



STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
OFFICE OF FAIR HEARINGS

FILED

Jul 10, 2023, 8:17 am

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH0443

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on May 18, 2023, at 9:15 a.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Diana Hearod
Medical/Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent's decision to deny Petitioner's request for durable medical equipment was incorrect.

PRELIMINARY STATEMENT

All parties appeared telephonically. Petitioner's Authorized Representative [REDACTED]

[REDACTED] appeared on behalf of the Petitioner. The following attended as

witnesses for Petitioner: [REDACTED]

Diana Hearod, Medical/Health Care Program Analyst for the Agency for Health Care Administration (“Agency or “AHCA”), appeared on behalf of Respondent. Dr. Rakesh Mittal (“Dr. Mittal”), Medical/Health Care Program Analyst for eQHealth Solutions (“eQHealth”), attended as a witness for Respondent.

George, interpreter number 31578792, appeared to offer translation services.

Petitioner did not introduce any exhibits at the hearing. Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a 128 -page evidence packet and a 49-page evidence packet. The 128-page evidence packet appears in the Office of Fair Hearings’ document management system as the file title “[REDACTED] FH. 05.182023.pdf” and the 49-page evidence packet appears as “23-FH0443_Child DME 1399_AHCA Evidence.pdf”. Absent an objection from the Petitioner, the undersigned admitted the 128-page evidence packet as Respondent’s Composite Exhibit 1 (“RCE 1”) and the 49-page evidence packet as Respondent’s Composite Exhibit 2 (“RCE 2”).

At the Fair Hearing the record was held open until May 22, 2023, to allow for the Petitioner to submit additional documents. Petitioner did not timely submit any documents to the Office of Fair Hearings.

FINDINGS OF FACT

1. Petitioner receives Medicaid services on a fee-for-service basis from the Agency. eQHealth is a Quality Improvement Organization contracted by the agency to review prior authorization requests for services. *See* page 2 of RCE 2.
2. Petitioner was approximately [REDACTED] at the time of the Fair Hearing. *See* page 16 of RCE 1. Petitioner is diagnosed with [REDACTED]. *Id.* at 107.

3. On [REDACTED] Petitioner underwent an [REDACTED]. *Id.* at 98. Petitioner did not tolerate the [REDACTED]. *Id.* at 99.

4. Petitioner requested an Airvo respiratory machine and related components. *Id.* at 17 – 18 and 86 – 87. In a Notice of Outcome (“NOO”), dated January 27, 2023, Respondent denied Petitioner’s request. *Id.* at 22 – 24. The NOO explained the basis for the denial as follows:

[T]he requested services are not medically necessary under the following standard(s):

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.

The NOO further provided:

PR Principal Reason – Denial:

The clinical information provided does not support Medicaid’s medical necessity definition.

Clinical Rationale for Decision: Request is for a Airvo Titration for this [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] For now deny this request.

...
Pages 22 – 23 of RCE 1.

5. Petitioner requested reconsideration of the Respondent’s decision. In a Notice of Reconsideration (“NRD”), dated February 2, 2023, Respondent upheld its decision. *Id.* at 33 – 34.

Respondent explained as follows:

PR Recon Determination: [REDACTED] with [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Uphold previous denial. All submitted documentation was reviewed. Would need evidence of [redacted] outside of the [redacted] to determine appropriate need for Airvo use.

...

Page 34 of RCE 1.

6. On March 2, 2023, Petitioner requested a Fair Hearing to challenge the denial of durable medical equipment. On April 28, 2023, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for [redacted]

7. [redacted]:

a. [redacted] is a [redacted] and [redacted]. [redacted] saw the Petitioner for the first time in [redacted]

b. [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

8. [redacted] testified to the following:

a. [redacted] teaches pediatric residents, nursing medicine residents, and ICU residents at a teaching hospital.

- b. The only documentation submitted was from [REDACTED].
- c. The use of high flow oxygen started mainly during the COVID pandemic – prior to that it was rarely used in the ICU setting. Even during the pandemic, high flow oxygen was only used with critically sick patients in ICUs.
- d. [REDACTED] does not see a use for Airvo outside of a pediatric ICU setting.
- e. [REDACTED] is unaware of lay people administering [REDACTED] at home. [REDACTED] is unaware of patients being treated in an outpatient setting with this device.
- f. Petitioner has not been seen in [REDACTED] [REDACTED].

CONCLUSIONS OF LAW

9. The Agency’s Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties pursuant to section 409.285(2) of the Florida Statutes (2019). This order is the final administrative decision of AHCA under Fla. Stat. § 409.285(2)(a).

10. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 59G-1.100(17)(b).

11. Because Petitioner is requesting a new service, Fla. Admin Code R. 59G-1.100(17)(g) assigns the burden of proof to Petitioner. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence” (Black’s Law Dictionary at 1201, 7th Ed.)

12. The Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook (July 2010) (“DME Coverage Handbook”), incorporated by reference

in Fla. Admin. Code R. 59G-4.070, governs requested for DME services available under Florida Medicaid. The DME Coverage Handbook provides the following:

Durable Medical Equipment (DME): Durable medical equipment (DME) is defined as medically-necessary equipment that can withstand repeated use, serves a medical purpose, and is appropriate for use in the recipient's home as determined by the Agency for Health Care Administration (AHCA).

...

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.

...

Authorized Prescribers of Durable Medical Equipment and Medical Supplies:

All durable medical equipment, medical supplies, and orthotic and prosthetic devices must be prescribed by the Medicaid recipient's:

- Treating physician, or
- Treating physician's physician assistant, or
- Treating physician's advanced registered nurse practitioner (ARNP), or
- Treating podiatrist.

