



STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
OFFICE OF FAIR HEARINGS

FILED

Mar 16, 2023, 8:39 am
OFFICE OF FAIR HEARINGS

[REDACTED],

PETITIONER,

AHCA Case No.: 22-FH1803

Plan ID No [REDACTED]
[REDACTED]

vs.

HUMANA MEDICAL PLAN, INC.,

RESPONDENT.

FINAL ORDER

Pursuant to notice, Hearing Officer Jaquetta Johnson convened a telephonic Fair Hearing on the instant case on January 3, 2023, at 9:31 a.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner:

[REDACTED]
Authorized Representative

For the Respondent:

Michael Moens
Grievance and Appeals Specialist
Humana Medical Plan, Inc.

STATEMENT OF ISSUE

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent’s denial of Evaluation and Management services (out-of-network/out-of-state evaluation and treatment) was incorrect.

PRELIMINARY STATEMENT

All parties appeared for the scheduled Fair Hearing telephonically. [REDACTED] [REDACTED] Petitioner's Authorized Representative and [REDACTED], appeared for the Fair Hearing to provide testimony on behalf of Petitioner, and [REDACTED] did not call any witnesses.

Michael Moens, Grievance and Appeals Specialist for Humana Medical Plan, Inc. ("Humana"), appeared for the Fair Hearing as representative for Respondent. Dr. Anne brady ("Dr. Brady"), a Medical Director for Humana, appeared for the Fair Hearing as a witness for Respondent.

Lee Ann Williams, a Medical Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared for the Fair Hearing as an observer

Prior to the Fair Hearing, petitioner sent to the Office of Fair Hearings a 6-page evidence packet, which was admitted into evidence a Petitioner's Composite Exhibit 1. Petitioner's Composite Exhibit 1 includes the following documents: a fax cover sheet; a meta cover sheet; a grievance/Appeal request form; a letter from [REDACTED]; and an untitled document.

Prior to the Fair Hearing, Respondent sent to the Office of Fair Hearings and Petitioner a 245-page evidence packet, which was admitted into evidence a Respondent's Composite Exhibit 1. Respondent's Composite Exhibit 1 includes the following documents: a Medicaid Fair Hearing Case Summary; Humana's plan appeal information; a Notice of Adverse Benefit Determination ("NABD") (dated September 21, 2022, and October 5, 2022); a Notice of Plan Appeal Resolution ("NPAR") (dated September 23, 2022); Humana authorization screenshots; various medical records; Humana's Plan of Care; Humana's Plan of Care summary; various medical records; and Humana Member Handbook – English.

FINDINGS OF FACT

1. Petitioner is an enrolled member of Humana. *See* Respondent’s Composite Exhibit 1, pages 1, 47-54. Humana is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in the state of Florida.

2. As of the date of the Fair Hearing, [REDACTED] (Q76.3). *Id.* at 47-76. Petitioner experiences back [REDACTED]. *Id.* at 66. Petitioner is seeking to see out-of-network providers for routine screening and diagnosis & treatment of Petitioner’s medical condition. *Id.* at 62. Petitioner submitted medical records in support of the request. *Id.* at 47-76. Petitioner’s in-provider, Karen M. Hamad, MD, submitted a referral for treatment and evaluation from Dr. Morningstar in the state of Florida. *Id.* at 62. Petitioner also received an evaluation from Ryan Fitzgerald, MD, an in-network provider that specializes in orthopedic and [REDACTED] surgery. *Id.* at 66. According to [REDACTED] at the Fair Hearing, Petitioner’s in-network recommended Durable Medical Equipment (e.g., [REDACTED]) to treat Petitioner’s medical condition, however, [REDACTED] was unhappy with the in-network provider’s assessment and sought on a second opinion.

3. On September 21, 2022, Humana issued an NABD denying Petitioner’s request for Evaluation and Management services (Megan Strauchman, DO). *Id.* at 11-15. The NABD explained the basis of the denial as follows, in pertinent part:

Humana Healthy Horizons has reviewed your request for your child to receive services from a provider, **Megan Strauchman, DO [“Dr. Strauchman”]**, who is not part of Humana’s network, which we received on September 19, 2022. After our review, this service has been: **DENIED** as of September 19, 2022.

We made our decision because:

- ✓ We determined that your requested services are **not medically necessary** because the services do not meet the reason(s) checked below: (*See Rule 59G-1.010*)

...

- **Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs.**
- **Must 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.**
- **Must be furnished in a manner not primarily intended for convenience of the recipient, caretaker, or provider.**

...

