FILED
Sep 12, 2023, 10:53 am
OFFICE OF FAIR HEARINGS

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

[redacted],

PETITIONER, **AHCA Case No.: 23-FH1449**

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION,

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned scheduled and convened a telephonic Medicaid Fair Hearing in the above-styled case on July 26, 2023, at 1:00 p.m., Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner: [redacted]
Petitioner's Authorized Representative

For the Respondent: Diana Hearod
Medical Healthcare Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Respondent proved by a preponderance of the evidence that Respondent's termination of Prescribed Pediatric Extended Care ("PPEC") services was correct.

PRELIMINARY STATEMENT

All parties appeared telephonically. [redacted] ("[redacted]"), Petitioner's Authorized Representative, appeared on behalf of Petitioner.

Diana Hearod, Medical/Health Care Program Analyst for the Agency for Health Care Administration ("AHCA" or "Agency"), appeared on behalf of the Respondent. Dr. Chris Kunis, M.D. ("Dr. Kunis"), Chief Medical Director at eQHealth Solutions, Inc. ("eQHealth"), appeared as a witness for the Respondent.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a two hundred and ninety-seven (297)-page evidence packet and a forty-six (46)-page evidence packet. The two hundred and ninety-seven (297)-page evidence packet appears in the Office of Fair Hearings' document management system as file title "[redacted] FH 07.07.2023.pdf." The forty-six (46)-page evidence packet appears in the Office of Fair Hearings' document management system as the file title "23-FH1449 AHCA PPEC Evidence.pdf.pdf". Absent an objection from the Petitioner, the undersigned admitted the two hundred and ninety-seven (297)-page evidence packet into evidence as Respondent's Composite Exhibit 1 ("RCE 1") and the forty-six (46)-page evidence packet into evidence as Respondent's Composite Exhibit 2 ("RCE 2").

Petitioner did not submit evidence in this case.

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 is an [redacted] ([redacted] old [redacted] at the time of the present hearing. *Id.* at 16. Petitioner is diagnosed with the following: [redacted] *Id*. at 17, 66.

3. Petitioner is not ventilator dependent, nor does [redacted] use a BiPap/CPAP or oxygen. *Id.* at 46. Petitioner does not have a gastrostomy tube or nasogastric tube. *Id*.

4. Petitioner's current medications are [redacted], [redacted] tab every [redacted] before going to [redacted], as needed; alternative is [redacted] as needed. *Id*. at 18. There are no scheduled medicines for Petitioner. *Id*. at 45, 67. Petitioner's nursing needs consist of daily, as needed, medications and monitoring. *Id*. at 26.

5. Petitioner was not [redacted]. *Id.* at 66, 67. Petitioner had an [redacted], where [redacted] was given [redacted] and [redacted] by the [redacted] on the same day. *Id*. at 18, 66. Petitioner had a second [redacted], where [redacted] was given [redacted]. *Id*. Petitioner made [redacted] annual visit to her [redacted] on [redacted], where [redacted] was found to be in [redacted]. *Id*. According to the Florida Home Health Assessment Tool, dated [redacted], ("FL HH Assessment), Petitioner's overall status as being [redacted]" *Id*. at 44.

6. Petitioner attends school and PPEC afterschool and non-school days. *Id.* at 18, 45.

7. Petitioner lives with [redacted] and [redacted] *Id*. at 18, 45 - 46. [redacted] is the only child in the household. Id. at 18, 46. The [redacted] works outside of the home. *Id*. at 18, 45.

8. Petitioner requested the continuation of partial day and full day PPEC services for the certification period of May 27, 2023, through November 22, 2023. *Id*. at 25.

9. On June 6, 2023, eQHealth sent Petitioner a Notice of Outcome ("Notice") terminating

Petitioner's PPEC services. *Id.* at 24 - 27. The Notice explained that the requested services were terminated because they were not medically necessary and explained as follows:

> The request for services is denied in whole or in part because they are not medically necessary as defined in 59G-1.010, Florida Administrative Code. Specifically the requested services are not medically necessary under the following standard(s):
>
> Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.
>
> The rationale for our decision is as follows:
>
> PR Principal Reason – Denial:
>
> Submitted information does not support the medical necessity for requested services.
>
> Clinical Rational for Decision: [redacted] with [redacted]. The patient is [redacted] Nursing needs consist of daily/PRN needs and monitoring.
>
> Deny all PPEC units. The patient lacks sufficient skilled nursing needs to warrant PPEC care.
>
> Date of Action is 6/9/2023.

Pages 25 - 26 of RCE 1.

10. On June 12, 2023, Petitioner requested a Fair Hearing due to Respondent's termination of PPEC services. The undersigned scheduled and convened a telephonic Medicaid Fair Hearing in the above-styled case on July 26, 2023, at 1:00 p.m. EST, and all parties were duly notified.

