STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

A. H., ON BEHALF OF R. H.,

Petitioner,

vs. Case No. 16-6837

DEPARTMENT OF MANAGEMENT SERVICES,

Respondent.
_______________________________/

RECOMMENDED ORDER

Pursuant to notice, a final hearing was held in this case on February 23, 2017, in Jacksonville, Florida, before Lawrence P. Stevenson, a duly designated Administrative Law Judge of the Division of Administrative Hearings ("DOAH").

APPEARANCES

For Petitioner: Pearl Harrison, Qualified Representative
3783 Hunt Club Road
Jacksonville, Florida 32224

For Respondent: Anita J. Patel, Esquire
Department of Management Services
4050 Esplanade Way, Suite 160
Tallahassee, Florida 32399-0950

STATEMENT OF THE ISSUES

At issue in this proceeding is whether Respondent's denial of Petitioner's Level II appeal should be upheld or whether the inpatient residential mental health services provided to R.H. by McLean Hospital's 3 East Dialectical Behavior Therapy ("DBT")

program from September 9, 2015, through September 22, 2015, and again from October 15, 2015, through December 11, 2015, were "medically necessary" and therefore covered under the terms of the State Employees' PPO Group Health Insurance Plan.

PRELIMINARY STATEMENT

By letter dated July 29, 2016, Respondent, Department of Management Services, Division of State Group Insurance ("DSGI"), notified Petitioner, A.H., that it intended to deny his Level II appeal, by which Petitioner challenged the decision of Blue Cross & Blue Shield of Florida, Inc., which operates under the trade name "Florida Blue," to deny coverage for the inpatient residential stay of his daughter, R.H., at McLean Hospital, an affiliate of Harvard Medical School located in Belmont, Massachusetts, from September 9, 2015, through September 22, 2015, and again from October 15, 2015, through December 11, 2015. On August 22, 2016, Petitioner submitted to DSGI a request for a formal hearing disputing DSGI's conclusion that R.H.'s inpatient residential admission was not medically necessary. DSGI referred the matter to DOAH on November 17, 2016.

The final hearing was originally scheduled for January 4, 2017. Two continuances were granted before the hearing was rescheduled for February 23, 2017, on which date it was convened and completed.

At the final hearing, Petitioner called no witnesses, relying on cross-examination of DSGI's witnesses under a stipulated relaxation of the scope limitation on cross-examination. Petitioner's Exhibits 3 through 10, 12, 13, 17, 19, 20, and 24 through 27 were admitted into evidence.

Respondent presented the testimony of Frank Santamaria, M.D., the care management medical director of Florida Blue and an expert in medical necessity determinations; Barbara Center, M.D., a psychiatrist who works for Prest & Associates, Inc., an independent review organization, and an expert in adolescent psychiatry and medical necessity determinations; Tara Adams, regional clinical director for New Directions Behavioral Health ("New Directions"), a behavioral managed health care organization that provides behavioral health and substance abuse services for Florida Blue; Kelly Register, a critical inquiry analyst for Florida Blue; Michael Shaw, the team leader for utilization management at New Directions; and Kathy Flippo, RN, who is DSGI's legal nurse coordinator and an expert in legal nurse consulting. Respondent's Exhibits 1 through 14 and 16 through 19 were admitted into evidence.

The two-volume transcript of the hearing was filed on March 15, 2017. The record was held open pending a ruling on the admissibility of some of Petitioner's exhibits. On March 21, 2017, an Order on Admission of Petitioner's Exhibits

and Closing Record was entered. The parties timely filed their Proposed Recommended Orders on March 31, 2017.

Unless otherwise noted, all statutory references are to Florida Statutes (2016).

FINDINGS OF FACT

1. DSGI is the state agency responsible for administration of the state group insurance program, pursuant to section 110.123, Florida Statutes.

2. Petitioner, A.H., is a State of Florida employee and was insured through the State Employees' PPO Group Health Insurance Plan (the "Plan"). R.H., the child of A.H., was eligible for coverage under A.H.'s health insurance policy as of September 1, 2015.

3. Pursuant to contract, Florida Blue acts as DSGI's third-party medical claims administrator for employee health insurance benefits.

4. New Directions is Florida Blue's subcontractor and third-party administrator for mental health and substance abuse reviews and authorizations.

5. "Utilization management" is the process of reviewing a service claim to determine whether the service is a covered benefit under the Plan and whether the service is "medically necessary" as that term is defined in the Plan. In cases involving mental health or substance abuse services, the service

must also satisfy the more detailed and specific coverage guidelines, titled "Medical Necessity Criteria," established by New Directions.[1/]

6. Consistent with general practice in the field, the "medical necessity" criteria of the New Directions document observe the following levels of care, in increasing order of intensity: psychiatric outpatient; psychiatric intensive outpatient; psychiatric partial hospitalization; psychiatric residential; and psychiatric acute residential. In the interests of conserving medical resources and preserving patient liberty, safety, and dignity, every effort is made to place patients in the least intensive level of care consistent with effective treatment of their presenting condition.

7. R.H., a female who was 15 years old during the period relevant to this proceeding, has been diagnosed with borderline personality disorder and has a history of eating disorders. Her treating psychologist in Florida, Nicolle Arbelaez Lopez, noted that R.H. was also being treated for generalized anxiety disorder.

8. R.H. had an inpatient admission to the Renfrew Center in Florida for eating disorder treatment in May 2015. R.H. transitioned to partial hospitalization over the summer, followed by a step down to the Renfrew Center's intensive outpatient program, then by a step up back to partial

hospitalization when her eating disorder behaviors worsened. Though less intensive than a full residential admission, intensive outpatient treatment and partial hospitalization allow patients to receive comparatively intensive treatment while remaining in their home environment.[2/] R.H.'s final discharge from the Renfrew Center was on August 21, 2015.

9. At the time she was admitted to McLean Hospital's 3 East DBT program, R.H. had a recent history of engaging in superficial cutting of her arm. On August 30, 2015, R.H. intentionally hit herself in the hand with a hammer. R.H.'s mother took her to the emergency room for treatment and told the treating personnel that R.H. had fallen down some stairs. The hammer blow caused swelling and bruising but no broken bones. R.H. was also continuing to purge and restrict her food intake.

