UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

W.B., by and through his father and legal Guardian David B., and A.W., by and through her mother and legal guardian, Brittany C., on behalf of themselves and all others similarly situated,

Plaintiffs,

Case No.:

v.

SIMONE MARSTILLER, in her official capacity as Secretary for the FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION,

Defendant.
_____/

A.W.'S MOTION FOR PRELIMINARY INJUNCTION

Pursuant to Rule 65 of the Federal Rules of Civil Procedure, class member and minor child, A.W., by and through her mother, Brittany C., moves for entry of a preliminary injunction and in support thereof files this Memorandum of Law with supporting exhibits.

I. INTRODUCTION

A.W. seeks to redress the harm Defendant imposed on her when she denied A.W.'s request for Medicaid services relying solely on Defendant's own standard of medical necessity set forth in Fla. Admin. Code R. 59G-1.010; a standard that

four separate Florida state court decisions have found to be more restrictive than what is allowed for under federal Medicaid law. More specifically, the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provisions of the federal Medicaid Act, 42 U.S.C. §§ 1396a(a)(43) & 1396d(r), mandate states to provide all medical services necessary to correct or ameliorate the health conditions of child Medicaid beneficiaries. Rather than rely on its erroneous medical necessity standard, had Defendant instead, met her obligation under EPSDT, A.W. would have easily established her need for the requested service. Due to the harm she is currently suffering and the risks Defendant's actions pose to A.W.'s health, however, A.W. cannot wait for final judgment to rectify this harm; thus, she makes this request for preliminary relief.

II. STATEMENT OF FACTS

A.W. is an eleven-year-old girl who lives at home with her family in Jacksonville, Florida. As a result of a premature birth at 24 weeks of gestation, A.W. is diagnosed with quadriplegic cerebral palsy, global developmental delay, muscle spasticity, partial epilepsy, neuromuscular scoliosis, cortical visual impairment, spastic hip dislocation, dysphagia causing pulmonary aspiration with swallowing, obstructive sleep apnea syndrome, and gastroesophageal reflux disease. (Ex. 2 & 5). She has seizures one to two times per month. (Ex. 3, ¶2).

A.W. is unable to perform any of her activities of daily living. (Ex. 2 & 5). She is nonverbal and cannot communicate her needs. (*Id.*) She uses a gastronomy tube (g-tube) for nourishment and is on a feeding schedule that includes enteral g-tube feeding continuously throughout the night. (*Id.*) She cannot move on her own and is completely dependent upon her caregivers. (*Id.*)

A.W. is a high risk for falling out of bed. (*Id.*) On May 5, 2021, A.W. fell out of bed and was found hanging by her foot with her face pressed against the wall. (Ex. 4, ¶22). A.W. has also previously been found in bed with her g-tube wrapped around her neck. (Ex. 4, ¶12) If A.W. is forced to use a traditional hospital bed (which can be fitted with rails to mitigate falls) as her home sleeping arrangement, then she risks entrapment, a safety problem posed by hospital beds for individuals like A.W., who have no control over their movements. (Ex. 5 & 7). Either sleeping arrangement – a standard bed or a traditional hospital bed with rails – could lead to A.W.'s serious injury. (*Id.*). While the previous accidents did not result in significant injury, there is no guarantee that will not occur in the future.

To address these safety concerns and otherwise support A.W.'s disabilities, A.W.'s treating providers prescribed A.W. a specialty medical bed, known as a Dream Series bed. (Ex. 5 & 7). On February 24, 2020, in response to A.W.'s treating providers' prescription for the Dream Series bed, the Quality Improvement Organization, eQHealth Soutions, Inc. (eQHealth), with whom Defendant contracts

to review certain requests for Medicaid services, denied the request. (Ex. 6). More specifically, eQHealth stated that A.W.'s request for the Dream Series bed is denied because the service is:

> "…not medically necessary as defined in Rule 59G-1.010(166), Florida Administrative Code. Specifically, the requested services are not medically necessary under the following standards:
>
> Individualized, specific, and consistent with the symptoms or confirmed diagnosis of the illness or injury under treatment, and not 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.
>
> The patient is a 10 year old with CP who is non-ambulatory, non-verbal, and has GT and the request is for a specialty bed. The request is excessive because a hospital bed should suffice. A specialy [sic] bed was previously denied last November."

(*Id*.)

On March 2, 2020, A.W.'s mother requested an administrative fair hearing to challenge eQHealth's February 24th denial. (Ex. 3). In reviewing the denial, while the hearing officer cites to the EPSDT provisions, the hearing officer ultimately finds that those provisions can be limited through the state's medical necessity standard and specifically that standard set forth in Fla. Admin. Code R.

59G-1.010 which provides that requests for Medicaid services, including services for children under age 21:

> "…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."

(*Id.*, ¶15).

The hearing officer ultimately upheld eQHealth's denial of the Dream Series bed. (*Id.*, ¶23). As of the date of this filing, Defendant continues to deny A.W.'s request for Medicaid to cover the Dream Series bed prescribed by her treating professionals.

III. ARGUMENT AND CITATION OF AUTHORITIES

The entry of a preliminary injunction to enforce A.W.'s right to medically necessary healthcare is necessary and proper in this case. A.W. has met the Eleventh Circuit's standard for entry of preliminary injunctive relief. A.W. demonstrates: (1) a substantial likelihood of success on the merits; (2) irreparable injury; (3) that the threatened injury to her outweighs any injury to the Defendants; and (4) that the issuance of an injunction is not adverse to the public interest. *See, e.g., Odebrecht Const., Inc. v. Sec'y, Fla. Dep't of Transp.*, 715 F.3d 1268, 1273-74 (11th Cir. 2013).

A. There is a substantial likelihood that A.W. will prevail on the merits of her claim that Defendant's denial of a specialty medical bed violates her rights under EPSDT.

1. Defendant is obligated under EPSDT to provide A.W. all Medicaid services necessary to correct or ameliorate her health conditions.

The Medicaid Act mandates that states participating in the Medicaid program provide EPSDT services to Medicaid-eligible children under 21 years of age. 42 U.S.C. §§ 1396a(a)(43) & 1396d(r). Under EPSDT, children must receive all services covered by the Medicaid Act that are necessary "to correct or ameliorate" any physical and mental illnesses and conditions discovered during a screen. 42 U.S.C. § 1396d(r)(5); *see also Pittman*, 998 F.2d 887, 889 (11th Cir. 1993). The State must provide any service covered by EPSDT "whether or not

such services are covered under the state plan." *Id*. In other words, Section 1396d(r)(5) of the Medicaid Act requires that participating states must "cover every type of health care or service necessary for EPSDT corrective or ameliorative purposes that is allowable under §1396d(a)." *Moore ex rel. Moore v. Reese,* 637 F.3d 1220, 1233-34 (11th Cir. 2011). The specialty medical bed requested by A.W. is a service listed in 42 U.S.C. § 1396d(a). 42 U.S.C. § 1396d(a)(7); 42 C.F.R. § 440.70(b)(3); *see also*, Fla. Stat. § 409.905(4).

2. A.W.'s treating professionals have demonstrated A.W.'s need for a specialty medical bed.

Dr. Carlin, a pediatrician who specializes in the care of medically fragile children, describes A.W.'s complex medical conditions. (Ex. 5). She details A.W.'s need for a specialty medical bed that addresses A.W.'s individual health conditions. (*Id*.) Dr. Carlin states that the Dream Series bed is medically necessary for A.W. because her progressing scoliosis requires "a bed that has a supportive mattress and bed frame." (*Id*.). Dr. Carlin also confirms the dangers posed by a non-medical bed as well as a traditional hospital bed, stating that A.W.'s:

> "medical history includes seizures and spasticity which place her at risk for falling out of bed or becoming entrapped between a bed and side rails. Alternative beds such as a hospital bed with side rails or a Pediacraft canopy bed do not adequately meet patient's needs. With a hospital bed, [A.W.] runs the risk of becoming entrapped between the mattress and side rails which can lead to injuries…[t]he DREAM [Series] bed style is designed to prevent entrapment and will protect the

> patient from falling of the bed due to her developmental delay, seizures, and spasticity."

(*Id*.)

Dr. Carlin then details how the adjustable head of the Dream Series bed allows A.W. "to be positioned during gastrostomy tube feedings to help prevent aspiration." (*Id*.) Dr. Carlin concludes her letter by emphasizing the importance of Medicaid providing the Dream Series bed which she states is necessary to "reduce the risk of injuries at bedtime." (*Id*.)

Dr. Carlin's recommendation for the Dream Series bed is further supported by Karen Reckamp, A.W.'s physical therapist. In her letter of medical necessity dated January 16, 2019, Ms. Reckamp details A.W.'s extensive medical history including an assessment of A.W. as spastic, the potential for A.W.'s limbs to become entrapped (stating that "A.W.'s right arm is getting caught between the wheelchair armrest and the tray"), and that A.W. is dependent on her caregivers for all transfers and mobility. (Ex. 7).

In the same letter, Ms. Reckamp provides an extensive narrative of A.W.'s need for the Dream Series bed finding that A.W. "has no independent mobility and is completely reliant on her caregivers for position changes throughout the night." (*Id*.) Ms. Reckamp states that, in her professional opinion, the Dream Series bed will "provide comfort, support, and positioning [which] is important for…[A.W.'s]…quality of life." (*Id*.)

The concerns detailed by A.W.'s treating professionals are also verified by A.W.'s medical records. eQHealth's own records reflected that A.W. has enteral g-tube feeds continuously through the night which supports Dr. Carlin's determination that A.W. requires a bed with an adjustable head (one that can be raised and/or lowered). (Ex. 2). eQHealth's records also state that A.W. has seizures one to two times per month and requires "total assistance with repositioning" which supports her treating professionals' conclusion that A.W.'s bed must mitigate her risk for entrapment, be padded to protect from injuries sustained during a seizure or moment of spasticity, and allow for easy access by her caregivers due to the constant need for assistance with positioning and transfers in and out of bed. (*Id*.)

Thus, A.W.'s need for the Dream Series bed to correct or ameliorate her health conditions is supported through extensive and detailed treatment records and the testimony of her treating professionals.

3. The standard on which Defendant relied to evaluate A.W.'s request for a specialty medical bed violates EPSDT.

As stated *supra*, under the Medicaid Act, children must receive all services listed in 42 U.S.C. § 1396d(a) necessary "to correct or ameliorate" a health condition. *See* 42 U.S.C. § 1396d(r)(5). Federal courts have interpreted "ameliorate" to mean the same as the term's common dictionary definition, that is "to make better or more tolerable." *Ekloff v. Rodgers*, 443 F. Supp. 1171, 1180

(U.S.D.C. Az. 2006) (internal quotations omitted). The impetus behind requiring states to cover Medicaid services for children under this broad standard is to "assure that health problems found are diagnosed and treated early, before they become more complex and their treatment more costly." *Id.* (citing the CMS State Medicaid Manual, §5010.B.).

