



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

FILED

Feb 02, 2024, 12:54 pm

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

vs.

AHCA Case No.: 23-FH2670

Plan ID No.: [REDACTED]

SIMPLY HEALTHCARE PLANS, INC.,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the Office of Fair Hearings (“OFH”) convened a telephonic Medicaid Fair Hearing in the above styled case on January 17, 2024, at 10:04 a.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner’s Authorized Representative

For the Respondent:

Sharon Nealy
State Fair Hearing Coordinator
Simply Healthcare Plans, Inc.

STATEMENT OF ISSUE

The issue is whether the Petitioner proved by a preponderance of the evidence that Respondent’s denial of Petitioner’s request for out-of-network speech therapy services was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED] (“[REDACTED]”) the Petitioner’s Authorized Representative and [REDACTED] appeared at the Fair Hearing and provided testimony. [REDACTED], MA, CCC-SLP (“[REDACTED]”) also testified on behalf of the Petitioner.

Sharon Nealey, State Fair Hearing Coordinator (“Ms. Nealey”) for Simply Healthcare Plans, Inc., (“Simply” or “Respondent”) appeared at the hearing and represented Respondent. Dr. Rebecca Moles, Medical Director (“Dr. Moles”) for Simply, provided testimony on behalf of the Respondent.

Doris Rivera, Medical Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for observational purposes.

Prior to the hearing, the Petitioner submitted a ten (10) page exhibit and a six (6) page exhibit to the Office of Fair Hearings (“OFH”) and the Respondent. The Petitioner’s six (6) page exhibit was admitted into evidence without objection, is identified herein as “Petitioner’s Composite Exhibit 1” and is maintained in the OFH document management system as “23-FH2670 DAR and Supporting Documents.pdf”. The Petitioner’s ten (10) page exhibit was admitted into evidence without objection, is identified as “Petitioner’s Composite Exhibit 2”, and is maintained in the OFH document management system as “23-FH2670 Email Correspondence.pdf”.

Prior to the hearing, Respondent submitted a forty-eight (48) page evidence package to the Petitioner and the OFH that was admitted into evidence without objection, is identified as

“Respondent’s Composite Exhibit 1” and is maintained in the OFH document management system as “FL Simply Packet [Petitioner] - Updated.pdf”.

FINDINGS OF FACT

1. The Petitioner is an enrolled member of Simply’s Statewide Medicaid managed Care Medical Plan. See Respondent’s Composite Exhibit 1, page 1. Simply is a managed care organization contracted by AHCA to provide services to eligible Medicaid recipients in Florida.

2. The Petitioner is a [REDACTED]
[REDACTED] See Respondent’s Composite Exhibit 1, page 7. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] See Respondent’s Composite Exhibit 1, page 11.

3. On July 10, 2023, the Petitioner’s Authorized Representative requested out-of-network speech therapy services with [REDACTED] for [REDACTED]. See Respondent’s Composite Exhibit 1, page 33. On July 14, 2023, the Respondent entered their Notice of Adverse Benefit Determination (“NABD”), which denied the Petitioner’s July 10, 2023, request for out-of-network speech therapy services with [REDACTED]. See Respondent’s Composite Exhibit 1, pages 33-37. In their NABD, the Respondent stated in-part as follows:

- We determined that your requested services are not medically necessary because the services do not meet the reason(s) checked below: *(See Rule 59G-1.010)*
 - Must be needed to protect life, prevent significant illness or disability, or alleviate severe pain.
 - Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient’s needs.

- Must meet accepted medical standards and not be experimental or investigational.
- Must be able to be 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.
- Must be furnished in a manner not primarily intended for convenience of the recipient, caretaker, or provider.

...

The facts that we used to make our decision are We cannot cover your child's care from the out of network place (speech therapy at [REDACTED]). This place is not in your child's plan. We have a place in our network that can take care of your child's health care needs.

[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]

They will be able to safely meet your child's health care needs. We will say yes to an out of network place only if we do not have a place in our network. This decision is based on the Florida Medicaid Member Handbook, Section 10: Accessing Services. Your reference number is: [REDACTED].

...

Id.

4. On August 8, 2023, the Petitioner requested a plan appeal of the Respondent's August 14, 2023, denial. On August 14, 2023, the Respondent issued their Notice of Plan Appeal Resolution ("NPAR") denying the Petitioner's plan appeal. See Respondent's Composite Exhibit 1, pages 52-54. The NPAR provided the Respondent's rationale for denying the Petitioner's appeal and stated in-part as follows:

We cannot cover your child's care from the out of network place (speech therapy at [REDACTED]). This place is not in your child's plan. We have a place in our network that can take care of your child's health care needs.

