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

[redacted]

APPEAL NO. 15F-07046

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on September 15, 2015, at approximately 1:04 p.m.

APPEARANCES

For Petitioner: [redacted] Petitioner

For Respondent: Suzanne Chillari, Medical Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

Whether the Agency was correct in denying Petitioner's request for chiropractic visits beyond the allowed 24 visits per year. The burden of proof on this issue is assigned to the Petitioner.

PRELIMINARY STATEMENT

Petitioner's chiropractor, [redacted] appeared as a witness for Petitioner. Appearing as witnesses for Respondent were Robert Walker (Regulatory Research Coordinator with Staywell), Marlene Kraft (Vice President of Quality Management with Palladian Health), Ralph Hague (Network Services Manager with Chiro Alliance), Dr. Paul Seniw (Vice President of Chiropractic Clinical Services with Palladian Health). Sheila Folger, Vendor Account Manager with Staywell, observed the hearing.

Respondent admitted seventeen exhibits into evidence, which were marked and entered as Respondent's Exhibits 1 through 17. Petitioner submitted no documentary evidence. Administrative notice was taken of the Florida Medicaid Chiropractic Services Coverage and Limitations Handbook (January 2010).

FINDINGS OF FACT

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

1. Petitioner is a Medicaid recipient over 21 years of age. She has many musculoskeletal problems causing her constant pain which keeps her up at night. Her diagnoses include [redacted] She is unable to metabolize any common pain killers so she has no pain relief option beyond exercise and non-medical treatments such as acupuncture.

2. Petitioner saw her chiropractor more than 24 visits. She believes this care has helped her pain and she wants to continue the treatment. She cannot afford to pay out of pocket for massage, acupuncture, physical therapy, or chiropractic visits. She exercises at home as much as she can to help her conditions.

3. A subsection of Palladian Health known as Chiro Alliance, handles the chiropractic related prior authorization reviews and claims for Staywell members. Staywell (through its contractor, Chiro Alliance) processed 30 claims for Petitioner's chiropractic visits. After the 24th claim, it denied claims due to maximum benefit reached.

4. Staywell's Member Handbook, and the Medicaid policy on chiropractic care, limit the benefit to 24 visits per year without exception. Staywell apparently allows for extra visits if the visits are prior authorized as medically necessary, but this is not documented in its handbook.

5. On or about July 13, 2015, Petitioner's chiropractor submitted a prior authorization request to Chiro Alliance for one visit per week without an end date, beyond the allotted 24 visits (which Petitioner has exhausted for this year). The request included x-rays and MRI reports. Chiro Alliance denied this request on July 14, 2015, stating that there was not enough information to show medical necessity for ongoing treatments. Specifically, the records review noted a lack of objective care assessments and outcomes, functional assessments, updated findings, and no goals or expected outcomes in a treatment plan that suggests Petitioner's problems will be significantly improved by chiropractic care. The denial stated that the determination was based on

Palladian Chiropractic Guidelines for Spine and Spinal-Related Care for the Neck, Mid Back and Low Back. The guidelines were not submitted as evidence in this case.

6. The Office of Appeal Hearings received Petitioner's fair hearing request on August 12, 2015. In response to Petitioner's hearing request, Chiro Alliance requested more information from the treating chiropractor, and received SOAP Notes for each of Petitioner's past visits. After reviewing the additional information, Chiro Alliance upheld the denial based on the same reasons: lack of defined goals and expected outcomes, lack of interim outcome measurements or functional assessments, lack of updated goals and objectives based on progress.

7. Petitioner's chiropractor uses the activator technique to treat his patients. This technique restores movements to joints. He does not use typical measurement tools, but does "functional outcome assessments" to Petitioner before and after each treatment to see progress. Each visit lasts approximately thirty minutes.

8. Petitioner reports her pain levels at each visit, but not using the standardized 1 through 10 pain scale that most medical professionals refer to. Her provider documents her pain complaints during each visit as "improved" or "worse." During the hearing, Petitioner self-reported her pain on an average day as between five and six, sometimes eight or nine (assuming 10 is the equivalent of childbirth pain).

9. The provider's goal is to help Petitioner's pain and restore her range of motion so that she may exercise at home and continue progress. The visit notes indicate "subjective" findings reported by the patient, "objective" assessments done along with the findings for each assessment ("improved", "worse", or "not examined") compared to

the last note, and "assessment" indicating his overall impression of the patient's condition as of the note date.

CONCLUSIONS OF LAW

10. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80, Florida Statutes.

11. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.

12. This hearing was held as a de novo proceeding pursuant to Florida Administrative Code Rule 65-2.056.

13. In accordance with Florida Administrative Code Rule 65-2.060(1), the burden of proof was assigned to the Petitioner. 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).

14. Section 409.912, Florida Statutes, notes that AHCA shall purchase goods and services for Medicaid recipients in the most cost-effective manner possible, consistent with the delivery of quality medical care.

15. The Florida Medicaid Provider General Handbook (Provider Handbook) – July 2012 is incorporated by reference in Florida Administrative Code Rule 59G-4. In accordance with the Florida law, the Provider Handbook discusses managed care coverage, stating on page 1-27:

> 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. Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

16. Page 1-30 of the Provider Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

17. As of August 16, 2015, there is no longer a Chiropractic Services Coverage and Limitations Handbook for Florida Medicaid. Florida Administrative Code Rule 59G-4.040(2) promulgates the new Chiropractic Services Coverage Policy ("Policy") which superseded the Handbook and is the applicable policy for this case. The policy notes on page 3, section 4.0 Coverage Information that:

> 4.1 General Criteria
> Florida Medicaid reimburses services that:
> • Are determined medically necessary.
> • Do not duplicate another service.
> • Meet the criteria as specified in this policy.
>
> 4.2 Specific Criteria
> Florida Medicaid reimburses for the following:
> • One new patient visit plus 23 established patient visits per year or 24 established patient visits per year
> • X-rays

18. There are no exceptions to this limitation found in the Policy. As excerpted in paragraphs 15 and 16 above, HMOs may choose to offer more than state Medicaid (also known as "fee-for-service") but are not permitted to be more restrictive or offer fewer services than state Medicaid.

19. Regarding authorization for the service, under section 7.1 on page 4, the Policy states: "[f]or recipients enrolled in a managed care plan, providers should request authorization through the recipient's managed care plan."

20. All services reimbursed by Florida Medicaid, whether through fee-for-service or through a managed care plan, must meet the definition of medical necessity. Florida Administrative Code, 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.

21. Petitioner followed procedure in requesting prior authorization for chiropractic treatment through her managed care plan. The plan covers 24 visits per year, in compliance with the Policy. The plan may authorize additional visits beyond the required 24 covered visits under Medicaid policy, as an expanded benefit specific to the plan. In this case, the plan will authorize visits in excess of the allotted 24 visits if those visits are prior authorized as medically necessary. The plan is obligated to follow the

definition of "medically necessary" as excerpted above, but may institute utilization guidelines to assist with the prior authorization review. Prior authorizations are subject to the plan's internal policies, guidelines, and procedures. The plan did not submit its internal guidelines for review during this proceeding, but there was testimony that the submitted documentation does not meet the guidelines for various reasons.

22. In order to meet medical necessity, the service must "be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain." Testimony confirmed that this service is to alleviate severe pain and Petitioner believes it is helping her.

23. Next, it must "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." The service appears to be consistent with Petitioner's diagnosed musculoskeletal symptoms. However, it cannot be determined from the records whether continued chiropractic treatment would be appropriate or in excess of her needs. The documentation does not adequately explain the progress made or what the desired end result of the treatment is.

24. Petitioner's provider testified that the goal is to give Petitioner pain relief and allow her to exercise to further help her pain. This is a vague goal and cannot be measured objectively.

25. Petitioner received chiropractic visits over the course of approximately one year. During that time, her progress has been inconsistent. The notes indicate "slightly improved" or "slightly worse" on a daily basis. Overall, it appears there are more "slightly improved" notes, but this doesn't indicate how much she has improved since

treatment began. There is no objective assessment of her abilities at the onset of treatment, during treatment, or at the end, to determine whether this treatment is actually working. The daily assessment is entirely based on the provider's opinion as of the date of the note and cannot be objectively verified, unlike (as an example) a degree of measurement showing a marked change in range of motion between current status and a month prior. There are no goals and no metrics to see if there is any progress being made, besides the provider's opinion. As it cannot be determined whether or not the service is in excess of her needs, the remaining prongs of the medical necessity determination do not require analysis.

26. The medical necessity definition explains that just because a provider prescribed or recommends something, it does not automatically make it medically necessary under Medicaid's rules. There is simply not enough information to make an objective assessment of whether or not this treatment is likely to have desired results in any set period of time. The treating provider's opinion, without any documented objective rationale, is the only clinical information as to the need for this treatment. An opinion does not allow for any substantial prior authorization review in compliance with any legal definitions or clinical guidelines.

27. The undersigned acknowledges Petitioner's unique situation and need for some relief. Petitioner is entitled to all the care that the applicable rules, regulations, and policies allow. There is not enough evidence in this case to support medical necessity of the requested treatment in compliance with the applicable rules.

28. After careful review of the relevant authorities, the testimony and the evidence in this matter, the hearing officer concludes that Petitioner did not meet her burden of

proof in this case. She is not precluded from re-submitting her request with any additional documentation to the plan. Any subsequent denials on future requests would give her new fair hearing appeal rights.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner's appeal is 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 November, 2015,

in Tallahassee, Florida.

Danielle Murray

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@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Dietra Cole, Area 8, AHCA Field Office Manager