STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

HEALTH OPTIONS, INC.,	)	
	)	
Petitioner,	)	
	)	
vs.	)	Case No. 02-3762
	)	
AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
	)	
Respondent.	)	
	)	

FINAL ORDER

Administrative Law Judge Don W. Davis of the Division of Administrative Hearings held a formal hearing in this case on January 13, 2003, in Tallahassee, Florida.

APPEARANCES

For Petitioner: Daniel Alter, Esquire
Bunnell, Woulfe, Kirschbaum, Keller, McIntrye & Gregoire, P.A.
Post Office Drawer 030340
Fort Lauderdale, Florida 33303

For Respondent: Ursula Eikman, Esquire
Agency for Health Care Administration
2727 Mahan Drive
Building 3, Mail Stop 3
Tallahassee, Florida 32308

STATEMENT OF THE ISSUE

This is a proceeding under Section 408.7056, Florida Statutes (2002), in which the issue is whether the denial by Health Options, Inc. (the Petitioner), of a request that it

cover additional lymphedema outpatient therapy after a mastectomy to treat C.B. (the Subscriber),[1] is consistent or inconsistent with the rules and laws that regulate managed care entities.[2]

PRELIMINARY STATEMENT

This matter involves a coverage dispute about outpatient rehabilitation services under the terms of a group Health Maintenance Organization (HMO) contract issued by the Petitioner to Atlantic States Bank for the benefit of its employees and their eligible dependents, inclusive of the Subscriber.

In May, 2001, the Subscriber underwent a partial mastectomy of her left breast. Following surgery, she required outpatient physical therapy known as decongestive therapy. The Petitioner denied coverage for continued therapy beyond a consecutive 62-day period.

By internal appeal to the Petitioner, the Subscriber challenged the denial of coverage for further outpatient rehabilitative therapy beyond the consecutive 62-day period from the date her therapy began. The Petitioner reaffirmed its initial coverage determination. The Subscriber filed an appeal with the Statewide Subscriber and Provider Assistance Panel (Panel) to hear and review her complaint in accordance with Section 408.7056, Florida Statutes. A hearing was then held before the Panel by video conference on July 15, 2002.

On August 2, 2002, the Panel determined that the Subscriber was entitled to coverage for continued outpatient rehabilitative therapy. On August 27, 2002, the Agency for Health Care Administration (AHCA), confirmed this decision and determined that the Petitioner should authorize continued decongestive rehabilitative therapy for the Subscriber.

On September 17, 2002, the Petitioner requested a summary hearing to contest AHCA's decision. Subsequently, on September 25, 2002, this matter was referred to the Divisison of Administrative Hearings (DOAH) for formal proceedings.

At the final hearing, the Petitioner presented no witnesses and offered one exhibit. AHCA presented the testimony of one witness, Dr. Joel Mattison, by telephone, as an expert witness on the prevailing medical standard for treatment of lymphedema. AHCA also presented two exhibits, a copy of Dr. Mattison's curriculum vitae and a copy of the Women's Cancer Rights Act of 1998.

The Transcript of the proceeding was filed on January 27, 2003. The parties were granted leave to file Proposed Final Orders within 20 days thereafter. Both parties have filed Proposed Final Orders, which have been reviewed and considered in the preparation of this Final Order.

FINDINGS OF FACT

1. The following facts were stipulated to at hearing by the Petitioner and AHCA:

(i) Effective April 1, 2002, the Subscriber in question was enrolled as a participant in a group HMO plan issued by the Petitioner to the Subscriber's employer for the benefit of its employees and their eligible dependents. This plan constitutes an "employee welfare benefit plan" pursuant to the Employee Retirement Income Security Act of 1974 (ERISA).

(ii) As a result of breast cancer, the Subscriber had a partial mastectomy of her left breast. Subsequent to her surgery, she required decongestic therapy due to lymphedema.

(iii) The Petitioner authorized and provided coverage for decongestic physical therapy benefits for the Subscriber for services rendered from a participating provider for the authorized period of August 9, 2001, through October 18, 2001.

(iv) The Petitioner denied coverage for additional decongestic physical therapy beyond the authorized period of August 9, 2001, through October 18, 2001, on the grounds that the Subscriber's

benefit had been exhausted under the terms of the Member Handbook.

2. The Member Handbook for the Subscriber's HMO, signed by Robert I. Lufrano, M.D., the president of the Petitioner’s company, establishes the description of the rights and obligations of the Subscriber and the Petitioner with respect to the coverage and/or benefits to be provided by the Petitioner. Pages 20-23 of the Member Handbook requires the preparation and review every 30 days of a treatment plan as recommended by the Subscriber’s primary care physician or authorized provider. Further, provisions of the Member Handbook document the Petitioner's obligation to comply with state and federal laws and regulations and states that the terms of the agreement shall be interpreted to comply with those laws.

3. Joel Mattison, M.D., is board-certified in plastic and reconstructive surgery. He holds a license in Florida and in North Carolina to practice medicine and surgery. Dr. Mattison has a specialty in plastic surgery and tropical diseases.

4. Dr. Mattison's testimony establishes that the most common treatment form for lymphedema is a method of massage known as decongestic therapy. Lymphedema is the type of problem that will reoccur and no current treatment permanently eliminates the problem. If treatment is not received, the patient will suffer swelling of the body part located near the

problem area causing trauma and infection with fungi and bacteria. The decongestic therapy is outpatient post-surgical follow-up care in keeping with the prevailing medical standard.

5. As established by Dr. Mattison's testimony, the massage, which is the prevailing medical standard of care for lymphedemas, could be needed in excess of 62 days.

6. Included in the therapy is the education of the patient to perform self-massage. The instruction in self-massage, however, is only part of the therapy and the other massage should not be discontinued.

7. The evidence does not establish that the Subscriber received any instruction in self-massage or her ability to perform this function.

8. In addition, Dr. Mattison testified that lymphedemas as a result of reconstruction and as a result of mastectomy, are indistinguishable without other indication, such as scars or patient history.

9. Dr. Mattison testified that lymphedema pumps are available to assist in treatment. While it is hoped that the patient will learn how to use the pump, patients cannot always be depended on to learn to use them.

10. The evidence fails to establish that the patient was offered a lymphedema pump or that using the lymphedema pump constitutes the prevailing medical standard.

CONCLUSIONS OF LAW

11. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of this proceeding. Sections 120.57, 120.574, and 408.7056(14), Florida Statutes.

12. Section 408.7056, Florida Statutes, provides for the establishment of a program to resolve disputes between managed care entities and subscribers who receive health care from such entities. Pertinent provisions of Section 408.7056, Florida Statutes, include the following:

> (3) The agency shall review all grievances within 60 days after receipt and make a determination whether the grievance shall be heard. Once the agency notifies the panel, the subscriber or provider, and the managed care entity that a grievance will be heard by the panel, the panel shall hear the grievance either in the network area or by teleconference no later than 120 days after the date the grievance was filed. The agency shall notify the parties, in writing, by facsimile transmission, or by phone, of the time and place of the hearing. The panel may take testimony under oath, request certified copies of documents, and take similar actions to collect information and documentation that will assist the panel in making findings of fact and a recommendation. The panel shall issue a written recommendation, supported by findings of fact, to the provider or subscriber, to the managed care entity, and to the agency or the department no later than 15 working days after hearing the grievance. If at the hearing the panel requests additional documentation or additional records, the time for issuing a

recommendation is tolled until the information or documentation requested has been provided to the panel. The proceedings of the panel are not subject to chapter 120.

* * *

(7) After hearing a grievance, the panel shall make a recommendation to the agency or the department which may include specific actions the managed care entity must take to comply with state laws or rules regulating managed care entities.

(8) A managed care entity, subscriber, or provider that is affected by a panel recommendation may within 10 days after receipt of the panel's recommendation, or 72 hours after receipt of a recommendation in an expedited grievance, furnish to the agency or department written evidence in opposition to the recommendation or findings of fact of the panel.

(9) No later than 30 days after the issuance of the panel's recommendation and, for an expedited grievance, no later than 10 days after the issuance of the panel's recommendation, the agency or the department may adopt the panel's recommendation or findings of fact in a proposed order or an emergency order, as provided in chapter 120, which it shall issue to the managed care entity. The agency or department may issue a proposed order or an emergency order, as provided in chapter 120, imposing fines or sanctions, including those contained in ss. 641.25 and 641.52. The agency or the department may reject all or part of the panel's recommendation. All fines collected under this subsection must be deposited into the Health Care Trust Fund.