In administering EPSDT, while states are "permitted (but not required) to set parameters that apply to the determination of medical necessity in individual cases…those parameters may not contradict or be more restrictive than the federal [EPSDT] statutory requirement." U.S. Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs. (CMS), *EPSDT: A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* at 23 (June 2014) (CMS, EPSDT Guide).[1] In evaluating the medical necessity of services under EPSDT, "the treating physician is a 'a key figure' and initially determines what…services are medically necessary." *M.H. v. Berry*, No. 15-cv-1427 TWT; 2021 WL 1192938 *6 (N.D. Ga. March 29, 2021). While both the state and treating physician have a role to play in determining medical necessity, states are "not empowered to act as the 'final arbiter' of medical necessity to arbitrarily ignore the reasons given in the treating physician's recommendation of…[medical services]." *Id.*; *see also Moore*,

[1] The EPSDT Guide can be accessed online at: *http?www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf.*

637 F.3d at 1259 ("[w]hile Congress could have conferred the 'final arbiter' role to the state, it did not.")

Defendant has adopted a definition that it applies to the determination of medical necessity under Fla. Admin. Code R. 59G-1.010. (Ex. 9; Dkt. #1). This definition sets parameters that contradict and are more restrictive than what is allowed for under EPSDT, a conclusion drawn time and time again by Florida courts. *See C.F. v. Department of Children and Families*, 934 So. 2d 1, 7 (Fla. 3d DCA 2005) (in evaluating whether a state agency correctly analyzed a child's need for Medicaid services under Fla. Admin. Code R. 59G-1.010, the court held that the agency "incorrectly used more restrictive definitions of 'medical necessity'…than federal law requires"); *see also*, *Q.H. v. Sunshine State Health Plan*, 307 So.3d 1, 14 (finding that the state "erred in applying the 'overly restrictive' definition of medical necessity set forth in the Florida Administrative Code, rather than the more expansive EPSDT standard of whether the treatment was necessary to 'correct or ameliorate the child's condition' "); *see also*, *I.B. v. Agency for Health Care Admin.*, 87 So.3d 6, 8-10 (Fla. 3d DCA 2012); *E.B. v. Agency for Health Care Admin.*, 94 So.3d 708, 708-709 (Fla. 4th DCA 2012).

Furthermore, Defendant takes the erroneous position that it is the final arbiter of medical necessity for all Medicaid services regardless of whether the service is prescribed for a child under age 21. *See* Fla. Admin. Code R. 59G-1.053

(AHCA "is the final arbiter of medical necessity for the purposes of determining Florida Medicaid reimbursement…"); (*see also*, Ex. 8) (in evaluating its EPSDT obligations under state and federal law, Defendant concludes that "…a treating physician's opinion regarding the medical necessity of a service is not dispositive or accorded deference."). By adopting this position, Defendant fails to accord proper weight or deference to the opinions of treating physicians in prescribing Medicaid services for children under age 21, a requirement under EPSDT. *M.H.* at *6; *Moore* at 1258-59.

A.W.'s case is no exception. Per Defendant's adopted policy, rather than assess whether A.W.'s request for a specialty medical bed is necessary "to correct or ameliorate" her health conditions, Defendant subjected A.W.'s initial request to the more stringent standard found in Fla. Admin. Code R. 59G-1.010. (Ex. 6). In addition, when A.W. challenged Defendant's denial through a Medicaid fair hearing, the AHCA hearing officer also relied on the medical necessity standard set forth in Fla. Admin. Code R. 59G-1.010 which, in turn, foreclosed A.W. from the opportunity to have her evidence weighed under EPSDT's broader "correct or ameliorate" standard. (Ex. 3).

In the final order upholding eQHealth's denial, the hearing officer arbitrarily ignored the professional opinions of Dr. Carlin and Ms. Reckamp stating that while A.W.'s mother:

> "provided the letters [of Dr. Carlin and Ms. Reckamp] to show that the specialty medical bed is medically necessary …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."

(Ex. 3, ¶20). This is the end of the hearing officer's reference to Dr. Carlin and Ms. Reckamp's opinions. The hearing officer's does not go on to analyze how a traditional hospital bed addresses the entrapment concerns raised by A.W.'s treating professionals; yet, it is precisely these entrapment concerns that A.W.'s specialty medical bed was designed to prevent. (*Compare* Ex. 3, ¶¶20-23 *with* Ex. 5 & 7). The hearing also does not address Ms. Reckamp's opinion that a Dream Series bed promotes A.W.'s quality of life. (*Compare* Ex. 3, ¶¶20-23 *with* Ex. 7).

By failing to acknowledge A.W.'s treating professionals' opinions and by failing to undertake any analysis as to why, specifically, Dr. Carlin's concerns about entrapment are not valid, the hearing officer's final order demonstrates how Defendant's erroneous standard operates in practice; namely, that Defendant does not accord weight or deference to the treating professional's opinion when making a prior authorization determination for a child under age 21. (Ex. 3; Ex. 8). As previously stated, this position conflicts with EPSDT. *M.H.* at *6; *Moore* at 1258-59.

There is also no evidence that eQHealth or the hearing officer took Ms. Reckamp's concerns about A.W.'s quality of life under consideration in denying

the bed. (Ex. 3). Thus, in addition to failing to accord weight or deference to Ms. Reckamp's professional opinion, Defendant also did not acknowledge that, in evaluating EPSDT services, "the child's quality of life must also be considered." *See* CMS, EPSDT Guide at 25.

Had Defendant, at any stage of evaluating A.W.'s request for Medicaid coverage, applied the correct standard – whether the specialty medical bed is necessary to correct or ameliorate A.W.'s multiple diagnoses and disabilities – the information provided by A.W.'s treating professionals and supported by her medical records would have established that the bed is medically necessary. The bed will make her health conditions more tolerable and will assure her health problems are addressed early "before they become more complex and their treatment more costly." *Ekloff* at 1171; *see also*, *C.F.* at 7; *Q.H.* at 14; *I.B.* at 6; *E.B.* at 708. Therefore, EPSDT requires the state to cover A.W.'s requested specialty medical bed and A.W. has a substantial likelihood of success on the merits of her claims under the Medicaid Act.

B. A.W. will suffer immediate and irreparable harm because of Defendant's denial of her prescribed durable medical equipment.

Courts have consistently found that "[t]he denial of medical benefits and resultant loss of essential medical services, constitutes an irreparable harm...." *Edmunds v. Levine*, 417 F. Supp. 2d 1323, 1342 (S.D. Fla. 2006) (citing *Cramer v. Chiles*, 33 F. Supp. 2d 1342, 1349 (S.D. Fla.1999)); *Mitson v. Coler*, 670 F. Supp.

1568, 1577 (S.D. Fla.1987); *Dodson v. Parham*, 427 F. Supp. 97, 108 (N.D.Ga.1977); *Beltran v. Myers*, 677 F.2d 1317, 1322 (9th Cir.1982); *Newton–Nations v. Rogers*, 316 F. Supp. 2d 883, 888 (D.Ariz.2004); *Doe v. Perales*, 782 F. Supp. 201, 204–205 (W.D.N.Y.1991); *Benjamin H. v. Ohl*, No. 3:99–0338, 1999 U.S. Dist. LEXIS 22469, at *36–*37 (S.D.W.V. July 15, 1999); *Mass. Ass'n of Older Americans v. Sharp*, 700 F.2d 749, 753 (1st Cir.1983). This includes denial of EPSDT benefits. *See K.G. ex rel. Garrido v. Dudek*, 839 F. Supp. 2d 1254 (S.D. Fla. 2011); *O.B. v. Norwood*, 170 F. Supp. 3d 1186, 1196 (U.S.D.C. N.D. Ill. 2016).

A.W. is currently suffering harm, as she has been denied the service that she needs. (Ex. 4, 5 & 7). Moreover, she has demonstrated that her health and well-being are in further jeopardy without the specialty medical bed prescribed by her treating physician to manage her many complex care needs, make her condition more tolerable, and keep her safe and healthy. (*Id.*) She has previously fallen out of bed. (Ex. 4, ¶22). She has also been found with her g-tube wrapped around her neck. (*Id.*) Luckily, she did not sustain serious injuries after either of these incidents but that is not a future guarantee.

In that same vein, A.W.'s treating physician has warned against the risks posed by A.W.'s current sleeping situation as well as those posed by a traditional hospital bed. (Ex. 5). A.W. requires prompt access to the Dream Series bed to

ameliorate her complex conditions. As such, A.W. has established that she is suffering and will continue to suffer irreparable harm resulting from Defendant's denial of a requested medical benefit to which she is entitled under EPSDT. *Edmunds* at 1342; *Mitson* at 1577; *Dodson* at 108; *Beltran* at 1322; *Newton-Nations* at 888; *Benjamin H.* at *36-37; *Mass. Ass'n of Older Americans* at 753.

C. The injury to A.W. outweighs any injury to Defendant.

As set forth in Paragraph A of this motion, Defendant is obligated under federal law to provide A.W. with the specialty medical bed prescribed by her treating physician because the bed is necessary to correct or ameliorate her condition. As set forth in Paragraph B of this motion, A.W., on the other hand, is a child who has been denied a service to which she is entitled under federal law and is essential to her health and safety. Denial of a Medicaid benefit, including an EPSDT benefit, has consistently been defined as irreparable harm. *Edmunds* at 1342; *K.G.* at 1254; *O.B.* at 1196.

Here, the harm to A.W. far "outweighs whatever minimal harm a preliminary injunction might visit upon the State." *Lebron*, 820 F. Supp. 2d at 1273, *aff'd*, *Lebron v. Sec'y, Fla. Dep't of Children & Families*, 710 F.3d 1202 (11th Cir. 2013). Defendant is designated under state law as the single state agency charged with the obligation of administering Medicaid benefits in compliance with federal law. Fla. Stat. §409.902. As such, meeting its obligation to provide A.W. her

EPSDT benefits as required by law would not cause undue administrative burden or financial strain. *See K.G.*, 839 F. Supp. 2d at 1268 (finding that requiring the state to expend $16,500-$25,000 to pay for an EPSDT benefit where the child movant had established that he was substantially likely to succeed on the merits of his EPSDT claim did not pose a fiscal harm to the state that outweighed plaintiff's irreparable harm from not receiving the benefit).

D. An injunction is not adverse to the public interest.

The public interest favors the entry of a preliminary injunction. Granting a preliminary injunction will serve the public interest in upholding the law and enforcing the mandates of the Medicaid Act by preventing A.W. from having her health put at risk due to a lack of necessary care to ameliorate her many complex conditions. The grant of effective injunctive relief would be a strong affirmation of the public interest in the enforcement of laws to achieve the purpose for which Congress enacted them. *See K.G.* at 1280 (finding that "[t]he issuance of an injunction in the instant case would provide K.G. with necessary medical services furthering the state purpose of the Medicaid program).

IV. CONCLUSION

A.W. has, by substantial evidence and overwhelming and consistent authority, demonstrated that Defendant is violating her right to have her requested Medicaid services be evaluated under a standard that accords with federal law.

A.W. has met her burden of showing that this is a proper case for injunctive relief and respectfully requests that the Court enter a preliminary injunction prohibiting Defendant from applying its medical necessity standard set for in Fla. Admin. Code R. 59G-1.010, and, instead, evaluate A.W.'s request for a specialty medical bed pursuant to EPSDT, and to grant all other and further relief as may be just and proper under the facts and the law.

Respectfully submitted this 6th day of August 2021.

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/s/ Katy DeBriere
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Counsel for Plaintiffs and Proposed Class Counsel

*Attorneys are appearing provisionally subject to approval to appear *pro hac vice*.

CERTIFICATE OF SERVICE

I hereby certify that on August 6, 2021, I electronically filed the foregoing with the Clerk of the Court by using the CM/ECF system. I further certify that I mailed the foregoing document and the notice of electronic filing by first-class mail to the following non-CM/ECF participants:

Simone Marstiller, Secretary
Agency for Health Care Administration
2727 Mahan Dr.
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(888) 419-3456

/s/ Katy DeBriere
Katherine DeBriere

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

W.B., by and through his father and legal guardian, David B., and A.W., by and through her mother and legal guardian, Brittany C., on behalf of themselves and all others similarly situated,

Plaintiffs,

v. Case No.:

SIMONE MARSTILLER, in her official capacity as Secretary for the FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION,

Defendant.
_____/

EXHIBIT INDEX – A.W.'S MOTION FOR PRELIMINARY INJUNCTION

Exhibit Number	**Title of Exhibit**
Exhibit 1	Appendix
Exhibit 2	Plaintiff A.W.'s Medical records
Exhibit 3	Plaintiff A.W. AHCA Final Order
Exhibit 4	Declaration of Brittany C.
Exhibit 5	Dr. Stephanie Carlin – Letter of Medical Necessity on behalf of Plaintiff A.W.
Exhibit 6	eQHealth Notice of Outcome as to Plaintiff A.W.
Exhibit 7	Karen Reckamp, Occupational Therapist – Letter of Medical Necessity on behalf of Plaintiff A.W.