The facts that we used to make our decision are: We have received a request for your child to receive services from a provider, Megan Strauchman, DO, who is not part of Humana's network, for a [REDACTED] [REDACTED]. This request cannot be approved. Your child has a Florida Statewide Medicaid Managed Care (SMMC) plan. This plan has providers (doctors and facilities) within the state that can give your child care. Your child's Humana Healthy Horizons in Florida Medicaid Member Handbook states that, for the most part, your child must use doctors, hospitals, and other health care providers that are in our provider network and are within the state.

Your child may only use providers that are not in our network under the following circumstances:

- **To get services that cannot be provided by a doctor in Humana's provider network**
- **In an emergency (when your child is so sick or hurt that their life or health is in danger if they do not get medical help right away)**

Your child's doctor did not provide any information that your child has any special needs related to their [REDACTED] that can only be performed by Megan Strauchman, DO. Your child's doctor did not provide information that this request is for emergency care. We are unable to approve the request for your child to go to this provider, who is not part of Humana's network. Humana has in-network providers in Florida who can provide your child the care that is needed. Please discuss this letter with your child's doctor to help you find an in-network provider for your child.

This decision was made by a Humana physician based on:

- The definition of medical necessity as defined in Chapter 59G-1.010 (2.83) Florida Administrative Code
- Humana Healthy Horizons in Florida Medicaid Member Handbook, Section 10 Titled: Accessing Services; Subsection Titled: Providers in Our Plan; Subsection Titled: Providers Not in Our Plan.

The treating physician has the opportunity to discuss this decision with a Humana Medical Director within 5 calendar days from the date of this letter. To request a peer-to-peer discussion, please call 800-223-6447 or fax request to 855-408-3420.

...

Sincerely,

Lorena Aliaga Deza, MD FL ["Dr. Deza"]

Medical Director

Respondent's Composite Exhibit 1, pages 11-15. (Emphasis added).

4. On October 5, 2022, Humana issued an NABD denying Petitioner's request for Evaluation and Management services (Dr. Mark W. Morningstar II). *Id.* at 21-25. The NABD explained the basis of the denial as follows, in pertinent part:

Humana Healthy Horizons has reviewed your request for your child to receive services from a provider, **Dr. Mark W. Morningstar II ["Dr. Morningstar"]**, who is not part of Humana's network, which we received on September 21, 2022. After our review, this service has been: **DENIED** as of September 19, 2022.

We made our decision because:

✓ We determined that your requested services are **not medically necessary** because the services do not meet the reason(s) checked below: (*See Rule 59G-1.010*)

...

- **Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs.**
- **Must 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.**
- **Must be furnished in a manner not primarily intended for convenience of the recipient, caretaker, or provider.**

...

The facts that we used to make our decision are: We have received a request for your child to receive services from a provider, Dr. Mark W. Morningstar II., who is not part of Humana's network, for a [REDACTED] [REDACTED]. This request cannot be approved. Your child has a Florida Statewide Medicaid Managed Care (SMMC) plan. This plan has providers (doctors and facilities) within the state that can give your childcare. Your child's Humana Healthy Horizons in Florida Medicaid Member Handbook states that, for the most part, your child must use doctors, hospitals, and other health care providers that are in our provider network and are within the state.

Your child may only use providers that are not in our network under the following circumstances:

- **To get services that cannot be provided by a doctor in Humana’s provider network**
- **In an emergency (when your child is so sick or hurt that their life or health is in danger if they do not get medical help right away)**

Your child’s doctor did not provide any information that your child has any special needs related to their [REDACTED] that can only be performed by Dr. Mark W. Morningstar II. Your child’s doctor did not provide information that this request is for emergency care. We are unable to approve the request for your child to go to this provider, who is not part of Humana’s network. Humana has in-network providers in Florida who can provide your child the care that is needed. Please discuss this letter with your child’s doctor to help you find an in-network provider for your child.

This decision was made by a Humana physician based on:

- The definition of medical necessity as defined in Chapter 59G-1.010 (2.83) Florida Administrative Code
- Humana Healthy Horizons in Florida Medicaid Member Handbook, Section 10 Titled: Accessing Services; Subsection Titled: Providers in Our Plan; Subsection Titled: Providers Not in Our Plan.

The treating physician has the opportunity to discuss this decision with a Humana Medical Director within 5 calendar days from the date of this letter. To request a peer-to-peer discussion, please call 800-223-6447 or fax request to 855-408-3420.

