



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

FILED

May 20, 2024, 12:51 pm

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 24-FH0132

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Medicaid Fair Hearing in the above-styled case on February 13, 2024, at 9:03 a.m., Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Linda Latson

Registered Nurse Specialist

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 and Director of Nursing at [REDACTED], appeared on behalf of Petitioner.

██████████ (“██████████”), Petitioner’s ██████████, appeared as a witness for Petitioner. ██████████
██████████ (“██████████”), Medical Director at ██████████, appeared as a witness for
Petitioner.

Linda Latson, Registered Nurse Specialist for the Agency for Health Care Administration (“AHCA” or “Agency”), appeared on behalf of the Respondent. Dr. Rakesh Mittal, M.D. (“Dr. Mittal”), Physician Consultant for eQHealth Solutions, Inc. (“eQHealth”), appeared as a witness for the Respondent.

Petitioner did not introduce any exhibits at the Fair Hearing.

Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and forty-four (144)-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ case management system as “██████████ FH 02.13.2024 1-90.pdf,” and “██████████ FH 02.13.2024 91-144.pdf.” Absent an objection from Petitioner, the undersigned admitted the evidence packet into evidence as Respondent’s Composite Exhibit 1.

Respondent also sent to the Office of Fair Hearings and Petitioner a forty-seven (47)-page evidence packet. The evidence packet appears in the Office of Fair Hearings’ case management system as “24-FH0132 AHCA Evidence.pdf.” Absent an objection from Petitioner, the undersigned admitted the evidence packet into evidence as Respondent’s Composite Exhibit 2.

FINDINGS OF FACT

1. Petitioner receives Medicaid services on a fee-for-service basis from the Agency. See Respondent’s Composite Exhibit 1 at page 16. eQHealth is a Quality Improvement Organization contracted by the Agency to review prior authorization requests for services. See Respondent’s

Composite Exhibit 2 at page 2. The Agency, through contractual agreement, authorized eQHealth to make Medical Necessity determinations for services requiring prior authorizations. *Id.*

2. As of the date of the Fair Hearing, Petitioner is [REDACTED]. See Respondent's Composite Exhibit 1 at page 16. The Physician Plan of Care for PPEC Services ("POC"), dated November 10, 2023, states that Petitioner's diagnoses include: [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] *Id.* at 142.

3. As stated in the POC, Petitioner is [REDACTED]. *Id.*

4. The Florida Home Health Assessment Tool, dated July 17, 2023, reflects that Petitioner's overall health status is "stable with no heightened risk(s) for serious complications and death."

Id. at 57. [REDACTED] is not ventilator dependent, does not require suctioning or nebulizers, does not use enteral feeds, and does not use oxygen, a BiPap, or a CPap. *Id.* at 58-60. Further, Petitioner does not have wounds or stomas. *Id.* at 61. Petitioner's [REDACTED]. *Id.* at

62.

5. Petitioner requested PPEC services for the certification period of November 24, 2023, through May 21, 2024. *Id.* at 20.

6. On November 22, 2023, eQHealth sent Petitioner a Notice of Outcome ("NOO") terminating PPEC services. See Respondent's Composite Exhibit 1 at pages 24-25. The NOO 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 rationale for Decision: Request is for PPEC services for this [REDACTED]
[REDACTED]
[REDACTED] No need for skilled nursing care. Deny this request.

Id.

7. On December 29, 2023, eQHealth sent Petitioner a Notice of Reconsideration Determination (“NRD”) upholding the termination of PPEC services. *Id.* at 39-40. The NRD stated the basis for the decision as follows:

The reason for the denial is that the services are not medically necessary as defined in 59G-1.010, Florida Administrative Code. Specifically, the services must be:

Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient’s needs.

The medical basis for the reconsideration decision is as follows:

PR Recon Determination: The patient is a [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] After reconsidering the submitted information, the original decision has to be upheld. There is no need for skilled nursing services therefore, PPEC has to be denied.

Id.

8. On January 9, 2024, [REDACTED] requested a Fair Hearing on behalf of Petitioner due to Respondent’s termination of PPEC services. On January 25, 2023, hearing officer Debbie Winicki

scheduled the hearing for February 13, 2024, at 9:00 a.m., EST, and all parties were duly notified.