Exhibit 8	AHCA EPSDT Memo
[redacted]	

Member Number: [redacted]	**Patient:** A[redacted] W[redacted]	**DOB:** [redacted]
Survey Date: 12/2/2019	**Survey Form:** FL HH Assessment 2017	**Program:** PPEC Program
Enrollment Date: 9/2/2014	**Finalized By:** Jynifer, Fortson	

Introduction :

Question Number	Question	Response
1	The recipient and or caregiver are aware that this questionnaire and answers are covered under the HIPAA act.	Yes
2	(Coordinator discussed program with caregiver)Parent/caregiver agrees to participate in Care Coordination program	Yes

Health Literacy :

Question Number	Question	Response
1	What is the primary language used in the home?	English
2	Are you comfortable speaking with me in English?	Speaks English
3	Do you have any cultural, religious or social practices that may affect your child's medical treatment?	No
4	I would like to talk to you about any difficulties that you may have in dealing with your child's healthcare needs. How often do you need to have someone help you read instructions, pamphlets, or other written materials from you child's doctor or pharmacist?	Never
5	Do you have problems learning about your child's medical condition because of understanding written materials that you get from your child's doctor, hospital or pharmacist?	No
6	Can you fill out medical forms without help from others?	Yes
7	Care Coordinator to answer based on observation/answers: Does the caregiver need assistance reading educational materials, understanding educational materials or filling out forms on the child's behalf?	No

Healthcare Team :

Question Number	Question	Response
1	What is the current payment sources for your child's care?	Medicaid - Traditional FFS
2	What type of services are being requested (check all that apply)	PPEC services PCS Services
3	Does your child have a primary care physician?	Yes

Member Number: [redacted]	**Patient:** A[redacted]W[redacted]	**DOB:** [redacted]
Survey Date: 12/2/2019	**Survey Form:** FL HH Assessment 2017	**Program:** PPEC Program
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Healthcare Team :

Question Number	Question	Response
4	What is the name of your child's primary care physician?	KOMATZ
5	When was the last time your child was seen by their Primary Care Physician?	7/2019
6	Are you maintaining a regular schedule of well child visits to your primary care physician?	Yes
7	Are your child's immunizations up to date?	Yes
8	If the recipient is under age 2, has he/she been screen for exposure to lead?	NA Recipient is over age 2
9	When is your child's next appointment with the primary care physician?	12/2019
10	What type of specialty physicians does your child see?	Orthopedics, Endocrine,Ophthalmology, GI.Nutrition,Neurology, Spasticity Clinic
11	When was the last time the recipient was seen by their specialty physician(s)?	11/2019
12	When is the next scheduled appointment with the specialist(s)?	TBD
13	Is transportation a problem to go to MD appointments or pick up prescriptions?	No
14	Does the parent/caregiver have all of the medical equipment that they need in order to care for their child?	Yes
15	What home equipment is currently in use (check all that apply)?	Wheelchair dependent Bath chair Stander Feeding equipment Splints Hoyer Lift Other Nebulizer TLSO brace, hip brace medical carseat and activity chair
16	Are there issues with or repairs needed for any equipment that is already in the home?	No
17	Does the recipient have a preferred DME provider?	Yes ALL ABOUT PEDS & Numotion
18	If the recipient is receiving any medical supplies, have there been any issues with timely receipt?	NA, does not need supplies or no issues
19	Does the recipient have an established pharmacy that they use regularly?	Yes

Member Number: [redacted]	**Patient:** A[redacted]W[redacted]	**DOB:** [redacted]
Survey Date: 12/2/2019	**Survey Form:** FL HH Assessment 2017	**Program:** PPEC Program
Enrollment Date: 9/2/2014	**Finalized By:** Jynifer, Fortson	

Healthcare Team :

Question Number	Question	Response
20	What was the outcome of the most recent inpatient discharge?	Recipient not hospitalized in the last 6 months
21	Has the recipient gone to the Emergency Department in the last 6 months?	No
22	Overall status Which description best fits the recipient's overall status?	Stable with no heightened risks for serious complications and death
23	Tell me about your child's health status in your own words.	she's doing well
24	Does the parent/caregiver appear to understand the child's diagnosis?	Yes
25	Tell me about the treatment plan that the physician has prescribed for your child in your own words	continue specialty visits

MEDICATION :

Question Number	Question	Response
1	Do you understand the purpose and proper administration of each of the medications you give your child?	Yes
2	Are there medications that have been ordered that are not being given?	No
3	Are there reason (financial or other) that you have been unable to obtain the medications that are ordered for your child?	No
4	Medication list was reviewed and updated in Medication profile in Care Coordination system	Yes, Medication profile was updated

ADMINISTRATION OF INTRAVENOUS FLUIDS/ANTIBIOTICS :

Question Number	Question	Response
1	Does the recipient receive IV/Infusion therapy (excludes TPN)?	No
2	Does the recipient get parenteral nutrition (TPN or lipids)?	No
3	What type of vascular access device does the recipient have?	None
4	Does the recipient have scheduled IV medications (other than IV pain medications)?	None
5	Does the recipient receive IV PRN pain medications?	None
6	Does the intravenous catheter require routine flushing?	None

Member Number: [redacted]	Patient: A[redacted] W[redacted]	DOB: [redacted]
Survey Date: 12/2/2019	Survey Form: FL HH Assessment 2017	Program: PPEC Program
Enrollment Date: 9/2/2014	Finalized By: Jynifer, Fortson	

LIVING ARRANGEMENTS :

Question Number	Question	Response
1	What is the number of competent adults living in the home?	Two
2	What is the number of adults who work outside of the home?	All
3	What is the number of children, 0-10 years of age, living in the home other than the recipient?	One
4	What is the number of physically or mentally disabled children/adults living in the home, other than the recipient?	Zero

SCHOOL :

Question Number	Question	Response
1	Does the recipient attend school or PPEC? Select all that apply.	PPEC School
2	Name and location of PPEC?	FLETCHER'S TC SOUTH
3	What is the PPEC schedule?	after school and non school days
4	Are skilled services needed during school hours?	Yes
5	Does the school provide a nurse for the recipient's skilled needs?	No
6	Does the school provide an aide for recipient's ADL needs?	No

SKILLED NURSING SERVICES: RESPIRATORY :

Question Number	Question	Response
1	Which best describes the recipient's airway status?	Normal
2	Which best describes the recipient's airway/tracheostomy care needs?	No suctioning required
3	Does the recipient use a ventilator?	Does not use a ventilator
4	If recipient does not have tracheostomy, what are the suctioning needs?	Requires no suctioning
5	What are the recipient's nebulizer needs?	PRN or BID nebulizers, Chest physiotherapy or Cough assist
6	What are the recipient's BIPAP/CPAP needs?	Does not use BiPAP/CPAP
7	Does the recipient receive chest percussive therapy?	No chest percussive therapy

Member Number:	Patient:	DOB:
[redacted]	A [redacted] W [redacted]	[redacted]
Survey Date: 12/2/2019	**Survey Form:** FL HH Assessment 2017	**Program:** PPEC Program
Enrollment Date: 9/2/2014	**Finalized By:** Jynifer, Fortson	

SKILLED NURSING SERVICES: RESPIRATORY :

Question Number	Question	Response
8	What are the recipient's oxygen therapy needs?	Does not use oxygen
9	What type of monitors are used in the home?	No monitors used
10	Has the recipient had sleep apnea or bradycardia requiring intervention within the last year?	No
11	Is the parent/caregiver certified in CPR?	Yes

GI/NUTRITION STATUS :

Question Number	Question	Response
1	What is the enteral G-Tube/J-Tube feeding schedule? Choose all that apply.	Enteral feeds QID or less Enteral feeds continuously at night only Enteral feeds over 30 minutes or less Enteral feeds via pump runs longer than 30 minutes/feed
2	In addition to feeds, are there boluses of water?	Yes
3	Oral feeding or eating - Current ability to feed self meals and snacks safely. Select those that apply.	Unable to feed self and must be assisted or supervised throughout the meal/snack
4	Does the recipient require aspiration precautions beyond routine positioning?	Yes

ELIMINATION STATUS :

Question Number	Question	Response
1	Urinary continence status:	Is incontinent at night only, or only occasionally, not appropriate for age
2	Bowel incontinence?	Occasionally incontinent of bowel, not appropriate for age
3	Does the recipient have an ostomy for bowel elimination?	No
4	Toilet transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.	Incontinent and does not do toilet transfers
5	Toilet Hygiene: Current ability to maintain perineal hygiene safely, adjust clothes and or incontinence pads before and after using toilet, commode. If managing ostomy, includes cleaning area around stoma but not managing equipment.	Depends entirely upon another person to maintain toileting hygiene, not appropriate for age

Member Number: [redacted]	Patient: A[redacted] W[redacted]	DOB: [redacted]
Survey Date: 12/2/2019	Survey Form: FL HH Assessment 2017	Program: PPEC Program
Enrollment Date: 9/2/2014	Finalized By: Jynifer, Fortson	

RENAL/UROLOGY :

Question Number	Question	Response
1	Is peritoneal dialysis done at home?	No
2	Does the recipient have a urinary catheter?	None
3	Does the recipient use external catheters?	No

NEUROLOGY :

Question Number	Question	Response
1	Which best describes the recipient's history of seizures?	Has seizures once to twice per month
2	Does the recipient have a Baclofen pump?	No

NEURO/EMOTIONAL/BEHAVIORAL STATUS :

Question Number	Question	Response
1	Cognitive functioning: Recipient's current (day of the assessment) level of alertness, orientation, comprehensive, concentration and immediate memory for simple commands.	Requires considerable assitance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half of the time, not appropriate for age
2	Has the physician or other care provider discussed ordering behavioral therapy or other evaluations to address behavioral issues?	No
3	Does the recipient currently receive or need a prescription for behavioral therapy services?	No

INTEGUMENTARY STATUS AND WOUND/STOMA CARE :

Question Number	Question	Response
1	Does the recipient have a risk of developing pressure ulcers? (Select all that apply)	Wheelchair dependent Incontinent of bowel/bladder
2	Wound Care? (Select one)	No wounds or stomas
3	Are the parents/guardian/caregiver receiving medical supplies for the recipient and have there been any issues or complications? List supplies needed and issues that need follow-up in the box below.	No

Member Number: [redacted]	**Patient:** A[redacted]W[redacted]	**DOB:** [redacted]
Survey Date: 12/2/2019	**Survey Form:** FL HH Assessment 2017	**Program:** PPEC Program
Enrollment Date: 9/2/2014	**Finalized By:** Jynifer, Fortson	

GROWTH AND DEVELOPMENT :

Question Number	Question	Response
1	Gross motor skills (best estimate of assessment or most recent evaluation done)? (Select one)	Child is at 1-3 years

SENSORY STATUS :

