



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

FILED

May 17, 2024, 1:42 pm

OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

AHCA Case No.: 24-FH0388

Plan ID No.: [REDACTED]

vs.

SIMPLY HEALTHCARE PLANS, INC.,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on March 19, 2024, at 1:01 p.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Florestine Harris
Grievance and Appeals
Simply Healthcare Plans, 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 [REDACTED] was incorrect.

PRELIMINARY STATEMENT

All parties appeared telephonically. Petitioner's Authorized Representative and [REDACTED], [REDACTED] (" [REDACTED] "), appeared for Fair Hearing to provide testimony on behalf of Petitioner.

Florestine Harris ("Ms. Harris"), Grievance and Appeals for Simply Healthcare Plans, Inc. ("Simply") appeared for Fair Hearing on behalf of Respondent. Ophelia Mall, M.D. ("Dr. Mall"), Medical Director for Simply, appeared for Fair Hearing as a witness for Respondent.

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

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent a four (4)-page evidence packet. The four (4)-page packet appears in the Office of Fair Hearings' document management system as file title "24-FH0388 Supporting Documents.pdf." Absent an objection from the Respondent, the undersigned admitted the two hundred and fourteen (214)-page packet into evidence as Petitioner's Composite Exhibit 1 ("PCE 1")

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and seventy (170)-page evidence packet. The one hundred and seventy (170)-page packet appears in the Office of Fair Hearings' document management system as file title "Florida Simply Evidence Packet [Petitioner].pdf." Absent an objection from the Petitioner, the undersigned admitted the one hundred and seventy (170)-page packet into evidence as Respondent's Composite Exhibit 1 ("RCE 1").

FINDINGS OF FACT

1. Petitioner is an enrolled member of Children's Medical Services ("CMS") Managed Medical Assistance ("MMA") program. See RCE 1 at page 2. CMS is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida. *Id.*

2. Petitioner is [REDACTED]. *Id.* at 9. Petitioner’s medical condition includes [REDACTED]. *Id.* The record does not indicate any prescribed medications.

3. Petitioner’s pediatric physician, [REDACTED], M.D. (“[REDACTED]”), submitted an Order Form (“Order Form”) for the requested [REDACTED]. The Order Form states:

Test Name [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Id. at 9.

4. Petitioner requested [REDACTED]. *Id.* at 7. In a Notice of Adverse Determination (“NABD”), dated December 27, 2023, Respondent denied Petitioner’s request. *Id.* at 10-12. The NABD 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)

...

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

The facts that we used to make our decision are:

We cannot cover the brand name [REDACTED] your child's doctor asked for. The item is a name brand item. Your child's health plan covers this item as a generic. Your child's doctor did not tell us why a name brand item is needed. We do not know if your child has rashes. We do not know if your child has an allergy. This was based on Florida Medicaid DME and Supply Services Coverage and Limitations Handbook, page 2-48-2-49. Your reference number is: [REDACTED].

Id. at 10-11.

5. On January 2, 2024, Petitioner requested a plan appeal for the denial of the [REDACTED]. [REDACTED]. *Id.* at 13, 15. In a Notice of Plan Appeal Resolution (“NPAR”) dated January 31, 2024, Respondent upheld their denial. *Id.* at 15-17. The NPAR explained as follows:

On 01/30/2024, after consideration of the information you provided to Simply in support of your plan appeal, Simply hereby DENIES your plan appeal. We cannot cover the brand name [REDACTED]. We have looked at your notes. We see that your child has [REDACTED]. This request was denied because it was for brand name items. Brand name items are not covered by Florida Medicaid, except when there is a clear provider documentation of need. We do not see this documented. This appeal is denied for not meeting criteria per: Florida Medicaid DME and Supply Services Coverage and Limitations Handbook, page 2-48 - 2-49. Your case was looked at by a Pediatrics & Neonatology Specialist for Simply.

Id. at 15.

6. On February 5, 2024, Petitioner requested a Fair Hearing to challenge the denial of the [REDACTED]. On February 22, 2024, undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions (“Scheduling Order”), setting the hearing for March 19, 2024, at 1:00 p.m. EST.

7. [REDACTED] is Petitioner’s [REDACTED]. [REDACTED] testified to the following:

- a. Petitioner has a [REDACTED] See PCE 1 at 3.
- b. Petitioner’s pediatrician requested assistance with [REDACTED]. See ¶ 3.
- c. [REDACTED] explained that [REDACTED] stated [REDACTED] has used brand name [REDACTED] or any brand [REDACTED] could afford in response to a series of questions during a phone call with the provider, but was not asking specifically for brand name [REDACTED].
- d. [REDACTED] asserted that brand name [REDACTED] are not required.
- e. Petitioner has no skin sensitivities or allergies.

8. Dr. Mall is a Medical Director for Simply. Dr. Mall testified to the following:

- a. Based on the information received, Simply reviewers understood Petitioner requested brand name [REDACTED]. Simply reviewers did not have justification such as allergies or rash to approve the request. See ¶ 2-6, 14.
- b. Based on [REDACTED]'s testimony, Dr. Mall explained that Petitioner likely would have been approved for generic brand [REDACTED] but for the ambiguity.

CONCLUSIONS OF LAW

9. 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 (2022). This order is the final administrative decision of AHCA under section 409.285(2)(a).

10. This hearing was held as a *de novo* proceeding pursuant to Rule 59G-1.100(17)(b), Florida Administrative Code ("Fla. Admin. Code R.").

