STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

HUMANA MEDICAL PLAN, INC.,	)	
	)	
Petitioner,	)	
	)	
vs.	)	Case No. 08-3616
	)	
OFFICE OF INSURANCE REGULATION,	)	
	)	
Respondent.	)	
	)	

FINAL ORDER

Pursuant to Notice, this cause was heard by Linda M. Rigot, the assigned Administrative Law Judge of the Division of Administrative Hearings, on December 10, 2008, in Tallahassee, Florida. Pursuant to the parties' agreement, a stipulated record was admitted in evidence, and the parties presented closing arguments on both the stipulated record and on a pending motion for summary final order.

APPEARANCES

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STATEMENT OF THE ISSUES

The issues presented are (1) whether the Subscriber Assistance Panel had jurisdiction to hear the Subscriber's appeal; (2) whether this matter is properly before the Division of Administrative Hearings; and (3) whether the cold water therapy device utilized by the Subscriber is covered under the subject Humana commercial policy.

PRELIMINARY STATEMENT

By letter dated June 18, 2008, Respondent Office of Insurance Regulation approved the recommendation of the Subscriber Assistance Panel and directed Petitioner Humana Medical Plan, Inc., to provide coverage for a cold water therapy device for a particular subscriber. Humana timely filed a petition for hearing challenging the Office's directive. This cause was thereafter transferred to the Division of Administrative Hearings to conduct the summary proceeding.

The final hearing was scheduled and continued several times at the request of the parties. During that time, the parties acknowledged that this cause is subject to a summary hearing by statute and that the Division of Administrative Hearings has the authority to issue a final order in this case. The parties

further agreed that an evidentiary hearing was not necessary and that this case could be decided upon a stipulated record.

Petitioner's Motion for Summary Final Order was filed on September 12, 2008, and Respondent's Response to Petitioner's Motion for Summary Final Order was filed on September 18, 2008. On September 24, 2008, the prior administrative law judge assigned to this matter reserved ruling on the Motion. At the final hearing scheduled in this cause, both parties presented arguments regarding the pending Motion. Petitioner's Motion for Summary Final Order is denied.

Petitioner's Unopposed Motion to Make Records Confidential was filed on December 1, 2008. The Motion specified that all exhibits and deposition transcripts be submitted under seal and that all evidence produced be exempt from disclosure. An Order Granting Motion to Make Records Confidential was entered on December 2, 2008. It is noted that some of the attachments to Petitioner's Motion for Summary Final Order and Respondent's Response to Petitioner's Motion for Summary Final Order contain references to the name of the Subscriber who is the subject of this proceeding, and the Motion and the Response are hereby also placed under seal to remain exempt from disclosure.

Petitioner's Exhibits numbered 1-10; Respondent's Exhibits lettered A-DD, GG-II, OO, and PP; and Joint Exhibit numbered 1 were admitted in evidence. Petitioner filed the deposition

transcripts of Michelle Sanders and Louis Hochheiser, M.D., and Respondent filed the deposition transcripts of the Subscriber's mother K.O., James I. Tighe, and Steven Page, M.D. The stipulated record, therefore, consists of the Exhibits, the deposition transcripts, and the Joint Pre-hearing Stipulation filed December 9, 2008.

The Transcript of the final hearing was filed on December 17, 2008, and both parties filed proposed final orders on January 5, 2009. Those documents have also been considered in the entry of this Final Order.

FINDINGS OF FACT

1. Petitioner Humana Medical Plan, Inc., is a health maintenance organization (hereinafter "Humana" or "HMO") authorized to operate in Florida pursuant to a certificate of authority issued in accordance with Part I of Chapter 641, Florida Statutes.

2. The affected agency in this proceeding is the Office of Insurance Regulation (hereinafter "Office").

3. Humana issued a large group contract providing health insurance coverage to the School District of Hillsborough County for the benefit of the School District's employees and their eligible dependents. During all times relevant to this proceeding, the Subscriber T. O. was enrolled in this HMO Plan.

4. The Office had previously reviewed and approved the terms of Humana's Certificate of Coverage at issue in this proceeding. The Certificate of Coverage is a contract between Humana and the School District. Pursuant to this contract, Humana provides an agreed-upon set of healthcare services to its subscribers in exchange for an agreed-upon sum of money.

5. Humana's Certificate of Coverage provides coverage for durable medical equipment (hereinafter "DME"), which is defined as equipment meeting all of the following criteria:

> A. it can stand repeated use;
>
> B. it is primarily and customarily used to serve a medical purpose rather than being primarily for comfort and convenience (i.e., scooter to allow a patient to go shopping);
>
> C. it is usually not useful to a person in the absence of sickness or injury;
>
> D. it is appropriate for home use;
>
> E. it is related to the patient's physical disorder; and
>
> F. the equipment must be used in the subscriber's home, a relative's home, or a home for the aged or other type of institution.

6. By the use of the word "and" to connect all of the criteria in the definition of DME, the contract provides coverage for a DME only if it meets all of the conditions. Thus, Humana is neither obligated nor authorized to provide

coverage for a DME if any of the criteria in the definition are not met.

7. The Certificate of Coverage also excludes coverage for supplies, care, or treatment that are not essential for the necessary care and treatment of an injury or sickness. The Certificate also provides that Humana has the full and exclusive discretionary authority to interpret the Plan's provisions, to make decisions regarding eligibility for coverage and benefits, and to resolve factual questions relating to coverage and benefits.

8. The Subscriber T. O., a then-13-year-old male, underwent reconstructive knee surgery to repair a torn anterior cruciate ligament. The surgery was performed by Dr. Steven Page, an orthopedic surgeon, on August 13, 2007. Dr. Page was part of a group practice known as Brandon Orthopedic Associates, which had a contract with Humana to provide in-network healthcare to Humana subscribers and was, therefore, a participating provider.

9. On August 7, 2007, the Subscriber's mother received an item of DME while in Dr. Page's office, which had been prescribed by Dr. Page. The DME was a cold water therapy device.

10. She did not receive the device from Dr. Page, and he had no discussion with her regarding whether the device would be

covered under her group insurance contract. Dr. Page made no representations to her regarding coverage or non-coverage, and she made no inquiry regarding whether her insurance would pay for the device. Instead, according to her own testimony, she made the decision that she would pay for the device herself if there was no coverage.

11. In a Letter of Medical Necessity dated August 7, Dr. Page prescribed the DME to be used for 14 days following surgery. The Letter further states that the device is being prescribed for its ability to reduce pain and edema, limit the patient's hospital stay, and facilitate recovery. It further states that ice or ice substitutes cannot be used continuously due to possible tissue damage.

12. The cold water therapy device delivered to the Subscriber was provided by Aberdeen Medical Services through office space within the office space of Dr. Page's practice group. Aberdeen does not have a contract with Humana to provide services to Humana's subscribers and is, therefore, a non-participating provider.

13. At the same time the cold water therapy device was delivered to the Subscriber, the Subscriber's mother signed Aberdeen's Assignment Agreement. The Agreement includes a paragraph entitled Assignment of Benefits, which provides that if the Subscriber's insurance company does not pay the claim in

full, the Subscriber assigns to Aberdeen all rights to any appeal granted by the Subscriber's insurance company.

14. When the Subscriber's mother failed to bring the cold water therapy device to the hospital on the day of her son's surgery, Dr. Page instructed the Subscriber's mother to return home to retrieve the device. He did not tell her that he would not perform the surgery if she did not retrieve the device, and he would not have refused to perform the surgery for a patient who chose not to use the device.

15. Aberdeen submitted a claim to Humana seeking to be paid $850 for the Subscriber's rental of the cold water therapy device for 14 days. Humana denied coverage for the device in September 2007, stating that there was no prior authorization on file. The contract between Dr. Page's practice group and Humana requires that prior authorization must be obtained before a Subscriber can receive treatment or services from a non-participating provider.

16. When Humana denied Aberdeen's claim for payment, Aberdeen initiated the internal appeal and grievance process with Humana. Humana requested that Aberdeen obtain the Subscriber's consent by having the Subscriber's mother complete an Appointment of Authorized Representative Form. The Form was completed by the Subscriber's mother and returned to Humana by Aberdeen.

17. Upon receiving confirmation that the Subscriber wished to be represented in the appeal by Aberdeen, Humana continued with the internal review process. Humana's Grievance and Appeal Panel considered the appeal and upheld the denial of coverage, stating that Humana considers the device to be a convenience item. Humana informed Aberdeen of the denial of the appeal by letter dated December 21, 2007, and further informed Aberdeen that an additional grievance procedure was available before the State's Subscriber Assistance Panel.

18. The Subscriber's mother filed a grievance with the Subscriber Assistance Panel (hereinafter "Panel") appealing Humana's denial of the claim.

19. The Panel heard the case on April 15, 2008. Two representatives from Humana and the Subscriber's mother appeared before the Panel by telephone. Aberdeen did not participate in the Panel review.

20. The Panel found that the cold water therapy device is excluded from coverage under the terms of the Subscriber's Certificate of Coverage. The Panel also found that the Subscriber's mother "detrimentally relied upon the participating physician's recommendation of the cold water therapy device and she was not given any other option as to alternative treatments." The Panel determined that Humana "acted inconsistently with its obligations to the Subscriber under the

rules and laws that regulated managed care entities" and recommended to the Office that Humana be ordered to provide coverage despite the device being excluded under the terms of the Certificate of Coverage. The Panel did not, however, cite to any "rules and laws" allegedly violated by Humana.

21. By letter dated June 18, 2008, the Office adopted by reference and incorporated all the terms of the Panel's Proposed Recommended Order and ordered Humana to provide coverage for the device, finding that "coverage ordered herein is necessary in order for representations made to the Subscriber via the Member Handbook and Certificate of Coverage to be unambiguous and not violative of Sections 641.31 and 641.3903, Florida Statutes." The letter fails to specify what representations made in the Member Handbook or the Certificate of Coverage are ambiguous and fails to specify what provisions within the two lengthy statutes cited would be violated if coverage were excluded in accordance with the Certificate of Coverage.

22. Humana filed with the Office a timely Petition for Summary Hearing, which was forwarded to the Division of Administrative Hearings on July 23, 2008.

23. The cold water therapy device at issue consists of an 8-quart water cooler that looks like a small drink cooler, a cuff, a pump, and a hose. The pump automatically exchanges water through the hose from the pump to the cooler to provide a

continuous flow of cold water through the cuff which is wrapped around the injured area.

24. As opposed to other treatment modalities such as an ice pack/compression bandage combination or a cuff/water cooler combination, the cold water therapy device involved in this case is designed to provide a continuous flow of cold water through the cuff and eliminate the need for the patient to remove and replace ice packs or manually exchange the warmed water in the cuff with cold water from the cooler. The cold water therapy device also provides compression to the injured area because of a compression strap and the water pressure inside the cuff. The device comes with directions to use 20 minutes on and 20 minutes off, so monitoring is required.

25. Humana requires providers to submit claims using claims codes. Humana's claims codes for cold water therapy devices include separate codes for a water-circulating cold pad with pump, for a pump for a water-circulating cold pad, and for a pad for a water-circulating unit. None of these devices or components is a covered benefit under the Certificate of Coverage involved in this case.

26. Neither Dr. Page nor Aberdeen obtained pre-authorization from Humana before providing the cold water therapy device to the Subscriber. According to the contract between Humana and Dr. Page's practice group, pre-authorization

was required before this device could be considered for coverage since it was supplied by a non-participating provider. Likewise, the Subscriber never attempted to contact Humana regarding any issue related to coverage prior to receiving this device.

27. Aberdeen's president testified at deposition that Humana has reimbursed Aberdeen in previous claims for the cold water therapy device at issue here. However, in those situations Aberdeen was reimbursed under different policies with different coverage terms than the one at issue in this case.

28. Moreover, if a specific code is available for a specific piece of DME, then that is the proper claims code to use for reimbursement purposes. Aberdeen has submitted claims for payment for cold water therapy devices under the claims code "E1399," a claims code that is used for unlisted DMEs. In conjunction with using that claims code, Aberdeen described the DME as being "electronic controlled thermal therapy acute pain management."

29. This claims code and this accompanying description are not applicable to the cold water therapy device for which Aberdeen was seeking reimbursement. The correct code should have been "E0218," the code for a water-circulating cold pad with pump. Humana admits that it has paid Aberdeen two claims in error due to Aberdeen's use of the wrong code.

30. The Subscriber's mother has paid nothing toward the rental of the cold water therapy device from Aberdeen. Aberdeen has not even sent an invoice or other request for payment to the Subscriber.

