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

[redacted]

APPEAL NO. 15F-07213

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 Dade
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 1, 2015, at 9:15 a.m.

APPEARANCES

For the Petitioner: [redacted] pro se

For the Respondent: Dianna Chirino, Senior Program Specialist, Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is the Agency action of August 19, 2015, through Simply Health Plan, to deny the petitioner's request for a Bariatric Surgery Procedure based on the request not being medically necessary. The burden of proof is assigned to the petitioner.

PRELIMINARY STATEMENT

Present as witnesses for the respondent were Diana Anda, Grievance and Appeals Supervisor, and Dr. Vincent Pantone, Chief Medical Officer, both from Simply Health Care. Present as an interpreter was [redacted] id number [redacted], from Propio Language Services.

The respondent submitted into evidence Respondent Composite Exhibit 1 and 2.

FINDINGS OF FACT

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

1. The petitioner is fifty years of age and is a Managed Medical Assistance Program (MMA) recipient living in [redacted] County, Florida. Simply Health Plan is the managed care agency authorized by AHCA to provide Medicaid services.

2. The petitioner is five foot two inches tall and currently weighs about 244 pounds. Her treating physician considers her morbidly obese. On or about August 13, 2015, the petitioner's treating physician submitted a pre-authorization request to Simply Health Plan for Bariatric Surgery.

3. Simply Health Plan determined the request for the bariatric surgery was not medically necessary based on the information received. On August 19, 2015, Simply Health Care provided a Notice of Action to the petitioner stating:

> We determined that the requested services are not medically necessary because the services...
>
> Must be individualized, specific, consistent with symptoms or diagnosis or illness or injury and not in excess of the patient's needs.
>
> ....

> The facts that we used to make the decision are: Your request for bariatric surgery is denied because according to the information received you have not made a diligent effort to achieve healthy body weight. There is no documentation that you have been following a consistent medically supervised weight loss diet plan prior to the decision to operate.

4. The respondent's physician witness indicated that Simply Health uses InterQual standards in helping to determine the approval or non-approval of weight loss surgery for Medicaid recipients. He indicated there was no consistent medically supervised weight loss and exercise program that was completed for at least six months prior to considering Bariatric Surgery for the petitioner.

5. The respondent's physician witness also reiterated that all of the medical information submitted for the request for the surgery was reviewed. He indicated that the February 4, 2015 report from the petitioner's treating physician provides no clear plan or documentation for the requested surgery. He indicated that another report from the petitioner's treating physician dated March 27 2015 does not show a dietary plan with instructions for the petitioner to follow. He indicated that a May 25, 2015 note from the petitioner's physician indicates the petitioner is compliant with a diet; however, there is no evidence that the "diet" was part of a supervised weight loss program. He indicated that a July 28, 2015 form titled "Diet History" was provided; "blank", as it did not indicate any physician supervised diet for the petitioner.

6. The petitioner argued that she has physical problems, such as knee and spinal problems that make it hard for her to exercise. She argued her treating physicians have authorized the weight loss surgery. She argued that she has been trying to eat as healthy as possible. She argued that she has had problems following any diet based on her medical issues.

7. The respondent physician witness agreed that the petitioner has medically proven orthopedic issues that would prevent her from exercising. He indicated that the main eligibility criteria for weight loss surgery is related to diet, and the petitioner has not met the criteria for the weight loss surgery based on the lack of a medically supervised diet or weight loss program.

PRINCIPLES OF LAW AND ANALYSIS

8. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to § 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

9. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

10. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence as provided by Rule 65-2.060(1), Florida Administrative Code.

11. § 409.912, Fla. Stat. states, in relevant parts:

> Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program.
>
> ....
>
> (2) The agency may contract with a provider service network, which may be reimbursed on a fee-for-service or prepaid basis.

12. The Florida Medicaid Provider General Handbook, incorporated by reference in the Medicaid Services Rules under Fla. Administrative Code Chapter 59G-4, states on Page 1-27, in part:

> 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.

13. Fla. Admin. Code R. 59G-1.010 states:

(166) "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.

(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

(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.

14. The InterQual standards used by the Agency as a guideline states:

Before surgery is considered, patients should undergo an adequate trial of inoperative weight loss. Dieting could have occurred at any time in the course of the patient's medical management and should incorporate nutritional counseling, behavioral modification, and appropriate physical activity. The goal is weight loss of 0.5 kg/week and to reduce weight 5% to 10%.

15. As shown in the Findings of Fact, the Agency, through Simply Health Plan, determined the request for Bariatric Surgery was not medically necessary based on the information provided.

16. For the case at hand, the evidence presented does not indicate the petitioner followed or was prescribed a medically supervised weight loss program that was completed for at least six months prior to considering Bariatric Surgery; thus, the hearing officer agrees with the respondent's arguments that petitioner's request for the Bariatric Surgery did not meet medical necessity criteria. The controlling authorities make clear that services should be excluded whenever a less costly, equally effective, service can be safely furnished.

17. After considering the evidence and all of the appropriate authorities set forth in the findings above, the hearing officer affirms the Agency's action to deny the petitioner's request for the Bariatric Surgery procedure for the reason noted above. The petitioner has not met her burden of proof.

DECISION

This appeal is denied and the Agency action 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 17th day of November, 2015,

in Tallahassee, Florida.

Robert Akel

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Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager