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

[redacted]

PETITIONER,

APPEAL NO. 15F-02762

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 12 Manatee
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on April 23, 2015, at 11:04 a.m.

For the Petitioner: [redacted]etitioner

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

STATEMENT OF ISSUE

Whether Respondent correctly denied Petitioner's request to reimburse his out-of-pocket expenses made to an in-network pharmacy when that in-network pharmacy failed to bill the managed care plan.

The burden of proof was assigned to the Petitioner in accordance with Florida Administrative Code Rule 65-2060(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).

PRELIMINARY STATEMENT

Robert Walker, Regulatory Research Coordinator, Erica Hatchman, Manager of Pharmacy Appeals, Brittany Lewis, Manager of Pharmacy Direct Reimbursement, all from Staywell, appeared as Respondent's witnesses. Lou Esposito, Medical Health Care Program Specialist with the Agency, observed the hearing.

At the time of the hearing, Petitioner submitted no exhibits into evidence and Respondent submitted six (6) exhibits into evidence, marked and entered as Respondent's exhibits 1 through 6.

Administrative notice was taken of Florida Statutes 409.901, 409.962 through 409.965, and 409.973, Florida Administrative Code Rules 59G-1.001 and 59G-1.010, and 42 C.F.R. 441.745.

FINDINGS OF FACT

1. Petitioner has been eligible for Medicaid services throughout the relevant period in this appeal. He has been enrolled in Staywell, a Medicaid managed care plan, since June 1, 2014. He has been receiving prescription medication from Exact Dose ("the pharmacy" or "provider"), a pharmacy contracted with Staywell.

2. Petitioner paid the pharmacy for medications every month for at least a year because the pharmacy told him it did not accept his insurance. Staywell confirmed the pharmacy is in-network. Although Petitioner fills some medications at Walgreens, another in-network pharmacy, he cannot fill his controlled substance medications there due to Walgreens own restrictions. Staywell suggested that the pharmacies may not want to fill his prescriptions because they are from an out-of-county doctor and there are multiple controlled substances.

3. Petitioner pays cash to the pharmacy for Carisoprodol, Diazepam, Methadone and Oxycodone. The pharmacy has not submitted claims to Staywell for any of these medications for this patient.

4. Staywell has a contract with the pharmacy through its pharmacy benefit provider, Catamaran. This agreement specifies that the pharmacy must bill Staywell and collect only the required co-pays from Staywell members.

5. Upon review of Petitioner's pharmacy payment history, Staywell discovered that Petitioner was charged well over the accepted daily price for the medications. Staywell will not reimburse Petitioner more than what it would have paid for the medications if the pharmacy properly billed the insurance.

6. Staywell's position is the pharmacy needs to submit the claims and once Staywell pays the claims, the pharmacy is responsible for reimbursing Petitioner. Catamaran is currently investigating the pharmacy's billing practices.

7. Petitioner's position is he paid the money to an in-network provider but he should not have been billed. He wants to get the money back that he should not have been charged to begin with.

8. Staywell will provide a case manager to Petitioner. The case manager will assist Petitioner with finding another pharmacy that will bill Staywell, and will assist with possibly finding another pain management doctor who is in the area.

CONCLUSIONS OF LAW

9. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes (2014).

10. This is a Final Order, pursuant to Sections 120.569, 120.57, and 409.285, Florida Statutes.

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

12. Florida Administrative Code Rule 59G-5.110(4) states "The provider cannot seek payment from a recipient for a compensable service for which a claim has been submitted, regardless of whether the claim has been approved, partially approved or denied by the agency."

