



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

**FILED**

Feb 01, 2023, 10:49 am

OFFICE OF FAIR HEARINGS

[REDACTED],

PETITIONER,

AHCA Case No.: 22-FH2264

Plan ID No.: [REDACTED]

vs.

CHILDREN'S MEDICAL SERVICES,

RESPONDENT.

\_\_\_\_\_ /

[REDACTED],

PETITIONER,

AHCA Case No.: 22-FH2265

Plan ID No.: [REDACTED]

vs.

CHILDREN'S MEDICAL SERVICES,

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic Fair Hearing on the instant case on December 29, 2022, at 2:30 p.m. Eastern Standard Time ("EST").

**APPEARANCES**

For the Petitioner:

[REDACTED]

Petitioner's Authorized Representative

For the Respondent:

Christian Pacheco  
Senior Director for Quality Improvement  
Children's Medical Services

**STATEMENT OF ISSUE**

The first issue is whether Petitioner proved by a preponderance of the evidence that Respondent's decision to deny Petitioner's request for an out-of-network allergist appointment was incorrect.

The second issue is whether Petitioner proved by a preponderance of the evidence that Respondent's decision to deny Petitioner's request for an out-of-network gastroenterologist visit was incorrect.

### **PRELIMINARY STATEMENT**

All parties appeared telephonically. Petitioner's Authorized Representative and mother [REDACTED] (" [REDACTED]"), appeared on behalf of the Petitioner.

Christian Pacheco, Senior Director of Quality Improvement for Children's Medical Services ("CMS") appeared on behalf of Respondent. The following attended as witnesses for Respondent: Dr. Andrew Metinko ("Dr. Metinko"), Medical Director for CMS; Dr. Don Fillips ("Dr. Fillips"), Medical Director for CMS; Chantel Pierre, Lead Clinical Appeals Coordinator for Sunshine Health Plan of Florida, Inc. ("Sunshine"); and Colleen Martin, Supervisor for Field Case Management for CMS. The following attended as observers: Altria White-Luttrel, of CMS; and Felicia Thomas, Vice President of Operations for CMS.

Chrissie Simmons, Medical/Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), and Sandra Durden, Medical/Health Care Program Analyst attended as observers.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent fifty (50)-pages of documents and four (4) videos. The fifty (50)-pages of documents appear in the Office of Fair Hearings document management system as file titles "22-FH2264 & 22-FH2265

Evidence.pdf”, “22-FH2264 & 22-FH2265 Evidence (pt 2).pdf”, “22-FH2264 & 22-FH2265 Evidence (pt 3).pdf”, “22-FH2264 & 22-FH2265 Evidence (pt 4).pdf”, and “22-FH2264 & 22-FH2265 Additional Documents.pdf”. The four (4) videos appear in the Office of Fair Hearings document management system as file titles “[REDACTED]091414.mp4”, “[REDACTED]104711.mp4”, “[REDACTED]174438.mp4”, and “[REDACTED]134955.mp4”. Absent an objection from the Respondent, the undersigned admitted the fifty (50)-pages of documents as Petitioner’s Composite Exhibit 1 (“PCE 1”), and the four (4) videos as Petitioner’s Exhibit 2 (“PE 2”).

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a one hundred and forty-nine (149)-page evidence packet. The one hundred and forty-nine (149)-page evidence packet appears in the Office of Fair Hearings document management system as file title “MFH Packet [REDACTED].pdf”. Absent an objection from the Petitioner, the undersigned admitted the one hundred and forty-nine (149)-page evidence packet into evidence as Respondent’s Composite Exhibit 1 (“RCE 1”).

### **FINDINGS OF FACT**

1. Petitioner is an enrolled member of CMS. *See* page 2 of RCE 1. CMS is a managed care organization contracted by the Agency to provide services to eligible Medicaid recipients in Florida.
2. Petitioner was [REDACTED] at the date of the Fair Hearing. *Id.* at 20. Petitioner has been diagnosed with [REDACTED], and [REDACTED]. *Id.* at 23. Petitioner may have a diagnosis of [REDACTED] (“[REDACTED]”). *See* page 20 of PCE 1.