11. Dr. Kunis' testimony established that Petitioner's PPEC services were terminated because based on the documentation submitted by the PPEC provider Petitioner no longer met the criteria for medical necessity. Dr. Kunis stated that upon his review of Petitioner's PPEC records, the Petitioner is receiving [redacted] and no longer has a need

for skilled nursing services. Dr. Kunis testimony established that based on his and his peers' review of Petitioner's medical records, Petitioner is [redacted] Dr. Kunis noted that Petitioner follows with [redacted] yearly, who in [redacted] found [redacted] stable. Petitioner has not had any reported [redacted]. Dr. Kunis acknowledged that Petitioner had two [redacted], but each time [redacted] was [redacted]. Dr. Kunis concluded that Petitioner's nursing needs appear to consist of monitoring and supervision, therefore, Petitioner lacks sufficient skilled nursing needs to warrant PPEC care.

12. [redacted] testified that while Petitioner does appear to be in stable condition, [redacted] main concern is the fact that Petitioner does have [redacted], which is a [redacted], and other consequences leading to [redacted]. [redacted] contends that Petitioner needs the skilled nursing care that [redacted] receives at PPEC, including being monitored for [redacted], as needed, [redacted], and [redacted]. [redacted] acknowledged that, to date, Petitioner has had [redacted], and that [redacted] attends school regularly with no skilled nursing care during school hours.

CONCLUSIONS OF LAW

13. 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), Florida Statutes. This order is the final

administrative decision of AHCA under section 409.285(2)(a).

14. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R.59G-1.100(17)(b), which states "[e]ach fair hearing shall be a de novo, evidentiary proceeding, and shall be conducted in a manner that meets the requirements of this rule."

15. The burden of proof in this proceeding is governed by Fla. Admin Code R. 59G-1.100(17)(g), which provides as follows:

> The burden of proof is on the party asserting the affirmative of an issue, except as otherwise required by statute. The burden of proof is on the Agency or plan, whichever is applicable, when the issue presented is the suspension, reduction, or termination of a previously authorized service. The burden of proof is on the recipient or enrollee, when the issue presented is the denial or a limited authorization of a service. The party with the burden of proof shall establish its position to the satisfaction of the Hearing Officer by a preponderance of the evidence.

16. In the instant case, Respondent terminated Petitioner's PPEC services. As such, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to Respondent. 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.)

17. The PPEC Policy, incorporated by reference in Fla. Admin. Code R. 59G- 4.260, governs PPEC services available under Florida Medicaid. The PPEC Policy provides the following:

> • **Description**
> Florida Medicaid prescribed pediatric extended care (PPEC) services provide skilled nursing supervision and therapeutic interventions in a non-residential setting to medically dependent or technologically dependent recipients.
> . . . .
> **1.3.7 Medically Necessary/Medical Necessity**
> As defined in Rule 59G-1.010, F.A.C.
> . . . .

2.2 Who Can Receive

Florida Medicaid recipients under the age of 21 years requiring medically necessary PPEC services and who:

- Require continuous therapeutic interventions or skilled nursing supervision, as described in section 400.902, F.S. and in Rule 59A- 13.007, F.A.C.
- Are determined medically stable by a physician and who are not a threat to self or others

Some services may be subject to additional coverage criteria as specified in section

. . . .

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid covers PPEC services provided in accordance with section 400.902, F.S., the applicable Florida Medicaid fee schedule, or as specified in this policy, on a full or partial day basis. Services must include the following at a minimum:

- Caregiver training
- Developmental therapies
- An appropriate escort for travel to and from the PPEC when Florida Medicaid nonemergency transportation is provided
- Medical services
- Nursing services
- Personal care services
- Psychosocial services
- Respiratory therapy services

The PPEC day begins when the recipient arrives at the PPEC or is picked up for escorted transportation to the PPEC.

The PPEC day ends when the recipient departs from the PPEC for the day or is returned home by escorted transportation from the PPEC.

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services,

treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's General Policies on authorization requirements.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not covered when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

5.2 Specific Non-Covered Criteria

Florida Medicaid does not cover the following as part of this service benefit:

- A full day and a partial day of PPEC services on the same date of service, for the same recipient
- Early intervention services when billed separately
- Food or formulas
- Supportive or contracted services as defined in section 400.902, F.S.
- Transportation services

Some services may be reimbursed through another Florida Medicaid-covered service. Please refer to the service-specific coverage policy for more information.

. . . .

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for- service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid's General Policies on authorization requirements.

7.2 Specific Criteria

Providers must obtain authorization from AHCA, or its designee, every 180 days or more frequently if there is a change in the recipient's condition requiring an alteration in services.