10. R.H.'s treating psychiatrist, Dr. Thania V. Quesdada, and her psychologist, Ms. Lopez, both urged that she be admitted to one of three nationally-recognized immersion DBT programs. Her family chose the program at McLean Hospital.

11. DBT is a cognitive behavioral treatment that was originally developed to treat chronically suicidal individuals diagnosed with borderline personality disorder, though it is now employed for treatment of other conditions, including eating disorders. DBT teaches behavioral coping skills such as

mindfulness, distress tolerance, interpersonal effectiveness, and emotional regulation.

12. At the hearing, DSGI did not dispute the general efficacy of DBT treatment. However, DSGI did dispute whether R.H.'s presentation merited "immersion" DBT, i.e., a residential inpatient admission.

13. McLean Hospital's 3 East DBT program is self-pay and requires a minimum stay of 28 days. The program does not accept insurance and does not assist patients with insurance reimbursement efforts. Because of its stance on insurance, the 3 East DBT program is obviously not an in-network provider under the Plan. Prior to admission, Petitioner was aware that the 3 East DBT program did not accept insurance.

14. R.H. was in residential treatment at McLean Hospital from September 9, 2015, through September 22, 2015.

15. While at McLean Hospital, R.H. engaged in restricting and purging behaviors that led to medical instability. She was discharged to Cambridge Eating Disorder Center on September 23, 2015. She remained at the Cambridge Center until October 15, 2015. R.H.'s stay at the Cambridge Center was pre-certified by New Directions and is not at issue in this proceeding.

16. On October 15, 2015, R.H. returned to McLean Hospital, again as a residential inpatient admission. She remained at McLean Hospital until her discharge on December 11, 2015.

17. The total billed amount for R.H.'s two stays at McLean Hospital was $96,950, which was paid by the family out-of-pocket.

18. Section 3-5 of the Plan sets forth the following under the heading "Mental Health and Substance Dependency Services": "Physician office visits, Intensive Outpatient Treatment, Inpatient and Partial Hospitalization and Residential Treatment Services are covered based on medical necessity."

19. The general definition of "Medically Necessary" is set forth at section 15-4 of the Plan:

> [s]ervices required to identify or treat the Illness, injury, Condition, or Mental and Nervous Disorder a Doctor has diagnosed or reasonably suspects. The service must be:
>
> 1. consistent with the symptom, diagnosis and treatment of the patient's Condition;
>
> 2. in accordance with standards of good medical practice;
>
> 3. required for reasons other than convenience of the patient or the Doctor;
>
> 4. approved by the appropriate medical body or board for the illness or injury in question; and
>
> 5. at the most appropriate level of medical supply, service, or care that can be safely provided.
>
> The fact that a service, prescription drug, or supply is prescribed by a Doctor does not necessarily mean that the service is Medically Necessary. Florida Blue, CVS/Caremark, and DSGI determine whether a

service, prescription drug, or supply is Medically Necessary.

20. New Directions' Medical Necessity Criteria guidelines provided the following admission criteria for psychiatric residential admissions:

Must meet all of the following:

1. A DSM diagnosis is the primary focus of active, daily treatment.

2. There is a reasonable expectation of reduction in behaviors/symptoms with treatment at this level of care.

3. The treatment is not primarily social, custodial, interpersonal, or respite care.

4. The member has documented symptoms and/or behaviors that are a significant deterioration from baseline functioning and create a significant functional impairment in at least three (3) of the following areas:

   a. primary support
   b. social/interpersonal
   c. occupational/educational
   d. health/medical compliance
   e. ability to maintain safety for either self or others

5. Must have one of the following:

a. The member's family members and/or support system demonstrate behaviors that are likely to undermine goals of treatment, such that treatment at a lower level of care is unlikely to be successful. This lack must be situational in nature and amenable to change as a result of the treatment process and resources identified during a residential confinement.

b. The member has a documented history of an inability to be managed at an intensive lower level of care.

c. There is a recent (in the last six months) history of multiple brief acute inpatient stays without a successful transition to a lower level of care, and at risk of admission to inpatient acute care.

21. New Directions' Medical Necessity Criteria guidelines provided the following admission criteria for eating disorder residential admissions:

Must meet 1-4 and either 5, 6, or 7

1. A DSM diagnosis found in the Feeding and Eating Disorder section is the primary focus of active, daily treatment.

2. There is a reasonable expectation of reduction in behaviors/symptoms with treatment at this level of care.

3. The treatment is not primarily social, custodial, interpersonal, or respite care.

4. The member has documented symptoms and/or behaviors that are a significant deterioration from baseline functioning and create a significant functional impairment in at least three (3) of the following areas:

a. primary support
b. social/interpersonal
c. occupational/educational
d. health/medical compliance
e. ability to maintain safety for either self or others

5. Must have one of the following:

a. The member's family members and/or support system demonstrate behaviors that

are likely to undermine goals of treatment, such that treatment at a lower level of care is unlikely to be successful. This lack must be situational in nature and amenable to change as a result of the treatment process and resources identified during a residential confinement.

b. The member has a documented history of an inability to be managed at an intensive lower level of care.

c. There is a recent (in the last six months) history of multiple brief acute inpatient stays without a successful transition to a lower level of care, and at risk of admission to inpatient acute care.

6. There are active biomedical complications that require 24-hour care, including, but not limited to:

	Adults	Children/Adolescents
Pulse	<40	<50
Blood Pressure	<90/60	<80/50
Orthostatic changes in BP (Supine to standing)	Systolic: >20 point drop Diastolic: > 10 point drop	Systolic: > 20 point drop Diastolic: > 10 point drop
Potassium	< 3 meq/l	Hypokalemia
Body temperature	< 97 F	Abnormal core temperature
Electrolytes/ serum chemistry	Significant deviation from normal	Significant deviation from normal

7. Must have either a. or b.:

a. A low body weight that can reasonably lead to instability in the absence of intervention as evidenced by one of the following:

i. Less than 85% of IBW or a BMI less than 16.5.

ii. Greater than 10% decrease in body weight within the last 30 days.

iii. In children and adolescents, greater than 10% decrease in body weight during a rapid growth cycle.

b. Persistence or worsening of eating disorder behavior despite recent (with [sic] the last three months), appropriate therapeutic intervention in a structured eating disorder treatment setting. If PHP or IOP is contraindicated, documentation of the rationale supporting the contraindication is required. One of the following must be present:

i. Compensatory behaviors (binging, purging, laxative abuse, excessive exercise, etc.) have caused significant physiological complications.

ii. Compensatory behaviors occur multiple times daily and have failed to respond to treatment at a lower level of care and acute physiologic imbalance can reasonably be expected.

22. New Directions' contact notes for this case indicate that it was called by someone named "Rachelle" on behalf of A.H.'s family on September 3, 2015. This person asked about the authorization process for McLean Hospital. No witness was presented who had direct knowledge of the contents of this conversation. The note indicates that "Rachelle" was advised that any authorization process must be initiated with New Directions by McLean Hospital.

23. On September 9, 2015, the day R.H. was admitted to McLean Hospital, Florida Blue received what its notes reference as a "critical inquiry" message regarding this admission. A Florida Blue employee phoned the number attached to the message but discovered it was not for A.H. but for "someone at AllState Insurance who is out of the office." (This person turned out to be Pearl Harrison, R.H.'s grandmother and qualified representative in this proceeding, who had not yet obtained a release to receive confidential medical information concerning R.H.). No number for A.H. could be found. Florida Blue contacted New Directions, which confirmed that no request for pre-authorization[3/] had been received from McLean Hospital or the member.

24. R.H.'s stays at McLean Hospital were not emergency admissions. The term "medical emergency" was not specifically defined in the 2015 Plan, but expert testimony at the hearing established that it is a term of common meaning and usage in the medical community. An emergency situation is one in which there is an immediate risk of death, serious bodily harm, or creation of an irreversible condition. If care is not administered immediately, the person will harm herself or someone else. Michael Shaw, the utilization management team leader for New Directions, explained that emergency care is not provided at the

residential level of care, but in an inpatient setting under lock and key.

25. The medical records indicated that R.H.'s last incident of self-harming behavior occurred about a week prior to her admission to McLean Hospital. Her injuries were superficial and she was in no immediate danger or risk of irreversible damage.

26. Section 7-1 of the Plan provides for hospital admissions, including the following pertinent language as to non-emergency admissions to non-network hospitals and pre-certification for stays at non-network hospitals:

> Non-Network Hospital: Non-emergency Admission
>
> Every non-emergency admission to a non-network Hospital must be pre-certified. This means that before services are provided Florida Blue must certify the Hospital admission and provide the number of days for which certification is given. Precertification of non-network Hospital stays is your responsibility, even if the Doctor admitting you or your dependent to the Hospital is a Network Provider. Failure to obtain pre-certification will result in penalties (higher out-of-pocket costs). For more information on penalties, see "If You Do Not Pre-Certify Your Stay" within this section below.
>
> To pre-certify your stay in a non-network Hospital, ask your Doctor to call Florida Blue at (800) 955-5692 before your Hospital admission and provide the reason for hospitalization, the proposed treatment or

surgery, testing, and the number of Hospital days anticipated.

Florida Blue will review your Doctor's request for admission certification and immediately notify your Doctor or the Hospital if your admission has been certified and the number of days for which certification has been given. If the admission is not certified, your Doctor may submit additional information for a second review.

If your Hospital stay is certified and you need to stay longer than the number of days for which certification was given, your Doctor must call Florida Blue to request certification for the additional days. Your Doctor should make this call as soon as possible.

* * *

If You Do Not Pre-Certify Your Stay: Non-Network Hospital

1. Benefits for covered services will be reduced by 25 percent of the covered charges, not to exceed a maximum benefit reduction of $500 IF you are admitted to a participating Hospital (Payment for Hospital Services or PHS Provider)[4/] that is not part of the Preferred Patient Care (PPC) Network and admission certification has not been requested on your behalf or the request is denied.

2. This Plan will not pay room and board benefits for your first two days of hospitalization IF your non-network Hospital admission is denied, but you are admitted to a non-network Hospital anyway.

3. This Plan will not pay room and board benefits for your entire Hospital stay IF you are admitted to a non-network Hospital

without having your Doctor call prior to the admission.

4. This Plan will not pay room and board benefits for the additional days that were not certified IF your non-network Hospital admission is certified but your stay is longer than the number of days for which the admission was certified.

27. The Plan's pre-certification requirement was not met. Neither A.H. nor McLean Hospital requested pre-certification. Mr. Shaw testified that he spoke to three different people at McLean Hospital, all of whom stated that the 3 East DBT program does not accept or work with insurance. Mr. Shaw was unable to generate the paperwork needed to begin the pre-certification process because McLean Hospital declined to share with him the necessary clinical information about R.H.[5/]

28. Although pre-certification was not obtained for R.H.'s stays at McLean Hospital, Florida Blue conducted a post-service review to determine whether the claim was eligible for reimbursement.

29. Petitioner submitted a request for a Level I appeal pursuant to Section 12 of the Plan, under which a person denied benefits or payment of a claim for medical services may obtain a review by Florida Blue. Petitioner submitted a package of R.H.'s medical records for review.

30. Prest & Associates, Inc., a URAC-approved independent review organization,[6/] was retained to conduct an independent

review of Petitioner's claim. Dr. Barbara Center, a staff psychiatrist with Prest & Associates, performed a review designed to determine the medical necessity of R.H.'s stays at McLean Hospital. Dr. Center is board-certified in General Psychiatry, Child and Adolescent Psychiatry, and Addiction Medicine.

31. Dr. Center reviewed the claim in terms of the New Directions criteria for psychiatric residential admissions and for eating disorder residential admissions. She performed two reviews, one for the admission starting on September 9, 2015, and another for the admission starting on October 15, 2015.