3. Phillip Mote, M.D. (“Dr. Mote”) wrote a letter, dated November 21, 2022, that stated as follows, in part:

[Petitioner] exhibits symptoms of [REDACTED] and has had [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED].

I feel it is deemed medically necessary for [Petitioner] to be evaluated by subspecialty clinic at [REDACTED] in Philadelphia given that there is no local [REDACTED] clinic here in the state of Florida and child has had severe course since birth. If you have any further question or concern do not hesitate to contact me. Thank you for your assistance in this matter.

...  
Page 28 of PCE 1.

4. Petitioner requested an office visit for a Gastroenterology/Nutrition specialist at the [REDACTED] (“[REDACTED]”). In a Notice of Adverse Benefit Determination (“NABD”), dated November 23, 2022, Respondent denied Petitioner’s request. *Id.* at 6 – 11. The NABD explained the basis of the denial as follows:

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.

...  
The facts that we used to make our decision are: The Sunshine Health Member’s Handbook (2021): Out of Network Care and Children’s Medical Services Health Plan Florida Medicaid Member Handbook, Section 10: Accessing Services were referenced in making this decision. This decision was made with regards to Early and Period Screening, Diagnostic and Treatment Services (EPSDT).

Rationale: We received a request to authorize an office visit for your child with an out of network provider Gastroenterology/Nutrition specialist at [REDACTED]. We are denying your child’s request for authorization because out of network services are not a covered benefit (not included in your child’s plan) when services are available within your plan in the State of Florida.

The clinical documents (records) that were submitted (sent in) to us for review do not establish the medical need for your child to see this out of network provider at the [REDACTED] for care. Your child is covered under the Children's Medical Services Sunshine Health Plan and according to this plan, your child must exhaust all services in Florida before any out of state referrals are approved. If further gastroenterology/nutrition services are needed for your child, they can be provided by the following in network providers.

...

Pages 6 – 7 of RCE 1.

5. Petitioner requested an office visit for an allergy specialist at [REDACTED]. In an NABD, dated November 30, 2022, Respondent denied Petitioner's request. *Id.* at 13 – 18. The NABD explained the basis of the denial as follows:

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.

...

The facts that we used to make our decision are:

The Sunshine Health Member's Handbook (2021): Out of Network Care and Children's Medical Services Health Plan Florida Medicaid Member Handbook, Section 10: Accessing Services. These services have also been reviewed under EPSDT (Early and Periodic Screening, Diagnostic and Treatment).

Rationale: We received a request to authorize an office visit consultation for your child with an out of network provider allergy specialist at [REDACTED]. We are denying your request for authorization because out of network services are not a covered benefit when services are available within your plan in the State of Florida. The clinical documents or records that were submitted to us for review do not establish the medical need for your child to see this out of network provider at the [REDACTED] for care. Your child is covered under the Children's Medical Services Sunshine Health Plan and according to this plan, you must exhaust all services in Florida before any out of state referrals are approved. If further allergy (a bad reaction to a medicine, environment, or food) services are needed for your child, they can be provided by the following in network providers.

...

Pages 13 – 14 of RCE 1.

6. Petitioner requested a plan appeal regarding the denial of an office visit for a gastroenterologist/nutrition specialist and received a Notice of Plan Appeal Resolution (“NPAR”), dated December 6, 2022, upholding the denial. *Id.* at 41 – 43. The NPAR explained as follows:

The facts that we used to make our decision are: the previous denial to authorize out of state and out of network services at the [REDACTED] is upheld based on a lack of medical necessity. Out of network and out of state services are not medically necessary when there are in network and/or in state options. Your child is covered under the Children's Medical Services Sunshine Health Plan and according to this plan, your child must exhaust all services in Florida before any out of state referrals are approved. [REDACTED] [REDACTED] can evaluate and treat children with [REDACTED] ([REDACTED]). The reasons for this decision are based on a set of standards. This included Sunshine Health Member Handbook and Sunshine Health Policy on Use of Out of Network Providers and Steerage, FL.UM.01.08. This decision was made with regards to EPSDT.

...

Pages 41 – 42 of RCE 1.

7. Petitioner requested a plan appeal regarding the denial of an office visit for an allergy specialist and received an NPAR dated December 3, 2022, upholding the denial. *Id.* at 66 – 69.

