STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[redacted]

PETITIONER,

vs.

FLORIDA DEPT OF CHILDREN AND FAMILIES
CIRCUIT: 05 Marion
UNIT: 88999

RESPONDENT.
_____/

APPEAL NO. 14F-10000

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, an administrative hearing convened before Hearing Officer Patricia Antonucci on December, 2014 at approximately 11:30 a.m. and reconvened on March 10, 2015 at 11:30 a.m. Both parties appeared via teleconference.

APPEARANCES

For the Petitioner: Elsie Cabrera, Public Benefits Coordinator,
Ocala Regional Medical Center

For the Respondent: Evelyn Ross, ACCESS Division of Disability Determination (DDD) Supervisor,
Department of Children and Families

STATEMENT OF ISSUE

At issue is whether Respondent, the Department of Children and Families (DCF of 'the Department'), was correct to deny Petitioner's request to for retroactive SSI-Related Medicaid, for March 2014.

PRELIMINARY STATEMENT

Petitioner was not present, but was represented by Elsie Cabrera, Public Benefits Coordinator at Ocala Regional Medical Center. Respondent was represented by Evelyn Ross, ACCESS DDD Supervisor with DCF.

Respondent's Exhibits 1 through 8, inclusive, were accepted into evidence. Following testimony, the record was held open for both parties to supplement the record and to exchange documentation referenced during hearing but not filed or copied to the opposing party. Additional time was allotted to allow for both parties to respond to material received after hearing.

Following receipt of supplemental documentation, the undersigned determined that this matter would reconvene in order to ensure that a full record was secured. By interim order, Respondent's Exhibits 9 through 17 and Petitioner's Exhibits 1 and 2 were entered into evidence prior to reconvening.

Pursuant to notice, the record was re-opened and hearing reconvened on March 10, 2015 at 11:30 a.m. Ms. Cabrera again appeared on behalf of Petitioner, and Ms. Ross on behalf of Respondent. Deborah K. Robinson with the Office of Appeal Hearings appeared as an observer.

During the reconvened hearing, Respondent referenced documentation previously filed and copied to Petitioner but not entered into evidence. This one-page document, which contains an entry in the Department's Running Record Comments dated March 11, 2014, is hereby entered as Respondent's Exhibit 18.

FINDINGS OF FACT

1. Petitioner is a 61-year-old male, born [redacted] On or about March 25, 2014, Petitioner entered Ocala Regional Medical Center, and applied for SSI-related Medicaid through the Department of Children and Families.

2. By letters (Notices) dated March 27, 2014, Petitioner was asked to complete, sign, and return an Authorization to Disclose Information and a Financial Release Form, and to participate in an eligibility interview. Said Notices also informed Petitioner, "If you do not keep your interview, we will be unable to determine your eligibility, and your application will be denied or your benefits may end."

3. Via Notice dated May 19, 2014, Respondent notified Petitioner that his application was denied (for March through June 2014), stating, "You failed to complete an interview necessary for us to determine your eligibility for this program."

4. Petitioner's representative contends that, in lieu of an interview, Petitioner filed a disability report. However, Respondent testified that this report was received and scanned into the Petitioner's file on or about July 24, 2014, along with his July application for benefits. No evidence has been presented to confirm that Petitioner filed the report prior to this date.

5. The copy of the disability report, which Petitioner admitted into evidence, was signed by Petitioner on March 20, 2014, but includes additional notations made by Petitioner's representative after that date (e.g., a reference to an April 2, 2014 hospital discharge and reference to a May 2014 doctor's visit). Petitioner's representative testified that these additions were made to update the report for subsequent Medicaid applications. Petitioner alleges a disability onset date of August 8, 2000.

6. There is also no evidence that Petitioner requested a hearing to challenge the Respondent's May 19, 2014 denial.

7. On or about July 23, 2014, Petitioner re-applied for benefits.

8. By letter dated July 24, 2014, Respondent denied this (July) application for the months of July, August, and September, noting "No household members are eligible for this program." Petitioner's representative notes that she incorrectly completed a portion of Petitioner's application, and was advised by the Department to refile same.

9. Again, there is no evidence that Petitioner appealed the Department's denial.

10. On or about August 6, 2014, Petitioner followed up with the Department's suggestion and re-applied for SSI-related Medicaid benefits.

11. By Notices dated August 11, 2014, Petitioner was asked to submit a new Authorization to Disclose Information and Financial Release Form.

12. On or about August 20, 2014, Petitioner was notified that his application for benefits was approved, such that he was eligible for Medicaid benefits, with a monthly share of cost (for August and September) of $968.00.

13. At hearing, Petitioner's representative and Respondent both confirmed that Petitioner has applied for benefits through the SSA, but was denied same in June of 2014. The denial code issued by SSA is N01; Petitioner's representative clarified that SSA denied Petitioner SSI due to receipt of an annuity and denied SSDI for lack of sufficient work history.