31. Whether Aberdeen will ever seek reimbursement for the device from the Subscriber is speculative. Whether Aberdeen can seek reimbursement from the Subscriber is questionable since the Office offered into evidence two forms provided to the Subscriber by Aberdeen. One of them is entitled: "Frequently Asked Questions Regarding Your Responsibilities for the Use of the Controlled Cold Therapy Device," and the other is entitled: "Most Frequently Asked Questions Regarding Your Responsibilities for the Use of the Controlled Cold Therapy Device." Both contain the question: "Will I be personally responsible for any of the bill for my use of this device?" The first form answers the question as follows: "We accept payment consistent with the terms of your applicable insurance." The second answers as follows: "We accept payment according to the terms of your applicable insurance and this is the extent of your responsibility."

32. Dr. Page uses the cold water therapy device for his patients who undergo surgery to repair the anterior cruciate ligament. He was impressed with an article in the American Journal of Knee Surgery, which found the device to be superior

to using crushed ice. He does not, however, know the prevailing medical standard among orthopedic surgeons as to use of the device. The fact that he knows many who do does not establish a standard of care. He agrees that not everything deemed medically necessary is covered by insurance and that under his contract with Humana, Humana has the authority to determine that the device is a convenience item and not a covered benefit.

33. Dr. Louis Hochheiser is Humana's Medical Director for clinical policy development. He oversees the committee that is responsible for examining new medical technologies, as well as writing and reviewing clinical policies. A clinical policy provides guidance to Humana's providers so they know what Humana covers, and it also serves as guidance for physicians and nurses doing case review to help ensure that all of Humana's subscribers are treated equally. The clinical policies are published on Humana's website and are available to its subscribers and providers.

34. When Humana is developing a clinical policy for a medical technology or device such as the cold water therapy device at issue in this case, a workgroup of the committee researches the device using medical literature and any statement or assessment that any specialty organization may have made on that particular device. Humana also subscribes to the services of two companies that examine and rate new technologies. Humana

also consults the rules of the Center for Medicare and Medicaid Services and reviews its competitors' positions with respect to any new technology.

35. When the workgroup has compiled and reviewed the information, it creates a draft clinical policy. One of the medical directors of the full committee then reviews the draft policy form and all the literature that was reviewed in creating the draft policy form. If necessary, the draft policy is revised after discussion and further research. Once the draft policy is approved, it is sent to the full committee for presentation, discussion, and approval. When the policy is approved, it is posted on Humana's website and sent to its providers as part of a quarterly update of new and revised policies. The provider contract between Humana and Dr. Page's practice group that requires the group's physicians to comply with Humana's policies and procedures includes such policies.

36. The voting members of the committee are physicians from three different areas of Humana: regional medical directors, market medical officers who work with Humana's providers, and Medicare medical directors. Approximately 20 physicians participate in the committee on a monthly basis. Additional input is provided by nurses, legal counsel, product development, sales and communications, but the voting and approval of clinical policies is only done by physicians.

37. The committee does not consider cost of the technology when it creates Humana's clinical policy forms but relies on medical evidence to make its decisions. If a technology is supported by the medical evidence, and if it makes improvements for Humana's subscribers, then the committee will approve the technology. If such approval results in a higher cost, this increased cost is addressed by Humana's actuaries and built into the cost of the health plan.

38. With respect to the development of the clinical policy on the cold water therapy device at issue in this case, Humana's technology assessment forum reviewed journal articles, information supplied by the two organizations that provide reviews of technology, and literature from the Institute of Arthritis and Musculoskeletal Skin Diseases' web site to determine the efficacy of cold and heat therapy based on the published literature.

39. There is no reliable evidence that cold water therapy devices provide better outcomes for patients than traditional cold packs. The only advantage to the cold water therapy devices compared to cold packs is that of convenience because the patient does not have to change cold packs if the patient is using the cold water therapy device.

CONCLUSIONS OF LAW

40. The Division of Administrative Hearings has jurisdiction over the subject matter and the parties hereto pursuant to Sections 120.569, 120.57(1), 120.574, and 408.7056, Florida Statutes.

41. The standard of review in this proceeding is de novo. Health Options, Inc. v. Office of Insurance Regulation, DOAH Case No. 06-1183 (F. O. Sept. 11, 2006).

42. The Administrative Law Judge's decision in a proceeding under Section 120.574, Florida Statutes, is final agency action subject to judicial review and is in the form of a final order rather than a recommended order. §§ 120.574(2)(f) and 408.7056(13), Fla. Stat.

43. As a threshold matter, because Humana has challenged the Subscriber's standing to participate in these proceedings, the Subscriber's standing must be addressed.

