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

[redacted]
PETITIONER,

APPEAL NO. 15F-00653

Vs.

CASE NO.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter on February 18, 2015, at 10:35 a.m. in Tampa, Florida.

APPEARANCES

For the Petitioner: [redacted], Petitioner

For the Respondent: David Beaven, Medical Healthcare Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is the whether the Agency for Health Care Administration (sometimes hereinafter referred to as "Respondent", "AHCA", or the "Agency") properly denied Petitioner's request for magnetic resonance imaging ("MRI") of the lumbar spine and his request to see an out of network provider.

PRELIMINARY STATEMENT

Petitioner appeared on his own behalf. His mother, [redacted] was present but did not provide testimony.

David Beaven, Medical Healthcare Program Analyst, appeared on behalf of the Agency for Health Care Administration. Respondent's Witnesses from Sunshine Health Plan ("Sunshine") included Paula Daley (Grievance and Appeals Coordinator), Donna Laber (Manager, Grievance and Appeals), and John Carter, M.D. (Medical Director). Jennifer Arteada, also with Sunshine, observed the hearing. Dr. Bryan Zimmerman, Physician Clinical Consultant with National Imaging Associates ("NIA") also appeared as a witness for Respondent.

During the hearing, Respondent introduced Respondent's Exhibits "1" through "3", all of which were accepted into evidence and marked accordingly. Petitioner introduced Petitioner's Exhibits "1" through "6", all of which were accepted into evidence and marked accordingly.

The hearing record in this matter was left open until the close of business on February 19, 2015 in order to allow Respondent to provide additional information and for Petitioner to submit any response to Respondent's post-hearing submissions. Respondent's post-hearing submissions were marked and entered into evidence as Respondent's Exhibits "4" and "5". There was no response from Petitioner. The hearing record was then closed on February 19, 2015.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following Findings of Fact are made:

1. Petitioner is an adult male. He has chronic hip and back pain as well as a recent arm injury from December 2014. As a result of his chronic pain, he saw a pain management doctor, who provided cortisone injections and various pain medications over an extended period of time. The pain management doctor also suggested therapeutic exercises and stretches for Petitioner to perform at home to assist with his pain.

2. Petitioner was diagnosed with lumbago. He had an MRI done in November 2012 of his lumbar area, which showed some disc protrusions and mild to moderate stenosis. Petitioner's treating provider ordered a lumbar spine MRI in December 2014 to compare to the 2012 MRI.

3. On or about December 4, 2014, Petitioner's treating provider submitted a request to Sunshine Health Plan on behalf of the petitioner for a MRI of the lumbar spine.

4. NIA is the Peer Review Organization ("PRO") contracted by Sunshine to determine whether services requested under Florida Medicaid are medically necessary.

5. Petitioner's request was reviewed by a NIA representative on or about December 5, 2014. The NIA representative requested additional information from the requesting provider. NIA was unable to reach the requesting provider or obtain more information. It denied the request for a MRI of the lumbar spine on December 8, 2014 stating as follows:

> Additional information is needed to determine medical necessity. The information we need includes more information about your situation, symptoms you're feeling, doctor's findings from examination, results of any tests and treatments for this problem.

6. The requesting provider subsequently submitted additional information on December 9, 2014. Specifically, the requesting provider submitted the findings from a hip x-ray in October 2014. NIA determined the additional information was insufficient to justify the requested MRI, and denied the request again on December 10, 2014.

7. The December 10, 2014 denial letter from NIA to Petitioner provides the following explanation for the denial:

> The requested service (Lumbar Spine MRI) or item is not medically necessary because there is pelvic, thigh and hip pain; no muscle weakness or abnormal reflexes. Details of a failure to respond to six weeks of conservative care including a combination of medications, physical therapy, chiropractic care, and/or a supervised home exercise program should be completed.

8. NIA was unable to ascertain the need for imaging at the lumbar spine level based on the information given to it by Petitioner's provider. NIA made multiple attempts to contact Petitioner's provider to arrange for a peer-to-peer consultation but was unsuccessful.

9. Petitioner watched his provider fax copious notes to Sunshine regarding his need for the lumbar MRI. He stated his provider called NIA for the peer review but could not get through due to long hold times. When Sunshine receives information from a provider related to a radiological scan, its procedures are to reply to the provider and request the provider submit the information directly to NIA. Sunshine did not receive any information from Petitioner's provider.

10. Petitioner injured his right arm in an accident on December 25, 2014. He went to the emergency room where the doctors did diagnostic testing including x-rays and MRIs of his arm. As a result, Petitioner was diagnosed with subscapularis and

supraspinitis tears. He noted that he was unable to position properly in the MRI due to pain, so the MRI was unable to capture full images of all of the necessary areas.

