

The record was held open for seven days for the submission of additional evidence which was received and entered into evidence as Respondent's Exhibit 2 and Petitioner's Exhibit 8.

ISSUE

At issue is the respondent's denial of the petitioner's request for a new wheelchair/stroller (TOM Positioning System/reclining stroller) through the Medicaid Program. The petitioner held the burden of proof.

FINDINGS OF FACT

1. The petitioner is a 6 year old Medicaid recipient. The petitioner has complex medical needs; his principal diagnosis is Mitochondrial Myopathy. He is developmentally delayed; his development is equivalent to that of a 3 month old infant. He has severe neurologic impairment; he can not walk or talk, he has poor head control, he is feed via a jejunostomy tube, he needs assistance with all the activities of daily living (feeding, toileting, bathing, dressing, etc.). He also has epilepsy, central regulatory dysfunction and shunted hydrocephalus. The petitioner weighs approximately 34 pounds and is approximately 40 inches tall. The petitioner's main method of transportation inside and outside of the home is via a wheelchair.

2. In August 2009, a request for a new custom wheelchair/stroller for the petitioner was submitted to the respondent. In September 2009, the respondent denied the request. The denial notice states in part; "This request exceeds plan maximums as a customer manual wheelchair was provided in 2006..."

3. On October 15, 2009, the petitioner's mother requested a hearing.

4. The respondent explained that wheelchair purchases require prior authorization. The authorization decision is based, in part, on a determination of

medical necessity and program limitations. The Medicaid Program allows eligible recipients to receive one wheelchair every five years. Medicaid approved the purchase of a wheelchair (Gizmo Freedom Design) for the petitioner in 2006; therefore, he is not eligible for another Medicaid funded wheelchair until 2011.

5. The petitioner's representative provided evidence (witness testimony and documentation) which proves that Medicaid did not purchase the 2006 wheelchair. Medicaid denied the claim for payment of the wheelchair because the wrong billing code was included on the claim form. In addition, the petitioner had third party insurance at that time; Medicaid is always the payer of last resort and required the bill be adjusted for the third party insurance company payment prior to submission to Medicaid. The medical equipment company never received payment from the insurance company or Medicaid (due to additional billing errors on its part). In the end, the company gave the wheelchair to the petitioner without payment of any kind. Per the company representative who testified at the hearing, "it was a write off".

6. The petitioner's representative argued that the respondent's 2009 denial of a new wheelchair should be reversed as Medicaid did not pay for the original wheelchair; the reason for the denial has proven to be invalid. After further research, the respondent admitted that Medicaid did not pay for the original wheelchair. The reviewing physical therapist explained that a review of prior authorization requests for the petitioner yielded the 2006 authorization (approval); she did not pursue the matter further and therefore, did not realize until the petitioner's representative raised the issue

that Medicaid did not actually pay for the 2006 wheelchair. The respondent argued that exceeding maximum benefit is only one component of the prior authorization process. The requested equipment must also be medically necessary and the least expensive alternative. The respondent asserted that no medical evidence was provided to explain why the petitioner could not, with modifications, continue to use his original wheelchair and therefore had not proven that a new wheelchair was medically necessary.

7. The petitioner's representative argued that his medical condition and physical growth have rendered the old wheelchair useless. The petitioner was two years old when the original chair was acquired; he was approximately 18 inches tall and weighed approximately 20 pounds. The petitioner is now age 6; his height and weight have almost doubled. He can no longer sit comfortably in the wheelchair; his mobility is restricted to the point that he sustains abdominal bruising as well as severe hip pain when sitting in the chair for long periods of time. The petitioner requires abdominal massages every hour or so to prevent bowel blockage; the massages must be done at a 140% to 180% angle. His old wheelchair does not recline; he must be lifted out of the wheelchair and placed on a flat surface up to 24 times per day. The situation is further complicated by the fact that it is not always possible to find a clean, flat surface on which to lay him (when the family is out of the home). Waiting until a flat surface can be located is not healthy for the petitioner's gastrointestinal system. Regarding modification of the petitioner's old wheelchair, a letter from a wheelchair manufacturer familiar to both parties (the reviewing physical therapist for AHCA admitted that he is an

expert in the field) states in part: "The Gizmo wheelchair he currently has can not be modified to accomplish a reclining back rest." The reviewing physical therapist countered that the expert's letter does not exclude the option of replacing the seat while maintaining the chair frame. She, however, admitted that she does not know if this proposed modification is possible on the current wheelchair as she has never seen the chair or observed the petitioner in it.

