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

[redacted]

APPEAL NO. 14F-10949

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 Dade
UNIT: AHCA

RESPONDENT.

_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matters on January 27, 2015, March 10, 2015, May 19, 2015, and September 10, 2015.

APPEARANCES

For the Petitioner: [redacted] Petitioner's son.

For the Respondent: Dianna Chirino, Senior Program Specialist, Agency for Health Care Administration (AHCA).

STATEMENT OF ISSUE

At issue is the denial of the Petitioner's request for the nutritional supplement Glucerna and Petitioner's request for an increase in personal care hours. The Petitioner has the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The Petitioner submitted numerous e-mails for the hearing which were marked Petitioner's Composite Exhibit 1 for identification only.

Appearing as witnesses for the Respondent were the following individuals from Sunshine Health, which is Petitioner's managed health care organization: India Smith, Grievance and Appeals Coordinator; Mayra Infantone, Case Management Director; Rosa Brugal, Case Manager; Mike Thomas, PDO Supervisor; Dr. John Carter, Medical Director; Rolande Francois, Case Manager Supervisor; and Karel Fernandez, Case Manager. Also present as representatives for Sunshine were Catherine Dorvil, Esq. and Mamie Joeveer, Esq. Also present as an observer for the Respondent was David Nam, Esq.

The Agency's evidence packet was entered into evidence as Respondent's composite Exhibit 1. After the March 10, 2015 hearing concluded, the record was left open for Sunshine to submit a copy of Petitioner's February 2014 health assessment. This document was subsequently received and marked as Respondent Exhibit 2.

The hearing was reconvened on September 10, 2015 for consideration of additional evidence submitted by the Respondent concerning Petitioner's coverage with her prior health plan, Coventry Health Plans, pursuant to the hearing officer's Order Reconvening Hearing and Requesting Additional Information. These documents were marked Respondent Exhibit 3.

Also present for the hearings were Spanish language interpreters from Propio Language Services – [redacted] Interpreter number [redacted] [redacted] Interpreter number [redacted] and [redacted] Interpreter number [redacted]

Petitioner raised other issues at the initial hearing such as the denial of a cervical collar, denial of adult diapers, and a denial of bathroom remodeling. However, since these services had apparently been approved by Sunshine, the undersigned did not consider those issues in this hearing. Petitioner subsequently filed separate hearing requests on those other issues, which were assigned different appeal case numbers.

FINDINGS OF FACT

1. The Petitioner is ninety years of age and lives with her son. Her medical conditions include [redacted] She is wheelchair-bound and utilizes adult diapers for incontinence.

2. The Petitioner is a Medicaid recipient who was enrolled in the Statewide Medicaid Managed Care (SMMC) – Long Term Care (LTC) plan. She began receiving services under the plan from Sunshine on February 1, 2014. She was previously covered by Coventry Health Plans.

3. The Agency For Health Care Administration (AHCA) is responsible for management of the managed long-term care plan contracts, statewide policy decisions and interpretation of all federal and state laws, and rules and regulations governing the contract. Managed Care Organizations such as Sunshine provide services to Medicaid recipients pursuant to a contract with AHCA, a partial copy of which is included in Respondent Exhibit 1.

4. On September 29, 2014, Sunshine sent a notice to Petitioner stating her September 19, 2014 request for the nutritional supplement Glucerna had been denied.

The notice stated the reason for the denial, which was "member does not meet Florida State Criteria for Enteral Formula."

5. On September 11, 2014, Sunshine sent a notice to Petitioner stating her request for an increase in personal care hours through the PDO program was denied. The notice stated the request was denied because "member's needs as of last assessment completed on 8/21/2014 does not show need for increase in hours." The PDO program refers to "Participant Directed Option" under which the participant may choose the provider of services. In the Petitioner's case, her son was serving as the caregiver providing her personal care assistance.

6. At the time of the denial of the request for an increase in personal care hours, Petitioner was receiving thirty four (34) hours weekly of personal care assistance and her son was the provider of those services. Petitioner requested an increase of three hours weekly in those hours. Respondent's witness, Mr. Thomas, stated that the request for an increase in hours was denied based on Petitioner's August 2014 health assessment and a determination that there was no need for an increase in hours.

