



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

FILED

Oct 11, 2023, 11:02 am

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH1778

Plan ID No.: [REDACTED]

vs.

CHILDREN'S MEDICAL SERVICES,

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the Office of Fair Hearings convened a telephonic Medicaid Fair Hearing in the above styled case on September 5, 2023, at 9:03 a.m. Eastern Standard Time ("EST").

**APPEARANCES**

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Chantal Pierre  
Clinical Appeals Coordinator  
Sunshine State Health Plan, Inc.

**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 [REDACTED] [REDACTED] or "medical equipment") was incorrect.

**PRELIMINARY STATEMENT**

All parties appeared telephonically. Petitioner's Authorized Representative and [REDACTED] appeared at the Fair Hearing on behalf of Petitioner. Dr. Antonio Rodriguez, Director of Pediatric Pulmonology at [REDACTED] and Petitioner's Pulmonologist, appeared at the Fair Hearing as a witness for Petitioner.

Chantal Pierre, Clinical Appeals Coordinator, for Sunshine State Health Plan, Inc. ("Sunshine Health") appeared at the Fair Hearing on behalf of Respondent. Dr. Don Fillipps ("Dr. Fillipps"), Medical Director for Children's Medical Services under Sunshine Health, appeared as a witness for Respondent. The following employees of Sunshine Health attended as witnesses but did not testify at the Fair Hearing: Michelle Johnson, Care Manager for Children's Medical Services, and Marie Pierre, Children's Medical Services Supervisor. The following employees of Children's Medical Services appears at the Fair Hearing as observers and did not provide testimony: Katelyn Boswell, attorney for Florida Department of Health Children's Medical Services; Aldria White-Futrell, Compliance Officer with Florida Department of Health Children's Medical Services; Dr. Mansooreh Salari, Children's Medical Services Medical Director; and Raquel Smith, Manager with Children's Medical Services.

Doris Rivera, Medical Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared for the Fair Hearing as an observer.

Petitioner did not submit any documents prior to the hearing.

Prior to the Fair Hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and fifty-one (151)-page evidence packet. The evidence appears in the Office of Fair Hearings' document management system as "MFH packet [Petitioner's surname].pdf." Absent

an objection from Petitioner, the undersigned admitted the one hundred and fifty-one (151)-page evidence packet into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”).

**FINDINGS OF FACT**

1. Petitioner is an enrolled member of Sunshine Health. See RCE 1 at page 2. Sunshine Health is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida.

2. As of the date of the Fair Hearing, Petitioner is [REDACTED]. *Id.* at 10. Petitioner has the following medical conditions: [REDACTED]  
[REDACTED] *Id.* at 21, 25, 29, and 55.

3. On April 12, 2023, Petitioner requested approval for the [REDACTED]. *Id.* at 4. In the Notice of Adverse Benefit Determination (“NABD”), Respondent denied Petitioner’s request as of April 9, 2023. *Id.* at 4 – 9. The NABD explained the basis of the decision as follows:

- We determined that your requested services are not medically necessary because the services do not meet either of the reasons checked below: (See Rule 59G-1.010)  
...  
Must be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not be in excess of your child’s needs  
...
  - Other Authority

The facts that we used to make our decision are: InterQual 2022: Secretion Clearance Devices and Centene Clinical Policy on Durable Medical Equipment. This decision was made with regards to Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT).

Rationale: The request to authorize a [REDACTED] for airway clearance is denied based on a lack of documented (record) medical necessity (need). The clinical notes that we received do not indicate your child has any of the following conditions:

[Redacted text block]

...  
RCE 1 at 4 – 5.

4. On May 4, 2023, Petitioner requested a plan appeal and received a Notice of Plan Appeal Resolution (“NPAR”), dated May 19, 2023, denying Petitioner’s appeal. *Id.* at 72 – 75. The NPAR states, in pertinent part:

[Redacted text block]

[Redacted text block]

[Redacted text block]

[Redacted text block]

[Redacted text block]

t [REDACTED]  
[REDACTED].

...

RCE 1 at 72 – 73.

5. On July 14, 2023, Petitioner requested a Fair Hearing to challenge the denial of the [REDACTED]. On August 18, 2023, the Hearing Officer issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for September 5, 2023, at 9:00 a.m. EST.

