

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



FILED

May 07, 2024, 11:35 am

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 24-FH0263

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on February 26, 2024, at 1:00 p.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Sandra Durden
Medical Healthcare Program Analyst
Agency for Healthcare Administration

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 was incorrect.

PRELIMINARY STATEMENT

All parties appeared telephonically. Petitioner's Authorized Representative, [REDACTED] ('[REDACTED]'), Petitioner's physical therapist, appeared on behalf of the Petitioner. [REDACTED] [REDACTED] appeared as a witness for Petitioner.

Sandra Durden, (“Ms. Durden”), Medical Healthcare Program Analyst for the Agency for Healthcare Administration (“Agency” or “AHCA”), appeared on behalf of Respondent. Dr. Chris Kunis (“Dr. Kunis”), Medical Director for eQHealth Solutions (“eQHealth”), attended as a witness for Respondent.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a ninety-seven (97)-page evidence packet and an eighty-two (82)-page evidence packet. The ninety-seven (97) page evidence packet appears in the Office of Fair Hearings’ document management system as file title “[REDACTED] FH 02.26.2024.pdf”. The eighty-two (82)-page evidence packet appears in the Office of Fair Hearings document management system as file title “24-FH0263 AHCA Evidence.pdf” Absent an objection from Petitioner, the undersigned admitted the ninety-seven (97)-page evidence packet as Respondent’s Composite Exhibit 1 (“RCE 1”) and the eighty-two (82)-page evidence packet as Respondent’s Composite Exhibit 2 (“RCE 2”).

FINDINGS OF FACT

1. Petitioner receives Medicaid services on a fee-for service basis from the Agency. eQHealth is a Quality Improvement Organization (“QIO”) contracted by the agency to review prior authorization requests for services. RCE 2 at 2.
2. At the date of the hearing, Petitioner was [REDACTED]. *Id.* at 16. Petitioner is diagnosed with [REDACTED]. *Id.*
3. Petitioner requested a motorized power wheelchair base. *Id.* at 23. Specifically, Petitioner has requested a *Permobil K0861 M Corpus VS with an ActiveHeight Power Adjustable Seat and Power Standing Function*. *Id.* at 45.

4. In a Notice of Outcome (“NOO”), dated October 23, 2023, Respondent denied Petitioner’s request. *Id.* at 23-24. The NOO explained the basis of the denial 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).

...

- Individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient’s needs.

The rationale for our decision is as follows:

PR Principal Reason- Denial:

The clinical information provided does not support Medicaid’s medical necessity definition.

Clinical rationale for decision: Request is for a PWC for this [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] Deny this request.

Id.

5. Petitioner requested reconsideration of the Respondent’s decision. In a Notice of Reconsideration Determination (“NRD”), dated November 22, 2023, Respondent upheld its decision. *Id.* at 34-35. The NRD explained the reason for the denial as follows in pertinent part.

The reason for the denial is that the services are not medically necessary as defined in 59G-1 point 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.
Furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caregiver or the provider.

The rationale for our decision is as follows:

PR Recon determination: [REDACTED]
[REDACTED]

Uphold previous denial of new power wheelchair. The documentation was reviewed. No warranty information or cost for repairing the current wheelchair has been submitted. Also, the new power wheelchair request contains multiple power features that are not medically necessary.

...

Id.

6. On January 23, 2024, Petitioner requested a Fair Hearing to challenge the denial of Petitioner's request for durable medical equipment. On February 6, 2024, the undersigned issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for February 26, 2024, at 1:00 p.m. EST.

7. [REDACTED] testified to the following:

- a. Petitioner is [REDACTED].
- b. Petitioner has been using a power wheelchair that was replaced in [REDACTED].
- c. [REDACTED] is Petitioner's physical therapist.
- d. The repairs to the current power wheelchair would cost over \$16,000.
- e. The request was made early because of the cost of the repairs. NuMotion did an assessment with the use of the wheelchair that they are requesting.
- f. [REDACTED]
[REDACTED]
- g. The request is for a wheelchair with a sit to stand function. This wheelchair will enable Petitioner to become more independent. [REDACTED] [REDACTED] believes the requested chair will enable Petitioner to:

- i. [REDACTED]
[REDACTED]
[REDACTED]

iii. [REDACTED] believes if Petitioner were able to be in a standing position in the standing wheelchair, [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

8. [REDACTED], Petitioner's [REDACTED] testified as follows:

a. [REDACTED]
[REDACTED]

9. Dr. Kunis testified as follows:

- a. Petitioner's current chair was provided in [REDACTED] and should last five years.
- b. Medicaid guidelines will approve one chair every five years. This current request came in [REDACTED] which is less than five years.
- c. Power seat elevation and sit to stand functions do not meet medical necessity criteria due to Petitioner's inability to pivot, do a safe transfer and inability to use the device independently.
- d. Petitioner is [REDACTED]
[REDACTED].
- e. There are concerns with Petitioner falling forward in the standing function due to poor lower body strength. Petitioner is unable to stand without assistance and cannot walk with a walker for functional distances.

f. Petitioner requires maximum assistance with [REDACTED] ADLs. Petitioner has variable

[REDACTED]

[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 section 409.285(2) of the Florida Statutes (2019). 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. 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.)