[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]

They will be able to safely meet your child's health care needs. We will say yes to an out of network place only if we do not have a place in our network. This decision is based on the Florida Medicaid Member Handbook, Section 10: Accessing Services. Your reference number is: [REDACTED].

...

Respondent's Composite Exhibit 1, pages 40 - 42.

5. The Petitioner requested a Fair Hearing due to the denial of the out-of-network speech therapy services with [REDACTED]. Pursuant to a December 28, 2023, Scheduling Order by this Hearing Officer, all parties were duly notified and the Fair Hearing in this matter occurred on January 17, 2024, at 10:00 a.m. EST.

6. The Respondent's Florida Medicaid Member Handbook states in-part that "[F]or the most part, you must use doctors, hospitals, and other health care providers that are in our provider network." See Respondent's Composite Exhibit 1, page 44. The Member Handbook further states "If we cannot find a provider in our provider network for these services, we will help you find another provider that is not in our network." *Id* at page 45.

7. The Petitioner's Authorized Representative and [REDACTED] testified that [REDACTED] requires specialized speech therapy treatment that not all providers are qualified to provide. [REDACTED] testified that [REDACTED] is qualified to provide this specialized treatment and can

do so in the Petitioner's home. [REDACTED] testified about [REDACTED] communications with [REDACTED], the founder of the [REDACTED], who told [REDACTED] that speech therapists that have "DTCC", "ReST", "Kaufman", and/or "PROMPT" specialized training are qualified to provide [REDACTED] with the specialized speech therapy [REDACTED] needs. See Petitioner's Composite Exhibit 2, page 5. [REDACTED] further testified that two (2) of the Respondent's providers [REDACTED] contacted do not specifically have "DTCC" training and one of the providers, [REDACTED], does not have a speech therapist that is trained to treat [REDACTED]. See Petitioner's Composite Exhibit 2, pages 7 and 8. Finally, [REDACTED] testified [REDACTED] feels it is important that the Petitioner obtain [REDACTED] speech therapy treatment in [REDACTED] home, versus at school or in a clinic.

8. [REDACTED], is a licensed speech therapist, has taken the six (6) hour online Kaufman training for [REDACTED] and has been treating the Petitioner with [REDACTED] fees personally paid by the Petitioner's [REDACTED]. [REDACTED] testified on behalf of the Petitioner that the [REDACTED] is more effective if it is provided in a home setting, and that time is of the essence to receive treatment to effectively build the Petitioner's ability to properly speak.

9. Dr. Moles testified for the Respondent that home based therapy services are only reserved for patients that are home-bound, which the Petitioner is not. Dr. Moles acknowledged that Simply has speech therapists within their network that are capable of treating the Petitioner, and even though the two (2) providers cited by the Petitioner do not have "DTCC" training, as acknowledged by [REDACTED], there are other trainings that qualify a speech therapist to treat patients with [REDACTED].

CONCLUSIONS OF LAW

10. 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). This order is the final administrative decision of AHCA under Fla. Stat. § 409.285(2)(a).

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

12. 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.

13. Because Petitioner is requesting 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.).

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 the age of 21 years, 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 Speech Language Pathology Services Coverage Policy (October 2016) (“Speech Pathology Coverage Policy”), which is incorporated by reference in Fla. Admin. Code R. 59G-4.324, states in-part as follows:

1.0 Introduction

1.1 Description

Speech-language pathology services provide for the evaluation and treatment of speech-language disorders to remediate and maintain communication functioning, acquire a skill set, restore a skill set, and enhance communication.

1.1.1 Florida Medicaid Policies

This policy is intended for use by speech-language pathology 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.

...

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

- the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid covers the following in accordance with the applicable fee schedule(s), or as specified in this policy:

- One initial AAC evaluation every five years, per recipient
- For recipients under the age of 21 years:
 - One initial speech-language pathology evaluation per year, per recipient
 - One speech-language re-evaluation every five months, per recipient
 - Up to 14 therapy treatment units per week (Sunday-Saturday), per recipient (maximum of four units per day)
 - Group therapy must be at least 30 minutes in duration, and may include no more than six participants (the group may include non-Medicaid recipients)
 - One follow-up AAC evaluation upon delivery of the device, per recipient
 - Up to eight 30-minute AAC fitting, adjustment, and training sessions per year, per recipient
 - Up to two AAC reevaluations per year, per recipient with an AAC device

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

17. The Florida Medicaid Definitions Policy (August 2017) ("Definitions Policy"), which is incorporated by reference in Fla. Admin. Code R. 59G-1.010, 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.

