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

[redacted]

APPEAL NO. 14F-10033

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 Dade
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on January 6, 2015, at 10:45 a.m.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Oscar Quintero, Program Operations Administrator, Agency for Health Care Administration (AHCA or Agency).

STATEMENT OF ISSUE

At issue is the Agency action of October 30, 2014, through Simply Health Plan, to deny the petitioner's request for a Laparoscopic Sleeve Gastrectomy based on not being medically necessary.

PRELIMINARY STATEMENT

Present as witnesses for the respondent were Lesvette Lopez, Grievance and Appeals Supervisor and Dr. Barbara Cowley, Chief Medical Officer, both from Simply Health Care.

Present as an interpreter was Lourdes Olmos.

The respondent submitted into evidence Respondent Composite Exhibit 1. The petitioner submitted into evidence Petitioner Exhibit 1.

FINDINGS OF FACT

1. The petitioner is fifty two years of age and is a Managed Medical Assistance Program (MMA) recipient living in Miami-Dade County, Florida. Simply Health Plan is the managed care agency authorized by AHCA to provide Medicaid services.

2. The petitioner is five foot four inches tall and currently weighs 245 pounds. Her treating physician considers her morbidly obese. Approximately on October 20, 2014, the petitioner's treating physician submitted a pre-authorization request to Simply Health Plan for a Laparoscopic Sleeve Gastrectomy.

3. Simply Health Plan determined the request for the Laparoscopic Sleeve Gastrectomy, which is a type of bariatric surgery, was not medically necessary based on the information received.

4. Dr. Cowley, respondent physician witness, explained that Simply Health uses a national standard for the type of medical procedure requested, the InterQual criteria. InterQual is used as a tool by Simply Health and has five criteria that must be met

before the medical procedure can be approved. If any one of the five is not met, then the procedure will be denied.

5. The first standard, the petitioner's BMI, was met as the petitioner's BMI is over 35 (she is measured at 41). The second standard is that the petitioner must follow a diet for six months. The physician witness indicated that the petitioner did not meet this criteria standard and thus, the request for the procedure was denied. She indicated that the petitioner also did not meet the endocrine standard as there was no glandular reason for weight gain. She indicated that the petitioner did have a psychological evaluation from a psychiatrist that did meet the standard. However, the respondent witness indicated even though there are more standards, the fact that she met or did not meet the rest of the standards does not matter.

6. The physician witness indicated that Simply Health reviewed all of the information submitted related to the petitioner's diet issue, which also included all of the petitioner's physicians' statements, when making the above conclusion. She indicated that there was no documentation submitted of the petitioner following a consistent medically supervised diet program prior to the decision to operate. She noted a chart submitted by the petitioner's diet physician dated April 14, 2014 (Respondent Composite Exhibit page 81) indicated the reasons contributing to her being overweight were: "Eating too fast...Drinking Sodas; Eating out frequently; Excessive appetite all of the time; Eating late at night; No physical activities and Do not follow nutrition regimen instructions." This witness also indicated that the petitioner was provided a diet regimen by her diet doctor and she did not follow the prescribed diet regimen.

7. A statement from the petitioner's diet doctor, dated October 6, 2014 states she "has participated in our program in different times. She has inconsistent compliance due to various flare-ups of her chronic Gastro intestinal condition, failing the weekly appointments visit require by the program. ...During the time she spent in our program she received comprehensive instructions and dietary counseling, which would ultimately may benefit the patient overall health status and well being."

8. The respondent's physician witness also indicated that because the petitioner takes prednisone, which is a drug that causes weight gain, this also was part of the Agency reason for the denial of the procedure.

9. The petitioner indicated that she has back, knee, and ankle pain that is due to her overweight situation. She indicated that because she has been in and out of the hospital, it is difficult for her to follow a diet. She indicated that based on her medical problems, she is unable to exercise. She indicated that in spite of the statements from the respondent's witness, the medical information provided to Simply Health is enough for her to be approved for the needed procedure.

10. The respondent's physician witness reiterated that the medical information as provided to Simply Health does not show the petitioner has followed a consistent medically supervised diet program.

CONCLUSIONS OF LAW

11. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to

§ 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

12. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

13. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner.

14. § 409.912, Fla. Stat. states, in relevant parts:

> Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program.
> (3) The agency may contract with health maintenance organizations certified pursuant to part I of chapter 641 for the provision of services to recipients. This subsection expires October 1, 2014.

15. The Florida Medicaid Provider General Handbook, incorporated by reference in the Medicaid Services Rules under Fla. Administrative Code Chapter 59G-4, states on Page 1-22, in part:

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.

16. Although the terms medically necessary and medical necessity are often used interchangeably and may be used in a variety of contexts, their definition for

Florida Medicaid purposes is contained in the Florida Administrative Code. Fla. Admin. Code R 59G-1.010 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.
>
> (b) "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.
>
> (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.

17. The InterQual standards used by the Agency as a guideline states:

> Before surgery is considered, patients should undergo an adequate trial of inoperative weight loss. Dieting could have occurred at any time in the course of the patient's medical management and should incorporate nutritional counseling, behavioral modification, and appropriate physical

activity. The goal is weight loss of 0.5 kg/week and to reduce weight 5% to 10%.

18. As shown in the Findings of Fact, the Agency through Simply Health Plan determined the request for the Laparoscopic Sleeve Gastrectomy was not medically necessary based on the information provided.

19. The petitioner argued that the evidence submitted shows she is in need of the weight loss surgery.

20. The respondent witness argued that the petitioner's request for the Laparoscopic Sleeve Gastrectomy was properly denied as it did not meet the medical necessity requirement's of the program. She argued that the evidence present shows the petitioner did not follow the prescribed diet.

21. For the case at hand, the evidence presented does not indicate the petitioner followed the prescribed diet program as provided by her diet physician; thus, the hearing officer agrees with the respondent's arguments that petitioner's request for the Laparoscopic Sleeve Gastrectomy did not meet medical necessity criteria. The controlling authorities make clear that services should be excluded whenever a less costly, equally effective, service can be safely furnished.

22. After considering the evidence and all of the appropriate authorities set forth in the findings above, the hearing officer affirms the Agency's action to deny the petitioner's request for the Laparoscopic Sleeve Gastrectomy procedure for the reason noted above. The petitioner has not met her burden of proof.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is denied and the Agency action affirmed.

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 petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 16th day of February, 2015, in Tallahassee, Florida.

Robert Akel

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