

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



FILED

Jan 25, 2024, 2:03 pm

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 23-FH2551

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on December 5, 2023, at 1:00 p.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner’s Authorized Representative

For the Respondent:

Linda Latson
Registered Nurse Specialist
Fair Hearing Liaison

STATEMENT OF ISSUE

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent’s decision to deny 2 additional hours of physical therapy (“PT”) per week was incorrect.

PRELIMINARY STATEMENT

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

Linda Latson, ("Ms. Latson") Registered Nurse Specialist and Fair Hearing Liaison for the Agency for Health Care Administration ("Agency"), appeared on behalf of Respondent. Dr. Rakesh Mittel ("Dr. Mittel"), Medical Director for the eQHealth Solutions, Inc., appeared as a witness for Respondent.

Prior to the hearing, Respondent sent to the Office of Fair Hearings a fifty-four (54)-page evidence packet and a forty-four (44)-page evidence packet. The fifty-four (54)-page evidence packet appears in the Office of Fair Hearings document management system as the file titled "[REDACTED] FH12.05.2023.pdf." Absent an objection from the Petitioner, the undersigned admitted the fifty-four (54)-page evidence packet into evidence as Respondent's Composite Exhibit 1 ("RCE 1"). The forty-four (44)-page evidence packet appears in the Office of Fair Hearings document management system as the file titled "23-FH2551 AHCA Evidence Pysical(sic)Therapy Svcs 44 Pages.pdf." Absent an objection from the Petitioner, the undersigned admitted the forty-four (44)-page evidence packet as Respondent's Composite Exhibit 2. ("RCE2")

FINDINGS OF FACT

1. AHCA is a single state agency responsible for administering the Medicaid program and for ensuring compliance with state and federal Medicaid Rules. *See* RCE 2 at 3.
2. Petitioner receives Medicaid services on a fee-for-service basis from the Agency. *See* RCE 1 at 16. eQHealth is a Quality Improvement Organization ("QIO") contracted by the Agency to review prior authorization requests for services. *See* RCE 2 at 2. The Agency through contractual

agreement authorized eQHealth to make medical necessity determinations regarding requests for fee-for-service Medicaid services requiring prior authorizations. *Id.*

3. Petitioner is [REDACTED]. RCE 1 at 41. Petitioner’s medical history includes [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. *Id.* at 16, 41. Petitioner’s provider requested authorization for 2 additional hours of physical therapy (“PT”) per week. *Id.* at 22. Petitioner’s Care Plan signed by Dr. Ana Dominguez, dated August 23, 2023, states:

[REDACTED]

Its is recommended to continue with therapy sessions and to be increased 3 times per week to maximize [REDACTED] functional and achievement to the modified goals and POC.

[REDACTED] presents with [REDACTED]

Id. at 51.

4. On August 28, 2023, Respondent issued a Notice of Outcome (“NOO”) denying Petitioner’s request for 2 additional hours of PT per week. *Id.* at 22-23. The NOO explained the basis for the denial as follows:

The request for services is denied in whole or in 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 standards:

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 the requested frequency and/or duration. Therapy services are approved for the partial length of service requested, based on the documentation provided.

Clinical Rationale for Decision: Provider is requesting to increase PT from x 1 visit per week > x 3 visits per week. Clinicals as submitted do not justify increase in PT. Approve PT x 1 visit per week, as approved previously, and deny the rest.

Id. at 22-23.

5. On October 5, 2023, Petitioner requested a Fair Hearing to challenge the denial of 2 additional hours of physical therapy per week. On November 21, 2023, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for December 5, 2023, at 1:00 p.m. EST.

6. [REDACTED], Petitioner’s Authorized Representative and [REDACTED] testified as follows:

a. [REDACTED] was authorized to have 3 hours of physical therapy per week prior to the pandemic.

b. [REDACTED] is [REDACTED]
[REDACTED].

c. [REDACTED] believes [REDACTED] is worse than [REDACTED] was [REDACTED] years ago.

7. Dr. Mittel, Medical Director with eQHealth, testified as follows:
 - a. Petitioner’s request was reviewed by a team of professionals including a Board-Certified physician as well as physical therapists. The team reviewed the documentation from Petitioner’s provider.
 - b. Petitioner has had no decline in [REDACTED] functional status pursuant to the Physical Therapy Evaluation (“PT Evaluation”). *Id.* at 41.
 - c. Petitioner’s FL HH Assessment 2017, (“Assessment”) concluded that [REDACTED] is able to transfer independently. *Id.* at 40. The PT Evaluation states that Petitioner is able to stand and ambulate without assistance, and the functional assessments in the evaluation were otherwise within normal limits from a physical therapy standpoint. *Id.* at 45-46.
 - d. After a review of the Assessment and PT Evaluation, it was concluded that there was no need for an increase in physical therapy, therefore, Petitioner was approved for one hour of physical therapy per week.

CONCLUSIONS OF LAW

8. 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 (2021). This order is the final administrative decision of AHCA under section 409.285(2)(a).
9. This hearing was held as a *de novo* proceeding pursuant to Florida Administrative Code Rule (“Fla. Admin. Code R.”) 59G-1.100(17)(b).
10. Because Petitioner requested additional services, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the 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.).

11. The Florida Medicaid Physical Therapy Services Coverage Policy (October 2016) (“PT Policy”), incorporated by reference in Fla. Admin. Code. R. 59G-4.320, governs PT services available under Florida Medicaid. The PT Policy provides as follows in pertinent part:

1.1 Description

Physical therapy services develop, maintain, improve, or restore neuro-muscular or sensory- motor function to relieve pain, acquire a skill set, restore a skill set, or control postural deviations.