Providers must submit a discharge request to AHCA, or its designee, to terminate a recipient's services. The discharge request must include both of the following:

- Last date services were provided to the recipient
- Number of units of service used during the current authorization period (through the discharge date)

18. Section Rule 59A-13.007(4)(a), F.A.C. states the following:

> (4) Each child admitted for service to a PPEC center must meet at least the following criteria:
> (a) Infants and children considered for admission to the PPEC center will be those who are medically or technologically dependent. . . .
> . . .

Further, section 400.902, F.S described "medically dependent or technologically dependent child" as follows:

> [A] child who because of a medical condition requires continuous therapeutic interventions or skilled nursing supervision which must be prescribed by a licensed physician and administered by, or under the direct supervision of, a licensed registered nurse.

19. Rule 59G-4.290 defines skilled nursing as follows:

(3) Skilled Services Criteria.

a) To be classified as requiring skilled nursing or skilled rehabilitative services in the community or in a nursing facility, the recipient must require the type of medical, nursing or rehabilitative services specified in this subsection.
b) Skilled Nursing. To be classified as skilled nursing service, the service must meet all of the following conditions:
    1. Ordered by and remain under the supervision of a physician;
    2. Sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse.
    3. Required to be performed by, or under the direct supervision of, a registered nurse or other health care professionals for safe and effect performance;
    4. Required on a daily basis;
    5. Reasonable and necessary to the treatment of a specified documented illness or injury; and,
    6. Consistent with the nature and severity of the individual's condition or the disease state or stage.
c) Examples of services that qualify as skilled nursing services:
    1. Intravenous medication or fluids.
    2. Intramuscular or subcutaneous injection and hypodermoclysis when:
    a. Administered by licensed nursing personnel at least 5 times weekly, excluding daily insulin administration; and,

b. Observation is necessary to assess the recipient's response to treatment or to identify adverse reactions.

3. Management and monitoring medication regime on a daily basis:

a. For drugs whose dosage requirements may rapidly change;

b. For drugs prone to cause adverse reactions, severe side effects or unfavorable reactions; and,

c. For residents with unstable reactions.

4. Levin tube and gastrostomy feedings; excluding feedings performed by residents, family members, or friends.

5. Administration of medical gases, aerosolized medication or oxygen which is started, monitored and regulated by professional staff.

6. Naso-pharyngeal and tracheotomy aspiration, excluding tracheotomy care in self-care residents.

7. Insertion, replacement, and sterile irrigation of catheters when:

a. Medically necessary or required for reasons other than to maintain satisfactory catheter functioning and dryness;

b. The medical need is documented by the physician;

c. Continuous irrigation, frequent insertion, special care or observation is required because of bleeding, infection, obstruction, or heavy sediment formations; and,

d. Care of a recently inserted supra-pubic catheter, inserted within 2-4 weeks, is required.

8. Colostomy and ileostomy care:

a. When medically necessary and required during early postoperative period;

b. During the period of initial self-care training, or

c. when complications are present and documented in the medical record.

9. Treatment of decubitus ulcers when:

a. Deep or wide without necrotic center;

b. Deep or wide with layers of necrotic tissue, or

c. Infected and draining.

10. Treatment of widespread infected or draining skin disorders.

11. Application of dressings involving prescription medication and aseptictechniques when documented as required on a daily basis. Excludes simple dressings involving non-infected cases, simple skin breaks, and healed postoperative incisions.

12. Heat treatments prescribed by a physician as daily treatment for a specific condition.

13. Rehabilitation nursing procedures required on a daily basis as necessary to restore functioning, including teaching and adaptive aspects of nursing.

20. Since the Petitioner is under twenty-one years old, the Early and Periodic Screening, Diagnosis, and Treatment ("EPSDT") requirements apply to the request for PPEC services. *See* 42 U.S.C. §§ 1396d(r)(1)-(S). Section 409.905, Florida Statutes, states:

> **(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES**.—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.

21. Once it is determined that EPSDT applies to a request for a service, the Florida Medicaid program determines the amount or necessity for that service based on the State of Florida's published definition of medical necessity. The Definitions Policy, which is incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines "medically necessary" or "medical necessity" as follows:

> **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 severe 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.

