



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

FILED

Jul 10, 2024, 1:23 pm

OFFICE OF FAIR HEARINGS

[Redacted]

PETITIONER,

AHCA Case No.: 24-FH1180

vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on June 6, 2024, at 2:04 p.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner:

[Redacted]

Petitioner's Authorized Representative

For the Respondent:

Marielisa Amador
Medical Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Respondent proved by a preponderance of the evidence that Respondent's decision to terminate Petitioner's prescribed pediatric extended care ("PPEC") services was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. [REDACTED] (“[REDACTED]”), Petitioner’s Authorized Representative and Nursing Administrator at [REDACTED] (“[REDACTED]”), appeared for Fair Hearing to provide testimony on behalf of Petitioner.

Marielisa Amador, Medical Health Care Program Analyst for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared for Fair Hearing as representative for Respondent. Chris Kunis, M.D. (“Dr. Kunis”), Medical Director for eQHealth Solutions Florida (“eQHealth”) and Kepro, appeared for Fair Hearing as a witness for Respondent.

Petitioner did not introduce any exhibits at the hearing.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred sixty-nine (169)-page evidence packet and a forty-seven (47)-page evidence packet. The one hundred sixty-nine (169)-page packet appears in the Office of Fair Hearings document management system as the file titles “[REDACTED] FH 05.23.2024 1-81.pdf,” “[REDACTED] FH 05.23.2024 82-124.pdf,” “[REDACTED] FH 05.23.2024 125- 162.pdf,” and “[REDACTED] FH 05.23.2024 163-169.pdf.” The forty-seven (47)-page evidence packet appears in the Office of Fair Hearings document management system as the file title “24-FH1180 AHCA Evidence (Pages 1-47 of 47).pdf.” Absent an objection from the Petitioner, the undersigned admitted the one hundred sixty-nine (169)-page evidence packet into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”) and the forty-seven (47)-page evidence packet into evidence 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 contracted by the Agency to review prior authorization requests for services. See RCE 2 at page 2.

2. Petitioner is [REDACTED]. See RCE 1 at page 16. Petitioner’s medical history includes

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] *Id.* at 16-17, 44.

3. Petitioner is prescribed the following medications: [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] *Id.* at 21, 143-145. Petitioner attends [REDACTED] five (5) days per week, and receives physical therapy (“PT”), occupational therapy (“OT”), and speech therapy (“ST”) three (3) times per week at the PPEC center. *Id.* at 21, 48, 52-53.

4. Petitioner requested continuation of PPEC services for the certification period of March 28, 2024, to September 23, 2024, specifically, 520 units of code T1026 (partial day services) and 130 units of code T1025 (full day services). In a Notice of Outcome (“NOO”), dated April 9, 2024,

Respondent terminated all units. *Id.* at 27-29. The NOO explained the basis for the termination as follows:

[T]he requested services are not medically necessary under the following standard(s):

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. 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.

The NOO further provided:

Submitted information does not support the medical necessity for requested services.

Clinical Rationale for Decision: [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] Nursing needs consist of PRN meds and nebs and monitoring.

Id. at 27-28.

5. On April 12, 2024, Petitioner requested a Fair Hearing to challenge the termination of PPEC services. On April 24, 2024, the undersigned issued an Order Scheduling Fair Hearing and Prehearing Instructions, setting the hearing for May 23, 2024, at 10:00 a.m. EST. At Petitioner's request, the undersigned issued an Order Granting Continuance and rescheduled the hearing for June 6, 2024, at 1:00 p.m. EST.

6. Dr. Kunis is the Medical Director for eQHealth. Dr. Kunis established the following at Fair Hearing:

- a. eQHealth uses nurses and physicians to review plans of care in accordance with the medical necessity guidelines established by AHCA. See ¶ 11-13.
 - b. Petitioner’s medications are prescribed as needed or twice per day. See ¶ 3.
 - c. Dr. Kunis argued that PT, OT, and ST can all be provided at any independent outpatient facility and attendance at PPEC is not a prerequisite to receive these therapies. See ¶ 3.
 - d. Dr. Kunis contended that Petitioner required intensive care due to [REDACTED], but [REDACTED] remaining conditions improved with age and no longer requires skilled nursing. See ¶ 2, 4.
7. [REDACTED] is the Director of Nursing at [REDACTED]. [REDACTED] testified at Fair Hearing that Petitioner lives in a neighboring county and has not yet found adequate alternative care following the termination of PPEC services.

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 (2022). 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 Rule 59G-1.100(17)(b), Florida Administrative Code (“Fla. Admin. Code R.”).
10. Because Respondent terminated a previously approved service, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the 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.)

11. 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 as follows:

1.0 Introduction

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.

...

2.0 Eligible Recipient

...

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 stable by a physician and who are not a threat to self or others

...

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 non-emergency 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 sectioned 1905(a) of the Social Security Act, 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

See RCE 2 at pages 38-42.

12. Rule 59A-13.007(4)(a), F.A.C. states the following:

(4) Each child admitted for service to a PPEC center must meet at least the following criteria:

(a) Infants and children considered for admission to the PPEC center will be those who are medically or technologically dependent. . . .

...

Further, section 400.902, F.S described “medically dependent or technologically dependent child” as follows:

[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.

13. Rule 59G-4.290, F.A.C. defines skilled nursing as follows:

(3) Skilled Services Criteria.