6. Petitioner’s authorized representative and [REDACTED], testified as follows:

- a. Petitioner currently has the [REDACTED] and has had it since [REDACTED] or the beginning [REDACTED]. [REDACTED] received information that [REDACTED] has one hundred and twenty (120) days to return the [REDACTED].
- b. Petitioner cannot [REDACTED] and it is not enough. The [REDACTED] system helps Petitioner a lot with [REDACTED] [REDACTED], so [REDACTED] won’t have to [REDACTED], and helps Petitioner not [REDACTED]. [REDACTED] does not like to [REDACTED] [REDACTED] because Petitioner does not like it.
- c. [REDACTED] does not like to give Petitioner medicine that is invasive or not necessary.
- d. Petitioner’s [REDACTED] [REDACTED], but [REDACTED] is concerned that it might.
- e. Petitioner is having more [REDACTED] this year.
- f. Both of Petitioner’s [REDACTED] as of a few months ago.
- g. Petitioner was recently diagnosed with [REDACTED].

h. [REDACTED] received a list of all of Petitioner's diagnosis from the hospital but did not provide the list.

7. Petitioner's Pulmonologist, Dr. Rodrigez, testified as follows:

a. Dr. Rodrigez has been following Petitioner since [REDACTED]. Petitioner is a complicated patient. Petitioner has significant [REDACTED].

b. Petitioner is [REDACTED].

c. Petitioner has [REDACTED]

d. Petitioner has difficulty [REDACTED].

e. The [REDACTED] helps [REDACTED] from Petitioner's [REDACTED].

f. In pediatrics, the diagnosis of children with [REDACTED]  
[REDACTED]  
[REDACTED]

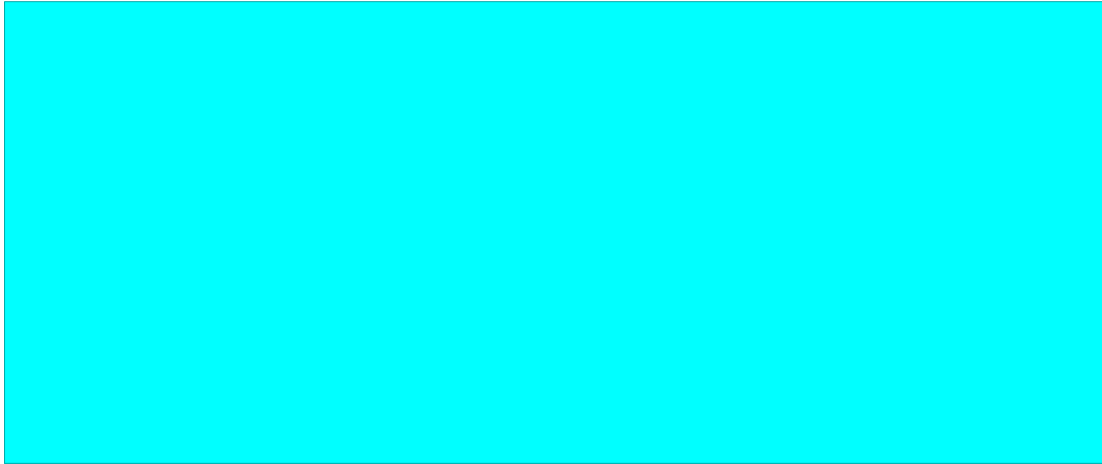
g. A [REDACTED] has not been done that shows Petitioner has [REDACTED]

8. Petitioner's doctor, Dr. Alicia Della-Volpe with [REDACTED], Inc., signed a prescription/order form, prescribing the [REDACTED] for Petitioner. *Id.* at 35.

9. [REDACTED], Registered Nurse and Clinical Reimbursement Advocate for [REDACTED], provided a letter on behalf of Petitioner requesting an approval of the [REDACTED]. The letter states, in pertinent part:

[REDACTED]  
[REDACTED]  
[REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED]



...  
RCE 1 at 31 – 33.

10. Dr. Phillips is a Long-Term Care Medical Director for Sunshine Health. Dr. Carter testified as follows:

- a. Respondent has not received any information or evidence that Petitioner has [REDACTED].
- b. Petitioner having the [REDACTED] is a disservice to Petitioner.
- c. The [REDACTED] company is notorious for providing [REDACTED] to members when they have not received approval to provide [REDACTED]. It is a difficult situation when a member has the [REDACTED] in hand and then is informed they do not have approval and need to turn the [REDACTED] back in.
- d. There is no indication in any of the documents that Petitioner's [REDACTED] [REDACTED] is such that [REDACTED] has [REDACTED] qualities to the [REDACTED] like you would say in an adult would be [REDACTED]
- e. The review for the request was based on the information that was provided and on the diagnoses listed on page 55 of RCE 1: [REDACTED]

[REDACTED]

