STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[redacted]

APPEAL NO. 13F-11188

PETITIONER,

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 13 Hillsborough
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, Hearing Officer Patricia C. Antonucci convened a hearing in the above-styled matter on January 30, 2014 at approximately 3:00 p.m. All parties and witnesses appeared via teleconference. As Petitioner is a Spanish speaker, an interpreter was sworn to provide translation during the entire proceeding.

APPEARANCES

For Petitioner: [redacted] Petitioner

For Respondent: David Beaven, Fair Hearings Coordinator,
Agency for Healthcare Administration

STATEMENT OF THE ISSUE

At issue is whether respondent, the Agency for Healthcare Administration (AHCA), properly denied Petitioner's request for bilateral breast reduction surgery (mammoplasty).

PRELIMINARY STATEMENT

By letter dated October 24, 2013, respondent's agent, eQHealth Solutions, (eQHealth), notified Petitioner of AHCA's intent to deny Petitioner's requested surgery. Petitioner requested a hearing to challenge this determination.

At hearing, Petitioner represented herself. She was accompanied on the phone line by her nephew, [redacted] though he did not provide testimony. Respondent was represented by David Beaven, Fair Hearings Coordinator with AHCA, Tampa Office. Respondent presented two witnesses: José Cortes, M.D., Assistant Medical Director, and Gary Erikson, RN and Fair Hearing Supervisor, both with eQHealth Solutions.

Respondent's Exhibits 1 through 8, inclusive, were admitted into evidence without objection. The record was held open for supplemental documentation, which was timely received and entered, as follows:

- Respondent's Composite Exhibit 9: Memorandum dated August 2, 2013 + cover sheet and cover letter to Petitioner (3 pages)

- Respondent's Composite Exhibit 10: cover letter + Petitioner's March 14, 2012 Physical Therapy Assessment (6 pages)

- Respondent's Exhibit 11: e-mail from eQHealth Solutions, reaffirming denial of request service after review of Petitioner's Physical Therapy Assessment.

Administrative notice was taken of Florida Administrative Code R. 59G-1.010(166), and pertinent portions of the Florida Medicaid Practitioner Services Coverage and Limitations Handbook.

The parties were notified at hearing that the record would close on February 22, 2014. However, Petitioner was instructed that she need not await a Final Order in this matter to continue conferring with AHCA.

FINDINGS OF FACT

1. The Petitioner is a 63-year old female, born [redacted]

2. Petitioner is and has been eligible to receive Medicaid services at all times relevant to these proceedings.

3. The Petitioner suffers from macromastia (abnormally large breasts), along with severe upper back, neck, and shoulder pain. She is approximately 5-foot, 6-inches tall, weighs about 201 pounds, and has a reported bra size of 40-42G. As a result of the macromastia, she has difficulty finding appropriate clothes and maintaining personal hygiene. She has a medical history which includes a stroke, hypertension, and a cerebral aneurysm.

4. On or about November 5, 2013, Petitioner's treating physician submitted a request for Medicaid's prior authorization of bilateral breast reduction surgery (procedure code 19318-50). Accompanying the request was information and documentation intended to demonstrate that the procedure is medically necessary.

5. The prior service authorization request and supporting documentation was reviewed by eQHealth Solutions, Inc (eQHealth). eQHealth is the peer review organization (PRO) contracted by AHCA to assess whether requested physician services are a medical necessity for the patient requesting same. eQHealth is also a Quality Improvement Organization (QIO).

6. Petitioner's service request was submitted to the PRO following a June 20, 2013 visit and August 16, 2013 follow-up with her treating physician. The physician's progress notes/records from these visits document Petitioner's symptoms of severe upper back, neck, and shoulder pain, noting that she has tried to lose weight but that her breast size makes exercise difficult. The notes also reference multiple rashes in the folds of the breast, state that Petitioner has trouble performing her activities of daily living, and note bra strap grooving in her shoulders. These records also include photographs.

7. The 'Assessment/Plan' portion of the physician visit notes state:

> 62 yo female with severe macromastia. Patient would likely benefit from reduction mammaplasty [*sic*]. Pt was encouraged to cont trying to lose weighth [*sic*]. It was also discussed with patient that she is a higher than average surgical risk. Photos were taken and will be submitted fro [*sic*] insurance approval. Pt will be scheduled for surgery following approval. I personally saw and evaluated the patient. I have reviewed and agree with the impressions and care plan of the Resident/Fellow.

8. Also included with the service request are a plastic surgery consultation form and a Final Imaging Report from Petitioner's most recent mammogram. The consultation form reflects Petitioner's notation of her symptoms, and estimates that the requested "outpatient" surgery will last 2.5 hours and require general anesthesia. Petitioner's last mammography was completed on December 29, 2012, with results noting:

> The breasts are extremely dense which limits mammographic sensitivity. Scattered microcalcifications in both breasts without facility or pleomorphic features are stable from prior exams. There are no suspicious masses, areas of architectural distortion or microcalcifications. No concerning features or malignancy.

