

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



FILED

May 22, 2024, 11:21 am
OFFICE OF FAIR HEARINGS

[REDACTED]

PETITIONER,
vs.

AHCA Case No.: 24-FH0253
Plan ID No.: [REDACTED]

UNITEDHEALTHCARE OF FLORIDA, 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 27, 2024, at 10:00 a.m. Eastern Standard Time (“EST”).

APPEARANCES

For the Petitioner: [REDACTED]
Petitioner’s Authorized Representative

For the Respondent: Deborah Havey-Levy
Program Integrity Manager
UnitedHealthcare of Florida, Inc.

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. [REDACTED] (“[REDACTED]”) the Petitioner’s [REDACTED] and Authorized Representative appeared at the hearing and provided testimony.

Deborah Havey-Levy (“Ms. Havey-Levy”) Program Integrity Manager for UnitedHealthcare of Florida, Inc. (“Respondent” or “United”), appeared for the hearing on behalf of the Respondent. In addition, Dr. Albena Bahrevia (“Dr. Bahervia”), Medical Director for the Respondent testified on behalf of United. Dr. Deborah Smith, the UHC Director of Pharmacy also testified at the Fair Hearing. Stephanie Lang, Program Operations Administrator 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 two hundred and seventy-seven (277)-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: “24-FH0253 Respondents Statement of Matters_Part 1 (Pgs. 1-81).pdf”; “24-FH0253 Respondents Statement of Matters_Part 2 (Pgs. 82-154).pdf”; “24-FH0253 Respondents Statement of Matters_Part 3 (Pgs. 155-277).pdf”.

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

FINDINGS OF FACT

1. Petitioner is an enrolled member of UHC's Community Plan Humana's Statewide Managed Medicaid Care (SMMC) Plan since October 2019. See Respondent's Composite Exhibit 1, page 1.

2. As of the time of the hearing, Petitioner is a [REDACTED]. See Respondent's Composite Exhibit 1, page 21.

3. On October 19, 2023, the Petitioner requested the prescription drug [REDACTED]. See Respondent's Composite Exhibit 1, page 2. On October 19, 2023, the Respondent issued a Notice of Adverse Benefit Determination ("NABD") denying the requested prescription drug benefit [REDACTED], stating it does not meet accepted medical standards. See Respondent's Composite Exhibit 1, pages 2-8. More specifically, the NABD stated in-part as follows:

The request does not meet your health plan's rules for medical necessity.

Clinical Rationale for Decision:

Per your health plan's criteria, this drug is covered if you meet the following:

1. Your present height is one of the following:
 - A. You[r] height is below average (greater than or equal to 2 standard deviations below the mean for age and gender).
 - B. Less than the 5th percentile for age and gender.
2. Your growth rate is less than 5cm per year.
3. Your bone age is at least one year behind your actual age.

We looked at your records. We have decided that what you asked for cannot be approved.

Please talk about this with your doctor.

This decision was made per the UnitedHealthcare Community Plan of Florida Human [REDACTED] Guideline.

...

Id.

4. On November 24, 2023, the Petitioner requested an appeal of the Respondent's decision to deny the [REDACTED]. On December 18, 2023, the Respondent sent Petitioner a Notice of Plan Appeal Resolution ("NPAR"), denying Petitioner's plan appeal. See Respondent's Composite Exhibit 1, pages 208-213. The NPAR stated in-part as follows:

Your appeal was reviewed by a medical director. She is a medical doctor. She is board certified in endocrinology. We looked at your records. What you asked for cannot be approved. This does not meet Florida Medicaid rules. You asked for a certain drug. This drug is called [REDACTED]. Based on my professional judgment, it is not medically needed. You must have a certain height. Plus have a certain growth. Plus have a certain bone measure. This is why we cannot approve your request. Please talk about this with your doctor. Florida Medicaid Health Plan height, growth and bone requirements: The patient's present height is ONE of the following: Greater than or equal to 2 standard deviations (SD) below the mean for age and gender Less than the 5th percentile for age and gender 2) The patient's growth velocity is less than 5 cm/year (centimeters per year) 3) Bone age is a minimum of one year behind chronological age.

I have reviewed this case as a FL licensed physician. I agree with the determination and the rationale used to make this decision. (Fatima Hussain, MD)

...

Id.

5. The Petitioner requested a Fair Hearing on January 23, 2024, due to the denial of the prescription [REDACTED]. On January 31, 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 27, 2024, at 10:00 a.m. EST.

