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

APPEAL NO. 09F-3753

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on July 22, 2009, at 9:27 a.m., in Miami, Florida. The petitioner was not present however he was represented by his mother, The respondent was represented by Jeffrey Douglas, program administrator with the Agency for Health Care Administration (AHCA). Telephonically present, as witnesses for the respondent were Dr. Robert A. Buzzeo, physician reviewer and Gary Erickson, RN both with Keystone Peer Review Organization (KēPRO) South. The hearing was previously scheduled for July 1, 2009 but was continued at the request of the petitioner.

ISSUE

At issue is the respondent's action of May 14, 2009 and June 1, 20098, in denying 1700 hours of home health aide (for personal care) for the certification period of May 5, 2009 through October 31, 2009. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner is thirteen years old and a Medicaid beneficiary in the state of Florida. The petitioner's diagnosis as reported to the respondent, "Autism, developmental delay, contracture of tendon." Services have continued throughout the appeals process.
2. The respondent has contracted KēPRO South to perform medical reviews of Private Duty Nursing and the Personal Care Prior Authorization Program for Medicaid beneficiaries. This prior authorization review determines medical necessity of the hours requested, under the terms of the Florida Medicaid Program. The request for service is only submitted by the provider, along with all information required, in order for KēPRO to make a determination on medical necessity for the level of service being requested.
3. On May 12, 2009, the provider .) requested 1700 hours of home health services for the certification period. The provider submitted medical and social information on the petitioner and his parents in order to justify the hours being requested.
4. The petitioner lives with his mother and father and a 21 month old sibling. The petitioner attends school Monday-Friday 7am-3:30pm and attends after school care. The father owns a barber shop and informed KēPRO that he works from 9am to 10pm, 7 days a week. The mother reported working as a real estate broker 9am-11pm, 7 days a week. The hours of service requested were

Monday-Friday 3pm-10pm and Saturday and Sunday from 9am-10pm, in order to assist the petitioner with activities of daily living and to supervise for safety.

5. On May 13, 2009, the physician consultant denied the request documenting that the hours that were being claimed as working hours, they considered as a "flex schedule" and they were unable to approve according to the Home Health Services Coverage and Limitations Handbook.
6. On May 13, 2009, a reconsideration was requested by the provider adding that the mother's schedule is not "flexible or varied" and that neither parent is at home and the parents work the hours as reported were "exact."
7. A second physician consultant reviewed the request and upheld the original decision to deny based on the reported hours and days of work, finding it difficult to believe that the parents are both away from home for over 12 hours a day, when there is also a 21 month old in the household. More accurate and specific hours of work needed to be provided.
8. The petitioner appealed the decision on June 4, 2009.

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 Florida Statute, Chapter 120.80.

Florida Statute 409.905 addresses Mandatory Medicaid services and states as follows:

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. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(4)(b) The agency shall implement a comprehensive utilization management program that requires prior authorization of all private duty nursing services...The utilization management program shall also include a process for periodically reviewing the ongoing use of private duty nursing services. The assessment of need shall be based on a child's condition, family support and care supplements, a family's ability to provide care, and a family's and child's schedule regarding work, school, sleep, and care for other family dependents...

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;
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.

Fla. Admin. Code 59G-4.130 Home Health Services states in part:

(1) This rule applies to all home health agencies licensed under Chapter 400, Part III, F.S., and certified by the Agency for Health Care Administration for participation in the Medicaid program for home health care.

(2) All home health agency providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Home Health Services Coverage and Limitations Handbook, July 2008, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which is incorporated in Rule 59G-4.001, F.A.C. ...

The Home Health Services Coverage and Limitations Handbook (July 2008), page 2-22 states in part:

Personal Care Services-Definition

Personal care services are to provide medically necessary assistance with activities of daily living that support a recipient's medical care needs.

Who Can Receive Personal Care Services

Medicaid reimburses personal care services for recipients under the age of 21 who: Have complex medical problems; and Require more individual and continuous care than can be provided through a home health aide visit.

Prior Authorization

All personal care services must be authorized by the Medicaid peer review organization prior to the provision of services. ...

The petitioner's mother explained that the hours of work and days being requested were not accurate. She states that she works in the mornings, but usually in the evenings

and does not need assistance on Sundays. The respondent advised the petitioner to have the provider submit a modification on the hours that were actually needed. The petitioner agreed to do so.

Based on the above authority the hearing officer finds that the agency's decision was correct at the time it was made, given the information provided. Therefore, the agency's decision to deny the 1700 hours is upheld.

DECISION

This appeal is denied as stated in the Conclusions of Law.

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 25th day of August, 2009,

in Tallahassee, Florida.

A. G. Littman

A. G. Littman
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