- f. There is no evidence that Petitioner has a condition that would impair the [REDACTED]
- g. Respondent uses the national standard of care criteria when reviewing cases called InterQual Criteria. Respondent provided the InterQual<sup>®</sup> 2022, Apr. 2022 CP: Durable Medical Equipment Criteria. See RCE 1 at 91 – 98. Petitioner did not meet criteria for approval of a [REDACTED]. Petitioner did not have any evidence of [REDACTED]
- h. Respondent denied Petitioner’s request based on the InterQual Criteria.
- i. Petitioner was approved for a [REDACTED]. It makes sense for someone who has [REDACTED] to need to have help [REDACTED] by giving them a device to provide a more effective [REDACTED]
- j. With Petitioner’s diagnosis and information submitted, there is no evidence that Petitioner met criteria to have the [REDACTED]

#### **CONCLUSIONS OF LAW**

11. The Agency’s Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties pursuant to Fla. Stat. § 409.285(2)(2019). This order is the final administrative decision of AHCA under Fla. Stat. § 409.285(2)(a).
12. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 59G-1.100(17)(b).

13. 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.)

14. 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,  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.

...

Pages 1-2; and 2-3 of DME Policy.

15. 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.

...

Page 2-10 of DME Policy.

16. The Florida Medicaid Definitions Policy (August 2017) (“Definitions Policy”), incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines “Medically Necessary” or “Medical Necessity” as follows:

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.

Definitions Policy at page 7.

17. 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.

18. Petitioner is under age 21, and therefore EPSDT applies to [redacted] 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.

19. In the instant case, Petitioner requested approval for the [redacted]. See supra ¶ 3. In the NABD dated April 9, 2023, Respondent denied Petitioner’s request, stating Petitioner’s request was not “individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury” and was “in excess of your child’s needs”. *Id.* The evidence shows that Petitioner is not afflicted by any of the conditions that would warrant a [redacted], i.e. [redacted]. As such, the [redacted] [redacted] is not consistent with symptoms or confirmed diagnosis of the illness or injury. Further, the NABD stated that the request was denied “based on a lack of documented (record) medical necessity (need).” *Id.* The evidence from Respondent states that the clinical notes received do not indicate that Petitioner has [redacted] [redacted], and that there is no indication in any of the documents that Petitioner’s [redacted] is such that [redacted] has [redacted] qualities to the [redacted] [redacted] [redacted] [redacted] [redacted]

20. As Petitioner bears the burden of proof, *see supra* ¶ 13, Petitioner must show that Respondent’s denial was incorrect. Petitioner’s authorized representative and pulmonologist testified that Petitioner needed the [REDACTED] system because Petitioner cannot [REDACTED]. *See supra* ¶ 6 – 7. However, Respondent’s NABD stated Petitioner’s request to authorize a [REDACTED] for clearway was denied based on a lack of documented for medical necessity. *See supra* ¶ 3. Further, Respondent stated that the clinical notes received do not indicate that Petitioner has [REDACTED]. *Id.* In direct support, Dr. Fillips testified that there is no indication in any of the documents that Petitioner’s chronic lung disease is such that [REDACTED]. *See supra* ¶ 10.

21. Petitioner provided a prescription from [REDACTED] doctor prescribing the [REDACTED] and a letter from a registered nurse requesting the [REDACTED]. *See supra* ¶ 8 – 9. However, the fact that a provider prescribed, recommended, or approved medical or allied care, goods, or services does not, itself, make such care, goods, or services medically necessary or a medical necessity or a covered service. *See supra* ¶ 16.

22. [REDACTED] testified that [REDACTED] wants Petitioner to have the [REDACTED] because [REDACTED] does not like to give Petitioner other treatments or medicine that is invasive. *See supra* ¶ 6. However, services cannot be furnished in a manner primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider. *See supra* ¶ 15. Further, [REDACTED] stance indicates [REDACTED] awareness of other treatment options for Petitioner. As such, Petitioner’s


request is in opposition to the prong of medical necessity that states allied care, goods, or services must “[b]e 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 ¶ 16.

23. 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 DME at issue is medically necessary for Petitioner. Looking at all the evidence relevant to the particular needs of Petitioner, Petitioner has not demonstrated that the [REDACTED] is 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 the denial of durable medical equipment was incorrect.

**DECISION**

Respondent’s denial of durable medical equipment is **AFFIRMED**. Petitioner’s appeal based on Respondent’s denial in this matter is **DENIED**.

**DONE AND ORDERED** this 11th day of October, 2023 in Tallahassee, Leon County, Florida.

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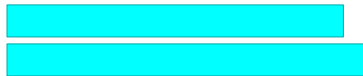
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**KAMEISHA PRESLEY, Hearing Officer**  
**Agency for Health Care Administration**  
**Office of Fair Hearings**  
**2727 Mahan Drive, Mail Stop # 11**  
**Tallahassee, FL 32308-5407**

**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:**



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CMSPlanContract@flhealth.gov**

**AHCA Medicaid Hearing Unit  
MedicaidHearingUnit@ahca.myflorida.com**