32. Dr. Center stated that the McLean Hospital medical records provided by Petitioner gave a detailed description of R.H.'s history of present illness, past psychiatric history, and other elements of her history that were adequate for making a medical necessity determination.

33. As to the September 9 admission, Dr. Center concluded that medical necessity criteria were not met for either a psychiatric residential or an eating disorder residential admission. As to the psychiatric residential criteria, Dr. Center concluded that R.H.'s admission failed to satisfy criteria 3, 4, and 5.

34. Dr. Center testified that criterion 4 looks at symptoms and behaviors that represent a significant

deterioration from the patient's baseline functioning in several areas. R.H.'s primary support structures were stable. Her mother was clearly involved in her care and had the support of other family members. Dr. Center stated that the medical records showed no sign of substantial social or interpersonal deterioration, aside from some typical difficulty in starting high school. R.H. was having no medical instability at the time of admission. She was not at a dangerously low body weight. She had a recent onset of self-harming behaviors, but there was no documentation of acute risk issues that warranted placement in 24-hour care.

35. As to criterion 5, Dr. Center testified that the records showed no indication that R.H.'s family and support system was unsupportive or unable to take her to treatment and participate in her care. There was no documentation that R.H. could not progress in a less intensive level of care. Dr. Center noted that R.H.'s prior treatment for eating disorders had been at varying levels of care and that R.H. had not had multiple brief acute inpatient stays.

36. Criterion 3 is a diagnosis of exclusion, meaning that if there is no apparent medical necessity for the residential placement, then the reason must be "primarily social, custodial, interpersonal or respite care." Dr. Center found in the records no support for a 24-hour residential placement. She noted that

R.H.'s self-injury was of a recent onset and that McLean Hospital had ruled out any immediate prospect of self-injury or serious threat to other people. Cutting is not uncommon among adolescents and does not rise to the level of requiring residential care. Mental health providers distinguish between self-injurious behaviors and suicidal ideation, and McLean Hospital did not describe R.H. as suicidal.

37. Dr. Center testified that, at the request of Mr. Shaw, she also reviewed R.H.'s admission in terms of the New Directions eating disorder residential criteria. Dr. Center noted that R.H. was not at a dangerous body weight (122 pounds, with a BMI of 22.2) at the time of her admission on September 9. There was no indication of medical instability or of out-of-control eating disorders requiring 24-hour care. Dr. Center testified that DBT is routinely taught on an outpatient basis and that she recommended outpatient treatment for the stay beginning on September 9. She opined that R.H. did not meet numbers 3 through 7 of the New Directions eating disorder residential criteria.

38. As to the McLean Hospital admission beginning on October 15, 2015, Dr. Center recommended intensive outpatient treatment. Dr. Center knew that R.H. had been transitioned from McLean Hospital to the Cambridge Center to address the eating disorder as her primary symptom. Dr. Center felt that

continuing R.H. in an intensive outpatient setting would help her stabilize and maintain the progress she had made at the Cambridge Center.

39. Dr. Center stated that a basic tenet of medical care, and especially psychiatric care, is that the patient be treated in the least restrictive setting possible under the circumstances. She stated that it is always best to treat people in the environment they live in. Treatment in the 24-hour residential setting removes the patient from the stressors she will have to deal with when she goes home.

40. Upon her readmission to the McLean Hospital from Cambridge Center, R.H. denied suicidal ideation and homicidal ideation, and the record disclosed nothing to indicate suicidal thoughts. R.H. denied auditory or visual hallucinations and her mood was described as "euthymic," i.e., essentially normal.

41. Dr. Center acknowledged that the medical record showed that R.H. had been in intensive outpatient treatment for her eating disorder at the Renfrew Center in Florida from July 23 through August 21, 2015, with limited success. Dr. Center stated that the issue for R.H. had recently changed from her eating disorder to her self-harming behavior and believed that an intensive outpatient program focusing on skills to deal with self-injurious behaviors would be the appropriate placement under the circumstances.

42. Dr. Center also acknowledged that her review did not include the records of R.H.’s treating psychiatrist and therapist during her stay at Renfrew, and that their notes indicated that R.H.’s condition had regressed while in intensive outpatient care. Dr. Center testified that these records might have persuaded her to recommend a higher level of care, such as a partial hospital program, but that she still would not have recommended residential placement.

43. After Dr. Center rendered her opinion that R.H.’s residential stays at McLean Hospital were not medically necessary, the claim was reviewed by Dr. Frank Santamaria, Florida Blue’s care management medical director. In rendering his opinion, Dr. Santamaria reviewed the medical records sent by Petitioner and McLean Hospital, the log of contact notes kept by New Directions, and Dr. Center’s report.[7/] He testified that the available records were adequate to allow him to render an opinion as to medical necessity.

44. Dr. Santamaria concluded that, as to the New Directions criteria for psychiatric residential admissions, R.H. failed to meet criteria 3, 4, and 5. He opined generally that when assessing the need for a residential stay, he is looking for someone who is at risk of self-harm or harming others or who has an acute severe psychiatric condition such as a psychotic disorder that requires confinement. Dr. Santamaria noted that

R.H.'s eating disorder was not the primary concern at the time of her admissions to McLean Hospital; however, because the eating disorder was occurring at the same time as the psychiatric problem, he was also looking for medical manifestations of the eating disorder, such as severe weight loss affecting blood chemistry.

45. Criterion 4 requires documented symptoms and/or behaviors that are a significant deterioration from baseline functioning and create a significant functional impairment in at least three of five listed areas. Under area 4a, "primary support," Dr. Santamaria noted that R.H. had good support from her mother and grandmother. He did not believe that primary support was a problem.[8/]

46. As to area 4b, "social/interpersonal," the notes indicated that R.H. recently had an altercation with a friend. Dr. Santamaria did not find such an altercation out of the ordinary for a 15-year-old and thus found no functional impairment under 4b.