11. Petitioner went to a different emergency room the following day due to his pain, and the orthopedic doctor there diagnosed him with a tricep tendon rupture. Petitioner has a history with this orthopedic doctor, Dr. Infante, as he performed surgery on the Petitioner approximately one year prior. He is familiar with Petitioner's case history. The doctor gave Petitioner pain medication and advised Petitioner to follow up with him in a week. This doctor is not in Sunshine's network.

12. Petitioner's primary care physician, Dr. Cintas, requested approval for Petitioner to see Dr. Infante, who is out of network. Sunshine denied this request by advising Dr. Cintas that Petitioner should first seek an in-network doctor.

13. Sunshine has orthopedic specialists in network in Petitioner's area. Petitioner had difficulty finding an updated, accurate list of these providers. He attempted to call some listed in Sunshine's member handbook, and those providers were not accepting new patients or had left the network.

14. Petitioner feels that Sunshine was unprofessional and unhelpful throughout this process. Sunshine offered to have a case manager contact Petitioner and help him coordinate his care.

CONCLUSIONS OF LAW

15. 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.

16. 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.

17. This is a Final Order, pursuant to Sections 120.569 and 120.57, Florida Statutes.

18. This hearing was held as a *de novo* proceeding, in accordance with Florida Administrative Code Rule 65-2.056.

19. The burden of proof was assigned to Petitioner in accordance with Florida Administrative Code Rule 65-2.060(1). The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Florida Administrative Code Rule 65-2.060(1).

20. Section 409.912, Florida Statutes (2014), provides that AHCA shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care.

21. Section 409.905, Florida Statutes (2014), 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....

22. 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.

Lumbar Spine MRI

23. Part of the medical necessity rule above is that the service must be consistent with the generally accepted professional medical standards as determined by the Medicaid program. NIA has a set of guidelines that it uses to determine medical necessity of lumbar spine MRI requests. Petitioner's request for a lumbar spine MRI did not meet any of the lumbar spine MRI guidelines criteria.

24. NIA's guidelines specify in order to grant a request for lumbar spine MRI to evaluate chronic changes or new back pain, the request must show, at a minimum:

- Failure of conservative treatment for at least six (6) weeks.
- With progression or worsening of symptoms during the course of conservative treatment.
- With an abnormal electromyography (EMG) or nerve conduction study if radicular symptoms are present.

25. While Petitioner did provide notes indicating he had a prior MRI and was seeing a pain management doctor, these did not show that he had failed conservative

treatment. The evidence shows that Petitioner has chronic pain and had appointments with a pain management doctor. Petitioner's testimony is not medical documentation showing failure of a conservative treatment or progressive or worsening symptoms during the course of that treatment.

26. There is not enough medical documentation to support a lumbar MRI at the present time. The information the requesting doctor gave NIA showed that Petitioner had a negative hip x-ray prior to the instant lumbar MRI request. This alone did not indicate further need for imaging, nor did it indicate a need for imaging of the lumbar region specifically, and it did not meet any of NIA's guidelines, so NIA could not grant the request.

27. Pursuant to all of the above, Petitioner has not met his burden of proof that the Agency incorrectly denied his request for magnetic resonance imaging of the lumbar spine.

Out-of-Network Physician

28. Petitioner's second issue is his request to see an out-of-network orthopedic specialist. All requests must meet the medical necessity definition set forth above.

29. Sunshine has orthopedic specialists available in Petitioner's area. There is no evidence showing that these providers are unavailable, unwilling, or unable to treat Petitioner. There is no evidence to show that Petitioner's request to see a particular doctor is medically necessary when other competent doctors, who are in network, are available.

30. Although Petitioner's primary care doctor wrote a letter on Petitioner's behalf to support the request, just because a doctor orders or requests something does not mean it meets the medical necessity definition set forth above.

31. Petitioner wants this particular doctor to treat his newly sustained arm injury. Although he has a history with this particular doctor, the history is unrelated to his new injury. The doctor saw him in the emergency room and requested follow up, but this does not mean that other physicians will be unable to treat Petitioner or catch up on the limited case history related to the arm injury.

32. After reviewing the relevant evidence, Petitioner did not meet his burden of proof to show the out-of-network provider request was wrongfully denied.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is hereby DENIED.

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 April, 2015,

in Tallahassee, Florida.

Danielle Murray
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
Lorraine Campanaro, Area 6, AHCA Field Office Manager