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

FILED
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OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

[redacted]

APPEAL NO. 15F-02413

PETITIONER,

VS.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 06 PASCO
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

A telephonic administrative hearing in the above-referenced appeal was convened on April 22, 2015 at approximately 1:01 p.m.

APPEARANCES

For the Petitioner: [redacted] Petitioner

For the Respondent: Stephanie Lang, Registered Nurse Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

Whether the Respondent properly denied Petitioner's request for an L2 to L3 discectomy (CPT 63056) to relieve Petitioner's back pain. The burden of proof on this issue lies with Petitioner.

PRELIMINARY STATEMENT

The Agency for Healthcare Administration (AHCA or Agency) is responsible for administering Florida's Medicaid Program. AHCA contracts with managed care plans to provide services to Medicaid recipients in Florida.

Tracy Parks, Clinical Manager for Quality; Laura Withrow, Manager of the Quality Management Department; Dr. Amy Zitiello and Dr. Mary Jones, Medical Directors, all with Amerigroup, appeared as Respondent's witnesses during the hearing. Lou Esposito, Medical Health Care Program Analyst with the Respondent, observed the hearing.

Respondent entered six exhibits into the record at the time of hearing, marked as Respondent's Exhibits 1 through 6. Petitioner submitted one composite exhibit at the time of hearing, marked and entered as Petitioner's Composite Exhibit 1.

FINDINGS OF FACT

Based upon 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 female with a history of back and leg pain, and is diagnosed with fibromyalgia. She is currently enrolled with managed care plan Amerigroup and was enrolled with Amerigroup during the relevant time periods.

2. Petitioner was injured in a car crash around 1993, and since then saw multiple doctors and specialists for her pain. MRIs consistently show disc protrusions, herniations, and degeneration in the lumbar spine. Her intense pain causes her to move less, and she gains weight. She does not want to take and become dependent on pain medications. She walks with a cane and leans on things as she goes. She is uncomfortable in sitting, standing, and laying positions. Her balance is off and she has fallen down before. She has some continence issues and her left leg goes numb.

3. During the years since her accident, she saw a chiropractor, had diagnostic imaging, and had physical therapy, all with little to no success. She had a sacroiliac

joint injection in 1995, and a lumbar epidural injection in 2014. Physical therapy was ordered in 2012 and completed in 2013. A 2004 MRI report lists radiculopathy as part of her clinical history. See Petitioner's Exhibit 1.

4. Petitioner saw a specialist who suggested the discectomy, which may help relieve some of her pain. Petitioner's doctor requested preauthorization for the lumbar discectomy (CPT code 63056) on or about January 19, 2015. He included relevant medical documentation with the request. Part of the doctor's note reads as follows:

> ...I informed her that her fibromyalgia may be contributing to her back pain and that I cannot help.... I explained to the patient that this [surgery] would not take care of her back pain and hopefully will take care of her leg pain. I gave her alternatives to continue conservative therapy. At this time the patient wished to continue with surgical intervention.... (Respondent's Exhibit 2)

5. MCMC, Amerigroup's third party review contractor, denied Petitioner's request because it did not meet clinical guidelines for the service. The doctor at MCMC who reviewed and denied the request is a board certified orthopedic surgeon.

6. Petitioner requested an appeal of that decision. An MCMC physician spoke to Petitioner's ordering doctor on February 3, 2015 and determined that the denial should be upheld. Amerigroup's Associate Medical Director (Dr. Varani) also looked at the appeal request. He denied Petitioner's request by letter dated March 3, 2015 with the following statement:

> We do not see that you have narrowing of your spinal canal. We do not see that you have a severe pinching of your spinal cord or nerves. We do not see that you have a tumor or infection near your spine. We do not see that you have problems from birth that may need back surgery. For these reasons we do not believe this is medically necessary is for you. We based this decision on the health plan clinical guideline, Lumbar Laminectomy, Hemi-Laminectomy, Laminotomy, and/or Discectomy (CG-SURG-38). This patient underwent a midline epidural injection, but a left

> L2-3 transforaminal epidural would be the procedure of choice to relieve her symptoms. The patient also has a majority of low back pain, which the surgery is not likely to improve. Furthermore, an appropriate trial of non steroidal anti inflammatory drugs (NSAIDs) and physical therapy has not been documented.
> ...The issue is not the disc or the procedure but the degree to which the member has attempted medical management including optimizing medication and completing an adequate trial of physical therapy, neither of which have been documented. (Respondent's Exhibit 4)

7. Petitioner requested a fair hearing following the second denial. Her position is that she has dealt with this pain for about 20 years and any potential relief would be welcomed. The Agency's position is that she does not meet medical necessity clinical guidelines for the surgery, should try more conservative treatment, and should rule out fibromyalgia as the cause of the pain the surgery seeks to fix.

PRINCIPLES OF LAW AND ANALYSIS

8. 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.

9. 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.

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

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

12. 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).

13. 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.

14. 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....

15. 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.

16. 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. The clinical guidelines are used as the professional medical standards to determine medical necessity.

17. The clinical guidelines for the requested procedure state as follows:

[The procedure] is considered medically necessary when at least one of the following criteria is met:

1. Conus medullaris syndrome (spinal cord compression) confirmed by appropriate imaging studies with severe or progressive neurologic deficits consistent with spinal cord compression (for example, fecal or urinary incontinence); **OR**
2. Cauda equina syndrome with neurologic deficits (bowel or bladder dysfunction, saddle anesthesia, bilateral neurologic abnormalities of the lower extremities) confirmed by physical examination and appropriate imaging studies; **OR**
3. Lumbar spinal stenosis and/or foraminal stenosis confirmed by appropriate imaging studies, with either:
    a. severe and progressive symptoms of pain or neurogenic claudication (buttock or leg) unresponsive to at least 6 weeks of conservative nonoperative therapy; **or**
    b. significant motor deficit preventing ambulation; **OR**
4. Lumbar herniated intervertebral disc with nerve root compression confirmed by appropriate imaging studies and the following additional criteria are met:
    a. Radicular pain with physical findings of nerve compression (for example, absent lower extremity reflex or loss of sensation in dermatomal distribution) or alternative clinical findings consistent with radiculopathy; **and**
    b. All other reasonable sources of pain have been ruled out; **and**
    c. Findings on imaging correspond to the clinical findings and neurological examination; **and**
    d. Symptoms are interfering with either:
        i. functional activities of daily living and persist despite at least 6 weeks of conservative nonoperative therapy; **or**
        ii. are associated with significant or progressive motor deficits; **OR**
5. When performed with dorsal rhizotomy as a treatment for spasticity (for example, cerebral palsy); **OR**

6. When performed with biopsy or excision when signs or symptoms indicative of lumbar disease (for example, pain, motor weakness) and imaging suggests tumor or metastatic neoplasm, an infectious process (for example, epidural abscess), arteriovenous malformation, malignant or non-malignant mass; **OR**
7. Acute fracture causing symptomatic nerve root compression.

Note: Conservative non-operative therapy consists of an appropriate combination of medication (for example, Non-Steroidal Anti-Inflammatory Drugs [NSAIDs], analgesics), physical therapy, spinal manipulation therapy, epidural steroid injections, or other interventions based on the individual's specific presentation, physical findings and imaging results. (Respondent Exhibit 3)

18. Petitioner does not have a diagnosis indicating she meets criteria 1 or 2 above. There is no clinical documentation showing stenosis required by criteria 3. As to criteria 4, she must meet all of the additional subcriteria in order to meet medical necessity. Although one report from 2004 mentions radiculopathy, there is no recent clinical information showing radiculopathy or loss of sensation, so she does not meet criteria 4a. As fibromyalgia has not been ruled out as the cause of the leg pain the surgery seeks to repair, she does not meet criteria 4b. As she does not meet all of the number 4 criteria, she does not meet medical necessity under that section. She does not have spasticity as required to meet criteria 5. She does not have imaging suggesting a tumor or mass as needed for criteria 6. There is also no evidence of a fracture, necessary to meet criteria 7.

19. It is not disputed that Petitioner is in a lot of pain and it impacts her daily life. She is entitled to all the benefits and care that the law permits. At the present time, based on the submitted information, her condition does not meet the necessary criteria for this particular service. She is encouraged to work with her physician to find appropriate treatments and to resubmit a request for surgical authorization if her situation or condition changes.

20. Based on the evidence presented, the Petitioner did not meet her burden of proof and the Agency's action was proper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Petitioner's appeal is hereby DENIED and the Agency's action is 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 10th day of June, 2015,

in Tallahassee, Florida.

Danielle Murray
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Copies Furnished To [redacted] Petitioner
Don Fuller, Area 5, AHCA Field Office Manager