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

[redacted]

APPEAL NO. 15F-06213

PETITIONER,

vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing in the above-styled matter convened on October 29, 2015 at approximately 1:00 p.m. All parties and witnesses appeared via teleconference.

APPEARANCES

For the Petitioner: [redacted] Petitioner

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

STATEMENT OF ISSUE

At issue is a decision by Respondent, the Agency for Health Care Administration (AHCA or "the Agency), through its contracted health plans, to deny Petitioner's request for Magnetic Resonance Imaging (MRI) scans of the cervical and lumber spine. Petitioner bears the burden of proving, by a preponderance of the evidence, that this denial was improper.

PRELIMINARY STATEMENT

The Agency for Health Care Administration is responsible for administering Florida's Medicaid Program. In the instant case, AHCA has contracted with the Managed Care Organization (MCO), Amerigroup, to provide services to enrolled Medicaid recipients. Amerigroup, in turn, contracts with AIM Specialty Health (AIM) to conduct prior authorization reviews of requests for diagnostic imaging.

This matter was initially scheduled to convene for hearing on September 17, 2015 at 10:00 a.m. Petitioner failed to appear for hearing, but later called the Office of Appeal Hearings to request rescheduling. Both parties were notified in advance of the rescheduled hearing date.

Petitioner appeared as her own representative. Respondent was represented by Stephanie Lang, RN, AHCA Registered Nurse Specialist/Fair Hearing Coordinator, who presented two witnesses: Laura Winthrow, Manager in Amerigroup's Quality Management Department, and Jennifer Eklund, M.D., Associate Medical Director of Government Programs with AIM.

Although Petitioner had not received her copy of Respondent's evidence packet prior to hearing, she opted to proceed, as scheduled. Respondent's Exhibits 1 through 6, inclusive, were accepted into evidence. Administrative Notice was taken of pertinent legal authority. The record was held open until November 6, 2015, so that Respondent might furnish Petitioner with a copy of the evidence, and Petitioner might file any needed response to same. The undersigned received a certificate of service that the evidence was furnished to Petitioner, but has not received any further correspondence or any responsive filing thereto.

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 (57 years old at the time of hearing) with a medical history including back pain as the result of an automobile accident. She works as a hair-dresser, but has had to cut down on her hours, as she is unable to stand for long periods of time. She feels the pain is getting worse and worries she might need surgery. She is also concerned that if she is unable to work, she will lose her Medicaid coverage.

2. On June 18, 2015, Petitioner's treating physician called in to AIM a request for cervical and lumbar MRIs, noting a diagnosis of [redacted]" Later that same day, the physician called AIM, again. Per AIM's records and testimony, the diagnoses provided were [redacted], and the following additional information was obtained:

> No ddx [differential diagnosis]. No physician supervised conservative treatment for 4 weeks. Unknown if the patient is a potential candidate for epidural injection or surgery. No XR. No hx of malignancy, fever, or unexplained weight loss. No focal neuroglial deficits.

3. Also on June 18, 2015, the reviewing AIM nurse sent a request to the prescribing physician, asking that he participate in a peer-to-peer review. After the physician failed to respond, the MRI request was transferred to AIM's physician consultants for a medical necessity review.

4. On June 22, 2015, AIM denied the request as failing to meet clinical criteria; however, this denial was transferred to holding so as to await participation in a peer-to-peer conference. When the prescribing physician failed to return AIM's correspondence by June 24, 2015, the MRI denial was finalized.

5. Via Amerigroup Notices of Case Action (NOCAs) dated June 24, 2015, Petitioner was informed that her requests for lumbar spine and cervical spine MRIs were denied because they were not "individualized, specific and consistent with symptoms or diagnosis or illness or injury and not... in excess of the patient's needs." The cervical NOCA stated:

> Our records show that you are being treated for [redacted]. This test is medically necessary when the pain has not improved after 3 to 4 weeks of treatment by your doctor. Your doctor needs to have seen you in the office after treatment. You also need to be a candidate for surgery or steroid injection. Our records do not show that this is the case for you. We used AIM Specialty Health Guideline for Magnetic Resonance Imaging (MRI)... to make this decision. You may view this guideline at http://www.aimspecialtyhealth.com/marketing/guidelines/185/index.html.

The lumbar NOCA utilized the same language, but referenced [redacted] and 4 to 6 weeks of unsuccessful treatment.

6. The above-referenced guidelines were submitted into evidence, and reflect the following criteria for MRIs:

> **Non-specific** [redacted]
> • In a patient where focused history and physical exam suggest non-specific cervical pain and/or referred upper extremity pain and all of the following are met:
> ○ Patient is a potential candidate for surgery or epidural steroid injection; **AND**
> ○ Patient has, following clinical examination, completed a minimum of 3-4 consecutive weeks of physician supervised conservative therapy for the current episode of pain, including but not limited to any of the following:

■ NSAIDs
■ Muscle relaxants
■ Steroids
■ Physical therapy; **AND**
○ After trial of conservative therapy as listed above, patient fails to show substantial improvement on clinical re-evaluation; **OR**
● In the pediatric population, pain in the cervical spine region may not require completion of the 3-4 week course of conservative treatment; **OR**
● [redacted] not meeting the above criteria but associated with "red flag" symptoms such as unexplained weight loss, history of malignant disease, fever, abnormal serum electrophoresis suggestive of multiple myeloma, history of drug abuse or tuberculosis

...

