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



APPEAL NO. 09F-4110

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 8:22 a.m., in Miami, Florida. The petitioner was not present. However, he was represented by his sister, power of attorney. The respondent was represented by Phyllis Bentil, program specialist with the Agency for Health Care Administration (AHCA). Telephonically present as witnesses for the respondent were Dr. Stuart B. Chesky, medical director and Theresa Ashey, nurse reviewer, both with Keystone Peer Review Organization (KēPRO) South.

## ISSUE

At issue is the respondent's action of June 9, 2009 denying home health aide (HHA) visits two times a day, for the certification period of April 18, 2009 through June 16, 2009. As an initial request the petitioner has the burden of proof.

## FINDINGS OF FACT

1. The petitioner is forty-nine years old and a Medicaid beneficiary in the state of Florida. The petitioner's diagnosis as reported to the respondent, "Other specified type Schizophrenia chronic; urgency of urination; depressive disorder, not elsewhere classified; osteoarthrosis unspecified whether generalized or localized, site unspecified; unspecified essential hypertension."
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 services 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 June 2, 2009, the provider (Golden Age Home Health Inc.) requested HHA services for personal care, two times daily. The provider submitted medical and social information on the petitioner in order to justify the services being requested.
4. Additional information was requested from the provider which was received. A registered nurse reviewed the information and referred the request to a board certified family practice physician consultant, as the information provided did not support the requested service.
5. The physician consultant reviewed the medical information and denied the request documenting, "...Patient is documented as oriented, ambulatory and

continent. Not dependent for adls and appears as can participate in care. Appears as limits are based on psych dx and KePro is unable to support debilities based on psych dx. There is limited medical dx to support requested days."

6. On June 4, 2009, the provider responded "Yes, patient's psych does not allow him to care for himself." They also provided information on assistance needed; his joint pain; obesity; poor vision; weakness; medication reminder needed; etc.
7. On June 8, 2009, a second physician consultant reviewed the information submitted and documented, "...information submitted fails to show the medical necessity for this level of care. Rationale: this is a 49-year-old with schizophrenia, depression, DM and HTN. Agency states his psychiatrist will not allow him to care for himself. He lives with his sister who works. He is oriented times three, independent with transfers, independent with ambulation and is not incontinent. The above information indicates to me that patient and/or caregiver can participate in patient care. Also, patients debility seem to be related to his psychiatric illness. KePro is not authorized by Medicaid to review days related to psychiatric illness."
8. On June 9, 2009 a Notification of Denial was issued to the petitioner. The petitioner's sister appealed the decision on June 22, 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.

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. ...

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.

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

> Requirements to Receive Services
>
> Introduction-Medicaid reimburses home health services provided to an eligible Medicaid recipient when it is medically necessary to provide those services in his place of residence. ...
>
> Medically Necessary-Medicaid reimburses services that do not duplicate another provider's service and are medically necessary for the treatment of a specific documented medical disorder, disease or impairment.
>
> Covered, Limited and Excluded Services
>
> Covered Services for Adults-Medicaid reimburses the following services provided to eligible recipients age 21 years or older:
>
> - Licensed nurse and home health aide visits; ...
>
> Exclusions-Medicaid does not reimburse for the following services under the home health services program:
>
> - Audiology services;
> - Housekeeping, homemaker, and chore services, including shopping;
> - Meals-on-wheels;
> - Mental health and psychiatric services (these services are covered under the Medicaid Community Behavioral Health Program); ....

The petitioner's representative states that she does provide assistance to her brother, but she also works. She states that he doesn't drive; he takes a shower sometimes; needs to be reminded on taking medication and checking blood sugar; and needs assistance in making beds and preparing meals. The representative states that her brother needs additional assistance aside from what she offers.

The physician consultant stated that housekeeping and homemaker are excluded services and that a HHA would not be able to check the petitioner's blood sugar. He stated that the petitioner's mental health is the issue and not his physical health that does not meet medical necessity. The agency representative stated that she would contact the petitioner's representative with additional information on possible assistance for her brother through the Community Mental Health.

Based on the above authority and evidence received, the hearing officer finds that the agency's decision was correct as the petitioner did not meet medical necessity for the service.

## 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 15th day of September, 2009,

in Tallahassee, Florida.

A. G. Littman

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