Question Number	Question	Response
1	Vision with corrective lenses if the recipient usually wears them.	Severly impaired; cannot locate objects without hearing or touching or the recipient is nonresponsive
2	Is the recipient affiliated or receiving services from Lighthouse for the Blind?	No
3	What is the recipient's ability to hear (with hearing aid or hearing appliance if normally used)?	Adequate: hears normal conversation without difficulty
4	What is the recipient's understanding of verbal content in the recipient's own language (with hearing aid or device if used)?	Sometimes understands: understands only basic conversation or simple direct phrases. Frequently requires cues to understand.
5	Speech and oral (verbal)expression of language in recipient's own language.	Unable to express basic needs even with maximal promting or assistance, or recipient is unresponsive, not appropriate for age
6	Use of augmentative device (select one)	NA does not use augmentive devices
7	Does the recipient currently receive speech therapy? If yes, please specify services.	Yes BROOKS REHAB
8	Does the recipient have or need a prescription for speech therapy evaluation or has a physician discussed ordering speech therapy?	Yes

ACTIVITIES OF DAILY LIVING :

Question Number	Question	Response
1	Grooming: Current ability to tend safely to personal hygiene needs (ie washing face and hands, hair care, shaving or makeup, teeth care and fingernail care)	Depends entirely upon someone else for grooming needs, not appropriate for age.
2	Current ability to dress safely: Including undergarments, pullovers, front opening shirts and blouses, managing zippers, buttons and snaps (with or without dressing aids)	Depends entirely upon another person to dress, not appropriate for age
3	Bathing: Current ability to wash entire body safely. Excludes grooming (washing face and hands and shampooing hair)	Depends entirely upon another person to be bathed, not appropriate for age

Member Number: [redacted]	**Patient:** A[redacted] W[redacted]	**DOB:** [redacted]
Survey Date: 12/2/2019	**Survey Form:** FL HH Assessment 2017	**Program:** PPEC Program
Enrollment Date: 9/2/2014	**Finalized By:** Jynifer, Fortson	

ACTIVITIES OF DAILY LIVING :

Question Number	Question	Response
4	Does the recipient receive occupational therapy?	If yes, list provider name and phone number. List frequency of services BROOKS REHAB
5	Does the recipient have or need a prescription for an occupational therapy evaluation or has a physician discussed ordering occupational therapy?	Yes

AMBULATION/LOCOMOTION :

Question Number	Question	Response
1	Positioning	Requires total assistance with repositioning
2	Transferring: Current ability to move from bed to chair	Bedfast, unable to participate in transfers (this includes requiring single lift, two person lift or mechanical lift)
3	Ambulation/Locomotion: Current ability to walk safely, once in a standing position or use of a wheelchair, once in a seated position, on a variety of surfaces	Dependent upon others for locomotion/wheelchair operation, not appropriate for age
4	Exercise	Requires assistance with a PT or MD ordered exercise plan including passive or active range of motion, use of standers, gait trainers, or other similar equipment meant to improve development and muscle tone or stretching
5	Does the recipient currently receive physical therapy?	If yes, list provider name and phone number. List frequency of services
6	Does the recipient currently have or need a prescription for physical therapy evaluation or has a physician discussed physical therapy?	Yes

ADDITIONAL RESOURCES :

Question Number	Question	Response
1	Is the recipient/family currently involved with a local support group?	No
2	Does the recipient need referral to local support groups?	No
3	Is the recipient receiving hospice services?	No
4	Is the recipient receiving respite services?	No

5	Receiving CDC+ and/or PCS services?	Authorized for PCS services up to 12 hours per day, 7 days per week but not receiving at this time
6	PPEC services: List the number of days/week authorized	5
7	If enrolled in an MMA, list the name and phone number of the Coordinator from the MMA.	NA
Goal Setting :		
Question Number	**Question**	**Response**
1	What is the member/member caregiver's short term personal health goal (SMART format: Specific, Measureable, Actionable, Realistic, Time limited)?	A[redacted] WILL HAVE LESS G-TUBE FEEDS AND EAT MORE ORALLY
2	What is the member/member caregiver's long term personal health goal (SMART format: Specific, Measureable, Actionable, Realistic, Time limited)?	A[redacted] WILL EAT HALF HER MEALS BY MOUTH, MAYBE HAVE A COMMUNICATION DEVICE
AGING OUT :		
Question Number	**Question**	**Response**
1	Is the recipient age 17 or older?	No
2	Is the recipient age 20?	No

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

FILED
May 06, 2020, 8:21 am
OFFICE OF FAIR HEARINGS

A.W. C/O [redacted]

PETITIONER,

AHCA Case No.: [redacted]

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION,

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic Fair Hearing in this matter on April 7, 2020, at 9:30 a.m. Eastern Standard Time ("EST").

APPEARANCES

For the Petitioner: [redacted]
Petitioner's Authorized Representative

For the Respondent: Linda Latson, RN
Registered Nurse Specialist
Agency for Health Care 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 a specialty bed (Durable Medical Equipment Code E1399 – miscellaneous) was incorrect.

PRELIMINARY STATEMENT

All parties appeared telephonically. [redacted] Petitioner's Authorized Representative and mother, appeared on behalf of Petitioner.

Linda Latson, RN, Registered Nurse Specialist, appeared on behalf of the Agency for Health Care Administration ("Agency" or "Respondent"). Dr. Rakesh Mittal ("Dr. Mittal"), Physician Consultant for eQHealth Solutions Florida, Inc. ("eQHealth"), attended as a witness for Respondent.

Prior to hearing, Petitioner sent to the Office of Fair Hearings the following documents that were admitted into evidence as Petitioner's Composite Exhibit 1: Letter of Medical Necessity from Karen Reckamp, signed January 16, 2019; email from [redacted] with four attached black and white photos of Petitioner, dated March 24, 2020; fax cover pages from Melanie Hare, dated March 25, 2020; letter from Stephanie Carlin, dated March 24, 2020; another copy of the Letter of Medical Necessity from Karen Reckamp, signed January 16, 2019; and three color photographs of Petitioner received on March 31, 2020. Absent an objection from Respondent, the undersigned admitted the documents into the record as Petitioner's Composite 1.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a two hundred and three (203)-page evidence packet. The evidence packet included: an DME Fair Hearing cover page; a table of sections; Fair Hearing Call-in Instructions; Order Scheduling Fair Hearing by Telephone and Prehearing Instructions, dated March 17, 2020; Outpatient Review History; a Notice of Outcome ("NOO") addressed to Administrator, dated February 24, 2020; an NOO addressed to Stephanie Carlin, dated February 24, 2020; an NOO addressed to [redacted] dated February 24, 2020; Beds by George Quote, dated February 18, 2020; Beds by

George Spec Sheet; Beds by George Dream Series Quote/Order Form; letter from Stephanie Carlin, dated January 16, 2020; Referral Epic Order Requisition, signed January 16, 2020; Progress Notes, dated December 20, 2019; a fax transmittal cover sheet, dated January 16, 2020; a Pricing Invoice, dated February 18, 2020; a demographics screen shot; a screen shot of diagnosis codes and descriptions; a list of medications; FL HH Assessment 2017, dated December 2, 2019; care coordinator notes and communication logs; a facsimile cover sheet, dated February 24, 2020; demographic data; Plan of Care for PPEC services, dated February 21,2020; Fletcher's Tendercare PPEC Flow Chart, dated February 24, 2020; the Agency's memorandum regarding Fair Hearings Process Authorization for Quality Improvement Organization in Medical Necessity Determinations, dated May 16, 2018; the Agency's summary memorandum regarding medical necessity as a limitation on Medicaid services including EPSDT, dated August 45, 2014; the Guide to Explaining the Summary Memorandum, effective August 5, 2014; and excerpts from the DME and Medical Supply Services Coverage and Limitations Handbook. Absent an objection from Petitioner, the undersigned admitted the evidence packet into evidence as Respondent's Composite Exhibit 1.

FINDINGS OF FACT

1. Petitioner receives Medicaid services on a fee-for-service basis. eQHealth is a Quality Improvement Organization contracted by the Agency to review prior authorization requests for services. *See* Respondent's Composite Exhibit 1 at page 182.[1] The Agency, through contractual agreement, authorized eQHealth to make medical necessity determinations regarding requests

[1] After Page 181 of 181, page numbers refer to the consecutive page numbers of the combined exhibit and not to the page numbers on the bottom of the page.

for fee-for-service Medicaid services requiring authorizations. *Id.* eQHealth is explicitly authorized to make medical necessity determinations for durable medical equipment and to act as a witness for the Agency in all Fair Hearing proceedings resulting from decisions and actions made by eQHealth in accordance with the contract. *Id.*

2. As of the date of the hearing, Petitioner is a 10 year old female diagnosed with cerebral palsy, quadriplegia, epilepsy, cortical visual impairment, gastro-esophageal reflux disease ("GERD"), and circadian rhythm sleep disorder. *Id.* at 17 and 19. Petitioner has a history of insomnia. *Id.* at 42. Petitioner is non-ambulatory, uses a gastrostomy tube ("G-tube") for nourishment, has progressive scoliosis and seizures, and is a high risk for falling out of bed at night. *Id.* at 17, and 19. Petitioner attends Fletcher's Tendercare PPEC. *Id.* at 178 - 180.

3. Petitioner's FL HH Assessment 2017, dated December 2, 2019, states that Petitioner was not hospitalized in the last 6 months and is stable with no heightened risks for serious complications and death. *Id.* at 59. Petitioner does not use a ventilator, BiPAP/CPAP, or oxygen. *Id.* at 60 - 61. Petitioner's G-tube feeding schedule includes enteral feeds continuously at night. *Id.* at 61. Petitioner has seizures once to twice per month. *Id.* at 62. Petitioner eats some baby foods, *Id.* at 179, with the goal of "less G-tube feeds and eat(ing) more orally." *Id.* at 65.

4. On January 16, 2020, Petitioner's physician, Dr. Stephanie Carlin ("Dr. Carlin"), provided a letter, which states as follows:

> Due to [Petitioner's] progressing scoliosis shoe needs to be in a bed that has a supportive mattress and bed frame. [Petitioner's] medical history includes seizures and spasticity which place her at risk for falling out of bed or becoming entrapped between a bed an side rails. Alternative beds such as a hospital bed with side rails or a Pedicraft canopy bed do not adequately meet patient's need. With a hospital bed, [Petitioner] runs the risk of becoming entrapped between the mattress and side rails which can lead to injuries. This can also happen with the Pedicraft canopy bed as over time the netting will loosen and can lead to a slope

> in the side netting. The DREAM bed style is designed to prevent entrapment and will protect the patient from falling out of the bed due to her developmental delay, seizures, and spasticity. The manual adjustable head of the DREAM bed will allow for [Petitioner] to be positioned during gastrostomy type feedings to help prevent aspiration. It is imperative that [Petitioner] receives the Beds by George DREAM bed in order to reduce the risk of injuries at bedtime.

Id. at 39.

5. On January 16, 2020, Petitioner's physical therapist, Karen Reckamp, provided a letter of medical necessity stating as follows:

> This bed will accommodate [Petitioner] for a lifetime with only minor maintenance and mattress replacement. She is a very involved young lady with minimal expectations for significant improvement in her current functional status. [Petitioner] is completely dependent upon her mother for all care and positioning. This is extremely challenging for a parent and the ability to acquire required medical equipment and positioning devices is critical for the well-being of both the child and the caregiver.
>
> [Petitioner] cannot participate in typical childhood activities and her world is limited to therapy, medical appointments and school. She has no independent mobility and is completely reliant on her caregivers for position changes throughout the night. [Petitioner's] mother does not have nursing or respite care. A seemingly benign request for a bed that looks like a bed and not a hospital room is emotionally necessary for families and children with complex medical needs in order to lend a sense of normalcy to their daily lives. Unfortunately, funding sources do not consider this and view items such as beds as "not medically necessary." This is extremely unfortunate as children with special needs spend nearly half of their day in a bed. The ability of a bed to provide comfort, support and positioning is important for their quality of life.