The NPAR explained as follows:

The facts that we used to make our decision are: The request for Office Visit has been denied after review as not medically necessary. The reasons for this decision are based on a set of standards. This included not medically necessary.

...

Page 66 of RCE 1.

8. On December 7, 2022, Petitioner requested a Fair Hearing to challenge the denial of the office visits to [REDACTED]. On December 14, 2022, the undersigned issued an Order Consolidating and Scheduling Consolidated Fair Hearing by Telephone and Prehearing Instructions, setting the hearing for December 29, 2022, at 2:30 p.m. EST.

9. [REDACTED] testified to the following:

- a. Petitioner has previously had [REDACTED] for [REDACTED].
- b. Petitioner has started [REDACTED].
- c. Petitioner has been [REDACTED]  
[REDACTED] The majority of the visits were telehealth.
- d. Petitioner has had [REDACTED].

10. Dr. Metinko is a Medical Director for CMS. Dr. Metinko testified to the following:

- a. Petitioner’s diagnosis of [REDACTED] has not been established. Petitioner has not had a chance to be seen at the state-of-the-art Pediatric facilities in the state of Florida. Dr. Metinko believes that [REDACTED] has not been established because there is a disagreement among the doctors who have examined the Petitioner as to whether it is the proper diagnosis.
- b. Petitioner has not exhausted “[REDACTED]-level” facilities in the state. Exhausted does not need that every specialist needs to be seen, but rather “healthy distribution of at least two (2) or three (3) university-based programs”. [REDACTED]  
[REDACTED] can treat [REDACTED].
- c. Telehealth visits are appropriate when diagnoses are primarily history based, whereas [REDACTED] should have an in person visit to do [REDACTED] exam.

**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 section 409.285(2) of the Florida Statutes (2019). 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 Fla. Admin. Code R. 59G-1.100(17)(b).

13. Because Petitioner is requesting a new service, 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. The Florida Medicaid Gastrointestinal Services Coverage Policy (June 2016) (“GI Policy”), incorporated by reference in Fla. Admin. Code. R. 59G-4.026, governs gastrointestinal services available under Florida Medicaid. The GI Policy provides as follows:

**1.0 Introduction**

**1.1 Description**

Florida Medicaid gastrointestinal services provide diagnostic and therapeutic procedures relating to digestive disorders.

...

**1.3.4 Medically Necessary/Medical Necessity**

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

...

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

- Digestive surgical services including:
  - Restrictive bariatric surgeries that shrink the size of the stomach reducing the amount of food that it can hold
  - Malabsorptive bariatric surgeries that rearrange and/or remove part the digestive system limiting the amount of calories and nutrients that can be absorbed
  - Combination bariatric surgeries that combine both restrictive and malabsorptive techniques

- Bariatric surgery revisions, reversals or conversions for complications related to the surgery
- Gastroenterology
- Gastric Physiology

**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 sectioned 1905(a) of the Social Security Act, codified in Title 42 of the United 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 General Policies on authorization requirements.

...

15. The Florida Medicaid Allergy Services Coverage Policy (June 2016) (“Allergy Policy”), incorporated by reference in Fla. Admin. Code. R. 59G-4.013, governs allergy services available under Florida Medicaid. The Allergy Policy provides as follows:

**1.0 Introduction**

**1.1 Description**

Florida Medicaid allergy services provide diagnostic and therapeutic procedures relating to hypersensitivity disorders that may be manifested by generalized systemic reactions as well as by localized reactions in any organ system of the body.

...

**1.3.4 Medically Necessary/Medical Necessity**

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

...

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

- Allergy testing as follows:
  - In vitro specific IgE tests
  - Intracutaneous skin tests
  - Percutaneous skin tests
  - Ingestion challenge testing
- Allergen immunotherapy as follows:
  - Up to 156 doses every 366 days, per recipient, for procedure codes 95144 and 95165
  - Up to 52 doses every 366 days, per recipient, for procedure codes 95145-95149 and 95710

### **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 sectioned 1905(a) of the Social Security Act, codified in Title 42 of the United 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 General Policies on authorization requirements.

...

16. 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.