* * *

(13) Any information which would identify a subscriber or the spouse, relative, or guardian of a subscriber and which is contained in a report obtained by the

> Department of Insurance pursuant to this section is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.
>
> (14) A proposed order issued by the agency or department which only requires the managed care entity to take a specific action under subsection (7) is subject to a summary hearing in accordance with s. 120.574, unless all of the parties agree otherwise. If the managed care entity does not prevail at the hearing, the managed care entity must pay reasonable costs and attorney's fees of the agency or the department incurred in that proceeding.
>
> (15)(a) Any information which would identify a subscriber or the spouse, relative, or guardian of a subscriber which is contained in a document, report, or record prepared or reviewed by the panel or obtained by the agency pursuant to this section is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

13. The issue in this case is twofold: whether the Subscriber falls into the class of people intended to be protected by the federal "Women’s Health and Cancer Rights Act of 1998” (the Act); and, whether outpatient lymphedema treatment is required by Section 641.31(31)(a), Florida Statutes, for the Subscriber after her mastectomy.

14. The Member Handbook is evidence of the existence of the group plan. The Member Handbook also establishes the description of the rights and obligations of the Subscriber and the Petitioner with respect to the coverage and/or benefits to be provided by the Petitioner, inclusive of the Petitioner's

obligation to comply with state and federal laws and regulations.

15. Pursuant to provisions of the Act, the Petitioner is required to provide coverage for the Subscriber's lymphedema treatment. The Act was implemented to provide coverage and quality of care minimums for mastectomies and for breast reconstruction for women who have breast cancer. The Act is codified in Title 29 U.S.C. Section 1185b, which states in part:

> (a) In general
> A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for -
>
> (1) all stages of reconstruction of the breast on which the mastectomy has been performed;
> (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
> (3) prostheses and <u>physical complications of mastectomy, including lymphedemas</u>;
>
> In a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be . . . .
> (Emphasis added)

16. All women who have breast cancer who need mastectomies are covered under this Act. Howard v. Coventry Health Care of Iowa, 158 F. Supp.2d 937 (S.D. Iowa 2001),[3] states the legislative intent for the enactment of the Act was to "ban drive-through mastectomies" and to require that insurance plans cover the costs of breast reconstruction surgeries. See Women's Health and Cancer Rights Act, 1998 WL 235685 (Cong. Rec.), 144 Cong. Rec. S4644-01 at *S4646 (May 12, 1998).[4] This Act was intended to protect women with breast cancer and to ensure appropriate treatment for complications of mastectomy, including lymphedema.

17. The code states in Title 29 U.S.C. Section 1185b (e):

> Preemption, relation to state laws—
> (1) In general
> Nothing in this section shall be construed to preempt any State law in effect on October 21, 1998, with respect to health insurance coverage that requires coverage of at least the coverage of reconstructive breast surgery otherwise required under this section.
> (2) ERISA
> Nothing in this section shall be construed to affect or modify the provisions of section 1144 of this title with respect to group health plans.

18. Notably, as set forth in the foregoing federal provisions, if the state law conflicts with the federal law, then the state law preempts. No apparent conflict is discernible between state and federal provisions on the subject.

As codified in Section 641.31(31)(a), Florida Statutes (1997), a health maintenance contract must provide coverage for outpatient post surgical follow-up care in keeping with the prevailing medical standards after a mastectomy. As codified in Section 641.31(32), Florida Statutes, coverage for mastectomy must also include coverage for prosthetic devices and breast reconstruction.

19. The Florida law requires coverage of care after a mastectomy specifically in Section 641.31(31)(a), Florida Statutes, which states in pertinent part:

> (31)(a) . . . Such contract must also provide coverage for outpatient postsurgical followup care in keeping with prevailing medical standards by a licensed health care professional under contract with the health maintenance organization qualified to provide postsurgical mastectomy care. The treating physician under contract with the health maintenance organization, after consultation with the covered patient, may choose that the outpatient care be provided at the most medically appropriate setting, which may include the hospital, treating physician's office, outpatient center, or home of the covered patient. (Emphasis added)

20. Both the Florida Statute and the Act use the cost-sharing mechanism of deductibles and coinsurance for the plan to impose limitations on the lymphedemas treatment. The plain language of the state statute on mastectomy coverage,

Section 641.31(31)(c)2., Florida Statutes, and the federal code, does not permit durational limitation on the treatment.

21. Coverage limits are stated in the language from Title 29 U.S.C. Section 1185b(a)(3) as follows:

> Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage . . . .

22. Section 641.31(31)(c)2., Florida Statutes, states:

> This subsection does not prevent a contract from imposing deductibles, coinsurance, or other cost sharing in relation to benefits pursuant to this subsection, except that such cost sharing shall not exceed cost sharing with other benefits.

23. AHCA seeks a 30-day review of the rehabilitative treatment plan in accordance with provisions for rehabilitative services set forth on pages 20-23 of the Member Handbook, which requires the preparation and review every 30 days of a treatment plan as recommended by the Subscriber's primary care physician or authorized provider.

24. Section 408.7056(14), Florida Statutes (2002), concludes with the following provision:

> (14) . . . If the managed care entity does not prevail at the hearing, the managed care entity must pay reasonable costs and attorney's fees of the agency or the department incurred in that proceeding.

ORDER

Pursuant to the foregoing Findings of Fact and Conclusions of Law, it is ORDERED:

1. That the Petitioner reimburse the Subscriber for all lymphedema outpatient therapy received until the date of this Final Order for as long as the Subscriber maintained coverage under the Member Handbook;

2. That the Petitioner immediately reinstate coverage for the Subscriber's lymphedema outpatient therapy for so long as the treatment is medically necessary and the Subscriber maintains coverage under the Member Handbook;

3. That a rehabilitative treatment plan is created in consultation with the attending physician and patient, and reviewed by the Petitioner every 30 days until the lymphedema outpatient therapy is no longer medically necessary; and

4. That jurisdiction is retained solely for determination of the amount of reasonable costs and attorney's fees to be awarded to AHCA in this proceeding in accordance with Section 408.7056(14), Florida Statutes (2002), upon filing of appropriate pleadings by AHCA.

DONE AND ORDERED this 3rd day of March, 2003, in Tallahassee, Leon County, Florida.

DON W. DAVIS
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675 SUNCOM 278-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 3rd day of March, 2003.

ENDNOTES

1/ In view of the provisions of Subsections (13) and (15) of Section 408.7056, Florida Statutes, "the Subscriber" has been substituted for the name of the insured.

2/ Section 408.7056(1)(a), Florida Statutes, defines “managed care entity” as “a health maintenance organization or a prepaid health clinic certified under chapter 641, a prepaid health plan authorized under s. 409.912, or an exclusive provider organization certified under s. 627.6472.”

3/ A brief summary of this case is: United States District Court, S.D. Iowa, Central Division. Lisa HOWARD, Plaintiff v. COVENTRY HEALTH CARE OF IOWA, INC., Principal Financial Group, Inc., and Principal Mutual a/k/a Principal Life Insurance Company, Defendant, No. 4-01-CV-10196 (July 20, 2001). A group of breast cancer patients brought putative class action against health insurer in state court, asserting claims for tortious breach of statute, breach of contract, violation of public policy, and bad faith. After removing action, insurer moved to dismiss.

4/ After removing action, insurer moved to dismiss. The District Court, Longstaff, Chief Judge, held that: (1) there is no implied private cause of action under provision of Women's

Health and Cancer Rights Act addressing required health coverage for reconstructive surgery following mastectomies, and (2) claims for breach of contract, violation of public policy, and bad faith were preempted by Employee Retirement Income Security Act (ERISA).

COPIES FURNISHED:

Daniel Alter, Esquire
Bunnell, Woulfe, Kirschbaum, Keller,
McIntyre & Gregoire, P.A.
Post Office Drawer 030340
Fort Lauderdale, Florida 33303

Ursula Eikman, Esquire
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Florida 32308

Lealand McCharen, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308

Valda Clark Christian, General Counsel
Agency for Health Care Administration
2727 Mahan Drive
Fort Knox Building, Suite 3431
Tallahassee, Florida 32308

NOTICE OF RIGHT TO JUDICIAL REVIEW

A party who is adversely affected by this Final Order is entitled to judicial review pursuant to Section 120.68, Florida Statutes. Review proceedings are governed by the Florida Rules of Appellate Procedure. Such proceedings are commenced by filing the original notice of appeal with the Clerk of the Division of Administrative Hearings and a copy, accompanied by filing fees prescribed by law, with the District Court of Appeal, First District, or with the District Court of Appeal in the Appellate District where the party resides. The notice of appeal must be filed within 30 days of rendition of the order to be reviewed.