14. Per Ms. Ross, because SSA denied Petitioner for a non-medical reason, DCF's Division of Disability Determinations (DDD) conducted an independent disability review

upon receipt of Petitioner's medical records. It was this review which resulted in Petitioner's August Medicaid approval.

15. While no DDD representative testified at hearing, Ms. Ross explained that DDD utilized a disability determination date of May 1, 2014, and provided benefits retroactive to that date.

16. On September 9, 2014, Petitioner's representative requested an administrative hearing, asserting that because Petitioner initially applied for benefits in March of 2014, and because his medical condition and financial status were the same in March as at the time of approval (August 2014), Petitioner's benefits should be applied retroactive to the month of March.

17. Respondent requested that Petitioner's case be reviewed by the Department's Division of Disability Determination (DDD, housed at a Central Office with SSA) to determine if coverage retroactive to March 2014 was appropriate. A December 11, 2014 entry in the Department's Running Record Comments note:

> Response from SSA: This claim was allowed on 8/15/2014 with a begin date of 5/1/14 and a review date of 7/1/2021. Retro to 3/2014 can not be given.

Ms. Ross confirmed that this entry was input directly by the DDD worker who reviewed Petitioner's case.

18. In addition to the disability report, the medical records submitted by Petitioner's representative and reviewed by DDD include physician's notes from hospital admissions on March 10, 2014 and May 8, 2014, with discharge dates of April 2, 2014 and May 13, 2014, respectively.

19. Petitioner's March/April hospital records reflect that he was admitted to the hospital by paramedics, whom he called when he experienced shortness of breath and coughing. Petitioner was unresponsive upon admission, and his assessment/plan dated March 10, 2014 shows:

1. Acute respiratory failure.
2. Possible cardiogenic shock.
3. Hypotension secondary to cardiogenic shock.
4. Pneumonia.
5. Chronic obstructive pulmonary disease exacerbation.
6. Positive cardiac enzymes.
7. Leukocytosis.
8. History of coronary artery disease. The patient admitted to ICU. We will continue with the dopamine drop and Levophed drip. I just more suspect that this is more cardiogenic than sepsis that causes this hypotension and the issues, but we treat the patients with antibiotics to cover the pneumonia, order blood culture, sputum culture, and also check the cardiac enzyme, order a stat echocardiogram...and order CT of the brain and follow the patient.

20. Upon discharge on April 2, 2014, Petitioner's records reflect that patient slowly improved after his pneumonia was treated, but that his cough and shortness of breath persisted. Petitioner underwent a stress test and was found to have nonobstructive coronary artery disease. Physician notes indicate that Petitioner was "is not very compliant and not very motivated, and history of polysubstance abuse and there is drug-seeking behavior in the hospital as well." His discharge diagnoses include:

1. Cardiomyopathy with ejection fraction of 20%.
2. Bilateral pneumonia.
3. Respiratory failure.
4. Hypertension.
5. Hyperlipidemia.
6. Chronic obstructive pulmonary disease.
7. Coronary artery disease, status post stent and angioplasty.

21. Admission notes from May 8, 2014 state the Petitioner "has been recommended to have a LifeVest placed in the past, but apparently never followed through with his cardiologist to have this done. He present today with sternal chest pressure." The notes also reflect that Petitioner had previously declined all "lab draws," which impeded clearance for treatment. Surgical history was noted to include left heart catheterization as well as cervical spine repair and herniopathy. Petitioner ultimately agreed to have blood work performed, and he was assessed as follows:

1. Non-ST-elevation myocardial infarction.
2. Coronary artery disease.
3. Severe cardiomyopathy with an ejection fraction estimated less than 25%.
4. Chronic hepatitis C.
5. Hypertension.
6. Dyslipidemia.
7. Chronic generative joint disease of the cervical spine.

22. Petitioner's May 13, 2014 discharge records his discharge diagnoses as:

1. Rhabdomyolysis, improved.
2. Abnormal troponin, doubt non-ST elevation MI.
3. Acute renal failure, improved.
4. Elevated liver enzymes, acute on chronic, suspect hypotensive episode of unclear etiology.
5. History of hepatitis C.
6. Hematochezia one episode as well as secondary to likely ischemic colitis versus cocaine induced colitis by colonscopy on May 12, 2014.
7. Thrombocytopenia, cirrhosis related.
8. Leukocytosis improving.
9. Coronary artery disease.
10. Severe cardiomyopathy, ejection fraction less than 25%.
11. History of hypertension, dyslipidemia, and chronic degenerative joint disease.
12. Ulceration on the right back status post fall.
13. Aphthous ulcers, improved.
14. Hypernatremia, mild improved.

23. Although Respondent believed Petitioner had appealed the denial issued by the Social Security Administration in June of 2014, at hearing, Petitioner's representative stated that she was not aware of any such appeal.

24. Respondent has, to date, approved continuation of Petitioner's benefits. However, the Respondent affirms its position that benefits cannot be built-in beginning in March 2014.

CONCLUSIONS OF LAW

25. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat. § 409.285. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

26. This proceeding is a *de novo* proceeding, pursuant to Fla. Admin. Code R. 65-2.056.

27. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the Petitioner, who seeks retroactive coverage of Medicaid.