Petitioner's Composite Exhibit 1 at 4.

6. On February 24, 2020, Respondent issued an NOO denying Petitioner's request for a code E1399 specialty bed. *Id.* at 28-29. The NOO stated the basis for the denial as follows:

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

Individualized, specific, and consistent with the symptoms or confirmed diagnosis of the illness or injury under treatment, and not 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.

The patient is a 10 year old with CP who is non-ambulatory, non-verbal, and has GT and the request is for a specialty bed. The request is excessive because a hospital bed should suffice. A specialty bed was previously denied last November.

Id. at 28.

7. On March 2, 2020, Petitioner's Authorized Representative timely requested a Medicaid Fair Hearing based on Respondent's denial of Petitioner's request for a specialty bed. The Fair Hearing was set for April 7, 2020, at 9:30 a.m. EST, and all parties were duly notified.

8. At the hearing, [redacted] testified that Petitioner receives continuous G-tube feeding at night. She testified that Petitioner uses a regular bed that does not incline, and the bed rail is not stable. She testified that Petitioner needs a bed that can be raised at the head due to Petitioner's GERD. [redacted] testified that a specialty bed is needed to prevent Petitioner from falling out of bed, getting her arm trapped in the bed rail, or hitting her head and having a seizure. [redacted] testified that Petitioner has fallen out of bed in the past and been found with the G-tube wrapped around her neck or pulled completely out.

9. [redacted] testified that a specialty bed is preferable to a hospital bed. She argued that Petitioner is going to be bed bound for rest of life and needs something comfortable that fits her medical needs and is safe.

10. Dr. Mittal testified that he reviewed all the information provided by Petitioner and agrees with the decision to deny the specialty bed because a hospital bed will meet Petitioner's medical

needs. Dr. Mittal testified that Petitioner currently sleeps in a regular bed that has no side bars, pads, or supports to protect her. Dr. Mittal testified that acute care and tertiary care hospitals, treating chronically sick and disabled children, use hospital beds rather than specialty beds. Like Petitioner, the children in these hospitals also have seizures and G-tubes (as well as IV's, catheters and ventilators), and they are protected in bed. Dr. Mittal testified that a hospital bed is height adjustable, can be raised at the head for Petitioner's GERD, and can be used with foam padding that is thick and secure so that the Petitioner can be protected at night.

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), Florida Statutes.

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

13. 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.).

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. A state may place medical necessity limitations on EPSDT services. *See* 42 C.F.R. §§ 440.230(a), (b), (d). Section 409.905(2), Florida Statutes, 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. Section 2.83 of the Definitions Policy, incorporated by reference into 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 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.
>
> Medically necessary or medical necessity for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the

provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

17. The DME Handbook, incorporated by reference in Fla. Admin. Code R. 59G-4.070, governs requested DME services available under Florida Medicaid. The DME 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).
>
> . . .
>
> **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 and the specific requirements described in this 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.
>
> . . .
>
> **Reimbursement Information:**
> The Medicaid fee reimbursed for durable medical equipment (DME) and medical supplies including labor, travel, delivery, shipping, handling, fees for measuring, casting, fitting, adjusting or dispensing items or products.
>
> . . .
>
> Introduction
> The DME and Medical Supply Services Provider Fee Schedules are tables of columns listing the Medicaid reimbursable Healthcare Common Procedure Coding System (HCPCS) Level II Procedure Codes, their descriptors, and other information pertinent to each code.
>
> . . .
>
> **Hospital Beds, Mattresses, and Rails**

> A standard hospital bed consists of a modified latch spring assembly mattress, bed ends with casters, and two manually operated foot end cranks.
>
> It is equipped with IV sockets and is capable of accommodating a trapeze bar, side rails, an overhead frame, and other accessories.
>
> Medicaid may reimburse for a hospital bed when the recipient requires repositioning of the body in a way not feasible in an ordinary bed, or attachments for the bed are required that cannot be used with an ordinary bed.
>
> . . .
>
> Fee Schedules
>
> The DME and Medical Supply Services Provider Fee Schedule for All Medicaid Recipients lists the DME and medical supplies covered for all Medicaid recipients, regardless of age.

18. Petitioner is a Medicaid recipient who is under 21 years of age. Thus, the provisions of the EPSDT program apply to the request for DME services in this case.

19. The Durable Medical Equipment Fee Schedule lists the durable medical equipment and medical supplies covered for all Medicaid recipient. The Durable Medical Equipment Fee Schedule includes a procedure cost and the maximum age that an enrollee is eligible to receive equipment. Prior authorization based on medical necessity is required for requests for specialized items (code E1399) that are not listed on the fee schedule. *See* Durable Medical Equipment and Medical Supply Services Provider Fee Schedule at pages 2 and 29.

20. On January 16, 2020, Petitioner's physician and physical therapist, issued letters in support of the Petitioner's specialty bed request. See *supra* ¶¶ 4 and 5. [redacted] provided the letters to show that the specialty bed is medically necessary. 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* ¶16.

21. In denying the requested DME services, Respondent stated in the NOO, dated February 24, 2019, that the services were not "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs." See *supra* ¶6.

22. Petitioner must establish that the requested durable medical equipment is medically necessary. According to [redacted] testimony and the evidence of record, Petitioner's medical needs include an inclining bed due to GERD, protective rails to prevent Petitioner from falling out of bed, and a stable bed that will protect Petitioner during nighttime G-tube feeds. *See supra* ¶¶2-4, 8. As Dr. Mittal testified, a hospital bed is sufficient to meet Petitioner's medical needs. *See supra* ¶10. A hospital bed is height adjustable, inclines, has stable rails, and can be used with thick foam padding to protect Petitioner. *See supra* ¶¶ 10 and 17. Based on Dr. Mittal's testimony, a hospital bed would meet Petitioner's medical needs and [redacted] safety concerns; thus, Petitioner did not show that a specialty bed is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the Petitioner's needs.

23. Accordingly, Petitioner did not establish that Medicaid the requested durable medical equipment is medically necessary. As such, the undersigned finds that Petitioner did not provide by a preponderance of the evidence that Respondent's denial of the requested durable medical equipment was incorrect.

IT IS HEREBY ORDERED AND ADJUDGED THAT:

Respondent's denial of medical equipment is **AFFIRMED**. Petitioner's request for medical equipment is **DENIED**.

DONE and **ORDERED** this 6th day of May, 2020, in Tallahassee, Leon County, Florida.

Laura Gallagher
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LAURA GALLAGHER, Hearing Officer
Agency for Health Care Administration
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Email: OfficeOfFairHearings@ahca.myflorida.com

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:

A.W. c/o [redacted]
11542 Brian Lakes Dr
Jacksonville, FL 32221

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com

DECLARATION OF BRITTANY C.

1. My name is Brittany C.

2. I am 31 years old and live in Jacksonville, Florida with my husband, Antonio W., and our two children: A.W. (11 years old); and A.W. (7 years old). I am also pregnant with our third child.

3. My daughter, A.W., is enrolled in Medicaid. She does not have a managed care plan but, instead, is enrolled in Fee For Service Medicaid. eQHealth Solutions, Inc. (eQHealth) is the entity that determines whether Medicaid will provide a requested service to A.W.

4. A.W. was born premature at 24 weeks. As a result, she has multiple medical complexities including spastic cerebral palsy, cortical visual impairment, seizures, and developmental delay.

5. A.W. is at a high risk for falling out of her bed because of her seizure disorder and because she has extreme spasticity.

6. A.W. cannot talk. She uses a Tobii Dynavox to communicate. If she is in danger or if she is hurt, she cannot call out for assistance.

7. A.W. is unable to walk and uses a wheelchair. When she is at home, we use a Hoyer lift which is a piece of durable medical equipment that enables one person to lift and transfer A.W. Without the Hoyer lift, it takes two people to lift her.

8. My daughter's ability to eat solid foods is very limited so she uses a gastronomy tube (g-tube) for supplemental nutrition.

9. My daughter is fully dependent on her caregivers for all activities of daily living.

10. My daughter's pediatrician is Dr. Stephanie Carlin, D.O., who practices at UFHealth's Bower Lyman Center for Medically Complex Children located in Jacksonville, Florida.

11. My daughter's occupational therapist who conducts evaluations for her durable medical equipment is Karen Reckamp. Ms. Reckamp works at Wolfson Children's Hospital – Rehabilitation Center also located in Jacksonville, Florida.

12. In winter 2019, Dr. Carlin, Ms. Reckamp, and I discussed the specialty medical bed that would best support A.W.'s needs. My concerns included that the bed needed to be enclosed to prevent falls, that it needed a special outlet to route the excess tubing from A.W.'s g-tube (because previously, A.W. has been found with the g-tube wrapped around her neck), and the bed should allow A.W.'s caregivers to access A.W. quickly and easily.

13. Dr. Carlin's concerns included A.W.'s worsening scoliosis necessitating a supportive mattress, the need to prevent A.W. from falling out of bed necessitating an enclosed bed structure, and the likelihood that A.W. could

become entrapped in a traditional hospital bed. Dr. Carlin also stated that A.W.'s specialty medical bed should have an adjustable head because A.W. risks aspiration due to her g-tube.

14. Ms. Reckamp's concerns were the same as mine and Dr. Carlin's but, in addition, Ms. Reckamp wanted to ensure that the prescribed bed took into consideration A.W.'s quality of life since A.W. spends most of her time in bed.

15. After those conversations, Dr. Carlin and Ms. Reckamp prescribed the Dream Series bed for A.W.

16. On February 24, 2020, in response to the request, eQHealth denied the Dream Series bed.

17. Frustrated and concerned about A.W.'s health and safety, I pursued the denial diligently and filed appeal with the Office of Fair Hearings – Agency for Health Care Administration (AHCA) on March 2, 2020.

18. The hearing was held on April 7, 2020. It lasted from 9:30am to 10:19am.

19. During the hearing, eQHealth insisted that a hospital bed with rails would be sufficient to meet A.W.'s needs. I tried to emphasize the safety concerns posed by a traditional hospital bed including the risk of g-tube entanglement as well as entrapment in the hospital bed rails and gaps between the frame and

mattress. It did not seem like the hearing officer took my concerns, or more importantly, the concerns of A.W.'s treating professionals into account.

20. The hearing officer sent me a final order upholding eQHealth's denial of the Dream Series bed. I also received a copy of the entire record on appeal which included an AHCA document entitled "Summary Memorandum: Medical Necessity as a Limitation on Medicaid Services, Including EPSDT" dated August 5, 2014. It had handwritten page numbers on the bottom right-hand corner beginning at 183 and ending at 194. I gave the record on appeal to my daughter's attorney, Katy DeBriere.

21. Since AHCA will not provide the Dream Series bed, I do not know what next steps I should take to ensure A.W.'s is safe when she is in bed. Given that Dr. Carlin and Ms. Reckamp emphasized the dangers of entrapment posed by a traditional hospital bed with rails, I do not want to choose that sleeping arrangement.

22. At the same time, I know A.W.'s current sleeping arrangement in a regular bed is also not safe. For example, on May 6, 2021, she fell out of bed and was found hanging by her foot with her head stuck between the wall and bed.

23. Like the scenario on May 6, 2021, there are moments when I do not even realize the potential risks that A.W. sleeping in a regular bed pose until they happen. This brings me great anxiety.

24. Due to AHCA's denial of the Dream Series bed, I have been placed in an untenable position where I must pick between two unsafe sleeping situations for my daughter. A.W. is non-verbal and because she cannot call out to us for help, I am constantly concerned about her safety at night. This interrupts my sleep significantly and impacts everyone in our home.

25. As a parent, my daughter's safety, well-being, and quality of life are at the forefront of my mind. For these reasons, I ask that the Court grant our request for preliminary relief on behalf of A.W. and order that AHCA evaluate A.W.'s need for the Dream Series bed under the correct standard - that is whether the bed is necessary to correct or ameliorate A.W.'s disabling conditions.

26. I greatly appreciate the Court's consideration of this matter.

Dated: 8/4/2021

Brittany C.

UFHealth
UNIVERSITY OF FLORIDA HEALTH

UF Health Jacksonville
BOWER LYMAN CENTER FOR MEDICALLY COMPLEX CHILDREN
841 PRUDENTIAL DR, SUITE 900
JACKSONVILLE FL 32207-8373
Dept Phone: 904-202-8920
Dept Fax: 904-633-0921
UFHealthJax.org

January 16, 2020

RE: A[redacted] W[redacted]
DOB: [redacted]

To Whom It May Concern:

I am writing this letter on behalf of my patient, A[redacted] W[redacted] who attends the Bower Lyman Center for Medically Complex Children for her primary care.

A[redacted] is a 9 year old female who has multiple medical complexities including spastic cerebral palsy, cortical visual impairment, seizures, and developmental delay. A[redacted] is nonverbal and nonambulatory. A[redacted] was a premature infant born at 24 weeks gestation and remained in the NICU at Wolfson Children's Hospital for 6 months. She had several surgeries including placement of a gastrostomy tube and has undergone bowel resection. A[redacted] had her tonsils and adenoids removed in 2013, underwent dorsal rhizotomy for spasticity in 2014 and then had osteotomies completed by Dr. Loveless in 2015. A[redacted] required her gallbladder to be removed in 2016. A[redacted] receives Physical Therapy, Occupational Therapy, Speech Therapy, and Vision Therapy. A[redacted] is completely dependent upon her caregiver for all activities of daily living (ADLs). Patient relies on her custom wheelchair for all mobility purposes.

As a matter of medical necessity, I would request the full size Beds By George DREAM Bed 2500 with clear view windows with air flow panel, casters, 30 inch transfer height, 5 ½ clearance for floor lift, IV pole and mounting bracket, storage drawers under bed rail, and access port for feeding tubes. Due to A[redacted] progressing scoliosis she needs to be in a bed that has a supportive mattress and bed frame. A[redacted] medical history includes seizures and spasticity which place her at risk for falling out of bed or becoming entrapped between a bed and side rails. Alternative beds such as a hospital bed with side rails or a Pedicraft canopy bed do not adequately meet patient's needs. With a hospital bed, A[redacted] runs the risk of becoming entrapped between the mattress and side rails which can lead to injuries. This can also happen with the Pedicraft Canopy bed as over time the netting will loosen and can lead to a slope in the side netting. The DREAM bed style is designed to prevent entrapment and will protect the patient from falling out of the bed due to her developmental delay, seizures, and spasticity. The manual adjustable head of the DREAM bed will allow for A[redacted] to be positioned during gastrostomy tube feedings to help prevent aspiration. It is imperative that A[redacted] receives the Beds By George DREAM Bed in order to reduce the risk of injuries at bedtime.

If you have any further questions, please feel free to contact our office.

Sincerely,

Stephanie Carlin, DO, FAAP
Bower Lyman Center for Medically Complex Children
841 Prudential Drive Suite 1900
Jacksonville, FL 32207
Phone: (904) 202-8920
Fax: (904) 633-0931

eQHealth Solutions – Florida Division
5802 Benjamin Center Drive
Suite 105
Tampa, FL 33634

Date of Notice: 2/24/2020
Review Complete Date: 2/20/2020
Review Request Date: 2/18/2020
Billing Provider Name & Number: 003207800
ALL ABOUT PEDIATRICS,LLC
Setting: DME
Doctor's Name & Number:
STEPHANIE CARLIN
Recipient Name: A[redacted] W[redacted]
Recipient's Medicaid Number: [redacted]
Admit Date: 3/15/2020

Brittany C[redacted]
[redacted]
JACKSONVILLE, FL [redacted]

NOTICE OF OUTCOME

Dear Brittany C[redacted]

eQHealth Solutions reviews requests for DME services under the Florida Medicaid program. Nurses and physicians with experience in DME review the information from your provider in order to determine medical necessity.

Your provider submitted a request for services. A physician reviewed the request and based on the information provided to us our findings are below.

Our decision includes the number of units approved or denied in the "Total Units" column.

Code	Description	From	Thru	Total Units		Rental Type If Rented
E1399	Specialized Medical Equipment/Supplies	3/15/20	5/14/20	Approved	0	
				Denied	1	

The request for services is denied in whole or in part because they are not medically necessary as defined in Rule 59G-1.010(166), 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:

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

The patient is a 10 year old with CP who is non-ambulatory, non-verbal, and has a GT and the request is for a specialty bed. The request is excessive because a hospital bed should suffice. A specialy bed was previously denied last November.

Date of action is 2/21/2020

Right to Reconsideration

If you do not agree with this decision, you, your doctor, or your provider can ask eQHealth to reconsider and have another physician review the case. A request for reconsideration must be submitted to eQHealth before 3/6/2020.

eQHealth Solutions – Florida Division
Attention: Reconsideration
5802 Benjamin Center Drive
Suite 105
Tampa, Florida 33634
(855) 444-3747

If you ask for reconsideration, A[redacted] W[redacted] still has a right to a fair hearing.

You do not have to ask for reconsideration. If you do not, A[redacted] W[redacted] can ask for a fair hearing as follows.

Right to Fair Hearing

You may ask for a fair hearing within 90 calendar days from the date this notice was mailed by contacting AHCA by telephone at (877)-254-1055, by fax at (239)-338- 2642, by email at MedicaidHearingUnit@ahca.myflorida.com, or in writing at:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 60127
Ft. Myers, FL 33906

You may represent yourself at the hearing or use legal counsel, a relative, a friend, or another person you authorize to represent you.

Sincerely,

Medical Director
Chris Kunis, MD

650 DME OP Outcome-Denial

47144890

Notice: This notice is only for the persons it was sent to and should not be used by anyone else. If it was sent to you by mistake you should not use it in any way. If it should not have been sent to you, please call us right away at 855-444-3747. Please destroy the letter.

Wolfson Children's Hospital

Changing Health Care for Good.

W[redacted], A[redacted] DOB: [redacted]

LETTER OF MEDICAL NECESSITY
BEDS BY GEORGE DREAM BED

W[redacted], A[redacted] DOB: [redacted]

Past Medical History, Problems, Diagnoses
A[redacted] is a 10 year old child accompanied to the evaluation by her mother who provided pertinent medical and developmental history. Caregiver expressed the following concerns: A[redacted] has been denied a special needs bed x 2 and cannot be safely positioned in a standard bed. Mom would like assistance with finding a solution

Past Medical History, Problems, Diagnoses
Birth History:
Birth Weight: 0.55 kg (1 lb 3.4 oz)
Delivery Method: C-Section, Unspecified
Gestation Age: 24 wks
Pregnancy complications: none.
Birth complications: none.
Perinatal complications: In the NICU for 6 months, ventilator for 3-4 months. Home with g-tube but no oxygen. Brain bleed- grade 1 per Nemours records.

MRI findings from April 10, 2012 showed "markedly thin corpus callosum and markedly diminished white matter throughout the cerebral hemispheres, compatible with periventricular leukomalacia."

MRI of the brain done on March 21, 2018 showed "Unchanged periventricular leukomalacia."

MRI of the spine done on March 21, 2018 showed "No evidence of spinal cord abnormality. Clumped appearance of proximal cauda equina nerve roots, suggestive of arachnoid adhesions."

CURRENT MEDICAL SERVICES: Ophthalmology, GI, Nutrition, Orthopedics, Endocrinology, Neurology

SURGICAL HISTORY:
CHOLECYSTECTOMY 01/18/2016n-Open lysis of intestinal adhesions and cholecystectomy; GASTROSTOMY; HIP SURGERY 05/08/2015 - varus derotational osteotomy proximal femur, with blade plate; OSTEOTOMY, HIP 9/18/2015 San Diego pelvic osteotomy, left hip, Removal proximal orthopedic proximal femoral blade plate, bilateral ; RHIZOTOMY 12/09/2014; TONSILLECTOMY AND ADENOIDECTOMY

Patient Identified Fall Risk Factors : Dependent for all transfers and mobility
Fall Preventative Safeguards : Ensure wheelchair brakes are locked and seat belts are secure, Use lift device to transfer patient > 30lbs.

Diagnoses(Active)

Congenital quadriplegia	*Ranking:* Primary ; *Diagnosis Code:*	G80.8
Delayed developmental milestone	*Ranking:* Tertiary ; *Diagnosis Code:*	R62.0
Neuromuscular scoliosis	*Ranking:* Secondary ; *Diagnosis Code:*	M41.40

Wolfson Children's Hospital

Changing Health Care for Good.

W[redacted], A[redacted] DOB: [redacted]

General Information
Reason for Referral : Wheelchair modifications; Patient Lift, Vehicle Lift, Bed
Individuals Present at Evaluation : Patient, Caregiver, Supplier, Therapist
Supplier : National Seating and Mobility (David Wix)

Impairments/Limitations : Abnormal Tone, Ambulation Deficits, Balance Deficits, Cognitive Deficits, ROM Deficits, Strength Deficits, Gross Motor Impairment/Delay, Neurodevelopmental Impairment/Delay

Home Environment
Living Situation : Lives with Family
Lives In : Single level home
Lives With : Parent(s)/Guardian

Functional
School Mobility Requirements : Wheelchair needed throughout the day at school

Integumentary Assessment
Skin Integrity : Intact

ADL
Basic ADL W/C Status Grid

	Bathing Upper Extremity	Bathing Lower Extremity	Dressing Upper Extremity	Dressing Lower Extremity
Assist Level :	Dependent	Dependent	Dependent	Dependent

	Self Feeding	Toileting
Assist Level :	Dependent	Dependent

Bowel Management : Incontinent
Bladder Management : Incontinent
Pt Has Limitations Without Wheelchair : Entirely limited

Current Seating and Mobility
Current Mobility Base : Dependent with tilt
Current Mobility Manufacturer : Freedom NXT
Current Condition of Mobility Base : Need repairs
Posture in Current Seating System : Poor head position, Trunk leans to the side

Wheelchair Skills
Bed To and From Chair : Dependent
Wheelchair To and From Commode : Dependent
Manual Wheelchair Propulsion : Dependent

Balance and Transfers
Sitting Balance : Does not sit
Standing Balance : Does not stand
Transfer Type : 2 person lift, Hoyer lift

Wolfson Children's Hospital

Changing Health Care for Good.

W[redacted], A[redacted] DOB: [redacted]

Ambulation : Unable

Measurements
Shoulder Width : 17 inches
Chest Width : 10 inches
Hip Width : 11 inches
Top of Head : 26 inches
Seat to Top Left Shoulder : 17 inches
Seat to Top Right Shoulder : 17 inches
Left Upper Leg Length : 14 inches
Right Upper Leg Length : 14 inches
Left Lower Leg Length : 12 inches
Right Lower Leg Length : 12 inches
.