8. In March 2009, the petitioner began using a loaner (demo) stroller/wheelchair (the TOM Stroller). The petitioner's mother, his registered nurse and his physical therapist all testified that the new chair is spacious and comfortable; it also reclines to the required angle necessary to massage the petitioner's abdomen. The need to place the petitioner on a flat surface on an hourly basis has been eliminated as has the abdominal bruising and hip pain he experienced while using the old wheelchair. The witnesses asserted that his improved medical condition proves that a new stroller/wheelchair is medically necessary. The respondent reiterated its argument that modifications to the old wheelchair could yield the same results; therefore medically necessity has not been proven.

9. The respondent also argued that Medicaid rules require the least costly option be chosen. On average wheelchair modifications cost $2000; the new stroller/wheel chair requested for the petitioner costs $3000. The petitioner's representatives believe the cost comparison is irrelevant in this case as expert opinion has ruled out the modification option.

CONCLUSIONS OF LAW

By agreement between the Agency for Health Care Administration and the Department of Families and Children, jurisdiction to conduct this type of hearing has been conveyed to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80 F.S.

Fla. Admin Code 59G-1.010 Definitions 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; 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.

Fla. Admin. Code Rule section 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 supply providers enrolled in the Medicaid program must comply with the Florida Medicaid Durable Medical Equipment and Supply Services Coverage and Limitations Handbook, July 2008, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, HCFA 1500, which is incorporated by reference in Rule 59G-4.001, F.A.C. Both handbooks are available from the Medicaid fiscal agent...

Durable Medical Equipment/ Medical Supply Services Coverage And Limitations Handbook, July 2008, sets forth the description of a wheelchair and documentation requirements for a customized wheelchair (pages 2-90 and 2-93):

A wheelchair is a chair mounted on wheels used to transport a non-ambulatory individual or an individual with severely limited mobility...

Medicaid will reimburse for a wheelchair when the recipient is non-ambulatory or has severely limited mobility and it is medically documented that a wheelchair is medically necessary to accommodate the recipient's physical characteristics.
Medicaid will reimburse and provide maintenance for only one wheelchair (regardless of type) or power operated vehicle (POV) procedure code per recipient, per maximum limit period, as stated in the DME and Medical Supply Services Provider Fee Schedule.

The following types of wheelchairs and POVs devices require prior authorization:

- customized manual wheelchairs,
- customized power wheelchairs,
- non-custom power wheelchairs,
- motorized scooters (POV), and
- power conversion kits...

In September 2009, the respondent denied the petitioner's request for a new wheelchair. "Exceeding plan maximums" was the reason given on the denial notice. The respondent believed that Medicaid purchased a wheelchair for the petitioner in 2006; Medicaid policy makes it clear that the program will supply one wheelchair every five years. Therefore, the new request exceeded plan limits. Evidence provided during the hearing conclusively proved that Medicaid did not supply the petitioner's 2006 wheelchair. Due to the manufacturer's billing errors, no one paid for the wheelchair. The company wrote off the expense and gave the chair to the petitioner free of charge.

The respondent contends that a new wheelchair is not medically necessary as the petitioner's old wheelchair can possibly be modified accommodate his current needs. The respondent admitted that it had no first hand knowledge regarding the modification capabilities of the petitioner's current wheelchair. The evidence demonstrates that the petitioner can no longer use his original wheelchair in its current condition. The testimony of the petitioner's nurse, and physical therapist as well as a letter from a stipulated expert in the field of wheelchair manufacturing all contradict the respondent's assertions that modifications to the current wheelchair will meet the petitioner's medical needs. The nurse and physical therapist believe that the petitioner's old wheelchair causes him severe physical pain.

The respondent argued that Medicaid regulations require the least expense alternative be chosen; the denial decision was correct because on average wheelchair modifications cost about $1000 less than purchasing new equipment. The petitioner's

representative believes this argument is without merit the instant case as the expert evidence shows that the petitioner's chair can not be modified to meet his current needs.

After carefully reviewing the testimony, evidence and controlling legal authorities, the undersigned hearing officer concludes that the petitioner met its burden. The evidence proves that the petitioner requires a new wheelchair to prevent significant illness (blocked bowels, stomach bruising) and to alleviate severe pain (hip pain caused by inadequate space). Expert evidence explains that the petitioner's old wheelchair can not be modified to meet his current needs. The respondent admitted that it had no personal knowledge about the petitioner's current wheelchair or its capability of being modified in the ways required to meet the petitioner's needs. Lastly, the respondent's contention that modification of the current wheelchair is cheaper than purchasing a new wheelchair is moot as expert opinion makes it clear that the petitioner's current wheelchair can not be modified to meet his needs. The respondent's denial of the petitioner's request for a new wheelchair is reversed. The request is granted and the agency is to provide the wheelchair as requested.

DECISION

The appeal is granted as explained in the above conclusions

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 19th day of January, 2010,

in Tallahassee, Florida.

Leslie Green

Leslie Green
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Copies Furnished To: