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

[redacted]

APPEAL NO. 14F-00240

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 17 Broward
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in this matter telephonically on February 19, 2014, at 1:15 p.m. The hearing was reconvened on February 24, 2014, at 3:45 p.m.

APPEARANCES

For the Petitioner: [redacted]
Petitioner's Mother

For the Respondent: Ken Hamblin
Area 10 Medicaid Fair Hearing Coordinator
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether the decision of the Agency for Health Care Administration to deny the Petitioner's request for payment of out-of-state medical expenses incurred as the result of an emergency is correct.

PRELIMINARY STATEMENT

[redacted] the Petitioner's mother, appeared on behalf of the Petitioner, [redacted] ("Petitioner"), who was not present. Also appearing on behalf of the Petitioner at the first hearing was the Petitioner's father, [redacted] [redacted] may sometimes hereinafter be referred to as the Petitioner's "representative".

Ken Hamblin, Area 10 Medicaid Fair Hearing Coordinator for the Agency for Health Care Administration (sometimes hereinafter referred to as the "Respondent", "AHCA", or the "Agency"), appeared on behalf of the Agency. The following appeared as witnesses on behalf of the Agency for Health Care Administration: Stacy Sarvis, Medical Health Care Program Analyst with the Agency for Health Care Administration; Emma Sosa, Grievance and Appeals Specialist with Better Health; and Rosa Nemnom, Claims Manager with Better Health.

The Petitioner introduced Petitioner's Composite Exhibit "1", inclusive, at the hearing, which was accepted into evidence and marked accordingly. The Respondent introduced Respondent's Composite Exhibit "1", inclusive, at the hearing, which was accepted into evidence and marked accordingly.

FINDINGS OF FACT

Based upon the oral and documentary evidence presented at the final hearing and on the entire proceeding, the following Findings of Fact are made:

1. The Petitioner's date of birth is [redacted].

2. Petitioner was eligible to receive Medicaid benefits at all times relevant to these proceedings.

3. The Petitioner receives her Medicaid benefits through Better Health, LLC ("Better Health"). Better Health is a Provider Service Network ("PSN") which provides services to certain Medicaid eligible individuals in Broward County, Florida.

4. The Petitioner was enrolled in Better Health on June 1, 2012.

5. The Petitioner was in Canton, Mississippi on June 14, 2013 when she had a medical emergency. She had to be transported to the emergency room of a local hospital by ambulance.

6. As a result of the emergency, the Petitioner incurred the following costs: American Medical Response South in the amount of $1,285.00 for the medical transport to the hospital; Madison River Oaks Medical Center in the amount of $7,458.92 for the emergency room visit; Madison Emergency Group, LLC in the amount of $1,447.00 for the professional fee of the attending physician at the emergency room; and Madison Radiology Associates, P.A. in the amount of $219.00 for work associated with a C-T scan performed on the Petitioner.

7. The Agency for Health Care Administration does not dispute the services were rendered or that they were rendered as the result of an emergency situation.

8. As a Provider Service Network, Better Health will forward any claims for out-of-state medical services to the Agency for Health Care Administration for final processing.

9. The Better Health Claims Manager testified that when she contacted American Medical Response South and identified herself as a representative of the Petitioner's health plan and explained Better Health would assist with the processing of

their claim, American Medical Response South stated it would not send a claim to Better Health because the charge had been written off.

10. American Medical Response South mailed a statement to Better Health and the Petitioner indicating a $1,285.00 adjustment to the account and a zero (0) balance.

11. The Better Health Claims Manager testified that when she contacted Madison River Oaks Medical Center and identified herself as a representative of the Petitioner's health plan and explained Better Health would assist with the processing of their claim, Madison River Oaks Medical Center explained the charges had already been written off as an out-of-state adjustment and that they would not submit a claim to Better Health.

12. Madison River Oaks Medical Center sent a statement to Better Health indicating a $7,458.92 adjustment to the account and a zero (0) balance.

13. On November 26, 2013, Better Health received a claim from Madison Radiology Associates, P.A., which it forwarded to the Agency for processing. This claim was denied by the Respondent because the provider is not a Florida Medicaid Provider.

14. On December 26, 2013, Better Health received a claim from Madison Emergency Group, LLC, which it forwarded to the Agency for processing. This claim was denied by the Respondent because the provider is not a Florida Medicaid Provider.

15. If a claim is denied because the provider is not a Florida Medicaid provider, the denial letter will include information on how to become a Florida Medicaid provider.

16. The process by which to become a Florida Medicaid Provider includes completing an application which is sent directly to the Florida Medicaid Fiscal Agent for processing. Once a provider is approved, the provider must resubmit any prior claims for processing. In the present case, the provider would resubmit the claims to Better Health.

17. Madison Radiology Associates, P.A. and Madison Emergency Group, LLC are not Florida Medicaid Providers. No testimony or evidence was presented at the hearing demonstrating or even alleging they have submitted applications to the Florida Medicaid Fiscal Agent for the purpose of becoming Florida Medicaid Providers.

18. The Agency's representative explained at the hearing that there is no mechanism in place by which Medicaid can make a payment to a non-Florida Medicaid Provider.

19. The Petitioner's representative has contacted numerous offices in both Florida and Mississippi to request their assistance in having her daughter's medical bills paid. She submitted copies of receipts and other evidence documenting her administrative costs associated with these mailings at the hearing and asked that she be reimbursed for her administrative expenses.

CONCLUSIONS OF LAW

20. By agreement between the Agency for Health Care Administration and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to § 120.80, Fla. Stat.

21. The Florida Medicaid Program is authorized by Chapter 409, Fla. Stat., and Chapter 59G, Florida Administrative Code. The Agency for Health Care Administration administers the Florida Medicaid Program.

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

23. In accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof is assigned to the Petitioner.

24. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

25. Fla. Admin. Cole R. 59G-5.010(1) explains "...unless otherwise specified in Chapter 59G-4, F.A.C., all providers and billing agents are required to enroll in the Medicaid program...."

26. The Florida Medicaid Provider General Handbook (July 2012) "Handbook" is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code R. 59G-5.020.

27. The Handbook, on Page 2-41, states as follows

> All other out-of-state providers may enroll in Medicaid only if they have furnished eligible services under the circumstances listed in the following sections to an eligible Medicaid recipient. These providers follow special out-of-state enrollment procedures and are enrolled with "out-of-state" status.

It then goes on to explain

> Florida Medicaid will reimburse out-of-state providers who provide services under the following circumstances:

- An emergency arising from an accident or illness that occurs while the recipient is out of state; ...

28. In addressing claims for out-of-state emergency treatment on Page 2-42, the Handbook provides the following instructions

> An out-of-state provider completes a claim for emergency services according to the instructions in the reimbursement handbook. The provider must submit the claim to the Florida Medicaid fiscal agent for payment. The provider must attach documentation to the claim justifying the emergency.

29. In the present case, Madison River Oaks Medical Center and American Medical Response South did not submit claims to Better Health for payment of the medical services rendered to the Petitioner. Instead, the providers chose to write off the balance on the Petitioner's accounts. They then sent account statements indicating the charges had been reversed and showing a zero (0) balance. Without a claim from the providers, the Agency cannot issue payment for these services.

30. With regard to the claims for payment submitted to Better Health by Madison Radiology Associates, P.A. and Madison Emergency Group, LLC, the claims were denied by the Agency because the providers are not Florida Medicaid Providers. No testimony or evidence was presented at the hearing demonstrating or even alleging that these providers are, in fact, Florida Medicaid Providers. Since the providers are not enrolled as Florida Medicaid Providers, the Agency correctly denied their claims.

31. Based on the above, the Petitioner has not met her burden of proof that the Agency improperly denied payment to any of the out-of-state providers.

32. Fla. Admin. Code R. 65-2.056 sets forth the bases under which a Hearing Officer may hold a hearing and render relief. It states as follows

> The Hearing shall include consideration of:
>
> (1) Any Agency action, or failure to act with reasonable promptness, on a claim of Financial Assistance, Social Services, Medical Assistance, or Food Stamp Program Benefits, which includes delay in reaching a decision on eligibility or in making a payment, refusal to consider a request for or undue delay in making an adjustment in payment, and discontinuance, termination or reduction of such assistance.
>
> (2) Agency's decision regarding eligibility for Financial Assistance, Social Services, Medical Assistance or Food Stamp Program Benefits in both initial and subsequent determination, the amount of Financial or Medical Assistance or a change in payments.
>
> (3) The Hearing Officer must determine whether the department's decision on eligibility or procedural compliance was correct at the time the decision was made. The hearings are de novo hearings, in that, either party may present new or additional evidence not previously considered by the department in making its decision.

33. The bases under which a Hearing Officer may hold a hearing are also set forth in the Code of Federal Regulations. 42 CFR § 431.200 Basis and scope explains

> This subpart—
>
> (a) Implements section 1902(a)(3) of the Act, which requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly;
>
> (b) Prescribes procedures for an opportunity for a hearing if the State agency or PAHP takes action, as stated in this subpart, to suspend, terminate, or reduce services, or an MCO or PIHP takes action under subpart F of part 438 of this chapter; and

34. 42 CFR § 431.201 Definitions goes on to state

> For purposes of this subpart:
>
> *Action* means a termination, suspension, or reduction of Medicaid eligibility or covered services. It also means determinations by

> skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act....

35. The above authorities define the circumstances under which a Hearing Officer may take jurisdiction of a matter and render a decision upon the relief sought. They explain that a Hearing Officer may hear a case regarding the termination, suspension, or reduction of Medicaid eligibility or covered services. These authorities do not provide the Hearing Officer with any authority to order reimbursement of costs associated with filing or pursuing a claim for reimbursement of services. Although the Hearing Officer and Office of Appeal Hearings have no statutory jurisdiction to award the costs requested by the Petitioner, the Petitioner may pursue these claims in a court of competent jurisdiction.

36. In rendering this decision, the undersigned hearing officer considered all of the testimony and documentary evidence presented during the hearing process and reviewed all relevant provisions regarding reimbursement of claims for out-of-state services set forth in the Florida Administrative Code and the rules governing the Florida Medicaid program.

DECISION

The Petitioner's appeal is hereby DENIED.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. 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, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. 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 agency has no funds to assist in this review.

DONE and ORDERED this 28th day of March, 2014,

in Tallahassee, Florida.

Peter J. Tsamis
Hearing Officer
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Copies Furnished To: [redacted], Petitioner
Ken Hamblin, Area 10, AHCA Program Operations Adminstrator