7. Mr. Thomas also stated that effective October 31, 2014, the PDO hours were terminated because Petitioner's son became her designated power of attorney and, therefore, she was no longer eligible to participate in the PDO program. At that time, a home health agency began providing the personal care assistance to the Petitioner. Petitioner's son continued to provide the care to his mother as an employee of that home health agency.

8. With regard to the personal care hours, Petitioner's son stated he believed the hours should have been increased from thirty four to thirty seven hours weekly because

Sunshine had offered to provide three hours weekly of respite care. He rejected the respite care and felt that Sunshine should have added those three hours to the personal care hours so that those hours would total thirty seven hours weekly.

9. Regarding the Glucerna, Respondent's witness, Dr. Carter from Sunshine, stated this request was denied because Petitioner's BMI (body mass index), which is a measure of nutritional status, was normal. He also stated Petitioner had no medical diagnosis showing that she cannot eat or swallow normal food.

10. Petitioner's son stated his mother had been consuming Glucerna for five years and it helped her control her [redacted] by elimination blood sugar spikes. He stated that after his mother stopped consuming Glucerna, her blood sugar levels increased, her Alzheimer's condition worsened, and she became totally homebound. Petitioner was receiving Glucerna from Coventry Health Plans prior to her enrollment with Sunshine on February 1, 2014 and she has never received Glucerna through Sunshine. Her supply of Glucerna was exhausted in January 2014.

11. Respondent's representative stated that continuity of care requirements require a Medicaid recipient to continue receiving the same services for a period of sixty (60) days when changing from one plan provider to another. The new LTC plan provider should then conduct an assessment of the patient and make a determination as to which services are needed by the patient. Petitioner enrolled with Coventry Health Plans on December 1, 2013 and then enrolled with Sunshine on February 1, 2014. Sunshine performed an assessment on February 13, 2014 and determined Petitioner had a need for home-delivered meals, but not for Glucerna.

PRINCIPLES OF LAW AND ANALYSIS

12. By agreement between the Agency for Health Care Administration (AHCA) 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. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

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

14. The standard of proof in an administrative hearing is a preponderance of the evidence, in accordance with Rule 65-2.060 (1), Fla. Admin. Code. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

15. Fla. Stat. § 409.979 sets forth eligibility requirements for the Long-Term Care Program and states:

> (1) Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:
>
> (a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.
>
> (b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).

16. As stated in the Findings of Fact, the Petitioner was determined to be eligible and enrolled in the Long Term Care Program.

17. Covered services under the AHCA contract for LTC plans include Personal Care Services, Nutritional Assessments, Home Delivered Meals, and Medical

Equipment and Supplies, among other services. The contract also provides for a Participant Direction Option (PDO).

18. The following is one of the PDO provisions in the AHCA Contract:

> Enrollees who receive PDO services shall be called "participants" in any PDO specific published materials. The enrollee shall have employer authority. An enrollee may delegate their employer authority to a representative. **The representative can neither be paid for services as a representative, nor be a direct service worker** [emphasis added].

19. Based on this provision, Sunshine properly terminated Petitioner's PDO personal care hours effective October 31, 2014 when her son became her representative/agent pursuant to a power of attorney document. Petitioner continued receiving the same amount of personal care services after that date through a home health agency and her son continued to be her provider of services as an employee of that home health agency. Accordingly, any request for an increase in PDO personal care hours is now moot since the Petitioner is no longer entitled to participate in the PDO program. In any event, the undersigned concludes Petitioner has not demonstrated that an increase in hours was necessary since insufficient evidence was presented to justify an increase in those service hours or to establish that thirty four hours weekly was insufficient to meet Petitioner's needs.