6. The Optum Rx Prescription Drug Prior Authorization Guidelines regarding the use of [REDACTED] (2022) provides the approval criteria for [REDACTED] and states that a patient's height deficiency must be greater than or equal to 2.0 standard deviations below the mean age for a patient's age and gender, and that a Patient's bone age is a minimum of one (1) year behind the Patient's chronological age. See Respondent's Composite Exhibit 1, pages 99-100.

7. During the Fair Hearing, the Petitioner's [REDACTED] testified that [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

8. Dr. Bahrevia testified that UHC followed the Medicaid guidelines in this matter and that the Petitioner does not meet the parameters for the use of [REDACTED]. Dr. Bahrevia testified that one of the parameters for qualify for [REDACTED] is that the patients' growth velocity must be less than five (5) centimeters per year and that is not the case for the Petitioner.

9. Dr. Smith, the Respondent's Director of Pharmacy testified that [REDACTED] is a [REDACTED] [REDACTED] and that there are other preferred [REDACTED] drugs that are less expensive. Dr. Smith also testified that the clinical information in this case did not meet the guidelines for the use of [REDACTED]. [REDACTED]

[REDACTED] See Respondent's Composite Exhibit 1, page 35. Dr. Smith testified that the parameters for the use of [REDACTED] require bone age to be at least one (1) year behind a patients' chronological age and this is not the case with the Petitioner. In addition, the Petitioner's "growth plates" of [REDACTED] bones are documented as being "open" and indicates the Petitioner's bones are still growing. Finally, Dr. Smith testified that a patient's "height deviation" should exceed at least two standard (2) deviations on the "growth curve" and that is not the case with the Petitioner. See also Respondent's Composite Exhibit 1, page 47.

10. [REDACTED] is the Petitioner's treating physician and has provided a letter reflecting the Petitioner's stature is [REDACTED] standard deviations on the growth curve and stating the

use of [REDACTED] is medically necessary for the Petitioner. See Respondent's Composite Exhibit 1, pages 47-48.

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 Fla. Stat. § 409.285(2). 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. 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.

14. 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.).

15. 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. A state may place medical necessity limitations on EPSDT services. See 42 C.F.R. §§ 440.230(a), (b), (d).

17. Section 409.905(2), Florida Statutes, 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. 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

....

Prescription Drugs Coverage Policy at pages 1-4.

19. 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.

20. In the instant case, Respondent denied the prescription drug [REDACTED] [REDACTED] for the treatment of the Petitioner's short stature. See supra ¶ 3 and

4. As established on the record by the evidence and testimony, Respondent denied Petitioner's request for [REDACTED] finding it was not medically necessary and did not meet the Medicaid guidelines for the use of this drug by the Petitioner. See supra ¶¶ 3, 4, 6, 8 and 9.

21. As provided in the Prescription Drug Coverage Policy, the EPSDT requirements, the Definitions Policy, and the Optum Rx Prior Authorization Guidelines, the recipient must meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. In this matter, the Petitioner did not satisfy any of the requirements for medical necessity. See supra ¶¶ 3, 4, 6, 8 and 9. Specifically, Petitioner's height is not greater than two (2) standard deviations below the mean for age and gender; Petitioner's growth rate is not less than five (5) cm per year; and Petitioner's bone age is not one (1) year behind [REDACTED] actual age. See ¶¶ 8 – 10. As such, Petitioner did not show that approval of [REDACTED] met "generally accepted professional medical standards as determined by the Medicaid program" and was "not experimental or investigational."

22. Considering the totality of Petitioner's circumstances, including [REDACTED] request for the prescription drug [REDACTED] to treat the Petitioner's short stature, the Petitioner

has failed to prove by a preponderance of the evidence that the requested prescription drug is medically necessary under the Florida Medicaid program. See supra ¶¶ 17, 18, and 19. Looking at all the evidence relevant to the particular needs of Petitioner, the record does not demonstrate that [REDACTED] is necessary to correct or ameliorate a defect or a physical and mental illness or condition for the Petitioner.

23. In light of the testimony and evidence, Respondent's Composite Exhibit 1, the Prescription Drug Coverage Policy, the EPSDT requirements, the Definitions Policy and the Optum Rx Prior Authorization Guidelines, the undersigned Hearing Officer finds that Petitioner failed to meet [REDACTED] burden of proving that the requested prescription drug [REDACTED] was medically necessary under the Florida Medicaid Program. 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] was incorrect.

DECISION

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

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

DONE AND ORDERED this 22nd day of May, 2024, in Tallahassee, Leon County, Florida.

Alan J. Leifer
Alan J. Leifer
24-FH0253
2024.05.22 09:00:41
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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.

COPIES FURNISHED TO:

[REDACTED]
[REDACTED]

UnitedHealthcare of Florida, Inc.
UHC_Hearings@uhc.com

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com