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

[redacted]

APPEAL NO. 15F-07668

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 17 Broward
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 5, 2015 at 10:00 a.m.

APPEARANCES

For Petitioner: [redacted]
Pro Se

For Respondent: Linda Latson
Registered Nurse Specialist

STATEMENT OF ISSUE

At issue is whether Respondent's denial of the prescription drug [redacted] was proper. The burden of proof is assigned to the Petitioner.

PRELIMINARY STATEMENT

The Petitioner did not submit any documents as evidence for the hearing other than the hearing request which was already part of the record.

Appearing as witnesses for the Respondent were Mindy Aikman, Grievance and Appeals Specialist, and Dr. Ian Nathanson, Medical Director, from Humana, which is Petitioner's managed care plan.

Respondent submitted the following documents into evidence for the hearing: Exhibit 1 – Member Information and Prior Authorization Request; Exhibit 2 – Denial Notice; Exhibit 3 – Grievance/Appeal Documents; Exhibit 4 – Medical Director Review; and Exhibit 5 – Determination Letter.

FINDINGS OF FACT

1. The Petitioner is a fifty-one year old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. She receives services under the plan from Humana.

2. On or about June 15, 2015, Petitioner's treating physician submitted a prior authorization request to Humana for the prescription drug [redacted] The prior authorization request also contained medical records describing Petitioner's need for this medication.

3. On June 18, 2015, Humana sent a notice to Petitioner stating her request for [redacted] had been denied. The notice stated the following:

> [redacted] is one of the drugs that are not covered by Medicaid. You should work with your doctor or other prescriber to determine if a drug on our list of covered drugs is medically appropriate for treating your condition.

4. Petitioner testified she needs the medication due to inflammation in her left knee. She stated she received this medication previously for her right knee through Medicaid in 2013 and 2014 when she was covered by a different plan (Molina Healthcare). She also stated she has been denied an alternate medication call [redacted]

5. Respondent's witness, Dr. Nathanson, stated that Medicaid MMA plans must follow Medicaid guidelines and [redacted] is not on the Medicaid Preferred Drug List (PDL).

CONCLUSIONS OF LAW

6. By agreement between the Agency for Health Care Administration and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to § 120.80, Fla. Stat.

7. This is a final order pursuant to § 120.569 and § 120.57, Fla. Stat.

8. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

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

10. The Florida Medicaid program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid program is administered by the Respondent.

11. The Florida Medicaid Provider Handbook (Provider Handbook) is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Chapter 59G-4. In accordance with the above Statute, the Handbook states 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.

12. In this proceeding, Humana is the health maintenance organization which provides Petitioner's Medicaid services.

13. Page 1-28 of the Provider Handbook lists HMO covered services. The service list includes prescribed drug services.

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

15. The Prescribed Drug Services Handbook has been promulgated into rule by reference in Fla. Admin. Code R. 59G-4.250. Relevant to this proceeding:

> Page 1-4:
>
> HMO prescribed drug services are defined the same as for the Medicaid fee-for-service program and include all legend drug products covered by fee-for-service Medicaid as defined in Chapter 2 of this handbook, Legend Drugs. Medicaid's contract with HMOs states that Medicaid HMOs may use prior authorization and/or step therapy to encourage compliance with the preferred drug list.
>
> Page 2-2:
>
> To be reimbursed by Medicaid, a drug must be medically necessary and either (a) prescribed for medically accepted indications and dosages found

> in the drug labeling or drug compendia ..., or (b) prior authorized by a qualified clinical specialists approved by the Agency. Notwithstanding this rule, the Agency may exclude or otherwise restrict coverage of a drug in accordance with Section 1927 of the Social Security Act.

16. The definition of "medically necessary" is found in the Fla. Admin. Code R. 59G-1.010, which states, in part:

> (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...
>
> (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.

17. Pertaining to the PDL, the Drug Handbook continues by providing the following additional information:

> Page 2-4:
>
> The Preferred Drug List (PDL) is a listing of prescription products recommended by the Pharmaceutical and Therapeutics (P&T) Committee for consideration by AHCA as efficacious, safe, and cost effective choices when prescribing for Medicaid patients.
> ...

> Products included on the PDL must be prescribed first unless the patient has previously used these products unsuccessfully or the prescriber submits documentation justifying the use of a none-PDL product.
> ...
>
> Non- PDL drugs may be approved for reimbursement upon prior authorization.
>
> Page 2-5:
>
> Approval of reimbursement for alternative medications that are not listed on the preferred drug list shall be considered if listed products have been tried without success within the previous twelve months. The step-therapy prior authorization may require the prescriber to use medications in a similar drug class or that are indicated for a similar medical indication unless contraindicated in the Food and Drug Administration labeling. The trial period between the specified steps may vary according to the medical indication. A drug product may be approved without meeting the step-therapy prior authorization criteria if the prescribing physician provides the agency with additional written medical or clinical documentation that the product is medically necessary because:
>
> - There is not a drug on the preferred drug list which is an acceptable clinical alternative to treat the disease or medical condition; or
> - The alternatives have been ineffective in the treatment of the beneficiary's disease; or
> - Based on historic evidence and known characteristics of the patient and the drug, the drug is likely to be ineffective; or
> - The number of doses has been ineffective.

18. The Findings of Fact establish [redacted] is not included on Respondent's PDL.

19. Clinical evidence was not presented demonstrating PDL medications were attempted in the last year and found to be ineffective. As such, it was not demonstrated that the above step therapy process was addressed.

20. Petitioner has not established that the following conditions of medical necessity have been satisfied:

> 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 defined by the Medicaid program and not be experimental or investigational;

21. The greater weight of evidence in this matter does not establish Respondent's denial of [redacted] was improper.

DECISION

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

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 03 day of December, 2015, in Tallahassee, Florida.

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