9. On September 11, 2013, a physician reviewer for eQHealth reviewed Petitioner's request. Via letter dated September 16, 2013, the PRO notified Petitioner and her treating physician of its intent to deny surgery. Said letter stated, in pertinent part:

> The reason for the denial is that the services are not medically necessary as defined in 59G-1.010 (166), Florida Administrative Code (F.A.C.), specifically the services must 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.
>
> The rationale for our decision is as follows: The documentation submitted does not describe what treatment and or therapy that [sic] the recipient has been on and for how long. In addition there is no documentation that the rash has failed prescription medications. Recommend denial of requested procedure at this time.

10. On October 23, 2013, Petitioner's provider submitted a reconsideration request, noting that Petitioner has rashes on her breasts during the summer months, for which she uses over-the-counter, antibiotic cream. While the rash gets better, it always comes back.

11. On October 23, 2013, eQHealth conducted a reconsideration review, generating a notice to Petitioner and her physician on October 24, 2013. Petitioner's copy of the Reconsideration Notice stated that the denial was upheld, but did not contain any rationale. The copy of the Notice provided to her physician stated:

> The Agency for Health Care Administration's definition of medical necessity is stated in 59G-1.010 (166), Florida Administrative Code (F.A.C.) and in Appendix B (page B-9) of the Florida Medicaid Provider General Handbook. Services must be medically necessary and must at a minimum... 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.

> The medical basis for the reconsideration decision is as follows: Patient with macromastia with complaints of back and neck pain. There is no documented evidence of failed conservative therapy including pain medications and physical therapy. Will recommend upholding the original denial decision at this time.

12. On or about November 11, 2013, petitioner requested a hearing to challenge Respondent's determination.

13. At hearing, Petitioner again indicated that she is in constant pain, suffering from headaches, back and neck aches, but stated that she never had a rash. She attended physical therapy for a period of 6 months, saw a chiropractor five times, and takes muscle relaxants, but did not realize she was supposed to provide documentation of these treatments/therapies. She feels that the weight of her breasts is still affecting her everyday life and hopes that surgery will resolve her pain.

14. eQHealth, as the PRO, reiterated that without documentation of attempts at more conservative therapy, the PRO would not be able to approve Petitioner's requested surgery. AHCA also noted that prior to approval, Petitioner would need to submit a mammography report no more than six months old. AHCA suggested that Petitioner take a copy of the Medicaid Handbook to her physician to guide him in preparing all required documentation.

15. After hearing, Petitioner supplemented the record with a Physical Therapy Assessment from March 14, 2012. This Assessment notes, "Patient returns to PT with worsening complaints of left shoulder pain since 5/8/11 following brain surgery for a subarachnoid hemmorage [*sic*] where she was positioned on a stretcher bed, as per pt." While macromastia is listed as one of approximately 11 "problems," there is no

indication that PT is specifically focused on treatment of pain or limitations caused by Petitioner's breast size.

16. On February 10, 2014, the PRO responded to the PT Assessment, noting that the therapy was not related to macromastia, and eQHealth upholds its recommendation to deny surgery.

CONCLUSIONS OF LAW

17. By agreement between AHCA and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction to conduct this hearing pursuant to Florida Statutes Chapter 120.

18. Legal authority governing the Florida Medicaid Program is found in Fla. Stat., Chapter 409, and in Chapter 59G of the Florida Administrative Code. Respondent, AHCA, administers the Medicaid Program.

19. The Florida Practitioner Services Coverage and Limitations Handbook (Practitioner Handbook) has been incorporated, by reference, into Fla. Admin. Code R. 59G-4.205. The most current version of the Practitioner Handbook was promulgated April 1, 2014, and all page numbers referenced in this Order correspond to the 2014 version. The 2012 edition of the Physician Surgical Fee Schedule is incorporated by Fla. Admin. Code R. 59G-4.002.

20. This is a Final Order, pursuant to § 120.569 and § 120.57, Fla. Stat.

21. This hearing was held as a *de novo* proceeding, in accordance with Fla. Admin. Code R. 65-2.056.

22. The burden of proof in the instant case is assigned to the Petitioner, who seeks prior authorization for services via Medicaid. The standard of proof in an administrative hearing is preponderance of the evidence. (See Fla. Admin. Code R. 65-2.060(1).)

23. Fla. Stat. § 409.905 addresses mandatory Medicaid services under the State Medicaid Plan:

> Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law....
>
> (9) PHYSICIAN SERVICES.—The agency shall pay for covered services and procedures rendered to a recipient by, or under the personal supervision of, a person licensed under state law to practice medicine or osteopathic medicine. These services may be furnished in the physician's office, the Medicaid recipient's home, a hospital, a nursing facility, or elsewhere, but shall be medically necessary for the treatment of an injury, illness, or disease within the scope of the practice of medicine or osteopathic medicine as defined by state law. The agency shall not pay for services that are clinically unproven, experimental, or for purely cosmetic purposes.

24. The Practitioner Handbook further describes the services covered under Florida Medicaid "Physician Services," including Surgery Services. Page 2-108 of the Practitioner Handbook defines Surgical Procedures, noting "Surgical services are manual and operative procedures for correction of deformities and defects, repair of injuries, and diagnosis and cure of certain diseases."