Neuro-Motor Assessment
Upper Extremity Tone
Left Upper Extremity : Spastic, Hypertonic
Right Upper Extremity : Spastic, Hypertonic

Lower Extremity Tone
Left Lower Extremity : Hypertonic, Spastic
Right Lower Extremity : Hypertonic, Spastic
Trunk : Hypotonic

Head/Neck Position
Position : Flexed
Head Control : Absent
Tone/Movement : strong forward pull of head into flexion, has trialed a chin prompt system but does not work per mom

Trunk and Upper Body Position
Anterior/Posterior : Increased thoracic kyphosis
Position Flexibility : Partly flexible
Left/Right : Convex left
Curvature : C-Curve
Left Flexibility : Partly flexible
Elbows ROM : Left Elbow Flexed, Right Elbow Flexed
Shoulders/Elbows Strength Concerns : right arm is getting caught between wheelchair armrest and the tray

UE ROM
Left Upper Extremity Active Range : Impaired
Left Upper Extremity Passive Range : Impaired
Right Upper Extremity Active Range : Impaired
Right Upper Extremity Passive Range : Impaired

Left Wrist and Hand Strength/Dexterity : Impaired
Right Wrist and Hand Strength/Dexterity : Impaired

Hip and Pelvis Position
Anterior/Posterior : Posterior tilt

Wolfson Children's Hospital

Changing Health Care for Good.

W[redacted], A[redacted] DOB: [redacted]

Position Flexibility : Partly flexible
Obliquity : Right side low
Obliquity Flexibility : Partly flexible
Position : Adduct
Position Flexibility : Partly flexible

LE ROM
Left Lower Extremity Active Range : Impaired
Left Lower Extremity Passive Range : Impaired
Right Lower Extremity Active Range : Impaired
Right Lower Extremity Passive Range : Impaired

RECOMMENDED SPECIAL NEEDS BED

Beds by George Dream Series
https://bedsbygeorge.com/safety/our_beds/models/2500.php

1. 30" transfer
2. Lift kit
3. Full Size
4. Casters
5. Clear view windows with air flow panel
6. Access port for tubing
7. Manual adjust head and foot board – due to history of
8. Full articulation

This bed will accommodate A[redacted] for a lifetime with only minor maintenance and mattress replacement. She is a very involved young lady with minimal expectations for significant improvement in her current functional status. A[redacted] is completely dependent upon her mother for all care and positioning. This is extremely challenging for a parent and the ability to acquire required medical equipment and positioning devices is critical for the well-being of both the child and the caregiver.

A[redacted] cannot participate in typical childhood activities and her world is limited to therapy, medical appointments and school. She has no independent mobility and is completely reliant on her caregivers for position changes throughout the night. A[redacted] mother does not have nursing or respite care. A seemingly benign request for a bed that looks like a bed and not a hospital room is emotionally necessary for families and children with complex medical needs in order to lend a sense of normalcy to their daily lives. Unfortunately, funding sources do not consider this and view items such as beds as "not medically necessary." This is extremely unfortunate as children with special needs spend nearly half of their day in a bed. The ability of a bed to provide comfort, support and positioning is important for their quality of life.

Karen Reckamp, OTR/L, ATP, SMS OT4378

Karen Reckamp, OTR/L, ATP, SMS 1/16/2019

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

MEMORANDUM

DATE: April 25, 2017

TO: Stuart Williams, General Counsel, Agency for Health Care Administration

FROM: Tracy George, Chief Appellate Counsel, Agency for Health Care Administration[1]

SUBJECT: Summary Memorandum: Medical Necessity as a Limitation on Medicaid Services, Including EPSDT

Introduction

The purposes of this Summary Memorandum are to: a) identify the federal law authorizing states to limit Medicaid services, including early and periodic screening, diagnosis, and treatment ("EPSDT"), based on medical necessity; b) explain how Florida Medicaid utilizes medical necessity limitations in its case-by-case services determinations; and c) identify guiding principles in the federal case law that inform the Florida Medicaid medical necessity inquiry.

A. Overview of the Medicaid Program.

1. The State and Federal Medicaid Agencies.

In Florida, AHCA is the "single state agency" responsible for administering the Medicaid Program and for ensuring compliance with state and federal Medicaid laws and rules. 42 U.S.C. § 1396a(a)(5); 42 C.F.R. § 431.10(b); §§ 409.811(2), 409.8132, 409.818(3), 409.902, Fla. Stat. The Federal Medicaid agency is the Department of Health and Human Service, Centers for

[1] Tracy George drafted the original memorandum, issued on August 5, 2014. Subsequent updates were provided by Kevin Dewar, Assistant General Counsel, Agency for Health Care Administration.

Medicaid and Medicare Services ("CMS"). 5 C.F.R. § 5501.102(a)(6); 42 C.F.R. § 400.200. *See, generally,* 42 C.F.R. ch. IV.C.

2. The Medicaid State Plan and Services.

Medicaid is a cooperative federal-state program, established pursuant to Title XIX of the Social Security Act, for funding medical services for the needy. 42 U.S.C. § 1396, *et seq.* A state that chooses to participate in Medicaid submits a plan, known as the "Medicaid State Plan," to CMS. *Harris v. James*, 127 F.3d 993, 996 (11th Cir. 1997). If CMS approves the Medicaid State Plan, the state and federal governments jointly pay for medical services in accordance with its terms. *Id.*

The twenty-nine (29) services that can be provided under a Medicaid State Plan are listed in 42 U.S.C. §§ 1396d(a)(1) through (a)(29). Coverage of eight (8) of these services, including early and periodic screening, diagnosis, and treatment ("EPSDT") services, is mandatory, and the services must be provided by every Medicaid-participating state. Because coverage of the remaining twenty-one (21) services is optional, each state can choose whether to provide them in its Medicaid State Plan. *See* 42 U.S.C. § 1396a(a)(10)(A) (requiring state plans to provide at least the services listed in 42 U.S.C. §§ 1396d(a)(1)-(a)(5), (a)(17), (a)(21), (a)(28)); § 409.905, Fla. Stat. (listing mandatory Medicaid services); § 409.906, Fla. Stat. (listing the optional Medicaid services Florida provides).

3. Federal EPSDT Requirements

Under federal Medicaid law, states must provide EPSDT services for qualified children under age 21 when requested under the Medicaid state plan. 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § 1396d(a)(4).

EPSDT services include periodic and age-appropriate health screenings (i.e. comprehensive health and developmental history, physical examinations, appropriate immunizations, laboratory tests, and health education), vision, dental, and hearing screenings, and appropriate follow-up treatment whenever a screening shows a follow-up treatment to be medically necessary. 42 U.S.C. §§ 1396d(r)(1)-(4). They also include:

> 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 screening services, whether or not such services are covered under the state plan.

42 U.S.C. § 1396d(r)(5).

Sections 5010 through 5360 of the State Medicaid Manual, which was promulgated by CMS and is binding on all state Medicaid programs, describes how states must provide EPSDT services to meet federal requirements. CMS State Medicaid Manual ch.1, § B.1, ch. 5 §§ 5010-5360 (available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html).

B. Federal Law Allows States to Place Limitations on Medicaid Services, Including EPSDT Services.

The federal regulations and the CMS State Medicaid Manual expressly authorize states to place amount, duration, and scope limitations, as well as medical necessity limitations, on Medicaid services, including EPSDT services. 42 C.F.R. §§ 440.230(a), (b), (d). The CMS State Medicaid Manual expands on the federal regulation with respect to EPSDT services. It provides:

> Services under EPSDT must be sufficient in amount duration or scope to reasonably achieve their purpose. The amount, duration, or scope of EPSDT services to recipients may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. **Appropriate limits may be placed on EPSDT services based on medical necessity.**

* * *

> **[The states] make the determination as to whether the [EPSDT] service is necessary. You are not required to provide any items or services which you determine are not safe or effective or which are considered experimental.**
>
> * * *
>
> 42 C.F.R. 440.230 allows you to establish the amount duration and scope of services provided under the EPSDT benefit. Any limitations imposed must be reasonable and services must be sufficient to achieve their purpose (within the context of service the needs of individuals under age 21). You may define the service as long as the definition comports with the requirements of the statute in that all services included in § 1905(a) of the [Medicaid] Act that are **medically necessary to ameliorate or correct defects and physical or mental illnesses and conditions** discovered by the screening services are provided.

CMS State Medicaid Manual at §§ 5110, 5122.F., 5123 (emphasis added).

Thus, according to the federal regulations and CMS State Medicaid Manual, each state may limit Medicaid services, including EPSDT services, based on its own definition of "medical necessity," so long as the limitation is reasonable and services are provided in sufficient amounts to achieve their purpose.

C. Florida's Definition of Medical Necessity.

Florida has expressly incorporated "medical necessity" as a requirement for all Medicaid services. In sections 409.905 and 409.906, Florida Statutes, governing mandatory and optional Medicaid services in Florida, the legislature expressly instructs that all mandatory and optional Medicaid services "shall be provided only when medically necessary and in accordance with state and federal law." The legislature, further, gives AHCA the authority to determine whether medical necessity exists in any given case, including cases involving EPSDT services for children under 21 years of age. *See* § 409.905(2), Fla. Stat. ("The agency shall pay for early and periodic screening and diagnosis for 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 . . . .").

To guide its case-by-case determinations of medical necessity, AHCA has promulgated Florida Administrative Code Rule 59G-1.010(166). This Rule defines "medical necessity" to **exclude** experimental treatments, unproven treatments, ineffective treatments, cosmetic treatments, treatments that are inconsistent with generally accepted medical standards, and treatments or services that are excessive and purely for the convenience of the recipient or the recipient's family. *Id.* Specifically, the Rule states:

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
>
> (a) Meet the following conditions:
>
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
>
> 2. 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;
>
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
>
> 4. 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; and
>
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
>
> * * *
>
> (c) 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.

Fla. Admin. Code R. 59G-1.010(166)(a), (c).

It should be noted, however, that subparagraph (a)(5) of the medical necessity definition does not apply when determining the medically necessity of private duty nursing services. Fla. Admin. Code R. 59G-4.261(4); *Florida Medicaid Private Duty Nursing Services Coverage Policy*, November 2016, incorporated by reference into Fla. Admin Code R. 59G-4.261, Section 1.3.6.

D. Analysis of the "Medical Necessity" Inquiry for EPSDT Services.

In *Moore v. Medows*, 324 Fed. Appx. 773 (11th Cir. 2009) (unpublished opinion), the Eleventh Circuit held that a private physician's opinion as to the "medical necessity" of a treatment for a child Medicaid recipient is not dispositive, and that the state Medicaid program also has a role in determining what medical measures are necessary to "correct or ameliorate" the child's medical condition. 324 Fed. Appx. at 774. Specifically, the *Medows* Court stated:

> While it is true that, after the 1989 amendments to the Medicaid Act, the state must fund any medically necessary treatment that [a child Medicaid recipient] requires, *Pittman v. Department of Health and Rehabilitative Services*, 998 F.2d 887, 891-92 (11th Cir. 1993), it does not follow that the state is wholly excluded from the process of determining what treatment is medically necessary. Instead, both the state and [treating] physician have roles in determining what medical measures are necessary to "correct or ameliorate" [a child Medicaid recipient's] medical conditions. *Rush v. Parham*, 625 F.2d 1150, 1155 (5th Cir. 1980); 42 C.F.R. 440.230 ("(d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures."); *see* 42 U.S.C. § 1396d(r)(5). A private physician's word on medical necessity is not dispositive.

Id.

Thereafter, in *Moore v. Reese*, 637 F.3d 1220 (2011), the Eleventh Circuit approved and expanded on the *Medows* Court's reasoning, conducting a thorough review of the federal Medicaid statutes, regulations, manuals, and precedents, and summarizing them into six (6) "guiding principles."

> (1) [A State] is required to provide . . . services to [a child Medicaid recipient], who meets the EPSDT eligibility requirements **when such services are medically necessary to correct or ameliorate [his or her] illness and condition. . . .**

> (2) A state Medicaid plan must include reasonable standards . . . for determining such eligibility for and the extent of medical assistance . . . and such standards must be "consistent with the objectives of the Medicaid Act, specifically, its EPSDT program. . . .
>
> (3) **A state may adopt a definition of medical necessity that places limits on a physician's discretion. . . . A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition.** . . . Furthermore, a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case and a treating physician is required to operate within such reasonable limitations as the state may impose.
>
> (4) The treating physician assumes the primary responsibility of determining what treatment should be made available to his patients. **Both the treating physician and the state have roles to play, however, and [a] private physician's word on medical necessity is not dispositive.**
>
> (5) **A state may establish the amount, duration, and scope of [medical services] provided under the required EPSDT benefit. The state is not required to provide medically unnecessary, albeit desirable, EPSDT service.** However, a state's provision of a required EPSDT benefit . . . must be sufficient in amount, duration, and scope to reasonably achieve its purpose.
>
> (6) **A state may place appropriate limits on a service based on such criteria as medical necessity. In so doing, a state can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis, and may present its own evidence of medical necessity in disputes between the state and Medicaid patients.**

Reese, 637 F.3d at 1255 (emphasis added, internal quotation marks and citations omitted).

There are two Florida district court opinions that applied the Florida Medicaid program's definition of medical necessity in Rule 59G-1.010(166) consistent with the federal law. *See Cabello v. Ag. for Health Care Admin.*, 79 So. 3d 123, 124 (Fla. 3d DCA 2012) (upholding the reduction of a child's Medicaid-paid services because the Hearing Officer's ruling was based on substantial and competent evidence in the record showing that the services provided were not

authorized as medically necessary, such as to meet the requirements of Medicaid's Home Health Services Program) (citing Fla. Admin. Code R. 59G-1.010(166)(a)); *Lorenzo v. Ag. for Health Care Admin.*, 985 So. 2d 703 (Fla. 4th DCA 2008) (upholding the denial of Medicaid-paid hyperbaric oxygen treatments for a child on grounds that there was no evidence that the treatment was an effective, non-experimental, medically necessary treatment for the patient's condition). There is, however, a previous decision from the Third District Court that is in conflict with federal law—*C.F. v. Department of Children and Families*, 934 So. 2d 1 (Fla. 3d DCA 2005).

In *C.F.*, the Third District erroneously held that more weight should be afforded a treating physicians' opinion regarding the "medical necessity" of a service and that the "medical necessity" definition is not the same for adults and children. The *C.F.* court, interpreting 42 U.S.C. § 1396a(42) and 42 U.S.C. § 1396d(a)(13), specifically found that "the hearing officer improperly applied the restrictive definition of 'medical necessity'" found in Rule 59G-1.010(166). According to the court, the hearing officer should have applied the federal, EPSDT definition of medical necessity for children. 934 So. 2d at 5-7. Although *C.F.* talks about a federal definition of medical necessity, there is no federal EPSDT definition of medical necessity; rather the only definition of medical necessity is found in Florida's Rule 59G-1.010(166). In fact, the federal government has not, through legislation or regulation, defined the term "medical necessity" for adults or children. Instead, the federal government has left the defining of this term to the states. 42 C.F.R. §§ 440.230(a), (b), (d).

Compounding the problem, the Third District also erroneously held that "[a] state agency must give considerable and substantial weight to the opinions of treating physicians" and "failure to credit the opinion of the treating physician must be accompanied by a showing of good cause." 934 So. 2d at 7 (citing *Snyder v. Dep't of Child. & Fams.*, 705 So. 2d 1067, 1068-69 (Fla. 1st DCA

1998)). Applying this standard to the case before it, the court found that "[h]ere, the Hearing Officer's reason for rejecting the pediatrician's opinion does not meet the burden of 'good cause.' The opinion of C.F.'s treating physician should have been given greater weight than the opinion of the [state] reviewer, who had never met C.F. or consulted with C.F.'s treating physician." *Id.*

The *C.F.* court's reliance on *Snyder*'s heightened deference to the treating physician's opinion is misplaced. *Snyder* erroneously relies on social security disability law to impose a treating physician rule in the context of Medicaid services.[2] The federal regulations governing the Social Security Act disability program at the time *Snyder* was decided expressly required deference be given to the treating physician and, thus, the requirement of special deference to the treating physician was legislatively imposed. 20 C.F.R. § 404.1527(c)(2); 20 C.F.R. § 416.927(c)(2).[3] By contrast, there are no legislatively imposed requirements regarding deference to the treating physician's opinion in the federal Medicaid law.[4] *See* 42 U.S.C. § 1396, et seq.; 42 C.F.R. § 430, et seq. And, as discussed throughout this memorandum, federal case law affords no deference to the treating physician's opinion in Medicaid cases and federal regulations no longer give any

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[2] Although not pertinent to this analysis, the *C.F.* court incorrectly applied the federal EPSDT requirements to services requested under the Florida Medicaid Home and Community-Based Waiver program, rather than under the Medicaid State Plan. 934 So. 2d at 2, 4, 6-7; *see also* 42 U.S.C. § 1396d(r).

[3] As of March 27, 2017, the federal regulations that govern the Social Security Act disability program no longer give deference to the treating physician. See 20 C.F.R. § 404.1520c(a) (Stating that "We will not defer or give any specific evidentiary weight, including controlling weight, to any medical opinion(s) or prior administrative medical finding(s), including those from your medical sources.")

[4] Importantly, in *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003), the United States Supreme Court held that courts may not require administrators of a federal statutory scheme to accord special weight to a treating physician nor may courts impose a special burden on administrators to explain when they credit reliable evidence that conflicts with a treating physician's evaluation absent a statute or regulation requiring such deference to a treating physician. *Id.* at 829-34.

deference at all to the treating physician in the context of the Social Security Act disability program. *Reese*, 637 F.3d at 1255; 20 C.F.R. § 404.1520c(a). Thus, the *C.F.* court's deference to the treating physician's opinion, where no statutory scheme imposes such deference, was in error.

In summary, states may place limits on Medicaid state plan services, including EPSDT services. Those limits include limitations based on amount, duration, and scope of services, and limitations on services based on the state's definition of "medical necessity." Additionally, a treating physician's opinion regarding the medical necessity of a service is not dispositive or accorded deference. Instead, the state can review the medical necessity of a treatment prescribed by a treating physician on a case-by-case basis and present its own evidence of whether the service is medically necessary. *Reese*, 637 F.3d at 1255-1261; *Medows*, 324 Fed. Appx. at 774.

AHCA is bound to follow the Eleventh Circuit's decisions interpreting federal law. The Eleventh Circuit cases of *Medows* and *Reese* were decided after, and presumably in consideration of, all intermediate Florida appellate court decisions which reached a result contrary to that decision (*see, e.g., Cook ex rel. Cook v. Agency for Persons with Disabilities*, 967 So. 2d 1002 (Fla. 1st DCA 2007), *C.F. v. Department of Children and Families*, 934 So. 2d 1 (Fla. 3d DCA 2005), and *Snyder v. Department of Children and Families*, 705 So. 2d 1067 (Fla. 1st DCA 1998)). AHCA, then, must follow *Medows* and *Reese* even if they conflict with earlier opinions of Florida District Courts of Appeal. Moreover, because it is proper for Florida courts to "accord[] unusual weight to a decision on an issue rendered by a federal circuit in which the state is located [when] deciding federal questions where there is no Supreme Court authority," Florida's District Courts of Appeal should properly defer to the Eleventh Circuit's opinions, especially the published opinion in *Reese*, when reviewing agency action taken in accordance with that decision. *See Pignato v. Great W. Bank*, 664 So. 2d 1011, 1015 (Fla. 4th DCA 1995).

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

Guide to Explaining the Summary Memorandum

Effective Date: April 25, 2017

The concepts discussed in the April 25, 2017 Summary Memorandum can be summarized and explained as follows:

- The Medicaid program is a program in which the state and federal governments work together to pay for necessary medical services for the needy, in accordance with federal law and the state's Medicaid State Plan.

- According to federal law, each state's Medicaid program must provide early and periodic screening, diagnosis, and treatment (EPSDT) for children under the age of 21, when requested under its Medicaid State Plan (as opposed to a Medicaid waiver). EPSDT includes:

    - Health screenings (including comprehensive health and developmental history, physical exams, appropriate immunizations, lab test, and health education);
    - Vision, dental, and hearing screenings, and appropriate follow-up treatment when necessary; and
    - Other health care, diagnostic services, treatment, and other measures necessary to correct or ameliorate defects, physical illness, mental illness, and conditions discovered through screening services.

- Federal Medicaid law allows states to limit Medicaid-paid goods or services, including EPSDT for children under age 21. Important things to take away from the federal law are:

    - A state may limit goods and services, including EPSDT, based on amount, duration or scope, and/or based on medical necessity.
    - It is up to the state to decide whether a particular service is medically necessary. States are not required to provide any item or service that the state determines is not safe, not effective, or is considered experimental. States are not required to provide EPSDT that is desirable but not medically necessary.
    - If a state choses to place any limitations on EPSDT, including any limitation based on medical necessity, that limitation must be reasonable, and individual services must be provided in a sufficient amount, duration, and scope to achieve the purpose of the service.

- The Florida Medicaid program limits goods and services based on medical necessity. AHCA uses the definition of medical necessity at Florida Administrative Code Rule 59G-1.010(166), in all of its case-by-case Medicaid services determinations, including in cases where EPSDT is requested for a child under age 21. The only exception is that subsection

(5) of the definition, regarding convenience, does not apply in determining the level of private duty nursing (PDN) that is medically necessary for a child under age 21.

- Recent cases from the federal Eleventh Circuit Court of Appeals, *Moore v. Medows* and *Moore v. Reese*, clarify federal Medicaid law and guide the case-by-case determination of medical necessity in Florida. The following principles from these cases apply whether the medical necessity determination is made by AHCA, or by a DCF hearing officer through the fair hearing process:

    - There is no federal definition of medical necessity. Instead, the federal government has empowered each state to create its own definition of medical necessity and to limit Medicaid services, including EPSDT, based on that definition.
    - Both the state and the treating physician have roles in determining whether a good or services is medically necessary. The treating physician's opinion is not dispositive (i.e., is not the final word).
    - A state can review the medical necessity of a good or service prescribed by a treating physician on a case-by-case basis, and may present its own evidence of medical necessity in disputes between the State and Medicaid patients.

- There are two Florida district court opinions that applied the Florida Medicaid program's definition of medical necessity in Rule 59G-1.010(166), consistent with Federal law:

    - *Cabello v. Agency for Health Care Administration*, 79 So. 3d 123, 124 (Fla. 3d DCA 2012), upheld the reduction of a child's Medicaid-paid services because the Hearing Officer's ruling was based on competent and substantial evidence in the record showing that the services provided were not authorized as medically necessary, such as to meet the requirements of Medicaid's Home Health Services Program, and cited Fla. Administrative Code Rule 59G-1.010(166)(a); and
    - *Lorenzo v. Agency for Health Care Administration*, 985 So. 2d 703 (Fla. 4th DCA 2008), upheld the denial of Medicaid-paid hyperbaric oxygen treatments for a child on grounds that there was no evidence that the treatment was an effective, non-experimental, medically necessary treatment for the patient's condition.

- There is, however, a previous decision from the Third District that is in conflict with federal law—*C.F. v. Department of Children and Families*, 934 So. 2d 1 (Fla. 3d DCA 2005). *C.F.* is in conflict with federal law because it wrongly found that more weight should be afforded a treating physician's opinion regarding the medical necessity of services, that the medical necessity definition is not the same for adults and children, and that there is a federal definition of medical necessity when there is not. A more detailed explanation and a legal analysis of the reasons *C.F.* conflicts with federal law is located at pages 8 through 10 of the April 25, 2017 Summary Memorandum.