



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

FILED

Apr 17, 2024, 10:20 am
OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,

vs.

AHCA Case No.: 24-FH0081

Plan ID No.: [REDACTED]

HUMANA MEDICAL PLAN, INC.,

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the Office of Fair Hearings (“OFH”) convened a telephonic Medicaid Fair Hearing in the above styled case on February 20, 2024, at 10:03 a.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner:

[REDACTED]

Petitioner’s Authorized Representative

For the Respondent:

Markeshi Lee

Medicaid Fair Hearing Specialist

STATEMENT OF ISSUE

The issue is whether Petitioner proved by a preponderance of the evidence that Respondent’s denial of [REDACTED] was incorrect.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. The Petitioner’s [REDACTED] and Authorized Representative appeared at the hearing and provided testimony. Markeshi Lee, (“Ms. Lee”) Medicaid Fair Hearing Specialist for Humana Medical Plan, Inc. (“Respondent” or

“Humana”), appeared for the hearing on behalf of the Respondent. In addition, Dr. Anne Brady, (“Dr. Brady”), Medical Director for the Respondent testified on behalf of Humana. Dr. Connie Maggie and Dr. Shkelzen Hoxhad, both medical doctors for Humana appeared at the Fair Hearing for observation purposes. Linda Latson, Registered Nurse Specialist (“Ms. Latson”) for the Agency for Health Care Administration (“Agency” or “AHCA”), appeared at the Fair Hearing for observational purposes.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a three hundred and fifty-two (352)-page evidence packet that was admitted into evidence without objection, identified herein as “Respondent’s Composite Exhibit 1”, and is maintained in the Office of Fair Hearings document management system and designated as follows: “Evidence Package 24-FH0081_Part 1.pdf”; “Evidence Package 24-FH0081_Part 2.pdf”; “Evidence Package 24-FH0081_Part 5.pdf”; “Evidence Package 24-FH0081_Part 6.pdf”; “Evidence Package 24-FH0081_Part 7.pdf”; “Evidence Package 24-FH0081_Part 8.pdf”; “Evidence Package 24-FH0081_Part 9.pdf”; and “Evidence Package 24-FH0081_Part 10.pdf”.

The Petitioner did not submit any documents into evidence in this matter.

FINDINGS OF FACT

1. Petitioner is an enrolled member of Humana’s Statewide Managed Medicaid Medicaid Managed Care (SMMC) Plan since September 1, 2022. See Respondent’s Composite Exhibit 1, pages 1 and 18.
2. As of the time of the hearing, Petitioner is a [REDACTED] that has a history of [REDACTED]. See Respondent’s Composite Exhibit 1, page 56. The Petitioner complains of [REDACTED]. The Petitioner was previously prescribed physical

therapy but it did not help [REDACTED]. *Id.* The Petitioner has tried [REDACTED]
[REDACTED] *Id.* [REDACTED], APRN, described the Petitioner's
current medical status as "stable" and stated in [REDACTED] undated letter that the Petitioner "... would
benefit from [REDACTED]". See Respondent's Composite Exhibit 1, page 56.

3. On September 7, 2023, the Petitioner requested the prescription drug [REDACTED]
[REDACTED] pen to address the Petitioner's [REDACTED]. See Respondent's Composite Exhibit 1, page
13. On September 8, 2023, the Respondent issued a Notice of Adverse Benefit Determination
("NABD") denying the requested prescription drug benefit [REDACTED], citing that
it was not a covered benefit. See Respondent's Composite Exhibit 1, pages 13-16.

4. On October 5, 2023, the Petitioner requested an appeal of the Respondent's September
7, 2023, denial. See Respondent's Composite Exhibit 1, page 18. On October 5, 2023, the
Respondent sent Petitioner a Notice of Plan Appeal Resolution ("NPAR"), denying Petitioner's
plan appeal. See Respondent's Composite Exhibit 1, pages 18-20. The NPAR stated in-part as
follows:

The reason for the decision was based on the information received. You have
requested that we approve [REDACTED] [REDACTED]. We have looked at
[Petitioner's] medical records if provided and/or the records in our system.
[REDACTED] for the treatment of [REDACTED] is not a covered benefit. [The Petitioner]
has the Florida Statewide Medicaid Managed Care (SMMC) plan. Your request
cannot be approved. Discuss this letter with [REDACTED] doctor so [REDACTED] can get the care
you are requesting.

Humana has made this decision based upon Florida Medicaid Prescribed Drugs
Services Coverage Policy Section Titled: Exclusions (5.0); Subsection Titled: Specific
Non-Covered Criteria (5.2).

...

Id.

5. The Petitioner requested a Fair Hearing due to the denial of the prescription [REDACTED] to treat [REDACTED]. On January 13, 2024, the undersigned Hearing Officer issued an Order Scheduling Fair Hearing by Telephone and Prehearing Instructions that scheduled the Fair Hearing to be convened on February 20, 2024, at 10:00 a.m. EST.

6. During the Fair Hearing, the Petitioner's [REDACTED] testified [REDACTED] daughter [REDACTED] testified as to [REDACTED] belief that [REDACTED] has tried everything to [REDACTED].

7. Dr. Brady testified for the Respondent that this case that [REDACTED] may help the Petitioner [REDACTED] but that the use of [REDACTED] for [REDACTED] is not a covered benefit under the Florida Medicaid program.

CONCLUSIONS OF LAW

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

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

10. The burden of proof in this proceeding is governed by Fla. Admin. Code R. 59G-1.100(17)(g), which provides as follows:

The burden of proof is on the party asserting the affirmative of an issue, except as otherwise required by statute. The burden of proof is on the Agency or plan, whichever is applicable, when the issue presented is the suspension, reduction, or termination of a previously authorized service. The burden of proof is on the recipient or enrollee, when the issue presented is the denial or a limited authorization of a service. The party with the burden of proof shall establish its

position to the satisfaction of the Hearing Officer by a preponderance of the evidence.

11. Because Petitioner is requesting a new benefit, Fla. Admin. Code R. 59G-1.100(17)(g) assigns the burden of proof to the 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.).

12. Petitioner’s request for the prescription drug [REDACTED] is governed in part by the Florida Prescription Drugs Services Coverage Policy (December 2017) (“Prescription Drugs Coverage Policy”), which is incorporated by reference in Fla. Admin. Code R. 59G-4.250. The Prescription Drugs Coverage Policy provides the following, in pertinent part:

1.0 Introduction

1.1 Description

This policy describes Florida Medicaid’s coverage of outpatient prescription drugs.

1.1.1 Florida Medicaid Policies

This policy is intended for use by providers that render prescribed drug 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

Florida Medicaid managed care plans must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients enrolled in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

1.2 Legal Authority

Prescribed drug services are authorized by the following:

- Title XIX of the Social Security Act (SSA)
- Title 42, Code of Federal Regulations (CFR), Chapter IV
- Sections 409.906, 409.908, and 409.912, Florida Statutes (F.S.)
- Rule 59G-4.250, F.A.C.

.....

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

.....

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not covered 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 5.2 Specific Non-Covered Criteria Florida Medicaid does not cover the following as part of this service benefit:
 - Automatic fills
 - Compound drugs as partial refills
 - Drugs classified as ineffective by the United States (U.S.) Food and Drug Administration's (FDA): Drugs Efficacy Study Implementation and Identical, Related, and Similar Drugs
 - Drugs for cosmetic use
 - Drugs from an entity that does not have a rebate agreement with the Centers for Medicare and Medicaid Services
 - Drugs from an entity not licensed in accordance with Chapter 499, F.S.
 - Drugs that are included in, or reimbursed as, part of another Florida Medicaid service
 - Drugs that are not approved by the U.S. FDA
 - Drugs used to treat infertility or enhance fertility
 - Erectile dysfunction drugs, unless prescribed for a condition other than sexual or erectile dysfunction as approved by the U.S. FDA

- Hair growth restorers
- Intradialytic parenteral nutrition administered during a dialysis session
- Replacement services due to lost shipments or provider error
- Total parenteral nutrition billed as separate components versus a compounded product
- **Weight control medications**

....

Prescription Drugs Coverage Policy at pages 1-4. Respondent’s Composite Exhibit 1, pages 177-180.13. 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.

14. A state may place medical necessity limitations on EPSDT services. *See* 42 C.F.R. §§ 440.230(a), (b), (d). Pursuant to section 409.905(2), Florida Statutes:

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.

15. Once it is determined that EPSDT applies to a request for a service, the Florida Medicaid program determines the amount or necessity for that service based on the State of Florida’s published definition of medical necessity. The Florida Medicaid Definitions Policy (August 2017)

("Definitions Policy"), which is incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines "medical necessity" 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 severe 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.

16. In the instant case, Petitioner is under the age of 21, and therefore EPSDT applies to [REDACTED] request for the prescription drug at issue. See supra ¶ 2. Respondent denied the prescription drug [REDACTED] for the treatment of the Petitioner's [REDACTED]. See supra ¶ 3 and 4. As established on the record by the evidence and testimony, Respondent denied Petitioner's request for [REDACTED] because it is not a covered benefit under the Florida Medicaid program. *Id.*

17. Considering the totality of Petitioner's circumstances, including [REDACTED] request for the prescription drug [REDACTED], to treat the Petitioner's [REDACTED], coupled with the fact that the request drug is not requested for any other condition besides the

treatment of [REDACTED], the Petitioner has failed to prove by a preponderance of the evidence that the requested prescription drug is a covered benefit under the Florida Medicaid program. See supra ¶ 12 and 13.

18. In light of the testimony and evidence, Respondent's Composite Exhibit 1, the Prescription Drug Coverage Policy, and the Definitions Policy, the undersigned Hearing Officer finds that Petitioner failed to meet [REDACTED] burden of proving that the requested prescription drug [REDACTED], was a covered benefit under the Florida Medicaid Program. Looking at all the evidence relevant to the particular needs of Petitioner, Petitioner failed to demonstrate that the prescription drug at issue is necessary to correct or ameliorate a defect or a physical and mental illness or condition. Accordingly, the undersigned Hearing Officer concludes that Petitioner failed to prove by a preponderance of the evidence that Respondent's denial of the requested [REDACTED] pen was incorrect.

DECISION

The Respondent's denial of the prescription drug [REDACTED] pen is **AFFIRMED**.

The Petitioner's appeal based on Respondent's denial in this matter is **DENIED**.

DONE AND ORDERED this 17th day of April, 2024, in Tallahassee, Leon County, Florida.

Alan J. Leifer

Alan J. Leifer

24-FH0081

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ALAN LEIFER, 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.

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