22. The Authorization Requirements Policy, incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides general requirements for providers to obtain authorization to render Florida Medicaid services. It states the following:

1.2 Definitions
The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.
. . .
1.3.1 Authorization
The process of obtaining approval for reimbursement of a service based on medical necessity.
. . .
1.3.6 Provider
The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.
1.3.7 Quality Improvement Organization
Entity designated to perform utilization review, quality assurance, and quality improvement activities for Florida Medicaid-covered services rendered by fee-for- service providers (also known as the QIO).
. . .
2.0 Authorization Requirements
2.4.2 Requests for Additional Information
The QIO may request additional information, as necessary, to determine medical necessity.
. . .
3.0 Determination Process
3.1 Review Criteria
The QIO may use a national standardized set of criteria, or other set of criteria, approved by AHCA, as a guide for authorizations performed at the first review level. If services cannot be approved at the first level review, the QIO's physician peer reviewer will determine medical necessity using his or her clinical judgment, acceptable standards of care, state and federal laws, and AHCA's medical necessity definition.

3.2 Review Process

The QIO will review each authorization request and will approve, deny, or request additional information. The QIO may deny a portion of the requested units of service if it cannot substantiate medical necessity based upon the information submitted.

3.2.1 Continued Authorization Requests

The QIO shall not deny or reduce the amount, frequency, or duration of a service that is already being provided, unless:

- The reduction is to correct for factual errors or omissions in prior certifications.
- There is a documented improvement in the recipient's medical condition.
- There is a documented change in the recipient's circumstances.
- The reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level.

Florida Medicaid Authorization Requirements Policy, pages 1-3.

23. In the instant case, Petitioner requested PPEC services for the certification period of May 27, 2023, through November 22, 2023. *See supra* ¶ 8. As established on the record by the testimony and evidence, eQHealth terminated Petitioner's PPEC services, because the PPEC services were not medically necessary. *See supra* ¶ 9.

24. Florida Medicaid covers PPEC services that: are determined medically necessary; do not duplicate another service; and meet the criteria as specified in the PPEC Policy. *See supra* ¶ 17. PPEC provides "skilled nursing supervision and therapeutic interventions in a non-residential setting to medically dependent or technologically dependent recipients." *See supra* ¶ 17.

25. In this case, there was no testimony or evidence that Petitioner requires "skilled nursing supervision and therapeutic interventions" at a PPEC facility. The documentation regarding Petitioner's medical status, *see supra* ¶¶ 2 – 7, reflects that Petitioner does not meet the definition of a "medically dependent or technologically dependent child" as Petitioner is not "a

child who because of a medical condition requires continuous therapeutic interventions or skilled nursing supervision which must be prescribed by a licensed physician and administered by, or under the direct supervision of, a licensed registered nurse." *See supra* ¶ 18. Specifically, Petitioner is not ventilator dependent, nor does [redacted] use a Bi-Pap, C-Pap, oxygen, or tracheotomy. *See supra* ¶ 3. Petitioner does not have gastrostomy tube or nasogastric tube; or wound care issues. *See supra* ¶ 3. Petitioner had [redacted] in the previous certification period: [redacted] In both instances, Petitioner was [redacted] was [redacted]. *See supra* ¶ 5. [redacted] *See supra* ¶ 5. Petitioner's overall condition is presently [redacted]" *See supra* ¶ 5. Petitioner has no scheduled medications. *See* supra ¶ 4. Petitioner's nursing needs consist of daily medications, as needed, and monitoring. *See supra* ¶ 4.

26. Section 2.83 of the Definitions Policy mandates that to be medically necessary, "[t]he medical or allied care, goods, or services furnished or ordered must - [b]e 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;" and "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." *See supra* ¶ 21. Based upon the aforementioned facts and evidence, *supra* ¶ 25, Respondent demonstrated that the request for PPEC services was in excess of what Petitioner needs. Thus, Respondent established that the requested PPEC services are not medically necessary, as defined in Fla. Admin. Code R. 59G- 1.010, and required

by section 1.3.7 of the PPEC Policy. Looking at all the evidence relevant to the particular needs of Petitioner, the PPEC services at issue are not necessary to correct or ameliorate a defect or a physical and mental illness or condition.

27. In light of the parties' testimony, Respondent's Composite Exhibit 1, Respondent's Composite Exhibit 2, the PPEC Policy, the Authorization Requirements Policy, and the Definitions Policy, Respondent proved by a preponderance of the evidence that Respondent's termination of Petitioner's PPEC services was correct.

DECISION

Respondent's termination of Petitioner's PPEC services for the certification period of May 27, 2023, through November 22, 2023, is **AFFIRMED**. Petitioner's appeal based on Respondent's termination of PPEC services is hereby **DENIED**.

DONE and **ORDERED** this 12th day of September, 2023 in Tallahassee, Leon County, Florida.

Debbie K. Winicki
23-FH1449
2023.09.12 08:45:34 -04'00'

DEBBIE WINICKI, Hearing Officer
Agency for Health Care Administration
Office of Fair Hearings
2727 Mahan Drive, Mail Stop # 11
Tallahassee, FL 32308

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]

AHCA Medicaid Hearing Unit
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