- a) To be classified as requiring skilled nursing or skilled rehabilitative services in the community or in a nursing facility, the recipient must require the type of medical, nursing or rehabilitative services specified in this subsection.
- b) Skilled Nursing. To be classified as skilled nursing service, the service must meet all of the following conditions:
 - 1. Ordered by and remain under the supervision of a physician;
 - 2. Sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse.
 - 3. Required to be performed by, or under the direct supervision of, a registered nurse or other health care professionals for safe and effect performance;
 - 4. Required on a daily basis;
 - 5. Reasonable and necessary to the treatment of a specified documented illness or injury; and,
 - 6. Consistent with the nature and severity of the individual’s condition or the disease state or stage.
- c) Examples of services that qualify as skilled nursing services:
 - 1. Intravenous medication or fluids.
 - 2. Intramuscular or subcutaneous injection and hypodermoclysis when:
 - a. Administered by licensed nursing personnel at least 5 times weekly, excluding daily insulin administration; and,

- b. Observation is necessary to assess the recipient's response to treatment or to identify adverse reactions.
- 3. Management and monitoring medication regime on a daily basis:
 - a. For drugs whose dosage requirements may rapidly change;
 - b. For drugs prone to cause adverse reactions, severe side effects or unfavorable reactions; and,
 - c. For residents with unstable reactions.
- 4. Levin tube and gastrostomy feedings; excluding feedings performed by residents, family members, or friends.
- 5. Administration of medical gases, aerosolized medication or oxygen which is started, monitored and regulated by professional staff.
- 6. Naso-pharyngeal and tracheotomy aspiration, excluding tracheotomy care in self-care residents.
- 7. Insertion, replacement, and sterile irrigation of catheters when:
 - a. Medically necessary or required for reasons other than to maintain satisfactory catheter functioning and dryness;
 - b. The medical need is documented by the physician;
 - c. Continuous irrigation, frequent insertion, special care or observation is required because of bleeding, infection, obstruction, or heavy sediment formations; and,
 - d. Care of a recently inserted supra-pubic catheter, inserted within 2-4 weeks, is required.
- 8. Colostomy and ileostomy care:
 - a. When medically necessary and required during early postoperative period;
 - b. During the period of initial self-care training, or
 - c. when complications are present and documented in the medical record.
- 9. Treatment of decubitus ulcers when:
 - a. Deep or wide without necrotic center;
 - b. Deep or wide with layers of necrotic tissue, or
 - c. Infected and draining.
- 10. Treatment of widespread infected or draining skin disorders.
- 11. Application of dressings involving prescription medication and aseptic techniques when documented as required on a daily basis. Excludes simple dressings involving non-infected cases, simple skin breaks, and healed postoperative incisions.
- 12. Heat treatments prescribed by a physician as daily treatment for a specific condition.

13. Rehabilitation nursing procedures required on a daily basis as necessary to restore functioning, including teaching and adaptive aspects of nursing.

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 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.

16. 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:

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.

See RCE 2 at 23.

17. The Florida Medicaid Authorization Requirements Policy (June 2016) (“Authorization Policy”), incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides as follows:

1.1 Description

This policy contains general requirements for providers to obtain authorization to render Florida Medicaid services, when applicable.

...

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.

See RCE 2 at 32, 34.

18. In the NOO, dated April 9, 2024, Respondent terminated Petitioner’s PPEC services. See ¶ 4. The NOO cited the basis of the termination was that the services were not “individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment,” were “in excess of the patient’s needs,” and were not “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.” See ¶ 4. Respondent has the burden of proof to show by a preponderance of evidence that the Respondent’s determination was correct. See ¶ 10.

19. The role of PPEC services is to provide patients “who because of a medical condition requires continuous therapeutic interventions or skilled nursing supervision.” See ¶ 11-12. According to Rule 59G-4.290, F.A.C., skilled nursing requires that the service be, *inter alia*, sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse; required to be performed by, or under the direct supervision of, a registered nurse or other health care professionals for safe and effect performance; required on a daily basis; and consistent with the nature and severity of the individual’s condition. See ¶ 13. 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 ¶ 14-15. The Definitions Policy maintains a component of medical necessity that services must be “[i]ndividualized, specific, and consistent

with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs." See ¶ 16.

20. In the instant case, according to Dr. Kunis's testimony, eQHealth reviews plans of care in accordance with the medical necessity guidelines established by AHCA. See ¶ 6. Petitioner's medical history includes [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] See ¶ 3. Dr. Kunis argued that Petitioner's PT, OT, and ST can all be provided at any independent outpatient facility and attendance at PPEC is not a prerequisite to receive these therapies. See ¶ 6. Dr. Kunis contended that Petitioner required intensive care due to [REDACTED], but [REDACTED] remaining conditions improved with age. See ¶ 6.


21. The record does not demonstrate any scheduled medications for Petitioner during PPEC. See ¶ 3, 6. Petitioner's MAR log was not submitted by the provider, and that submitted by the parent does not indicate any medications that are unable to be administered outside of PPEC. See ¶ 3. Overall, the evidence shows Petitioner no longer requires PPEC service due to the lack of daily skilled nursing needs related to Petitioner's medical conditions. See ¶ 2-4, 6, 11-16. Accordingly, eQHealth as QIO for the Agency is authorized to terminate services when "the reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level." See ¶ 17.

22. Upon consideration of the testimony provided, evidence submitted, and applicable policies, the undersigned concludes that Respondent proved by a preponderance of the evidence that continuing PPEC services was not medically necessary for Petitioner. Looking at all the evidence relevant to the particular needs of Petitioner, Respondent has demonstrated that the PPEC services are not medically necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Respondent has proved by a preponderance of the evidence that Respondent's termination of PPEC services was correct.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

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

DONE AND ORDERED this 10th day of July, 2024 in Tallahassee, Leon County, Florida.

 Kimberly Roche
24-FH1180
2024.07.10 09:04:00
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KIMBERLY ROCHE, Hearing Officer
Agency for Health Care Administration
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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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