...

Sincerely,

Lorena Aliaga Deza, MD FL [“Dr. Deza”]

Medical Director

Respondent’s Composite Exhibit 1, pages 21-25. (Emphasis added).

5. On September 22, 2022, Petitioner requested a plan appeal. *Id.* at 3-8. On September 23, 2022, Humana issued an NPAR upholding the denial of Evaluation and Management services for out-of-network provider, Megan Strauchman, DO. *Id.* at 32-34. The NPAR states the following, in pertinent part:

On September 22, 2022, after consideration of the information you provided to Humana Healthy Horizons in support of your plan appeal, was reviewed by a

medical director who is a DO and board certified in Family Medicine and Osteopathic Manipulative Treatment hereby **denies your plan appeal**.

The reason for the decision was based on the information received. You have requested that we approve treatment with Megan Strauchman, DO who is not part of Humana's network for a diagnosis of [REDACTED]. We have reviewed the medical records submitted. Your child has the Florida Statewide Medicaid Managed Care (SMMC) plan. This plan has providers (doctors and facilities) that are able to give her care. Your child's Humana Florida Medicaid Member Handbook states that [REDACTED] must use doctors, hospitals, and other health care providers that are in our provider network.

Your child may only use providers that are not in our network:

- In an emergency (when you are so sick or hurt that your life or health is in danger if you do not get medical help right away).
- To get services that can't be provided by a doctor in Humana's provider network.

The information in your child's records does not show that this is emergency care or that her medical condition can only be treated by Megan Strauchman, DO. Humana has in-network providers in Florida who can provide your child with the care that you need. Please discuss this letter with your child's primary care physician to help you find an in-network provider for your child.

This decision was based on the definition of medical necessity as defined in Chapter 59G-1.010 (2.83) Florida Administrative Code and Humana's Florida Medicaid Member Handbook, Section 10 Titled: Accessing Services; Subsection titled: Providers in Our Plan; Subsection titled: Providers Not in Our Plan.

...

Sincerely,

Dr. Christopher Queen ["Dr. Queen"]

Medical Director

Respondent's Composite Exhibit 1, pages 32-34. (Emphasis added).

6. Also on September 23, 2022, Humana issued an NPAR upholding the denial of Evaluation and Management services for out-of-network provider, Dr. Mark Morningstar. *Id.* at 39-41. The NPAR states the following, in pertinent part:

On September 22, 2022, after consideration of the information you provided to Humana Healthy Horizons in support of your plan appeal, was reviewed by a

medical director who is a DO and board certified in Family Medicine and Osteopathic Manipulative Treatment hereby **denies your plan appeal**.

The reason for the decision was based on the information received. You have requested that we approve treatment with Dr. Mark Morningstar who is not part of Humana's network for a diagnosis of [REDACTED]. We have reviewed the medical records submitted. Your child has the Florida Statewide Medicaid Managed Care (SMMC) plan. This plan has providers (doctors and facilities) that are able to give her care. Your child's Humana Florida Medicaid Member Handbook states that [REDACTED] must use doctors, hospitals, and other health care providers that are in our provider network.

Your child may only use providers that are not in our network:

- **To get services that cannot be provided by a doctor in Humana's provider network**
- **In an emergency (when you are so sick or hurt that your life or health is in danger if you do not get medical help right away)**

We are unable to approve the request for your child to receive treatment with Dr. Mark Morningstar, as your child's doctor did not provide any information that your child has any special needs related to back problems that can only be treated by this provider. Your child's doctor did not provide any information that this request is for emergency care. Humana has in-network providers in Florida who can provide your child with the care that you are requesting for your child. Please discuss this letter with your child's Primary Care Physician (PCP) to help you find an in-network provider for your child.

This decision was based on the definition of medical necessity as defined in Chapter 59G-1.010 (2.83) Florida Administrative Code and Humana's Florida Medicaid Member Handbook, Section 10 Titled: Accessing Services; Subsection titled: Providers in Our Plan; Subsection titled: Providers Not in Our Plan.

...

Sincerely,

Dr. Christopher Queen ["Dr. Queen"]

Medical Director

Respondent's Composite Exhibit 1, pages 39-41. (Emphasis added).

7. Humana's Member Handbook states the following regarding a recipient's access to services provided by an out-of-network provider:

Section 10: Accessing Services

Before you get a service or go to a health care appointment, we have to make sure you need the service and that it is medically right for you. This is called **prior authorization**. To do this, we look at your medical history and information from your doctor or other health care providers. Then we will decide if that service can help you. We use rules from the Agency to make these decisions.