20. The AHCA contract also imposes continuity of care requirements on LTC plans, including the following provision:

> The Managed Care Plan shall be responsible for coordination of care for new enrollees transitioning into the Managed Care Plan. In the event a new enrollee is receiving prior authorized ongoing course of treatment with any provider, the Managed Care Plan shall be responsible for the costs of continuation of such course of treatment, without any form of authorization and without regard to whether such services are being provided by participating or non-participating providers.

> LTC Managed Care Plans shall provide continuation of LTC services until the enrollee receives an assessment, a plan of care is developed and services are arranged and authorized as required to address the long-term care needs of the enrollee, which shall be no more than sixty (60) days after the effective date of the enrollment.

21. In the Petitioner's case, she was receiving Glucerna from her previous managed care plan, Coventry, until her coverage under that plan ended on January 31, 2014. Her coverage with Sunshine began on February 1, 2014 but Sunshine never provided Petitioner with Glucerna. Sunshine performed its initial assessment of the Petitioner on February 13, 2014 and determined she needed home-delivered meals but not Glucerna.

22. According to the continuity of care requirements, Sunshine should have at least provided Petitioner with Glucerna until the medical assessment was performed on February 13, 2014. However, since that time period has passed, there is no remedy which can be ordered by the hearing officer and that issue is now moot. Medical necessity for the Glucerna at the present time has not been established since Petitioner's medical records do not indicate any malnutrition or inability to consume regular food. Therefore, the hearing officer cannot make a determination that Sunshine should begin supplying Glucerna to the Petitioner now.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is 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 16th day of November, 2015,

in Tallahassee, Florida.

Rafael Centurion
Hearing Officer
Building 5, Room 255
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Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager
David Nam, Esq.

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

[redacted]

APPEAL NO. 15F-09076

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 Dade
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in this matter on December 9, 2015 at 1:34 p.m.

APPEARANCES

For the Petitioner: [redacted] Pro Se

For the Respondent: Monica Otalora,
Senior Human Services Program Specialist,
Agency for Health Care Administration

STATEMENT OF ISSUE

The Petitioner is appealing the Agency for Health Care Administration's (AHCA's) decision, through DentaQuest, to deny the Petitioner's requests for the following dental procedures:

- D5214-partial lower denture;
- D4341-deep gum and root cleaning Upper Right quadrant, Upper Left Quadrant, Lower Left quadrant and Lower Right quadrant; and
- D7210-surgical extraction of tooth 29.

Because the issue under appeal involves requests for services, the burden of proof was assigned to the Petitioner.

PRELIMINARY STATEMENT

Dr. Franciso Fernandez, Medical Director and Dianna Anda, Grievance and Appeals Coordinator, appeared as Respondent's witnesses from Petitioner's managed care plan Simply Health Care. Appearing as Respondent's witnesses from DentaQuest were Dr. Frank Mantega, Dental Consultant and Jackelyn Salcedo, Complaints and Grievance Specialist.

Respondent submitted a 38-page document which was entered into evidence and marked Respondent Exhibit 1.

At the time of the hearing, Petitioner advised he was not currently having problems with tooth 29 and was concerned only with the denial of his lower partial denture (procedure D5214) and denial of deep gum and cleaning (procedure D4341).

FINDINGS OF FACTS

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

1. Petitioner is a 59 year-old Medicaid recipient enrolled with Simply Health Care Plan (Simply), a Florida Health Managed Care provider.

2. Simply requires prior authorization for services related to dental care and has subcontracted with DentaQuest to perform the prior authorization requests.

3. Petitioner asserts he needs lower partial dentures because he is currently not able to chew. He stated he has not yet received his upper partial dentures which have been approved.

4. Petitioner is [redacted] and has bleeding gums. He asserts it is medically necessary for him to have his gums and roots deep cleaned due to his [redacted]

5. DentaQuest's dentist explained that procedure D5214 partial lower denture was denied because with Petitioner's upper partial denture and remaining teeth in Petitioner's lower mouth, Petitioner has more than eight posterior contacts which provides a full complement for effective chewing. Therefore, the procedure is not currently medically necessary. The dentist advised that approval of partial lower dentures would require less than eight posterior contacts be available for chewing.

6. The dentist also advised that deep gum and root cleaning (procedure D4341) is not a Medicaid covered service. Petitioner's [redacted] status does not alter Medicaid's non-coverage of the procedure.

CONCLUSIONS OF LAW

7. By agreement between the Agency for Health Care Administration and the Department of Children and Families, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80 Florida Statutes.

8. This proceeding is a de novo proceeding pursuant to Florida Administrative Code R.65-2.056.

9. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Florida Administrative Code Rule 65-2.060(1).

10. Florida Statutes 409.971 – 409.973 establishes the requirement for Medicaid recipients to be enrolled in the statewide managed medical assistance program and the minimum benefits the managed care plans shall cover. Dental services are one of the mandatory services that must be provided.

11. § 409.912, Fla. Stat. also provides that the Agency may mandate prior authorization for Medicaid services.

12. Fla. Admin. Code R. 59G-1.010 defines "prior authorization" as:

> (226) "Prior authorization" means the approval by the Medicaid office for a Medicaid provider, or by a prepaid health plan for its affiliated providers, to deliver Medicaid covered medical or allied care, goods, or services in advance of the delivery of the care, goods, or services.

13. Fla. Admin. Code R. 59G-1.010 (166) provides…

> "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
>
> (a) Meet the following conditions:
>
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

14. Page 33, paragraph 5 of the Attachment II to the AHCA Standard Contract No. FP026 for managed care states in relevant part:

> The Agency shall be responsible for promulgating coverage requirements applicable to Managed Care Plan through the Florida Medicaid Coverage and Limitations Handbooks…

15. The Florida Medicaid Dental Services Coverage and Limitations Handbook-November 2011 (Handbook), incorporated by reference into Chapter 59G-4 Fla. Admin. Code, sets standards for dental services and describes on page 1-1

> The purpose of the dental program is to provide dental care to recipients under the age of 21 years, emergency dental services to recipients age 21 and older, and denture and denture-related services and oral and maxillofacial surgery services to all Medicaid-eligible recipients.

16. On page 2-3 of the Handbook it provides a description of the covered services for adults (21 years old and over):

> The adult dental program provides for the reimbursement of full and removable partial dentures. Extractions and other surgical procedures essential to the preparation of the mouth for dentures are reimbursable if the patient is to receive dentures. Procedures relating to dentures such as repairs, relines and adjustments are reimbursable.
>
> Medicaid will reimburse for medically-necessary emergency dental procedures to alleviate pain and or infection for eligible adult Medicaid recipients 21 years of age or older. Emergency dental care shall be limited to emergency problem-focused evaluations, necessary radiographs to make a diagnosis, extraction, and incision and drainage of abscess.

17. In addition to the Handbook, the Dental General Fee Schedule published by the Agency for Health Care Administration and dated January 1, 2014 indicates what dental

procedure codes are covered by Medicaid. Medicaid does not cover procedure code D4341 for adults (over 20 years old).

18. While the Petitioner asserted he needs the deep gum and root cleaning, procedure code D4341, Medicaid does not cover this service for adults.

19. Petitioner also asserted he needs lower partial dentures, procedure code D5214, in order to chew properly. However, the Respondent provided sufficient testimony that this procedure is not medically necessary once Petitioner has his upper partial dentures. Petitioner will have sufficient upper and lower teeth for effective chewing. Petitioner has not met his burden of proof that the services requested are medically necessary.

DECISION

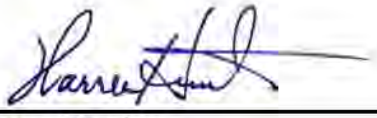
Based upon the foregoing Findings of Face and Conclusions of Law, the Agency for Health Care Administration acted correctly in denying service procedure codes D4341 and D5214 for the Petitioner. Therefore, Petitioner's appeal is denied.

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 31 day of December, 2015,

in Tallahassee, Florida.



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

FILED
Nov 24, 2015
Office of Appeal Hearings
Dept. of Children and Families

[redacted]

PETITIONER,

vs.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 08 Alachua
UNIT: 88778

RESPONDENT.
_____/

APPEAL NO. 15F-02609

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice and agreement, this hearing first convened before Hearing Officer Patricia C. Antonucci in Gainesville, Florida on July 10, 2015 at approximately 10:30 a.m.

APPEARANCES

For the Petitioner: [redacted] Petitioner's Son/Power of Attorney

For the Respondent: Matthew Lynn, Economic Self-Sufficiency Specialist
(via teleconference) (ESSS II), Department of Children and Families

STATEMENT OF ISSUE

Originally at issue was whether Respondent, the Department of Children and Families (DCF) properly calculated the amount of Petitioner's patient responsibility under his Institutional Care Placement (ICP) Medicaid. At hearing, this issue was further narrowed to whether Respondent should deduct from this patient responsibility

Petitioner's expenses for prescription medications currently paid out-of-pocket. Petitioner bears the burden of proving, by a preponderance of the evidence, that these expenses should be considered when calculating his Medicaid budget.

PRELIMINARY STATEMENT

By notice dated June 26, 2015, both parties were notified that this matter would convene for an in-person hearing on July 10, 2015. On the designated date, the undersigned hearing officer, [redacted] (Petitioner's son/representative), and Lynn Dann, ESS Supervisor with DCF, appeared in a conference room in Gainesville, Florida. Matthew Lynn, representing Respondent, joined the hearing via teleconference.

Respondent's Exhibits 1 through 6, inclusive, and Petitioner's Exhibits 1 through 5, inclusive, were entered into evidence. Following testimony, the record was held open to provide Respondent with a copy of documentation presented by Petitioner at hearing and allow for response to same. Respondent also supplemented the record with documentation referenced during hearing but not submitted into evidence: a Notice of Case Action dated July 13, 2015 (5 pages).

Via Order to Reconvene, these pages were copied to Petitioner, and this matter was set to reconvene for hearing on August 27, 2015 to discuss the content of the supplemental Notice. Due to an emergency hospitalization, Petitioner was unable to attend the hearing on August 27, 2015. As such, the reconvened hearing was rescheduled for October 7, 2015.

During telephonic hearing on October 7, 2015, Petitioner was again represented

by [redacted] and the Department, by Matthew Lynn. Both parties testified regarding the July 13, 2015 Notice, and the issue of Petitioner's out-of-pocket expenses for prescription drugs. The record was held open until October 16, 2015 to receive copies of Petitioner's prescription bills/invoices. This supplement was timely received, and the record closed. All supplemental evidence has now been entered as follows:

- Respondent's Exhibit 7 (5 pages): July 13, 2015 Notice of Case Action;
- Petitioner's Composite Exhibit 6 (total 14 pages): Cover e-mail dated October 12, 2015 (1 page); Statement from Geriatrics and Internal Medicine Practices (1 page); information and invoices from Omnicare Central Billing Center (9 pages); cover letter and notice from Florida Department of Management Services State Group Insurance (3 pages).

FINDINGS OF FACT

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

1. Petitioner is an [redacted] year-old male, born [redacted] He was admitted to a nursing home facility (NHF) in September of 2010, and has been receiving ICP benefits for many years. He is currently enrolled in a Medicaid Long Term Care (LTC) plan through Sunshine Health.

2. In December of 2014, Respondent sent a letter to Petitioner, notifying him of the need to recertify for ICP Medicaid, and requesting documentation to assist in determining Petitioner's eligibility. In response, Petitioner's son submitted to DCF financial documentation regarding Petitioner's life, health, and dental insurance, as well as his bank statements.

3. Via Notices of Case Action dated January 7, 2015 and March 9, 2015, Respondent informed Petitioner of changes to his patient responsibility (PR) – that is, the amount Petitioner must directly contribute towards his care at the NHF. Both Notices proposed to increase the monthly PR amount.

4. On or about March 24, 2015, Petitioner requested a hearing to challenge these increases; however, both the January and March Notices have since been superseded, and the patient responsibility adjusted, accordingly.

5. At hearing, both parties confirmed that Petitioner's sources of income include a pension, an IRA, and social security benefits, which total to $6,499.85 per month in gross, unearned income. He has a Qualified Income Trust (QIT), which Respondent concedes is properly funded, thus reducing his gross countable income to $1,036.55 per month.

6. Although Petitioner sustains substantial federal withholdings on both his pension and his IRA, DCF utilizes only gross income (plus standardized deductions) in its budgetary calculations. As such, federal withholdings are not considered within the Medicaid budget. Petitioner otherwise agrees that Respondent has properly calculated Petitioner's income.

7. As Petitioner's gross countable income is $1,036.55 and the maximum income for SSI-Related Medicaid eligibility is $2,199.00, Petitioner qualifies for ICP coverage.

8. The Petitioner's monthly expenses include court-ordered spousal support of $2,597.00, Blue Cross and Blue Shield (BCBS) health insurance of $719.22, and dental insurance of $90.00. Per DCF case notes, Petitioner's dental insurance was briefly

discontinued on or about December 31, 2014, but reestablished in March, 2015. Petitioner also incurs out-of-pocket co-pays for monthly prescriptions.

9. To determine Petitioner's PR, Respondent took his gross income ($6,499.85), and reduced same by a personal needs allowance of $105.00, resulting in $6,394.85. Respondent then applied additional deductions for spousal support, BCBS premiums, and dental insurance, grouping all three under "uncovered medical expenses" of $3,406.22.[1] For the months when Petitioner did not have dental coverage, the uncovered medical expenses were $90.00 less, or $3,316.22.

10. As Petitioner was allotted a deduction for his court-ordered spousal support, he was not also given a community spouse income allowance. Petitioner does not contest this issue, but received clarification from Respondent regarding the community spouse allowance option.

11. Via Notice of Case Action dated July 13, 2015, DCF memorialized the adjustments previously entered into Petitioner's budgets, as discussed at hearing. For the months of January and February, 2015, when Petitioner did not pay a $90.00 dental insurance premium, Petitioner's patient responsibility was $3,078.63 ($6,394.85 - $3,316.22.). For March through July, 2015, the patient responsibility was $2,988.63 ($6,394.85 - $3,406.22).

[1] Respondent explained that in the past, the Department did include a deduction for Petitioner's court-ordered spousal support in Petitioner's budget; however, because of the way this deduction was input into DCF's budgeting system, the spousal support deduction did not repopulate when the budget was re-run each month (or at recertification). In order to override this system default, Respondent entered the spousal support as an uncovered medical expense. Respondent believes this should prevent the system from deleting the spousal support in subsequent budgeting months.

12. Petitioner notes that he's encountered great frustration in trying to communicate with the Department regarding this case, often receiving Notices from the Department the day before an action required by said Notice is due. Petitioner states that, historically, he only begins to receive responses and assistance with case management *after* filing for an appeal. He has been able to resolve many of his concerns in the instant appeal since speaking directly with Matthew Lynn, but is concerned that the same confusion which resulted in improper changes to the PR will recur once the appeals process ends and his case returns to a non-appeal unit at DCF.

13. While Petitioner does not dispute that Respondent's adjusted calculations are correct, he believes that because he is paying for prescription medications (out of the QIT), the cost of same should be deducted from his budget as an additional, uncovered medical expense.

14. In support of his position that these are out-of-pocket expenses, Petitioner proffered correspondence (e-mails) from his LTC Plan, Sunshine Health, documenting that Sunshine does not offer prescription drug coverage. Sunshine's correspondence refers Petitioner to either Medicare or BCBS (his primary insurance) to assist with the costs of prescriptions.

15. Petitioner contends that, although he receives a discounted rate on prescriptions through BCBS, he still incurs monthly co-pays for his medications. It is Petitioner's understanding that BCBS is already contributing as much as it will towards the cost of prescribed medications. Petitioner further contends that he is not currently enrolled in Medicare Part D (prescription coverage).