25. Page 2-109 of the Practitioner Handbook states:

> Surgery that requires prior authorization when performed in a setting outside the inpatient hospital is identified on the Physician Fee Schedule by "PA" in the "Spec" column.
>
> ...

> If the services does not require authorization by the Medicaid QIO, but is identified as "PA" in the "Spec" column, a prior authorization is still required by Medicaid for the physician claim to be reimbursed.

26. Review of the Physician Surgical Fee Schedule reflects that Procedure Code 19318 (breast reduction) does, indeed, require prior authorization.

27. Page 2-114 – 2-115 of the Practitioner Handbook lists the very specific and thorough requirements for patients such as Petitioner, who request reduction mammoplasty services. The Handbook notes:

> Reduction mammoplasty must be prior authorized by Medicaid, regardless of the place of service. The rendering surgeon must obtain prior authorization for the procedure. Requests for outpatient surgical procedures must be submitted through the fiscal agent [i.e., AHCA]... Medical necessity for reduction mammoplasty may be determined through the prior authorization process for women aged 18 or older...
>
> <u>All of the following criteria must be met</u> for reduction mammoplasty:
>
> • Recipient has moderate to severe persistent symptoms in two or more of the anatomical areas listed below, affecting specified daily activities for at least 12 continuous months:
>
> - Pain in upper back;
> - Pain in neck;
> - Pain in shoulder;
> - Chronic headaches;
> - Painful kyphosis, documented by x-rays; and
> - Pain with ulceration from bra straps cutting into shoulders.
>
> • Photographic documentation confirms severe breast hypertrophy;
> • Recipient has undergone an evaluation by her primary care physician who determined that all of the following criteria are met, and the requesting surgeon concurs:
>
> - A signed and dated statement letter from the primary care physician and the surgeon stating that there is a reasonable likelihood that the symptoms are primarily due to macromastia, the recipient has been complaint with all alternative therapeutic measures prescribed, breast reduction is the recipient's last resort and reduction mammoplasty is likely to result in an

improvement of the recipient's chronic and specifically described pain that affects specified daily activities; and
- Pain symptoms have persisted, as documented in the physician's clinical notes, despite at least a 6-month trial of well-documented therapeutic measures, such as:
  - Supportive devices (describe device and continuous length of time used);
  - Analgesic or non-steroidal anti-inflammatory drugs (NSAIDs) interventions (list drug, dosage and length of continuous treatment);
  - Physical therapy, exercises, and posturing maneuvers (describe type and length of treatment).

• Women who are 40 years of age or older are required to have a mammogram that is negative for cancer, performed within 6 months prior to the date the surgeon signed the authorization request for reduction mammoplasty. A copy of the mammogram report must accompany the authorization request.

It must be noted that chronic intertrigo, eczema, dermatitis, and or ulceration in the inframammary fold in and of themselves are not considered medically necessary indications for reduction mammoplasty. The condition not only must be unresponsive to dermatological treatments (e.g., antibiotics or antifungal therapy) and conservative measures (e.g., good skin hygiene, adequate nutrition) for a period of six (6) months or longer, but must also satisfy the criteria stated above.

Documentation of medical necessity must also include:
• Detailed statement of recipient's complaints and symptoms;
• Current height;
• Current weight;
• Documentation of weight loss or gain during past 12 months;
• Current bra (including cup) size
• A list of prescribed, over-the-counter medications and supplements used by the recipient during the past 12 months (including dosage, frequency, purpose, and duration of treatment);
• A list of current medications used to address breast-related skin conditions, infections, or pain;
• The procedure to be used for removing breast tissue; and
• Description of the surgical procedure to be used for removal of excess breast tissue.
(emphasis added)

28. Any service requiring prior authorization must be determined medically necessary before it is approved. Florida Administrative Code Rule 59G-1.010(166) defines medical necessity, as follows:

> "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.

29. To the extent that the definition of medical necessity focuses on whether a requested service will meet an individual's needs in the most appropriate and conservative manner possible, the requirements of the Practitioner Handbook govern review of what constitutes a medically necessary surgery. As such, all of the criteria listed as prior authorization requirements for mammoplasty services (pages 2-114 – 2-115) must be fulfilled and documented. While notes from Petitioner's physician visits and consultation with the plastic surgeon reference portions of the required information, a larger portion of the required documentation has not been provided to support

Petitioner's request. Absent documentation that all criteria are met, it cannot be determined that the surgery is medically necessary.

DECISION

Based upon the lack of information provided, Petitioner's appeal is DENIED. Petitioner is encouraged to work with Respondent in order to determine if additional documentation can be obtained, such that submission of a new request for surgery would be appropriate.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 7th day of April, 2014,

in Tallahassee, Florida.

Patricia C. Antonucci
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal_Hearings@dcf.state.fl.us

Copies Furnished To: [redacted] Petitioner
Sue McPhee, Area 6, AHCA Field Office Manager