47. Area 4c, "occupational/educational," appeared to pose no problem because the records indicated that R.H. was an A-B student, despite her rocky first week of high school.

48. As to area 4d, "health/medical compliance," Dr. Santamaria noted that R.H. had been compliant with medical

instructions and her family had been good about seeking care for her.

49. As to area 4e, "ability to maintain safety for either self or others," Dr. Santamaria acknowledged that R.H. had hit her hand with a hammer and acted in other self-injurious ways, chiefly superficial cutting. He testified that such behaviors are not uncommon in younger populations and do not necessarily make the person a candidate for residential care. Self-injury alone does not satisfy the criterion, unless there is a concern for suicide or homicide. The hammer incident occurred in August, at least one week before R.H.'s admission to McLean Hospital. The McLean Hospital admission note of September 9, 2015, indicates no reported history of suicidal thinking. Dr. Santamaria found no documentation to indicate R.H. was aggressive against herself or others. She had no acute conditions such as psychotic disorders.

50. Dr. Santamaria noted that even if area 4e were deemed to have been met, criterion 4 requires significant functional impairment and degradation from baseline functioning in at least three of the listed areas, and that R.H. at most satisfied one area of the criterion.

51. Criterion 5 of the New Directions psychiatric residential criteria requires that one of three conditions relating to the patient's support system or treatment history be

met. Dr. Santamaria concluded that none of the three conditions were met. Condition 5c requires a recent history of multiple brief acute inpatient stays without a successful transition to a lower level of care. Dr. Santamaria conceded that the record he examined disclosed little information about prior therapies that had been tried with R.H., but he concluded that the record was sufficient to confirm that R.H. did not have multiple brief inpatient stays. He was reasonably confident that McLean Hospital would have documented such stays had they occurred because they would be a very significant part of her history. Dr. Santamaria also noted that R.H. had been able to transition to an intensive outpatient program from her inpatient admission to the Renfrew Center in May 2015.

52. Condition 5a requires that family members or the patient's support system demonstrate behaviors that are likely to undermine the goals of treatment, such that treatment at a lower level of care is unlikely to be successful. The record disclosed that R.H.'s mother, who was her custodial guardian, had a history of substance abuse but had gone through a rehabilitation program, attended Narcotics Anonymous regularly, and had been sober for one year at the time of R.H.'s October 15, 2015, admission to McLean Hospital. Dr. Santamaria testified that if R.H.'s mother were currently using drugs and R.H. had nowhere else to go, then condition 5a might be met.

However, the actual situation presented by the medical record did not establish that R.H. was living in an unsafe environment that could undermine her treatment.

53. As to condition 5b, a documented history of an inability to be managed at an intensive lower level of care, Dr. Santamaria concluded that R.H. had responded to various therapies in the past.

54. As noted above, criterion 3 of the New Directions psychiatric residential criteria is exclusionary, i.e., if the placement appears not to be medically necessary, then one begins to seek another motivation, such as the desire for a change of pace or a respite for the family. Dr. Santamaria noted that DBT does not require placement at the residential level. It can be done at an intensive outpatient or partial hospitalization level, both of which are lower levels of care than residential.[9/] This fact made Dr. Santamaria suspect that the prime motive for R.H.'s placement may have been custodial.

55. Dr. Santamaria testified that he also analyzed R.H.'s admission under the New Directions eating disorder residential criteria. He stated that he could not be certain from the record whether McLean Hospital was treating R.H.'s eating disorder, as well as providing DBT, but he knew that McLean Hospital was mindful of the eating disorder. He also knew that R.H.'s transfer to the Cambridge Center was partly because her

eating disorder was becoming worse. Dr. Santamaria concluded that R.H. did not satisfy criteria 3 through 7 for an eating disorder residential admission.

56. Dr. Santamaria testified that R.H. did not meet eating disorder residential criteria 3 through 5 for the same reasons she did not meet the identical criteria 3 through 5 of the psychiatric residential criteria.

57. Criterion 6 concerns biomedical complications of an eating disorder. Dr. Santamaria reviewed the medical records and concluded that R.H. presented none of the complications that would require 24-hour care at the time of her admission on September 9, 2015.

58. Dr. Santamaria likewise found that R.H. satisfied neither factor 7a nor 7b of Criterion 7. As to 7a, R.H. did not present with a low body weight and there was no documentation that she had lost 10 percent of her body weight in the last 30 days. As to 7b, there was no evidence that R.H.'s "compensatory behaviors," i.e., binging and purging, had caused "significant physiological complications" or that such behaviors occurred multiple times daily and did not respond to treatment "at an intensive lower level of care."

59. Dr. Santamaria testified that his analysis as to the October 15, 2015, admission was identical to that for the September 9, 2015, admission. As to both admissions, he

believed that intensive outpatient was the appropriate level of care. Dr. Santamaria defined "intensive outpatient" as three hours of intensive therapy for at least three days per week. He believed that this level of care could address all of R.H.'s issues, including her self-injurious behavior.

60. Dr. Santamaria concluded that if R.H. tried the intensive outpatient level of care and failed, then a higher level could be considered. Like Dr. Center, he stated that he might have recommended a partial hospitalization setting had he known that intensive outpatient had been tried and failed, but he still would not have recommended a 24-hour residential admission.

61. Petitioner's presentation implied that Florida Blue and/or Prest & Associates base their coverage decisions on financial considerations rather than strictly on the merits of the claims. Dr. Center and Dr. Santamaria both testified that they had no incentive, financial or otherwise, to deny a claim for reimbursement. Their testimony on this point is credible. Petitioner offered no direct evidence that Florida Blue or Prest & Associates directly pressure their physician employees to reject meritorious claims, and there is no evidence that Dr. Santamaria or Dr. Center based their recommendations on anything other than their assessment of R.H.'s medical records in light of the relevant medical necessity criteria.

62. Petitioner raised questions about the completeness of the records examined by Dr. Santamaria and Dr. Center and sounded a skeptical note as to the diligence of the physicians' efforts to obtain additional documentation. As found above, both Dr. Santamaria and Dr. Center testified that they had adequate documentation to render an opinion as to medical necessity in this case. Both physicians stated that in other cases they have taken additional steps to obtain missing information, including making peer-to-peer calls to the treating physicians or reaching out to the case managers, but that no such steps were necessary in this case.