...

Providers not in our plan

There are some services that you may be able to get from providers who are not in our provider network. These services are:

- Family planning services and supplies
- Women's preventative health services, such as breast exams, screenings for cervical cancer, and prenatal care
- Treatment of sexually transmitted diseases
- Emergency care

If we cannot find a provider in our provider network for these services, we will help you find another provider that is not in our network. Remember to check with us first before you use a provider that is not in our provider network. If you have questions, call Member Services.

Respondent's Composite Exhibit 1, pages 97-98. (Emphasis added).

8. On October 4, 2022, [REDACTED] requested a Fair Hearing on behalf of Petitioner regarding the denial of Evaluation and Management services for out-of-state/out-of-network providers. On December 9, 2022, the undersigned Hearing Officer issued a notice, to all parties of records, scheduling the Fair Hearing to be convened by telephone on January 3, 2023, at 9:30 a.m. EST.

9. According to [REDACTED] testimony presented at the Fair Hearing, [REDACTED] is not a medical professional. Petitioner is requesting an evaluation from out-of-network providers (Dr. Strauchman; Dr. Morningstar) after not experiencing sufficient medical care from Humana's in-network provider. Dr. Strauchman and Dr. Morningstar are seeking to render specialized physical therapy services (e.g., PT exercises). Dr. Morningstar works under Dr. Strauchman. [REDACTED] located two out-of-network providers, through internet search, with whom [REDACTED] believes would

provide the Petitioner with sufficient medical care for Petitioner's medical condition [REDACTED]. Dr. Morningstar II is a chiropractor located in the state of Michigan, and Dr. Strauchman is an integrative medicine specialist located in the state of Michigan. [REDACTED] asserts that Humana does not have a single provider in the state of Florida capable of diagnosing and treating Petitioner's medical condition; [REDACTED] provided no documentation to support this assertion. [REDACTED] acknowledged that the services requested are fundamentally Physical Therapy.

10. According to Dr. Brady's testimony presented at the Fair Hearing, Humana's position is that although Physical Therapy has benefits for children diagnosed with [REDACTED], it is not nationally recognized, available conclusive evidence and peer reviewed that Physical Therapy as the effective treatment of [REDACTED]. Humana has identified several [REDACTED] providers in the state of Florida that would be capable of evaluating and treating the Petitioner. Dr. Brady asserted that travelling out-of-state for physical therapy, that has not been nationally recognized to effectively treat [REDACTED], is not 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.

CONCLUSIONS OF LAW

11. The Agency's Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties pursuant to Florida Statutes ("Fla. Stat.") § 409.285(2) (2022). This Order is the final administrative decision of AHCA under Fla. Stat. § 409.285(2)(a).

12. This hearing was held as a *de novo* proceeding pursuant to Florida Administrative Code Rule ("Fla. Admin. Code R.") 59G-1.100(17)(b).

13. Because Petitioner is requesting new services, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to Petitioner. The standard of proof in an administrative hearing is a

preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence” (Black’s Law Dictionary at 1201, 7th Ed.).

14. Petitioner’s requests for Evaluation and Management services are governed by the Florida Medicaid Evaluation and Management Services Coverage Policy (June 2016) (“Florida Medicaid Evaluation Policy”), which is incorporated by reference in Fla. Admin. Code R. 59G-4.087. The Florida Medicaid Evaluation Policy provides the following, in pertinent part:

1.0 Description and Program Goal

Florida Medicaid evaluation and management services provide for physician visits to maintain a recipient’s health, prevent disease, and treat illness.

1.1.1 Florida Medicaid Policies

This policy is intended for use by providers of evaluation and management services that render services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid’s general policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration’s (AHCA) Web site at <http://ahca.myflorida.com/Medicaid/review/index.shtml>.

1.1.2 Statewide Medicaid Managed Care Plans

This Florida Medicaid policy provides the minimum service requirements for all providers of evaluation and management services. This includes providers who contract with Florida Medicaid managed care plans (i.e., **provider service networks** and health maintenance organizations). Providers must comply with the service coverage requirements outlined in this policy, unless otherwise specified in AHCA’s contract with the Florida Medicaid managed care plan. The provision of services to recipients in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

...

1.3 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

1.3.5 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

1.3.7 Provider

The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

1.3.8 Recipient

For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

...