Non-specific [redacted]
● In a patient where focused history and physical exam suggest non-specific lumbar pain and/or referred buttock or lower extremity pain and all of the following are met:
○ Patient is a potential candidate for surgery or epidural steroid injection; **AND**
○ Patient has, following clinical examination, completed a minimum of 4-6 consecutive weeks of physician supervised conservative therapy for the current episode of pain, including but not limited to any of the following:
■ NSAIDs
■ Muscle relaxants
■ Steroids
■ Physical therapy; **AND**
○ After trial of conservative therapy as listed above, patient fails to show substantial improvement on clinical re-evaluation; **OR**
● In the pediatric population, pain in the lumbar spine region may not require completion of the 4-6 week course of conservative treatment; **OR**
● [redacted] not meeting the above criteria but associated with "red flag" symptoms such as unexplained weight loss, history of malignant disease, fever, abnormal serum electrophoresis suggestive of multiple myeloma, history of drug abuse or tuberculosis.
(emphasis original)

7. With regard to appeal rights, both NOCAs read:

How to Ask for an Appeal:
You can ask for an appeal in writing or by calling us. Your case manager can help you with this, if you have one. We must receive the request *within 30 days* of the date of this letter. Here is where to call or send your request:

Medical Appeals

> Greivance and Appeals Coordinator
> Amerigroup
> ...
> PHONE: 1-800-600-441 (TTY 1-800-855-2880)
> ...
> Within five days of getting your appeal, we will tell you in writing that we got your appeal unless you ask for an expedited (fast) appeal. We will give you an answer to your appeal within 45 days of you asking for an appeal.
> (all emphasis original)

8. On or about July 2, 2015, Petitioner filed a verbal request for an appeal with Amerigroup.

9. On July 20, 2015, Amerigroup administratively closed this request for appeal because "the required written follow up was not received within the allotted time (10 calendar days)."

10. On July 22, 2015, Petitioner filed an appeal with the Office of Appeal Hearings.

11. At hearing, Dr. Eklund (AIM) explained that without any supporting information from the prescribing physician, AIM was unable to determine if the clinical criteria were met, and was thus unable to approve the MRIs.

12. Petitioner stated that her physician told her he does not participate in peer-to-peer conversations. She explained that she has had difficulty locating participating physicians since enrolling with Amerigroup, and her former physician, who has her medical records, does not accept the plan. She knows her diagnosis is a [redacted] but is unable to obtain the records to show this is the case. She does not experience any of the symptoms noted in the guidelines as "red flags," but does experience pain.

13. Amerigroup noted that, had Petitioner followed her verbal request for appeal with a written request, they could have assisted her in obtaining medical records; however, since she did not, they closed out her grievance without any further action. It is Amerigroup's position that the requirement to follow a verbal request with a written one is contained within their member handbook. Said handbook is not part of the record.

CONCLUSIONS OF LAW

14. 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.

15. 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.

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

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

18. The burden of proof was assigned to Petitioner in accordance with Florida Administrative Code Rule 65-2.060(1).

19. The standard of proof in an administrative hearing is by a preponderance of the evidence (See Fla. Admin. Code R. 65-2060(1)), which requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

20. Section 409.905, Florida Statutes, 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....

21. 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.

22. The medical necessity rule, cited above, incorporates a requirement that the service requested be consistent with the generally accepted professional medical standards, as determined by the Medicaid program. The Medicaid Practitioner Services Coverage and Limitations Handbook (April 2014) ("the Handbook") is promulgated into

law by Florida Administrative Code Rule 59G-4.205(2). At page 2-99, the Handbook explains that radiology and nuclear medicine requests, such as Petitioner's request for an MRI, require prior authorization, noting:

> Prior authorization (PA) is the approval process required prior to providing certain Medicaid services to recipients. Medicaid will not reimburse for the designated, outpatient, non-emergent diagnostic imaging services without prior authorization.

23. In conducting its PA reviews, Amerigroup, through AIM, utilizes guidelines to determine the medical necessity of a requested service. Said guidelines, as outlined in paragraph 6, above, require that a patient requesting an MRI, who is not in the pediatric population and does not exhibit "red flag" symptoms, must document unsuccessful trials of more conservative treatment, such as drug or physical therapy, before an MRI will be authorized. No such documentation was submitted in Petitioner's case.

24. With regard to Amerigroup's handling of Petitioner's internal appeal/grievance, the undersigned sees no indication within Amerigroup's NOCA that an appeal filed with Amerigroup via telephone must be followed up in writing. Instead, the NOCA very clearly states that a member may file an appeal "in writing or by calling us" (emphasis added). Regardless of what may be written in Amerigroup's member handbook, the instructions set forth in their NOCA are clear, and were properly followed by Petitioner. Amerigroup prematurely terminated the grievance process; however, while this is poor customer service, it ultimately has no bearing on the outcome of this appeal.

25. It is unfortunate that Petitioner's prescribing physician is resistant to peer-to-peer conferences and does not seem amenable to assisting Petitioner in obtaining the

services she desires. As Petitioner has noted her frustration in finding physicians who participate in Amerigroup, the Amerigroup witness provided the following customer call center number, to assist in Petitioner's search: 1-800-600-4441. If Petitioner is still unable to locate providers, or experiences any other frustration with her health plan, she is encouraged to call the Medicaid Managed Care Complaint Line at 1-877-254-1055.

26. Based upon review of the entire record, Petitioner has not met her burden to show that Respondent's denial was improper. Should she wish to resubmit a request for MRIs with additional supporting documentation, she is encouraged to do so. If said request is denied, Petitioner will reserve the right to appeal that, distinct, denial.

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 11 day of December, 2015,

in Tallahassee, Florida.

Patricia C. Antonucci
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Copies Furnished To: [redacted] Petitioner
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