28. The hearing officer's review of retroactive coverage is limited, in part, by Fla. Admin. Code R. 65-2.046 (Time Limits in Which to Request a Hearing):

> (1) The appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs. ...The time period begins with the date following:
>
> (a) The date on the written notification of the decision on an application.
>
> (b) The date on the written notification of reduction or termination of program benefits.
>
> (c) The date of the Department's written notification of denial or a request or other action which aggrieves the petitioner when that denial or action is other than an

application decision or a decision to reduce or terminate program benefits.

(2) The time limitation does not apply when the Department fails to send a required notification, fails to take action of a specific request or denies a request without informing the appellant. If the notice is not mailed on the day it is dated, the time period commences on the date it is mailed.

29. Petitioner was notified that his March 2014 application for benefits was denied on or about May 19, 2014. Insofar as that decision was never appealed, and because Petitioner did not request any hearing on his Medicaid eligiblity until September of 2014, the March denial, itself, cannot be reviewed.

30. Absent review of the Respondent's determination to deny benefits, the only means by which the undersigned may review retroactive coverage is set forth in the Department's Policy Manual.

31. Policy Manual Section 0640.0509 addresses retroactive Medicaid (MSSI), noting, in pertinent part:

> Medicaid is available for any one or more of the three calendar months preceding the application month, provided:
> 1. at least one member of the SFU has received Medicaid reimbursable services during the retroactive period, and
> 2. the individual meets all factors of eligibility during the month(s) he requests retroactive Medicaid.
>
> The applicant may request retroactive Medicaid at any time, as long as the coverage period is for any one of three months prior to any Medicaid or SSI application.
> This retroactive coverage is not affected by:
> 1. the application's disposition (approval or denial);
> 2. whether or not the individual was alive at the time of the application; or
> 3. when the request for assistance or request to add was made.
>
> (emphasis added)

32. Although Petitioner contends that his financial and medical status in March of 2014 were the same as when he was approved for benefits in August of 2014, disability

could not be established based on Petitioner's March 25, 2014 application. Petitioner asserts a date of disability onset in August of 2000, but has submitted medical documentation only for the month of March, April, and May 2014. While these documents do contain information regarding Petitioner's medical history, they do not include dates of onset.

33. As Petitioner is not over the age of 65 (see Policy Manual Section 1440.1201), the only means alleged by which he might qualify for Medicaid is by nature of an established disability. Although no representative from DDD appeared at hearing to explain why May 1, 2014 was selected as the disability determination date, Petitioner's medical records from March 10, 2014 are dissimilar enough from subsequent records in May of 2014 that the undersigned is unable to conclude the same conditions which resulted in DDD's May 2014 approval were present and disabling at the time of Petitioner's March 25, 2014 application.

34. Absent evidence that the same disabling conditions were present in March of 2014, there is no proof that Petitioner met the technical requirements for Medicaid eligibility in March or April. Retroactive coverage is only built in when all eligibility factors are present for each, retroactive month.

35. With regard to SSA's denial of disability, Federal Regulations at 42 C.F.R. § 435.541, "Determinations of disability," state, in pertinent part:

> **(b)** ***Effect of SSA determinations.***
>
> **(1)** Except in the circumstances specified in paragraph (c)(3) of this section—
> **(i)** An SSA disability determination is binding on an agency until the determination is changed by SSA.
> **(ii)** If the SSA determination is changed, the new determination is also binding on the agency.

(underlined emphasis added)

36. This restriction is also incorporated into the Department's Policy Manual Section 1440.1206, which addresses continuation of DCF-determined disability benefits, noting:

> **Change in Disability Determination by SSA (MSSI, SFP)**
> When the Social Security Administration (SSA) renders a disability decision that is different than that made by DCF, the SSA decision must be adopted unless the SSA decision was based on a condition different than that which the state reviewed.
>
> If SSA determines the individual is not disabled or that the disability has ceased, action must be taken to close the SSI-Related Medicaid benefits on FLORIDA that are based upon disability, allowing for ten days advance notice of adverse action. Should the individual file a timely appeal with SSA, Medicaid benefits must be continued, pending a final decision by SSA.
>
> (underlined emphasis added)

37. Petitioner's Medicaid benefits have continued, to date. However, if Petitioner does not pursue appeal of SSA's denial, the Department may seek to terminate Petitioner's Medicaid. Should this occur, Petitioner will be provided advance notification, inclusive of new appeal rights.

38. In seeking retroactive coverage, Petitioner bears the burden to show that he meets eligibility requirements for said coverage to be built. Petitioner has not met that burden, and has not shown that Respondent incorrectly denied him disability-based Medicaid coverage retroactive to March of 2014.

39. Based upon the entire record of this proceeding, Respondent's denial of retroactive coverage was proper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner's appeal is DENIED. The Respondent's action is hereby affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 9th day of April, 2015,

in Tallahassee, Florida.

Patricia C. Antonucci

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