18. In this case, the Petitioner requested out-of-network speech therapy services with [REDACTED] for [REDACTED]. See supra ¶ 3. As established on the record by the evidence and testimony, the Respondent denied the Petitioner's request because that the services requested are from a speech therapy provider that is not in the Respondent's provider network. See supra ¶¶ 3 and 4.

19. The Respondent's Member Handbook serves as a guide for all the services that are available to the Petitioner and provides that "[F]or the most part, you must use doctors, hospitals, and other health care providers that are in our provider network." See supra ¶ 6. The Member Handbook further states "If we cannot find a provider in our provider network for these services, we will help you find another provider that is not in our network." *Id.* In their NABD and NPAR, the Respondent identified three (3) speech therapy providers in the Respondent's network that can provide the services that Petitioner is seeking. See supra ¶¶ 3 and 4. The in-network requirement for members to obtain health care is not absolute.

20. If the Petitioner were to demonstrate that the three (3) providers Respondent identified in their NPAR and NABD cannot or are unwilling to provide the services the Petitioner requires, namely speech therapy to treat a [REDACTED] diagnosed with [REDACTED], the Respondent's own guidelines provide the authority for the approval of the Petitioner's request. See supra ¶ 6.

21. The Petitioner's evidence included correspondence from [REDACTED], the founder of the [REDACTED], who told [REDACTED] that speech therapists that have "DTCC", "ReST", "Kaufman", and/or "PROMPT" specialized training are qualified to provider [REDACTED] with the specialized speech therapy [REDACTED] needs. See supra ¶ 7. [REDACTED] testified and provided correspondence that two (2) of the Respondent's providers [REDACTED] contacted do not specifically have "DTCC" training but did not submit evidence that the speech therapy providers did not have personnel with "ReST", "Kaufman", and/or "PROMPT" specialized training who may also be qualified to provider [REDACTED] with the specialized speech therapy [REDACTED] needs. *Id.*

22. The Petition did provide compelling evidence that one (1) of the three (3) speech therapy providers does not have a speech language pathologist on site who has specialized

knowledge/expertise in [REDACTED], the Petitioner did not provide any compelling testimony beyond a preponderance of the evidence that the two (2) remaining speech therapy providers identified by the Respondent in their NABD and NPAR do not have “ReST”, “Kaufman”, or “PROMPT” training or cannot or will not provide speech therapy to treat a [REDACTED] diagnosed with [REDACTED].

23. Considering the totality of the Petitioner’s circumstances, including [REDACTED] medical condition and diagnosis, and the services the Petitioner is seeking, the Petitioner has not proved by a preponderance of the evidence that the speech therapy services the Petitioner is seeking is not available in the Respondent’s provider network. See supra ¶¶ 3, 4 and 9. Moreover, it was not shown that the request for services with the specified provider are not “primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider”. As such, it was not shown that services with the requested provider are medically necessary for Petitioner.

24. In light of the testimony and evidence, Petitioner’s Composite Exhibit 1, Petitioner’s Composite Exhibit 2, Respondent’s Composite Exhibit 1, and the Respondent’s Medicaid Member Handbook, the undersigned Hearing Officer finds the Petitioner did not meet [REDACTED] burden of proving the eligible speech therapy providers identified by the Respondent were unwilling or unable to provide the speech therapy to treat a [REDACTED] diagnosed with [REDACTED]. Looking at all the evidence relevant to the particular needs of Petitioner, Petitioner has not demonstrated that services through the requested out-of-network provider are necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, the undersigned Hearing Officer concludes that Petitioner has not proved by a preponderance of the evidence

that Respondent's denial of the requested speech therapy to treat a [REDACTED] diagnosed with [REDACTED] outside of the Respondent's provider network was incorrect.

DECISION

Respondent's denial of speech therapy to treat a [REDACTED] diagnosed with [REDACTED] by a provider outside of the Respondents' provider network is hereby **AFFIRMED**.

Petitioner's appeal based on Respondent's denial in this matter is **DENIED**.

DONE AND ORDERED this 2nd day of February , 2024, in Tallahassee, Leon County, Florida.

Alan J. Leifer
Alan J. Leifer 23-FH2670
2024.02.02 10:44:08
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ALAN J. LEIFER, 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.

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