3.0 Eligible Provider

3.1 General Criteria

Providers must be at least one of the following to be reimbursed for services rendered to eligible recipients:

- Enrolled directly with Florida Medicaid if providing services through a fee-for-service delivery system
- Enrolled directly or registered with Florida Medicaid if providing services through a managed care plan

3.2 Who Can Provide

- Practitioners licensed within their scope of practice to perform this service
- County health departments administered by the Department of Health in accordance with Chapter 154, F.S.
- Federally qualified health centers approved by the Public Health Service
- Rural health clinics certified by Medicare

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid reimburses for services that meet all of the following:

- 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 services in accordance with the American Medical Association's Current Procedural Terminology and the applicable Florida Medicaid fee schedule(s), or as specified in this policy:

4.2.1 Adult Health Screening Services

One adult health screening every 365 days, for recipients age 21 years and older.

4.2.2 Child Health Check-Up Services

Preventative medicine services for recipients under the age of 21 years, in accordance with the American Academy of Pediatrics periodicity schedule.

4.2.3 Custodial Care Facility Services and Nursing Facility Services

One evaluation and management visit per month, per recipient.

4.2.4 Office Visits

- As medically necessary for recipients under the age of 21 years and pregnant recipients age 21 years and older.
- Up to two office visits per month, per specialty, for recipients age 21 years and older.

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the Humana States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's authorization requirements policy.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not reimbursed when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

15. States must provide Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") services to Medicaid-eligible children under age 21 when requested under the Medicaid state plan. See 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § 1396d(a)(4). According to 42 U.S.C. § 1396d(r)(5), EPSDT services mean, in relevant part, the following items and services:

Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illness and conditions discovered by the screen services, whether or not such services are covered under the state plan.

16. Petitioner is under the age of 21 years, and therefore EPSDT applies to [redacted] request for services. However, a state may place medical necessity limitations on EPSDT services. See 42 C.F.R. §§ 440.230(a), (b), (d). Fla. Stat. § 409.905(2) limits EPSDT services with a medical necessity standard:

The [Agency] shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

17. The Florida Medicaid Definitions Policy, incorporated by reference in Fla. Admin. Code R. 59G-1.010, provides definitions of commonly used terms that are applicable to all sections of Rule Division 59G, Florida Administrative Code (F.A.C.), unless specifically stated otherwise in a service-specific coverage policy or rule. The Florida Medicaid Definitions Policy states as follows:

2.83 Medically Necessary or Medical Necessity

The medical or allied care, goods, or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate pain
- **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**
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- **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**

- **Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider**

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.

(Emphasis added).

16. Based on the NABD, and the NPAR, Respondent denied Petitioner's request for out-of-network/out-of-state evaluation for [REDACTED] based on medical necessity. *See supra* ¶ 3-6. Based on Dr. Brady's testimony, Respondent determined that an out-of-network/out-of-state evaluation was not medically necessary as Petitioner's request was not "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." *See supra* ¶ 3-6, 10. Respondent also determined that Petitioner's was in excess of Petitioner's needs and would be furnished in a manner primarily intended for the convenience of the recipient and/or recipient's caretaker. *See supra* ¶ 3-6, 10. Respondent's position is that they have in-network providers capable of performing a Physical Therapy evaluation and treatment for the Petitioner and an in-network service provider is reflective of the level of service that can be safely furnished, and for which is equally effective and more conservative or less costly treatment than Petitioner's request. *See supra* ¶ 3-6, 10.

19. The Florida Medicaid program covers Evaluation and Management services that are determined to be medically necessary. *See supra* ¶ 13. Evaluation and Management services includes, "physician visits to maintain a recipient's health, prevent disease, and treat illness." *See supra* ¶ 13. Medicaid services such as a physician evaluation must meet the Florida Medicaid program's medical necessity criteria (*see* section 2.83 of the Florida Medicaid Definitions policy). *See supra* ¶ 15. To be medically necessary, Petitioner must show that an out-of-network/out-of-

state evaluation is 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. Thus, [REDACTED] must show that Petitioner there is no Florida Medicaid provider who can perform an equally effective and more conservative or less costly evaluation that would be performed by the providers in the state of Michigan (Dr. Strauchman and Dr. Morningstar). This is a requirement of medical necessity stated in section 2.83 of the Florida Medicaid Definitions Policy. See supra ¶ 15; see also supra ¶ 15.