The prescribing professional must include the date, [redacted] signature, and current professional license number or national provider identification number on each documentation of medical necessity when requesting DME and services or medical supplies.

...

Service Criteria:

All DME, medical supplies, and orthotics and prosthetic devices must be:

- Medically necessary, and
- Functionally appropriate for the individual recipient, and
- Adequate for the intended medical purpose, and
- For conventional use, and
- For the exclusive use of the recipient.

DME items requested or supplied must not duplicate or perform the same function as other DME equipment or medical supplies currently in the recipient's possession.

13. The DME Coverage Handbook states the following with respect to acceptable documentation of Medical Necessity:

Acceptable Documentation of Medical Necessity

Medical necessity must be established for each service and documented, at a minimum, with the following:

- Written prescription not more than 12 months old, with the printed name and the dated signature of the recipient’s treating physician or the treating physician’s ARNP or physician assistant. The prescription can be received by the DME and medical supply provider before or after the DME service has been initiated, but the prescription cannot be dated more than 21 days after the initiation of service (date of service); or
- Current hospital discharge plan with the dated signature of the recipient’s treating physician or the treating physician’s ARNP or physician assistant that clearly describes the type of DME item or service ordered; or
- Certificate of Medical Necessity (CMN) not more than 12 months old, which includes the printed name and the dated signature of the recipient’s treating physician or the treating physician’s ARNP or physician assistant. Medicaid prohibits vendors from preparing sections of the CMN that are to be completed by the physician or authorized prescriber. The CMN cannot be dated more than 21 days after the initiation of service (date of service); and Plan of care, if a home health agency.

...

All documentation of medical necessity must include the type of medical equipment, services or consumable goods ordered, including the type, quantity, frequency and length of need ordered or prescribed. Prescribed oxygen services must include rates of flow, concentration, level of frequency, duration of use, and circumstances under which oxygen is to be used. If this information is not included, a new prescription that clarifies the order is required.

14. States must provide Early and Periodic Screening, Diagnostic, and Treatment (“EPSDT”) services to Medicaid-eligible children under age 21 when requested under the Medicaid state plan. *See* 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § 1396d(a)(4). According to 42 U.S.C. § 1396d(r)(5), EPSDT services mean, in relevant part, the following items and services:

Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illness and conditions discovered by the screen services, whether or not such services are covered under the state plan.

15. Petitioner is under age 21, and therefore EPSDT applies to the request for services. However, a state may place medical necessity limitations on EPSDT services. *See* 42 C.F.R. §§

440.230(a), (b), (d). Fla. Stat. § 409.905(2) limits EPSDT services with a medical necessity standard:

The [Agency] shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

16. The Definitions Policy (August 2017), incorporated by reference in Fla. Admin. Code R. 59G-1.010, provides the applicable definitions for Florida Statewide Medicaid Managed Care policy. The Definition Policy provides the following definitions applicable to the instant case:

2.2 Activities of Daily Living (ADLs)

ADLs include:

- Bathing
- Dressing
- Eating (oral feedings and fluid intake)
- Maintaining continence (examples include taking care of a catheter or colostomy bag or changing a disposable incontinence product when the recipient is unable to control bowel or bladder functions)
- Toileting
- Transferring

2.64 Instrumental Activities of Daily Living (IADLs)

When necessary for the recipient to function independently, including:

- Grocery shopping
- Laundry
- Light housework
- Meal preparation
- Money Management
- Personal hygiene
- Transportation
- Using the telephone to take care of essential tasks (examples include paying bills and setting up medical appointments)

2.83 Medically Necessary or Medical Necessity

The medical or allied care, goods, or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate pain
- 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
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- 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
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider

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.

17. Petitioner requested an Airvo respiratory system and related components. See ¶ 4. In the NOO, dated January 27, 2023, Respondent denied Petitioner’s request. *Id.* Respondent explained that the requested DME did not meet the medical necessity criterion “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.” *Id.* Respondent further explained that Petitioner’s provider needed to provide clinical trials regarding the use of CPAP. *Id.*

18. As provided by the EPSDT requirements, the recipient must meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. As provided in section 2.83 of the Definitions Policy, a component of medical necessity is that services must be “consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.” As shown by the record, Petitioner underwent a [REDACTED].

See ¶ 3. As explained by [REDACTED]


or the requested DME. See ¶ 7. [REDACTED] testified that Petitioner [REDACTED] [REDACTED]. *Id.* However, [REDACTED] provided credible evidence that this type of device is not used in an outpatient setting nor of lay people administering high flow oxygen. In all, Petitioner failed to demonstrate that the use of this device is consistent with “generally acceptable professional medical standards” when administered in an outpatient setting.

19. Upon consideration of the testimony provided, evidence submitted, and applicable polices, the undersigned concludes that Petitioner did not prove by a preponderance of the evidence that the request for durable medical equipment was necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Petitioner has not demonstrated that the requested durable medical equipment, are necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Petitioner did not prove by a preponderance of the evidence that Respondent’s denial of durable medical equipment was incorrect.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

Respondent’s denial is **AFFIRMED**. Petitioner’s appeal based on Respondent’s denial is **DENIED**.

DONE AND ORDERED this 10th day of July, 2023, in Tallahassee, Leon County, Florida.

 Joseph Mabry
23-FH0443
2023.07.10 07:47:55
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JOSEPH MABRY, Hearing Officer
Agency for Health Care Administration
Office of Fair Hearings

2727 Mahan Drive, Mail Stop # 11
Tallahassee, FL 32308-5407

NOTICE OF A RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW, WHICH SHALL BE INSTITUTED BY FILING THE ORIGINAL NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A COPY, ALONG WITH THE FILING FEE PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

Copies Furnished To:

[REDACTED]
[REDACTED]

AHCA Medicaid Hearing Unit
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