13. Petitioner's request for a power wheelchair is governed by the Florida Medicaid Durable Medical Equipment and Medical Supply Services Handbook (July 2010) ("DME Coverage Handbook"), incorporated by reference in Fla. Admin. Code R. 59G-4.070. 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).

...

Page 1-1 of DME Coverage Handbook.

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, his 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.

...

Page 2-2 of DME Coverage Handbook.

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.

...

Page 2-5 of DME Coverage Handbook.

Non-Covered Services and Exclusions

...

- Powered wheelchair component for standing

Page 2-97 of DME Coverage Handbook.

14. 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 Coverage Handbook.

15. The DME Coverage Handbook states the following with respect to requests for wheelchairs:

Description

A wheelchair is a seating device system mounted on wheels used to transport a non-ambulatory individual or an individual with severely limited mobility.

Service Requirements

Medicaid will reimburse for a wheelchair when the recipient is non-ambulatory or has severely limited mobility and it is medically documented that a wheelchair is medically necessary to accommodate the recipient's physical characteristics.

Medicaid will reimburse and provide maintenance for only one wheelchair (regardless of type) or power operated vehicle (POV) procedure code per recipient, per maximum limit period, as stated in the DME and Medical Supply Services Provider Fee Schedule. The following types of wheelchairs and POVs devices require prior authorization:

- Customized manual wheelchairs,
- Customized power wheelchairs,
- Non-custom power wheelchairs,
- Motorized scooters (POV), and
- Power Conversion kits.

Note: See the DME and Medical Supply Services Provider Fee Schedules for the maximum limits.

...

Medicaid will not approve a power wheelchair (custom or non-custom), power operated vehicle (POV), or wheelchair power upgrade, without documentation from an independent licensed physical therapist or occupational therapist or physiatrist, which documents the recipient's inability to perform activities of daily living in the home and the medical consequences that will occur without the equipment requested.

When a motorized wheelchair (custom or non-custom) or power-operated vehicle is prescribed, the documentation must state that the recipient has successfully demonstrated ■ consistent ability to safely and independently operate a powered mobility device or wheelchair.

The recipient must meet all of the following conditions:

- Has documented, severe abnormal upper extremity dysfunction or weakness; and
- Has demonstrated that ■ possesses sufficient eye and hand perceptual capabilities and the cognitive skills necessary to safely operate and guide the chair or POV independently, and is capable of evacuating a residence or building with minimal or no verbal prompting in case of an emergency; and
- Currently resides in or will primarily use the equipment in an environment conducive to the use of a motorized wheelchair of the type and size wheelchair requested.

Clinical documentation of a power wheelchair trial, supervised by an independent licensed physical therapist or occupational therapist or physiatrist, must accompany any first request for a custom power wheelchair.

Documentation of the recipient's current activities of daily living capabilities, ambulation, and transfer skills must also be included in the physical therapist's, occupational therapist's, or the physiatrist's clinical documentation.

Detailed documentation of home accessibility is required in a prior authorization request for any extra-wide wheelchair or powered mobility device.

Alternative funding sources should be explored for power or motorized wheelchairs and power mobility devices needed specifically for community leisure, vocational, or school use.

...

Wheelchair Evaluation

All wheelchair evaluations for custom manual and power wheelchairs must be completed by a licensed physical therapist, occupational therapist, or physiatrist using either the Custom Wheelchair Evaluation, AHCA Med Serv Form 015, (Appendix A) or another document that contains the same information that is requested on the form.

All wheelchair evaluations are valid for up to six months from the date the evaluation is signed and dated by the evaluator.

Documentation of home accessibility is required in a prior authorization request for an extra-wide wheelchair, custom or non-custom power wheelchair or POV.

...

Pages 2-91 – 2-96 of DME Handbook.

16. 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.

17. 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.

18. The 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.

...

Page 7 of Definitions Policy.

21. Petitioner requested a power wheelchair with power standing function. See ¶ 4.

Respondent denied Petitioner’s request in the NOO, dated October 23, 2023. See ¶ 4.

Furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caregiver or the provider.

See ¶ 16-18.

25. Lastly, Dr. Kunis testified that Petitioner would still need caregiver assistance, even with the power standing wheelchair. *Id.* Petitioner is not able to use a standing walker on [REDACTED] own and is unable to transfer from chair to walker. *Id.* [REDACTED]. *Id.* Petitioner did not demonstrate that the device is not "in excess of the patient's needs," and [F]urnished in a manner not primarily intended for the convenience of the recipient, the recipient's caregiver or the provider. See ¶ 7-8.

26. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned concludes that Petitioner did not prove by a preponderance of the evidence that the power wheelchair with power standing feature is medically necessary. Looking at all the evidence relevant to the particular needs of the Petitioner, Petitioner has not demonstrated that the power wheelchair with power standing feature is necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Petitioner has not shown that Respondent's denial was incorrect.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

Respondent's denial is **AFFIRMED**. Petitioner's appeal based on Respondent's denial is **DENIED**.

DONE and ORDERED this 7th day of May, 2024, in Tallahassee, Leon County, Florida.

Lynne Ringers

Lynne Ringers

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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]

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com