44. A Subscriber is entitled under Section 408.7056, Florida Statutes, to bring a grievance before the Panel. Although the statute is silent on the definition of "grievance," the statute is also clear that a challenge to the decision of the Panel and the Office is subject to proceedings under Chapter 120, Florida Statutes. § 408.7056(13), Fla. Stat. Thus, even if "grievance" is broadly interpreted to encompass every complaint a subscriber has against an HMO, the subscriber's

standing in this administrative proceeding is still determined under Chapter 120, Florida Statutes.

45. It is well settled that if a party's substantial interests are not affected, then the party lacks standing to participate in administrative proceedings. Agrico Chemical Co. v. Dept. of Environmental Regulation, 406 So. 2d 478, 482 (Fla. 2d DCA 1981). Humana argues that the Subscriber's mother lacked standing to participate in the proceeding before the Panel because her substantial interests have not been affected. She has not paid for the cold water therapy device, she has not been billed for the device, and the exhibits admitted in evidence indicate that she will not be billed and, arguably, cannot be.

46. Humana also argues that the Panel should not have heard the Subscriber's mother's grievance in light of the jurisdiction requirement found in Section 408.7056(2)(g), Florida Statutes. Humana reasons that Aberdeen is a non-participating provider which pursued Humana's internal grievance process, and that this is, therefore, a grievance related to an appeal by a non-participating provider, for which a different statutory process has been established.

47. Similarly, Humana argues that a grievance brought to the Panel must be filed "by a subscriber on behalf of a subscriber," and that this case is not brought on behalf of a subscriber since the Subscriber's mother is seeking to have a

claim paid to Aberdeen, not to her. Humana, in essence, argues that the real party in interest in this proceeding is not a subscriber and that, therefore, the Panel had no jurisdiction to hear the case or enter its order. The Office disagrees with these several arguments.

48. It may be that the Legislature intended the Panel to hear every type of grievance even if the person initiating the proceeding has suffered no injury and is not likely to suffer an injury. It may be that the Legislature intended to restrict the kinds of non-participating providers who have access to the process established by Section 408.7056, Florida Statutes. However, it is not necessary to resolve these and the parties' related arguments in this Final Order.

49. It is necessary for this type of dispute to travel through the Panel process and for the Panel's recommendation to be considered by the Office before a proceeding pursuant to the summary final order process described in Section 408.7056(13), Florida Statutes, can be filed and referred to the Division of Administrative Hearings (hereinafter "DOAH"). The contents of the Panel's recommendation and the Office's subsequent order on that recommendation become less important because the proceeding at DOAH is de novo.

50. The parties in this proceeding are Humana and the Office, and those parties do have interests that are

substantially affected by this proceeding. Accordingly, Humana's arguments regarding the Subscriber's lack of standing, regarding Aberdeen's non-participating provider status, and regarding the Panel's and the Office's lack of jurisdiction to consider the dispute are not persuasive. DOAH does have jurisdiction over this proceeding.

51. The rights and obligations of Humana under the HMO Plan are governed by the terms of the Certificate of Coverage and applicable state and federal laws and regulations. When construing the Certificate of Coverage, it must be read as a whole and each provision must be given its full meaning and operative effect. Excelsior Ins. Co. v. Pomona Park Bar & Package Store, 369 So. 2d 938, 941 (Fla. 1979).

52. All services provided under the insurance contract and any limitations to those services must be clearly and understandably stated in the certificate of coverage. §§ 641.185 and 641.31, Fla. Stat. If the contract is clear and unambiguous, courts must give effect to the policy as it was written and may not re-write the policy. Swire Pacific Holdings, Inc. v. Zurich Ins. Co., 845 So. 2d 161, 165 (Fla. 2003).

53. The terms of the Certificate of Coverage at issue in this case are unambiguous. Because the Office previously reviewed and approved the Certificate pursuant to Section

641.31, Florida Statutes, it is fair to conclude that the Office determined that the Certificate clearly stated the services to which a subscriber is entitled and included a clear and understandable statement of any limitations as required by Section 641.31(4). Moreover, the meaning of the word "convenience" is familiar, widely-understood, and not ambiguous. Further, the Certificate plainly grants Humana discretion to interpret the Plan and make coverage determinations.

