STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

JOHN ALLISON,

Petitioner,

vs. Case No. 15-2892

DEPARTMENT OF MANAGEMENT
SERVICES, DIVISION OF STATE
GROUP INSURANCE,

Respondent.
_______________________________/

RECOMMENDED ORDER

On July 14, 2015, an administrative hearing in this case was held by video teleconference in Sebastian and Tallahassee, Florida, before William F. Quattlebaum, Administrative Law Judge, Division of Administrative Hearings.

APPEARANCES

For Petitioner: John Allison, pro se
5859 Duskywing Drive
Cocoa, Florida 32955

For Respondent: Gavin D. Burgess, Esquire
Department of Management Services
4050 Esplanade Way, Suite 160
Tallahassee, Florida 32399-0950

STATEMENT OF THE ISSUE

The issue in the case is whether medical expenses incurred by state employee, John Allison (Petitioner), are covered benefits under the Petitioner's insurance plan.

PRELIMINARY STATEMENT

The Petitioner’s insurer has denied payment of certain medical expenses incurred by the Petitioner. The Petitioner appealed the denial to the Department of Management Services, Division of State Group Health Insurance (Respondent).

By letter dated November 7, 2014, the Respondent notified the Petitioner that his appeal was denied. The Petitioner thereafter filed a request for an informal hearing with the Respondent.

On March 31, 2015, an informal hearing was convened, during which the presiding hearing officer determined that there was a disputed issue of material fact presented by the case. The hearing officer entered an Order Transferring Matter to the Division of Administrative Hearings (DOAH). On May 22, 2015, the Respondent submitted the dispute to DOAH, which scheduled and conducted the formal hearing.

At the hearing, the Petitioner testified on his own behalf. The Respondent presented the testimony of one witness and had Exhibits 1 through 5 and 7 through 8 admitted into evidence.

No transcript of the hearing was filed. The Respondent filed a Proposed Recommended Order and the Petitioner submitted a letter, both of which have been considered in the preparation of this Recommended Order.

FINDINGS OF FACT

1. The Petitioner is employed by the State of Florida and receives medical benefits through an HMO Standard Medical Plan (the Plan) made available to state employees.

2. The Plan is administered by Aetna. The Respondent is the state agency responsible for resolving appeals of medical claims denied by Aetna.

3. Approximately five years ago, the Petitioner had surgery to install a "lap-band" into his abdomen.

4. A lap-band is a weight loss device used to restrict the amount of food that a patient can ingest at one time. The restriction reduces caloric intake and generally results in weight loss.

5. Prior to installation of the lap-band, the Petitioner was "morbidly obese" with a history of gastric reflux and previous esophageal strictures treated by dilation.

6. In 2014, the Petitioner began to re-experience reflux and had episodic problems swallowing food and liquid ("dysphagia"). He reported the issue to his physician during an office visit on April 30, 2014. The records of the office visit identify the reason for the appointment as "band issues."

7. The physician scheduled the Petitioner for fluoroscopy-guided lap-band adjustment, which was performed at Viera Hospital on May 6, 2014.

8. Fluoroscopy is an x-ray process that essentially provides a "real-time" moving image of a patient. Fluoroscopy can be used as a diagnostic tool for a variety of conditions.

9. The evidence in this case establishes that the Petitioner's physician ordered the procedure specifically to observe and adjust the Petitioner's lap-band.

10. The scheduling order for hospital radiology services identifies the procedure being performed as "lap-band fluoroscopy-guided adjustment." The post-procedure radiology imaging report identifies the service provided as "[f]luoroscopy assistance provided to assess and/or assist lap band adjustment."

11. Prior to the procedure, a request was submitted to Aetna for precertification of "adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline." According to the precertification form admitted as an exhibit at the hearing, Aetna responded, "the requested service does not require precertification but may not be eligible for coverage" under the Plan.

12. In order for a claim for benefits to be covered by the Plan, the treatment provided must be both medically necessary and a covered benefit. A treatment may be medically necessary but excluded from coverage.

13. The Plan contains the following exclusion relevant to surgical installation of a lap-band:

> Obesity and weight reduction treatment, including surgical operations and medical procedures for the treatment of morbid obesity, unless determined to be medically necessary by the Health Plan, such as intestinal or stomach by-pass surgery and a weight loss program required by the covered person's primary care physician prior to surgery.

14. Under the Plan, and absent evidence that the original installation of the Petitioner's lap-band was determined to be "medically necessary" by the Plan or required by the Petitioner's primary care physician prior to surgery, the installation of the lap-band would be a non-covered service.

15. At the hearing, the Petitioner testified that the charges related to the installation of the lap-band had been paid for by his previous insurer, but there was no evidence presented as to actual coverage or exclusions contained in the previous insurance. There is no evidence that the Petitioner's lap-band has been determined to be "medically necessary" or required by a primary care physician prior to surgery.

16. As to the specific service at issue in this case, the Petitioner's dysphagia was a complication caused by the lap-band and specifically excluded from coverage. The Plan specifically excludes "[c]omplications of non-covered services, including the diagnosis or treatment of any condition which arises as a complication of a non-covered service."

CONCLUSIONS OF LAW

17. The Division of Administrative Hearings has jurisdiction over the parties and subject matter of this proceeding. §§ 120.569 and 120.57, Fla. Stat.

18. Section 110.123(5), Florida Statutes, assigns responsibility to render final decisions on matters of enrollment, the existence of coverage, or covered benefits under the state group insurance program to the Respondent.

19. Absent a contrary statutory directive, the general rule is that the burden of proof in an administrative hearing is on the party asserting the affirmative of an issue. Young v. Dep't of Cmty. Aff., 625 So. 2d 831, 833-834 (Fla. 1993); Dep't of Transp. v. J.W.C. Co., 396 So. 2d 778, 788 (Fla. 1st DCA 1981); Balino v. Dep't of HRS, 348 So. 2d 349, 350 (Fla. 1st DCA 1977). As the party asserting the right to payment of his claim under the Plan, the Petitioner had the initial burden of demonstrating by a preponderance of the evidence that his claim is qualified for coverage. Assuming the Petitioner meets this requirement, the burden then shifts to the Respondent to establish that the claim is excluded from coverage under the terms of the policy. Herrera v. C.A. Seguros Catatumbo, 844 So. 2d 664, 668 (Fla. 3d DCA 2003); State Comprehensive Health Ass’n v. Carmichael, 706 So. 2d 319, 320 (Fla. 4th DCA 1997).

20. Insurance contracts are to be construed in accordance with the plain language of the policy, with any ambiguity construed against the insurer, and in favor of coverage. U.S. Fire Ins. Co. v. J.S.U.B., Inc., 979 So. 2d 871, 877 (Fla. 2007); Kohl v. Blue Cross & Blue Shield of Fla., Inc., 988 So. 2d 654, 658 (Fla. 4th DCA 2008). Exclusionary clauses are to be construed even more strictly than coverage clauses. Purelli v. State Farm Fire & Cas., 698 So. 2d 618, 620 (Fla. 2d DCA 1997). It is well settled that insurance policy exclusionary clauses that are ambiguous or otherwise susceptible to more than one meaning must be liberally construed in favor of the insured and strictly against the insurer. Harnett v. Southern Ins. Co., 181 So. 2d 524 (Fla. 1965); State Farm Mut. Auto Ins. Co. v. Pridgen 498 So. 2d 1245 (Fla. 1986). Ambiguity is not necessarily present simply because analysis is required to interpret the policy. However, ambiguity exists in an insurance policy when its terms make the policy subject to different reasonable interpretations, one of coverage and one of exclusion. Blue Shield of Fla., Inc., v. Woodlief, 359 So. 2d 883 (Fla. 1st DCA 1978); Traveler's Ins. Co. v. Gayfer's & Co., Inc., 366 So. 2d 1199 (Fla. 1st DCA 1979).

21. In this case, the Petitioner has failed to establish that his claim is qualified for coverage. Although the Petitioner testified that his previous insurer had approved and

paid the claims related to installation of the lap-band, the evidence failed to establish the circumstances under which the claims were paid, or that the lap-band was determined to be "medically necessary" by an insurer or was required by a primary care physician prior to surgery.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Department of Management Services, Division of State Group Health Insurance, enter a final order denying the Petitioner's claim for the fluoroscopy-guided lap-band adjustment performed at Viera Hospital on May 6, 2014.

DONE AND ENTERED this 6th day of August, 2015, in Tallahassee, Leon County, Florida.

William F. Quattlebaum

WILLIAM F. QUATTLEBAUM
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 6th day of August, 2015.

COPIES FURNISHED:

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.