17. The record also indicates that for an out-of-network/out-of-state evaluation to be approved as medically necessary by Respondent, one of the following conditions must be met: (1) It is an emergency; or (2) the recipient is receiving care that cannot be interrupted; or (3) there is not an in-network provider to give medically needed care. See supra ¶ 3-6. It appears both parties agree that the Petitioner's request does not meet the first two criteria as no documentation or testimony was presented addressing these criteria. Respondent determined that Petitioner did not meet the final criterion asserting that Humana has in-network providers capable of creating a treatment plan and treating the Petitioner. See supra ¶ 3-6, 10. [REDACTED] argued that the Humana has no provider in the state of Florida capable and competent enough to treat Petitioner's medical condition [REDACTED]. See supra ¶ 9. However, [REDACTED] provided no documentary evidence to support this position. Simply, [REDACTED] did not prove that Humana, a fairly larger Medicaid plan, has no provider in the state of Florida, a fairly large State, capable of treating [REDACTED]. [REDACTED] merely bolstered the qualifications of the out-of-state providers, which is neither in dispute nor the subject of the Fair Hearing. It appears there is no dispute that the out-of-state providers are qualified and competent to provide treatment and evaluation for

However, there is no evidence that it cannot be said for any of Humana's in-network providers in the state of Florida. There is an underlying premise, which neither party disputes, that an in-network provider visit would be more conservation and less costly than traveling from the state of Florida to the state of Michigan. The crux of this case rests on whether an in-network provider evaluation can be *equally effective* as an out-of-network evaluation. Petitioner's position is that effectiveness is based on independent internet research. See supra ¶ 9. However, there is no evidence that the out-of-network/out-of-state provider can provide care than an in-network provider cannot. The undersigned Hearing Officer found Dr. Brady's testimony regarding the competency and abilities of Respondent's in-network providers regarding the ability to provide the Petitioner with, *essentially*, Physical Therapy evaluation & treatment, to be credible and reliable.

18. The remaining documentary evidence to support Petitioner's request for an out-of-network/out-of-state evaluation is Dr. Hamad's referral, who herself is an in-network provider. See supra ¶ 2. With respect to the provider referrals (e.g., Dr. Hamad), Florida law states, "[t]he fact that a provider has . . . recommended . . . services does not, in itself, make such . . . services medically necessary." See supra ¶ 15. Simply put, Dr. Hamad's referral to an out-of-network/out-of-state evaluation does not, in and of itself, mean that the services are medically necessary or that the referral is the final determination whether a service is approved by the Florida Medicaid program. The provider and recipient must prove that all five criteria for medical necessity have been met. Nonetheless, the undersigned Hearing Officer considered Dr. Hamad's referral. Here, there is no evidence that Dr. Hamad evaluated the qualifications of every one of Humana's in-network providers, in the state of Florida, regarding whether Humana has a qualified provider to

diagnose and treat a child diagnosis with [REDACTED]. Dr. Hamad and [REDACTED] did not present any documentary evidence to this effect and instead asserted that Humana's in-network providers were unqualified to treat the Petitioner. Neither [REDACTED]' testimony nor Dr. Hamad's referral establish that the Physical Therapy services sought out by Dr. Morningstar and Dr. Strauchman cannot be provided by a provider in Respondent's network in the state of Florida.

19. Upon consideration of the testimony provided by both parties at the Fair Hearing, documentary evidence submitted, and applicable policies, the undersigned Hearing Officer concludes that Petitioner *did not* prove by a preponderance of the evidence that the requested Evaluation and Management services are medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Petitioner has not shown that the requested services are necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, the undersigned Hearing Officer finds that Petitioner *has not* proved by a preponderance of the evidence that Respondent's denial of Evaluation and Management services was incorrect.

IT IS THEREFORE ORDERED AND ADJUDGED THAT:

Respondent's denial of Evaluation and Management services (out-of-network/out-of-state evaluation and treatment) is **AFFIRMED**. Petitioner's appeal based on Respondent's denial of Evaluation and Management services (out-of-network/out-of-state evaluation and treatment) is **DENIED**.

DONE and ORDERED this 16th day of March, 2023, in Tallahassee, Leon County, Florida.

Laura Gallagher

22-FH1803

2023.03.16

07:40:36 -04'00'



LAURA GALLAGHER, Hearing Officer
Agency for Health Care Administration
Office of Fair Hearings
2727 Mahan Drive, Mail Stop # 11
Tallahassee, FL 32308-5407

NOTICE OF A RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW, WHICH SHALL BE INSTITUTED BY FILING THE ORIGINAL NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A COPY, ALONG WITH THE FILING FEE PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

COPIES FURNISHED TO:



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