17. Petitioner is under age 21, 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.

18. The Definitions Policy, incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines “Medically Necessary” or “Medical Necessity” as follows:

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.

#### **A. Allergist**

19. Petitioner requested an out-of-network office visit for an allergy specialist at [REDACTED]. See ¶ 5. In the NABD, dated November 30, 2022, Respondent denied Petitioner’s request. *Id.* Respondent explained that it is not medically necessary as the request did not meet the following prong of medical necessity: “[m]ust be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient’s needs”. *Id.* Respondent further

explained that Petitioner is “covered under the Children’s Medical Services Sunshine Health Plan and . . . must exhaust all services in Florida before any out of state referrals are approved.” *Id.*

20. As Petitioner bears the burden of proof, Petitioner must show that the request for the out-of-network office visit is medically necessary. A component of medical necessity is that such services be “individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury and not be in excess of the patient’s needs”. As shown by the record, Petitioner has previously been diagnosed with [REDACTED] and may have a diagnosis of [REDACTED]. See ¶ 2. In support of the request for the [REDACTED] visit, Petitioner provided a letter from Dr. Mote that stated that “there is no local [REDACTED] clinic here in the state of Florida”. See ¶ 3. However, Dr. Metinko provided credible testimony that there were multiple hospitals in Florida that were appropriate for Petitioner, specifically [REDACTED]. See ¶ 10. Further, Dr. Metinko elaborated that “exhausted” does not mean that Petitioner is to see every specialist in the state, but rather a “healthy distribution of at least two (2) or three (3) university-based programs”. *Id.* Although Petitioner has been examined by a number of doctors in the state, the majority have been via telehealth. See ¶ 9. As explained by Dr. Metinko, telehealth is appropriate when diagnoses are primarily history based, whereas in this case a doctor would need to do an in-person exam. See ¶ 10. In all, based on Dr. Metinko’s testimony it does not appear that Petitioner has fully taken advantage of the hospitals in the state of Florida and the request to go to [REDACTED] is premature, and therefore did not show that the request was not in excess of Petitioner’s needs.

21. Upon consideration of the testimony provided, evidence submitted, and applicable polices, the undersigned concludes that Petitioner did not prove by a preponderance of the

evidence that the visit to an allergist at [REDACTED] was medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Petitioner did not demonstrate that the office visit was necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Petitioner did not prove by a preponderance of the evidence that Respondent's denial of Petitioner's request for an out-of-network office visit was incorrect.

### **B. Gastroenterologist/Nutritionist**

22. Petitioner requested an out-of-network office visit for a gastroenterology/nutrition specialist at [REDACTED]. See ¶ 4. In the NABD, dated November 23, 2022, Respondent denied Petitioner's request. *Id.* Respondent explained that it not medically necessary as the request did not meet the following prong of medical necessity: "[m]ust be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs". *Id.* Respondent further explained that Petitioner is "covered under the Children's Medical Services Sunshine Health Plan and . . . must exhaust all services in Florida before any out of state referrals are approved." *Id.*

23. As discussed, *supra* ¶ 20, the record shows that Petitioner has not exhausted all of the options that [REDACTED] has available in Florida. As such, presently a visit to [REDACTED] has not been shown to be "individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs".

24. Upon consideration of the testimony provided, evidence submitted, and applicable polices, the undersigned concludes that Petitioner did not prove by a preponderance of the evidence that the visit to a gastroenterologist/nutritionist at [REDACTED] was medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, Petitioner did not


demonstrate that the office visit was necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, Petitioner did not prove by a preponderance of the evidence that Respondent's denial of Petitioner's request for an out-of-network office visit was incorrect.

**IT IS HEREBY ORDERED AND ADJUDGED THAT:**

Respondent's denial of Petitioner's request for an out-of-network visit to an allergist is **AFFIRMED**. Petitioner's appeal based on Respondent's denial is **DENIED**.

Respondent's denial of Petitioner's request for an out-of-network visit to gastroenterologist is **AFFIRMED**. Petitioner's appeal based on Respondent's denial is **DENIED**.

**DONE and ORDERED** this 1st day of February, 2023, in Tallahassee, Leon County, Florida.

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

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

**CMS**  
**CMSPlanContract@flhealth.gov**

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