11. Because Petitioner is requesting a new service, 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.)

12. The Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook (July 2010) ("DME and Medical Supply Handbook"), incorporated by reference in Fla. Admin. Code R. 59G-4.070, provides guidance concerning the medical supplies available under Florida Medicaid. The DME and Medical Supply Handbook provides the following, in pertinent part:

Purpose

The purpose of the DME and Medical Supply Services Program is to promote, maintain, or restore health and minimize the effects of illness, disability, or a disabling condition.

...

Medical Supplies

Medical supplies are defined as medically-necessary medical or surgical items that are consumable, expendable, disposable, or non-durable and appropriate for use in the recipient's home.

...

Disposable Incontinence Briefs, Diapers, Protective Underwear, Pull-Ons, Liners, Shields, Guards, Pads, Undergarments

Medical Necessity

The disposable incontinence supplies as specified in the section are reimbursable only for use by individuals with chronic incontinence caused by a permanent physical or mental condition, including cerebral palsy and developmental delay.

Age Requirements

Disposable incontinence briefs, diapers, protective underwear, pull-ons, liners, shields, guards, pads, and undergarments are covered for recipients four (4), when a child would normally be expected to achieve continence, through twenty (20) years of age.

Documentation

To receive incontinence supplies, the following documentation must be included in the recipient's record:

- Physician's prescription, including the specific diagnosis pertaining to the underlying condition(s) that lead to the need for incontinence products (the primary ICD-CM code). The prescription must specify the type of incontinence (the secondary ICD-CM code) for which the incontinence supplies were prescribed. The prescription must be written prior to the delivery of supplies.
- Measurements (e.g., waist and hip size, weight) which support reimbursement for the specific size of product supplied.
- Monthly record of specific type, brand, and size of product(s) supplied.
- Quantity of disposable supplies needed per month. Documentation must reflect the number of units by which each product is measured. For example, diapers are measured as individual units. If one package of 200 diapers is delivered, the delivery slip or invoice and the claim must reflect that 200 diapers were delivered and not that one package was delivered.

Service Limitations

For recipients four (4) through twenty (20) years of age with a physical or mental condition that results in chronic incontinence, diapers, briefs, protective underwear, pull-ons, liners, shields, guards, pads, undergarments may be reimbursed up to a combined total of 200 per calendar month.

Id. at page 27-28, 101-102.

13. 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.

14. Petitioner is under age 21, and therefore EPSDT applies to this 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.

15. 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:

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 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.

16. In the instant case, Petitioner requested [REDACTED]. See ¶ 4. In the NABD, dated December 27, 2023, Respondent denied Petitioner's request citing the lack of medical necessity, specifically that the request must be "individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs." See ¶ 4. In a NPAR dated January 31, 2024, Respondent upheld their denial. See ¶ 5. Petitioner has the burden of proof to show by a preponderance of evidence that the Respondent's determination was incorrect. See ¶ 11.

17. As provided by the EPSDT requirements, the recipient must meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. See ¶ 13-14. The Definitions Policy defines a component of medical necessity as "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 ¶ 15. The DME and Medical Supply Handbook maintains that Florida Medicaid reimburses for [REDACTED] by documentation of the physician's prescription,

measurements for the specific size of the supplies, monthly quantity, and monthly record of specific type, brand, and size of product(s) supplied. See ¶ 12.

18. As demonstrated in the record, Petitioner is a [REDACTED] child whose medical condition includes [REDACTED]. See ¶ 2. Petitioner has a [REDACTED]. See ¶ 2, 7. The record does not indicate Petitioner is prescribed any medications. See ¶ 2. At Fair Hearing, [REDACTED] described a phone call where [REDACTED] mentioned that [REDACTED] previously used brand name [REDACTED] but had not specifically requested brand name nor are they required. See ¶ 7. Petitioner has no skin sensitivities or allergies. See ¶ 7. According to Dr. Mall's testimony, it appeared that Petitioner requested brand name [REDACTED] based on the information received. See ¶ 8. Dr. Mall explained that Petitioner likely would have been approved for generic brand [REDACTED] but for the ambiguity. See ¶ 8. The record shows the Order Form submitted by Petitioner's pediatrician, [REDACTED], indicated "[n]ot specified on packages because it depends on the brand, any brand available." See ¶ 3.

19. The record shows Petitioner meets the age requirement and medical necessity criteria to receive [REDACTED]. See ¶ 2, 12, 13-14, 15. Based on the evidence of record, the denial of [REDACTED] was determined on what appears as a misinterpretation of the request. See ¶ 3, 4-5, 8. Although the Order Form indicates Petitioner's usual brand choices, the most pertinent part of the Order Form states, "any brand available." See ¶ 3. [REDACTED] testified that the request was for the same. See ¶ 7. Taken together, the undersigned does not find this request was exclusively for brand name [REDACTED]. See ¶ 3. The record does not show that Petitioner requires brand name [REDACTED]. See ¶ 3. Based on the aforementioned facts, the undersigned


concludes that the requested incontinence supplies are individualized, specific, and consistent with Petitioner's diagnosis. See ¶ 3, 7, 15.

20. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned concludes that Petitioner proved by a preponderance of the evidence that the requested [REDACTED] supplies is medically necessary. Accordingly, Petitioner proved by a preponderance of the evidence that Respondent's denial of incontinence supplies was incorrect.

IT IS THEREFORE ORDERED AND ADJUDGED THAT:

Respondent's denial of [REDACTED] supplies is **REVERSED**. Petitioner's appeal based on Respondent's denial of incontinence supplies is **GRANTED**.

DONE AND ORDERED this 17th day of May, 2024 in Tallahassee, Leon County, Florida.

 Kimberly Roche
24-FH0388
2024.05.17 08:39:58
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KIMBERLY ROCHE, 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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**Simply Healthcare Plans, Inc.
MedicaidFairHearings@simplyhealthcareplans.com**

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