The undersigned issued an amended scheduling order on January 31, 2024.

9. Dr. Mittal's testimony established the following:

a. Petitioner's [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

b. [REDACTED]
[REDACTED]. *Id.* at 18-19.

c. [REDACTED]
[REDACTED].

d. Petitioner takes [REDACTED]
[REDACTED] A skilled nurse is not required to administer the medication.

e. The documentation does not reflect that Petitioner needs daily skilled nursing services.

10. [REDACTED] testified that Petitioner is at risk for complications in the future and should continue with PPEC services. [REDACTED] testified that Petitioner continues to need the observation and monitoring provided at PPEC along with speech therapy, occupational therapy, and physical therapy. [REDACTED] indicated that Petitioner has multiple doctor appointments scheduled in the future. [REDACTED] asserted that [REDACTED] diagnosed Petitioner with [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 section 409.285(2), Florida Statutes. This order is the final administrative decision of AHCA under section 409.285(2)(a).

12. This hearing was held as a *de novo* proceeding pursuant to Florida Administrative Code Rule ("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."

13. 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.

14. 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.).

15. The Florida Medicaid Prescribed Pediatric Extended Care Services Coverage Policy (February 2018) (“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:

1.1 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)

Respondent's Composite Exhibit 2 at pages 40-43.

16. Section 400.902(6), Florida Statutes, defines "medically dependent or technologically dependent child" as "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."

17. 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.

18. 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 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.

Respondent’s Composite Exhibit 2 at page 23.

19. The Florida Medicaid Authorization Requirements Policy (June 2016) (“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.

Respondent's Composite Exhibit 2 at pages 32-34.

20. In the instant case, Petitioner's provider requested the continuation of PPEC services for the certification period of November 24, 2023, through May 21, 2024. *See supra* ¶ 5. As

established on the record by the testimony and evidence, eQHealth terminated Petitioner's PPEC services because the services were not medically necessary. *See supra* ¶ 6 and 7.

21. 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* ¶ 15. PPEC provides "skilled nursing supervision and therapeutic interventions in a non-residential setting to medically dependent or technologically dependent recipients." *See supra* ¶ 15.

22. In this case, Dr. Mittal provided credible and persuasive testimony that there was no evidence demonstrating that Petitioner requires daily "skilled nursing supervision and therapeutic interventions" at a PPEC facility. *See supra* ¶ 16. Further, the documentation regarding Petitioner's medical status, *supra* ¶¶ 2 – 4 and 9, reflects that he 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* ¶ 16. Specifically, overall health status is "stable with no heightened risk(s) for serious complications and death." *See supra* ¶ 4. [REDACTED] is not ventilator dependent, does not require suctioning or nebulizers, does not use enteral feeds, and does not use oxygen, a BiPap, or a CPap. *See supra* ¶ 4. Further, Petitioner does not have wounds or stomas. *See supra* ¶ 4. Petitioner's [REDACTED]. *See supra* ¶ 4. Petitioner's prescribed medication is given by mouth and can be administered by any responsible adult. [REDACTED]. [REDACTED]. *See supra* ¶ 9.

23. 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.” See supra ¶ 18. Based upon the aforementioned facts and evidence, the undersigned finds that Respondent demonstrated that the subject PPEC services are in excess of Petitioner’s needs. Thus, Respondent established that the PPEC services do not meet medical necessity criteria, as defined in Fla. Admin. Code R. 59G-1.010, and required by section 1.3.7 of the PPEC Policy.

24. [REDACTED] asserted that Petitioner’s request should be approved because PPEC services were recommended by Petitioner’s physician. See supra ¶ 10. However, 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. See supra ¶ 18.

25. In light of the both parties’ testimony, Respondent’s Composite Exhibit 1, Respondent’s Composite Exhibit 2, the PPEC Policy, the Authorization Requirements Policy, and the Definitions Policy, the record demonstrates by a preponderance of the evidence that Respondent’s termination of PPEC services was correct.

DECISION

Respondent’s termination of PPEC services is **AFFIRMED**. Petitioner’s appeal based on Respondent’s termination of PPEC services is hereby **DENIED**.

DONE and **ORDERED** this 20th day of May 2024, in Tallahassee, Leon County, Florida.

Laura Gallagher
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LAURA GALLAGHER, 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]

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