1.1.1 Florida Medicaid Policies

This policy is intended for use by physical therapy providers that render services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid’s General Policies (as defined in section 1.3) and any applicable service- specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration’s (AHCA) Web site at <http://ahca.myflorida.com/Medicaid/review/index.shtml>.

1.1.2 Statewide Medicaid Managed Care Plans

Florida Medicaid managed care plans must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients enrolled in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

1.3 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.

...

1.3.4 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

1.3.5 Provider

The term used to describe any entity, facility, person, or group enrolled with AHCA to furnish services under the Florida Medicaid program in accordance with the provider agreement.

1.3.6 Recipient

For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

...

2.0 Eligible Recipient

2.1 General Criteria

An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who Can Receive

Florida Medicaid recipients requiring medically necessary physical therapy services. Some services may be subject to additional coverage criteria as specified in section 4.0.

If a service is limited to recipients under the age of 21 years, it is specified in section 4.0. Otherwise, the service is covered for recipients of all ages.

...

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

...

4.3 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.

13. The Florida Medicaid Authorization Requirements Policy (“Authorization Requirements Policy”) (June 2016), incorporated by reference in Rule 59G-1.053, F.A.C., states, in pertinent part:

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.

...

1.3.7 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 error 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.

Id. at 32 - 34.

15. Given that Petitioner is twenty (20) years old, the Medicaid permits coverage for the services at issue. However, a state may place medical necessity limitations on Early and Periodic Screening, Diagnosis, and Treatment ("EPSDT") services. See 42 C.F.R. §§ 440.230(a), (b), (d).

Pursuant to section 409.905(2), Florida Statutes:

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. 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 definition of medical necessity. The Definitions Policy, which is incorporated by reference in Rule 59G-1.010, F.A.C., defines 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.

Id. at 23.

17. Respondent denied Petitioner's request for an additional two (2)- hours per week of physical therapy services. *See* ¶ 4. Respondent determined that the submitted information did not support the medical necessity of the requested additional services. Specifically, additional services were not shown to be "Individualized, specific and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs." *See* ¶ 4.

18. As stated in the PT Policy, Florida Medicaid covers services that meet all of the following: are determined to be medically necessary, do not duplicate another service, and meet the criteria as specified in the PT policy. *See* ¶ 12.

19. 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, one component of medical necessity is that services must be "[i]ndividualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs." *See* ¶ 11, 16.

20. Here, Dr. Mittal provided credible and persuasive testimony that Petitioner's condition did not warrant the requested additional physical therapy services requested. *See* ¶ 7. Dr. Mittal testified that Petitioner has had no decline in functional status and is able to stand and ambulate without assistance. *Id.* Therefore, the record shows that physical therapy is not warranted at the

frequency requested by Petitioner. See ¶ 3, 7. Dr. Mittal stated that Petitioner does not need an additional two (2)-hours per week of physical therapy. Therefore, Petitioner's request for additional physical therapy sessions would be "in excess of the patient's needs." See ¶ 7,16.

21. PT Policy makes clear that the plan of care ("POC") is the foundation of the delivery of PT services. See ¶ 11. The POC must be detailed enough to warrant the requested services, a providers must ensure that proper justification for the requested services is adequately documented in the POC. See ¶ 11. At the Fair Hearing, [REDACTED] asserted that [REDACTED] believes [REDACTED] is worse than [REDACTED] was [REDACTED] years ago. See ¶ 6. However, that position was not supported in the record. As Dr. Mittal testified, the PT Evaluation stated that Petitioner had not experienced a decline in functional status. Thus, the documentation submitted did not support Petitioner's request for an additional two (2) hours per week of PT services.

22. The POC identifies the medical condition (including diagnostic codes), a recipient's functional limitations, the specific therapy to be provided, the short and long-term therapeutic goals and objectives, medications, treatment, equipment, treatment frequency, length, and duration, therapeutic methods and monitoring criteria, diet if applicable, means of demonstrating and teaching the recipient, family and other relevant caregivers, and coordination with other prescribed services. See ¶ 14.

23. As Petitioner bears the burden of proof, the record must demonstrate that it is medically necessary for Petitioner to receive 2 additional hours per week of PT services. Here, Petitioner did not provide evidence to show that the requested services at the requested weekly frequency are "[i]ndividualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs." See ¶ 6. Therefore,

Petitioner did not prove by a preponderance of evidence that an increase in physical therapy services is medically necessary.

24. Upon consideration of the testimony provided, evidence submitted, and applicable polices, the undersigned concludes that Petitioner did not demonstrate by the greater weight of the evidence that an increase in physical therapy services is medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Petitioner has not shown that the services at issue are necessary to correct or ameliorate defect or a physical and mental illness condition. Accordingly, Petitioner has not proved by a preponderance of the evidence that Respondent's denial of 2 additional hours per week of physical therapy services was incorrect.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

Respondent's denial of additional physical therapy services is **AFFIRMED**. Petitioner's appeal based on Respondent's denial is **DENIED**.

DONE and **ORDERED** this 25th day of January 2024, in Tallahassee, Leon County, Florida.

 Lynne Ringers
23-FH2551
2024.01.25
~~09:01:48 - 05'00'~~
LYNNE RINGERS, 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]
[REDACTED]

AHCA Medicaid Hearing Unit
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