54. The insured has the initial burden to establish the affirmative of the issue presented, i.e., that there is coverage for the cold water therapy device under the contract. Fla. Dep't of Transp. v. J.W.C. Co., Inc., 396 So. 2d 778, 788 (Fla. 1st DCA 1981), citing Balino v. Dep't of Health and Rehab. Servs., 348 So. 2d 349, 350 (Fla. 1st DCA 1977). If the insured can first establish that a claim falls within the scope of coverage provided by the policy, then the insurer has the burden to prove that the loss arose from a cause that is excepted under the policy. State Farm Mut. Auto Ins. Co. v. Pridgen, 498 So. 2d 1245, 1248 (Fla. 1986); Hudson v. Prudential Prop. & Cas. Ins. Co., 450 So. 2d 565, 568 (Fla. 2d DCA 1984).

55. Thus, the Office has the burden to prove by a preponderance of the evidence that the Subscriber is entitled to coverage for the cold water therapy device. Although the parties agree that the device is a DME, Humana has proven that

the device is a convenience item, and, thus, under the definition of DME in the Certificate of Coverage, the Subscriber is not entitled to coverage for this particular DME. Therefore, the Office has not met its burden to prove that the Subscriber is entitled to coverage for the cold water therapy device. Specifically, the Office has failed to establish that the device is not a convenience item or that Humana has acted inconsistently with its obligations to the Subscriber.

56. Interestingly, the Panel and the Office both determined that there was no coverage for the DME under the Certificate of Coverage when they considered this case, but determined that coverage should be afforded despite the exclusion, asserting that there had been detrimental reliance, inconsistency with legal obligations, and ambiguity. No evidence has been offered in this proceeding to support any of those theories.

57. Rather, the preponderance of the evidence shows that Dr. Page made no representations to the Subscriber's mother regarding coverage, there is no legal requirement that Humana provide coverage for cold water therapy devices, and no provision in the Certificate of Coverage or the Member Handbook has been shown to be ambiguous. Thus, there is no factual support for the position of the Panel and the Office that Humana

should pay for the device in question although coverage was excluded under its Certificate of Coverage.

58. Although Dr. Page opined that the cold water therapy device was medically necessary, whether a service is medically necessary is irrelevant to the issue of whether a Subscriber is contractually entitled to coverage for the service or device under the applicable Certificate of Coverage. Further, the evidence is uncontroverted that Humana has the discretion to determine whether the device is medically necessary under the terms of the Certificate. Lastly, Dr. Page's testimony that he would not have refused to perform the surgery had the Subscriber's mother been unable to provide the device in inconsistent with, and appears to undermine, his opinion that the device was medically necessary.

59. Contract provisions that confer sole discretion on one of the contracting parties are valid if the discretion is exercised in good faith. Sepe v. City of Safety Harbor, 761 So. 2d 1182, 1185 (Fla. 2d DCA 2000). Here, Humana has provided ample evidence, after extensive research and consideration by medical personnel, that the cold water therapy device provides no benefits over traditional cold therapy except for convenience and that, therefore, the cold water therapy device was not medically necessary. There is no evidence of bad faith on the part of Humana in denying coverage to the Subscriber.

60. The Office has raised as a new issue during the DOAH proceeding an allegation that Humana's denial of coverage for the cold water therapy device was inconsistent with prevailing standards of medical practice in the community. Yet, the only evidence offered by the Office to support this allegation is that of Dr. Page who clearly testified that he did not know the prevailing standard of practice. This argument, therefore, requires no further discussion.

61. Section 408.7056(13), Florida Statutes, provides that if the managed care entity does not prevail at the hearing, the managed care entity must pay the reasonable costs and attorney's fees incurred by the Office. There is no corresponding provision requiring the Office to pay the managed care entity's costs and attorney's fees where, as here, the managed care entity prevails at the hearing. Therefore, no costs or attorney's fees are awarded to either party.

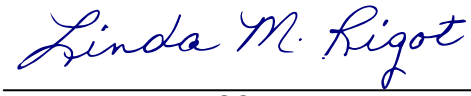
Based upon the foregoing Findings of Fact and Conclusions of Law, it is

ORDERED that:

1. Petitioner's Motion for Summary Final Order is denied as moot.

2. Humana Medical Plan, Inc., is not required to provide coverage for the cold water therapy device requested by the Subscriber.

DONE AND ORDERED this 3rd day of February, 2009, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
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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 agency 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.