63. Both physicians conceded that not all of the medical records were available to them at the time of their reviews. They did not have records from R.H.'s stays at the Renfrew Center and the Cambridge Center or the notes of R.H.'s treating physicians in Florida. Both Dr. Center and Dr. Santamaria credibly testified that nothing in these additional records would have changed their opinion as to the medical necessity of residential treatment for R.H.

64. Section 12 of the Plan, which sets forth the appeal process for a denied claim, expressly states: "Your appeal may include any additional documentation, information, evidence or testimony that you would like reviewed and considered during the appeal process." This language is included in the explanations

for both the Level I and Level II appeals. Nothing prevents the member from providing any documentation whatsoever during the appeal process. Dr. Center and Dr. Santamaria are physician reviewers, not medical investigators. If something Petitioner asserted to be relevant to the decision was missing from the files, it was not the fault of the reviewing physicians. It is ultimately the member's responsibility to provide appropriate documentation for review.

65. By letter dated April 5, 2016, Florida Blue notified Petitioner that it "remains unable to approve additional coverage and/or payment for the Residential Treatment." The letter set forth the following rationale for the denial:

> Per the State Employees' PPO Plan Booklet and Benefits Document page 5-5: "Services or supplies that are not Medically Necessary, as determined by Florida Blue and/or CVS Caremark clinical staff and Division of State Group Insurance, are non-covered." Specifically, coverage for the Mental Health (Eating Disorder) Residential stays is denied as it does not meet the definition of medical necessity. This is for hospital stay on and after 09/09/2015 and 10/15/2015. The final decision to proceed with the requested services is between the provider and the member. Records show that the member was not deemed to be a present risk to self or to others. Though the member had a preoccupation with weight sand [sic] eating, there was no evidence of inability to adequately care for self with functioning in multiple sphere areas, including stabilization of the eating disorder issues. There was no report of medical instability or psychosis. The

> member was in a body weight range. The member was described as having her eating disorder symptoms under control. From the clinical evidence, this member could have been safely treated at each occasion at a lesser level of care such as in an eating disorder intensive outpatient setting. This review was done using New Directions Clinical Care criteria and is based on the opinion of a board certified psychiatrist. Services that are not medically necessary are not covered under your health benefit plan.

66. The denial letter provided Petitioner with information regarding the Level II appeal process to DSGI, including a reference to the pertinent section of the Plan. The denial letter reiterated that Petitioner could submit any information or documentation that Petitioner believed could assist in DSGI's review of the appeal.

67. Petitioner submitted a request for a Level II appeal to DSGI on May 23, 2016. The Level II appeal was reviewed by DSGI's legal nurse coordinator, Kathy Flippo. Ms. Flippo reviewed all of the documents reviewed by Dr. Center and Dr. Santamaria, plus additional records submitted by Petitioner with the Level II appeal request.

68. Ms. Flippo determined that the stays at issue were non-emergency admissions that required pre-certification and that the pre-certification requirements of the Plan were not met.

69. Ms. Flippo reached the same conclusions as Dr. Center and Dr. Santamaria regarding the New Directions psychiatric residential criteria. Ms. Flippo concluded that R.H. did not meet criteria 3, 4, or 5.

70. Ms. Flippo testified that she did not review the case pursuant to the New Directions eating disorder residential criteria because Petitioner's Level II appeal addressed only the psychiatric issues and because R.H.'s eating disorder stay at the Cambridge Center was covered by Florida Blue.

71. By letter dated July 29, 2016, signed by Tami Fillyaw, director of DSGI, Petitioner was informed that the Level II appeal had been denied. The letter informed Petitioner of his rights under the Plan to file a petition for a formal or an informal hearing contesting the denial of the appeal and/or to request a binding external review from an Independent Review Organization ("IRO").[10/] Petitioner requested both an administrative hearing and an external review.[11/]

72. The external review was conducted under the auspices of the Medical Review Institute of America, Inc. ("MRIoA"), a URAC-accredited external review network. The MRIoA assigned a physician whom it stated is board-certified by the American Board of Psychiatry and Neurology in the specialties of General Psychiatry and Child & Adolescent Psychiatry.[12/] The external

review upheld the adverse determinations regarding coverage for the McLean Hospital stays.

73. In its decision letter dated November 11, 2016, the MRIoA provided the following relevant clinical summary and findings:

> At the time in question, the patient was a 15 year old female with a variety of difficulties related to depression, anxiety, eating disorder symptoms, and symptoms of obsessive compulsive disorder (OCD) with self-harming behaviors. This review has to do with a question of whether residential treatment center (RTC) level of care (LOC) for two episodes of service 9/9/15-9/22/15 and 10/15/15-12/11/15 met the plan criteria for medical necessity. It is noted that the patient was treated in a special eating disorders program on the dates between these two episodes.
>
> * * *
>
> The patient's presentation did not meet the plan criteria for medical necessity for the dates in question. Specifically, the patient did not meet criteria #5 of the Admission Criteria. The patient is noted to have a caring and effective support system that would have supported a less intensive level of care. There was no recent history of inability to be effectively treated at an intensive level of service below residential treatment center (RTC) level of care (LOC), and there was no recent history of inability to transition from inpatient treatment into a less intensive level of care.
>
> At the time of admission to residential treatment, it is clear that the patient struggled with mood dysregulation along with episodes of food restriction and self-harming behaviors. She was not responding

to attempts at outpatient treatment. The residential program in question was sought out specifically due to its approach to the utilization of DBT (dialectical behavior therapy). However, there is no indication that the patient could not have responded to attempts to escalate her treatment in the outpatient setting through the use of either intensive outpatient or partial hospitalization services. In particular, the patient could have been involved in a formal DBT program without utilization of residential treatment. Her symptom severity for the dates in question was not of a severity to require the use of round the clock observation and treatment. As a result, there was no medical necessity for residential treatment center (RTC) level of care (LOC).

* * *

The appeal letters from the patient's family, outpatient providers, and residential facility discuss the need for residential treatment due to the patient's symptoms severity, particularly the patient's episodes of self-harming behavior and the need for her to participate in the immersive DBT program utilized at the residential program in question. The patient's need for more intensive treatment is acknowledged. However, the patient's recent treatment history was one of outpatient treatment with a previous history of residential treatment for eating disorder symptoms. For the DOS in question, the patient could have obtained appropriate and effective DBT in a less restrictive setting, such as either a partial hospitalization program (PHP) or an intensive outpatient program (IOP).

Based on the above, the previous determination has been upheld.

74. At the hearing, Petitioner complained that, prior to receiving the letter denying the Level II appeal, he had no inkling that medical necessity determinations were based on criteria produced by New Directions. The Plan's definition of "medically necessary" does not reference the fact that Florida Blue relies on the New Directions criteria for medical necessity determinations in psychiatric and eating disorder admissions. Petitioner basically argues that not having the precise language of the New Directions medical necessity criteria deprived him and the medical providers of the ability to frame the coverage requests in such a way as to satisfy the criteria.

75. The record evidence shows Florida Blue does not make the New Directions medical necessity criteria directly available to its members. In fact, New Directions is nowhere mentioned in the Plan. Witnesses for DSGI correctly stated that anyone can download the criteria from the New Directions website, but Petitioner pointed out that one must be aware the criteria exist before one can download them. If this case is typical, it appears that a Florida Blue member must be denied coverage and go through the appeal process before Florida Blue makes him aware of precisely how the determination of medical necessity is made.

76. Dr. Santamaria testified that Florida Blue does not expect its members to have any knowledge of the New Directions

criteria or to "understand all the medical jargon." The member is expected to present Florida Blue with the best and most accurate medical information available (preferably before the services are rendered) and rely on Florida Blue to make the decision.

77. Dr. Santamaria stated, "Your role is not to do the utilization management. That's my role. Your role is, if you disagree with a coverage determination, to appeal it and to even have your doctor speak on your behalf or write a letter or do whatever. It's not your role to access the documents and to use them on your own. That--that's not what they were created for."

78. Dr. Santamaria emphasized that the member's "role" is not to "meet criteria" but to provide Florida Blue with information sufficient to allow its experts to apply the criteria. While his phrasing may be condescending, Dr. Santamaria's statement is basically accurate: the medical records determine whether the criteria have been met. Petitioner's awareness of the particulars of the criteria would not change the substance of the medical record.

79. The undersigned tends to agree with Petitioner that Florida Blue's process could be more transparent. However, Petitioner failed to show how the outcome would have been different if the New Directions medical necessity criteria had been available to him or McLean Hospital. Every expert who

examined the medical records agreed that R.H. did not meet the criteria for medical necessity. Their opinions are credited.

80. Ms. Flippo emphasized that Florida Blue did not deny coverage merely because McLean Hospital's 3 East DBT program was self-pay. If the member had been able to obtain pre-certification for hospitalization and a proper bill had been presented to Florida Blue, it would have been covered at the allowable non-network coverage amount.

81. Ms. Flippo also stated that even if pre-certification had been obtained, Florida Blue would certainly not have covered the 70 days that R.H. spent in McLean Hospital. Ms. Flippo had never seen more than 15 days at a time approved, even for members who were floridly psychotic and admitted under the Baker Act. With modern treatments and medications, it is seldom necessary to keep patients at a residential level of care for months at a time. All of the experts agreed that DBT is more commonly provided on an outpatient basis.

82. Additionally, Mr. Shaw pointed out that the ability of the insurer to pay the non-contracted, non-network rate to the hospital is contingent on the hospital's willingness to accept insurance payments. McLean Hospital's 3 East DBT program did not accept insurance. Mr. Shaw succinctly stated, "We're not obligated to pay you back because you made the choice to go to a facility that takes your money but not ours."

CONCLUSIONS OF LAW

83. The Division of Administrative Hearings has jurisdiction of the subject matter of and the parties to this proceeding. §§ 120.569 and 120.57(1), Fla. Stat.

84. Respondent is the agency charged by the Legislature with the duty to oversee the administration of the State Group Insurance Program, including the group disability insurance program.

85. Section 110.123, titled "State Group Insurance Plan," describes the powers and duties conferred on Respondent as follows, in relevant part:

> (5) DEPARTMENT POWERS AND DUTIES.— The department is responsible for the administration of the state group insurance program. The department shall initiate and supervise the program as established by this section and shall adopt such rules as are necessary to perform its responsibilities. To implement this program, the department shall, with prior approval by the Legislature:
>
> (a) Determine the benefits to be provided and the contributions to be required for the state group insurance program. Such determinations, whether for a contracted plan or a self-insurance plan pursuant to paragraph (c), do not constitute rules within the meaning of s. 120.52 or final orders within the meaning of s. 120.52. Any physician's fee schedule used in the health and accident plan shall not be available for inspection or copying by medical providers or other persons not involved in the administration of the program. However, in the determination of the design of the

> program, the department shall consider existing and complementary benefits provided by the Florida Retirement System and the Social Security System.
>
> * * *
>
> Final decisions concerning enrollment, the existence of coverage, or covered benefits under the state group insurance program shall not be delegated or deemed to have been delegated by the department.

86. The general rule is that the burden of proof, apart from a statutory directive, is on the party asserting the affirmative of an issue before an administrative tribunal. Young v. Dep't of Cmty. Aff., 625 So. 2d 831, 833-834 (Fla. 1993); Dep't of Transp. v. J.W.C. Co., Inc., 396 So. 2d 778, 788 (Fla. 1st DCA 1981); Balino v. Dep't of HRS, 348 So. 2d 349, 350 (Fla. 1st DCA 1977). Petitioner, as the party asserting the right to payment of his claim under the State Employees' PPO Plan, has the initial burden of demonstrating by a preponderance of the evidence that his claim qualified for coverage. If Petitioner meets this requirement, the burden shifts to Respondent to prove that the claim was not covered due to the application of a policy exclusion. Herrera v. C.A. Seguros Catatumbo, 844 So. 2d 664, 668 (Fla. 3d DCA 2003); State Comp. Health Ass'n v. Carmichael, 706 So. 2d 319, 320 (Fla. 4th DCA 1997).