13. Florida Administrative Code Rule 59G-5.020(1) requires all Medicaid enrolled providers to comply with the Florida Medicaid Provider General Handbook (July 2012) ("General Handbook"). According to page xii of the Prescribed Drug Services Coverage Limitations and Reimbursement Handbook (July 2014) ("Drug Handbook"), all pharmacy providers must comply with all of the applicable policies in the General Handbook as well as the Drug Handbook. The Drug Handbook is promulgated into law by Florida Administrative Code Rule 59G-4.250(2). Regarding whether Petitioner is entitled to reimbursement, the General Handbook and the Drug Handbook state the following identical language on their respective pages 1-3:

> Prior to rendering a service, a provider must inform the recipient of his responsibility for the payment of any services received that are not covered by Medicaid and must document this in writing in the recipient's medical record.
>
> Other than copayments and coinsurance, a provider cannot bill the recipient **except** under any of the following circumstances:
>
> **1. The provider chooses not to bill Medicaid for any part of that service and the recipient has been informed prior to the service being provided.** [emphasis added]

2. The service is not covered by Medicaid.
3. There is a balance due on an Enhanced Benefits Account (EBA) claim (i.e., there was insufficient credit balance to fully pay for the item).

14. These authorities state that a Medicaid provider can bill the recipient only if the recipient is informed he will be billed prior to rendering the service. In this case, Petitioner was informed prior to the service that he would need to pay for his prescriptions. Rather than contact his plan to find an alternative pharmacy or resolve the misinformation as to whether this pharmacy was in network, he chose to pay for the prescriptions over the course of at least one year. Although the pharmacy is contracted under Petitioner's managed care plan, it appears that the pharmacy chooses not to bill Medicaid. The pharmacy informed the Petitioner it would not be billing the plan when it told him it did not accept his plan and asked him to pay cash.

15. The General Handbook explains at page 1-6:

> A provider who bills Medicaid for reimbursement of a Medicaid-covered service must accept payment from Medicaid as payment in full. This does not include Medicaid copayments and Medicaid coinsurance....
>
> A provider who fails to bill Medicaid correctly and in a timely manner may not bill the recipient.
>
> A provider who bills Medicaid for reimbursement of a Medicaid-covered service may not:
>
> • File a lien against the recipient or the recipient's parent, legal guardian or estate;
> • Apply any money received from any non-Medicaid source to charges related to a claim paid by Medicaid. (This restriction is commonly referred to as the prohibition against "balance billing.");
> • Bill the recipient, the recipient's relatives or any person or persons acting as the recipient's designated representative; or
> • Turn a recipient's overdue account over to a collection agency, except in the situations described on the next page.

16. The plan's contract with the pharmacy states that "in order to receive payment from Catamaran for services provided to Catamaran members" the pharmacy must submit claims to Catamaran through specified channels. If the provider bills the plan at all, regardless of whether the claim is ultimately paid, the provider cannot bill the member. Fla. Admin. Code R. 59G-5.110(4); *see also* General Handbook at pages 1-6 and 1-7.

17. In this case, the provider did not bill Medicaid at all. If the provider had billed Medicaid, then it would be unable to bill Petitioner. The plan is attempting to resolve the matter with the provider under the terms of its contract. The undersigned has no jurisdiction over a third party contract.

18. When the provider is acting in violation of rule, statute, or contract, the Agency for Health Care Administration and the managed care plan have authority to investigate, educate, sanction, or otherwise take action with the provider. The Office of Appeal Hearings does not have jurisdiction over provider matters. The undersigned has no jurisdiction over the provider to order any remedy, nor is there jurisdiction to order the plan or Agency to sanction the provider in any particular way.

19. As a result, it appears the provider informed Petitioner of his obligations to pay the provider before rendering services. This means that as far as the legal authority on the matter suggests, Petitioner is not entitled to reimbursement from a provider that does not bill Medicaid and informed him prior to rendering services that it will not bill Medicaid. Whether or not the provider is required to bill the plan and whether it is acting in violation of its contract with the plan is outside of the scope of the Office of Appeal Hearings' jurisdiction.

20. Petitioner should work with his case manager to find an alternative pharmacy that will meet his needs and will properly bill the plan. Additionally, Petitioner may want to file a complaint against the pharmacy with the Agency for Health Care Administration's Consumer Complaint Line at (888) 419-3456.

DECISION

Based on the above Finding of Facts and Conclusions of law, the appeal is denied and Respondent's actions are 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 agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 13th day of May, 2015, in Tallahassee, Florida.

Danielle Murray

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Copies Furnished To: [redacted] Petitioner
Don Fuller, Area 6, AHCA Field Office Manager