87. 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).

88. Based on the Findings of Fact set forth above, Petitioner has not met his initial burden of demonstrating entitlement to reimbursement for R.H.'s stays at McLean Hospital's 3 East DBT program.

89. The Plan provides coverage for mental health treatment at the residential level of care only if the residential treatment is medically necessary.

90. The Plan requires non-emergency hospital stays to be pre-certified. Pre-certification requires a review of the claim for medical necessity prior to the provision of the service.

91. Petitioner provided no evidence to demonstrate that either of R.H.'s admissions to McLean Hospital was an emergency. DSGI's expert witnesses all agree that the admission was not an emergency.

92. Petitioner provided no evidence that he sought pre-certification. At best, the evidence indicates that Petitioner,

or some person on his behalf, made inquiries regarding coverage for the McLean Hospital stay shortly before R.H.'s first admission. The evidence established that New Directions attempted to address the issue but was rebuffed by McLean Hospital, which steadfastly refused to cooperate with the insurer, in keeping with its self-pay only policy. Petitioner clearly understood McLean Hospital's policy. The evidence was uncontroverted that McLean Hospital is a non-network provider.

93. His failure to obtain pre-certification notwithstanding, Petitioner was afforded the opportunity to have Florida Blue review the claim for medical necessity on a post-service basis.

94. Dr. Center, Dr. Santamaria, Ms. Flippo, and the MRIoA all completed independent reviews of the medical records for medical necessity and all concluded that the criteria were not met for either stay at McLean Hospital. The experts were unanimous in concluding that the residential level of care was not the most clinically appropriate level of care for R.H. at the time of either admission. Petitioner disagreed with the experts' conclusions but presented no countervailing evidence.

95. The Plan clearly states that the determination of medical necessity is made by Florida Blue and DSGI, not by the patient's treating physician. In this context, "medical necessity" is a definition used to establish coverage under the

Plan. “Medical necessity” does not limit the treating physician’s diagnostic and prescriptive options or prevent the Plan member from following the advice of the treating physician. However, the member must understand that the Plan is not required to cover the costs associated with a service outside the bounds of “medical necessity.”

96. Petitioner failed to meet his burden of demonstrating that the pre-certification requirement was met or that the services provided to R.H. were medically necessary for purposes of coverage under the Plan.

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 Insurance, issue a final order denying Petitioner’s claim for coverage under the State Employees’ PPO Plan for R.H.’s residential treatment at McLean Hospital from September 9, 2015, to September 30, 2015, and October 15, 2015, to December 11, 2015.

DONE AND ENTERED this 17th day of May, 2017, in Tallahassee, Leon County, Florida.

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

Filed with the Clerk of the
Division of Administrative Hearings
this 17th day of May, 2017.

ENDNOTES

[1/] The 2015 edition of the New Directions Medical Necessity Criteria is applicable to this case. Tara Adams, New Directions' regional clinical director, testified that the criteria are reviewed annually by the company's chief medical officer to ensure that the processes and standards of care are up to date.

[2/] R.H.'s stay at the Renfrew Center occurred before she was added to her father's policy on September 1, 2015.

[3/] The terms "pre-certification" and "pre-authorization" are used interchangeably in practice.

[4/] The PPO Plan defines PHS Providers as those "not in the Preferred Patient Care Network but who have a Hospital services agreement with Florida Blue to provide services, as Florida Blue PHS Providers, at a negotiated fee."

[5/] Indeed, the first McLean Hospital employee with whom Mr. Shaw spoke declined even to confirm that R.H. was a patient there. The hospital was entirely uncooperative regarding insurance billing.

[6] The Utilization Review Accreditation Commission is a nonprofit health care review and accreditation organization. In 1996, it officially changed its name to the acronym "URAC."

[7] At the hearing, Dr. Santamaria testified prior to Dr. Center. His testimony was lengthier and more detailed than Dr. Center's, largely because Dr. Center was present for Dr. Santamaria's testimony, agreed with nearly all of his analysis, and saw no need to repeat it. This is by way of explaining why the findings as to Dr. Santamaria's testimony are more detailed than those regarding Dr. Center's.

[8] Petitioner adamantly contested the family support issue. R.H. lived with her mother, a recovering addict who had been sober for a year and regularly attended Narcotics Anonymous. A.H. lived an hour away, and Ms. Harrison lived 300 miles away. Every testifying expert examined R.H.'s current family situation and found nothing about it that tended to undermine her treatment. Mr. Shaw pointed out that the family was able to pay $96,000 out-of-pocket for R.H.'s treatment and wished aloud that he had such support. While R.H.'s family situation may not have been ideal, it did not rise to the level of meeting criteria for 24-hour residential treatment.

[9] Mr. Shaw of New Directions testified that in his experience, 99 percent of people who choose DBT treatment obtain it on an outpatient basis.

[10] More specifically, an IRO decision reversing the denial of coverage would be binding on DSGI and allay the need for an administrative hearing; an IRO decision upholding the denial would not affect the member's right to pursue the administrative hearing.

[11] DSGI reasonably delayed referring Petitioner's administrative hearing request to DOAH until after the external review was completed.

[12] Oddly, the physician's full name is not given in the MRIoA's denial letter.

COPIES FURNISHED:

Pearl Harrison
3783 Hunt Club Road
Jacksonville, Florida 32224

Anita J. Patel, Esquire
Department of Management Services
Suite 160
4050 Esplanade Way
Tallahassee, Florida 32399
(eServed)

J. Andrew Atkinson, General Counsel
Office of the General Counsel
Department of Management Services
4050 Esplanade Way, Suite 160
Tallahassee, Florida 32399-0950
(eServed)

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.