16. Respondent concedes that Petitioner is not enrolled in Medicare Part D, and has also confirmed with Sunshine Health that they will not pay for Petitioner's prescriptions. Respondent further acknowledges that the NHF in which Petitioner resides does not have its own pharmacy. However, it is Respondent's position that because Petitioner has "full Medicaid," someone – either Sunshine or BCBS or Medicare – should be billed for and pay his prescription costs. Respondent contends that unless Petitioner submits documentation to show BCBS has denied a request to cover these costs, the Department cannot consider them as true unpaid medical expenses.

17. In terms of Petitioner's concern regarding the Department's handling of his case, Mr. Lynn encouraged Petitioner to sign up for e-mail alerts, so that he will receive immediate copies of all notifications issued by the Department. Mr. Lynn also encouraged Petitioner to continue to contact him, directly, if he encounters trouble in the future – even after his case is no longer in appeals.

18. Following hearing, Petitioner timely supplemented the record with copies of six (6) invoices for his prescription coverage, which he paid in May through October of 2015. Said invoices, from Omnicare Pharmacy Services, include a notation within the description field, "Co-pay is the financial responsibility of the covered beneficiary/guarantor." These invoices reflect monthly charges of: $107.68, $219.50; $258.50; $105.95; $81.11; and $82.22, respectively.

19. Along with these invoices, Petitioner submitted a bill for services at Geriatrics and Internal Medicine Practices; however, in the cover letter filed along with this supplemental documentation, Petitioner's son notes this is "[a] pending bill for my Dad

from his physician for services (I did not mention it at the hearings, but it is a bill that is unpaid. I am going to check with his various providers to see if they will cover)."

CONCLUSIONS OF LAW

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

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

22. The burden of proof is assigned to the Petitioner, pursuant to Fla. Admin. Code R. 65-2.060(1), as Respondent increased the PR following recertification (*see also* the ACCESS Florida Program Policy Manual, Section 0840.0100, **Eligibility Reviews (MSSI, SFP)**).

23. The standard of proof for an administrative hearing is "preponderance of the evidence," as provided by Fla. Admin. Code R. 65A-2.060(1).

24. At issue is Respondent's determination of Petitioner's PR under ICP Medicaid. As pertains to the PR, Petitioner disputes only the fact that his prescription costs are not included in his budget. As such, the undersigned's review is largely limited to this issue.

25. For the Institutional Care Medicaid Program, 42 C.F.R. § 435.603 sets forth allowable deductions in calculating the PR:

> c) *Required deductions.* In reducing its payment to the institution, the agency must deduct the following amounts, in the following order, from the individual's total income, as determined under paragraph (e) of this section. Income that was disregarded in determining eligibility must be considered in this process.

> (1) *Personal needs allowance.* A personal needs allowance that is reasonable in amount for clothing and other personal needs of the individual while in the institution. This protected personal needs allowance must be at least—(i) $30 a month for an aged, blind, or disabled individual, including a child applying for Medicaid on the basis of blindness or disability;(ii) $60 a month for an institutionalized couple if both spouses are aged, blind, or disabled and their income is considered available to each other in determining eligibility; and(iii) For other individuals, a reasonable amount set by the agency, based on a reasonable difference in their personal needs from those of the aged, blind, and disabled.
> ...
> (4) *Expenses not subject to third party payment.* Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—
> (i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and
> (ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

26. Fla. Admin. Code R. 65A-1.7141(1) echoes the language of the C.F.R., further explaining, as follows:

> (1) For institutional care services and Hospice, the following deductions are applied to the individual's income to determine patient responsibility in the following order:
> (a) A Personal Needs Allowance (PNA) of $105. Individuals residing in medical institutions and intermediate care facilities shall have $105 of their monthly income protected for their personal need allowance.
> ...
> (i) Uncovered medical expense deduction. The following policy will be applied in considering medical deductions for institutionalized individuals and individuals receiving HCBS services to calculate the amount allowed for the uncovered medical expense deduction:
> 1. For institutionalized persons or residents of medical institutions and intermediate care facilities, the deduction includes:
> a. Any premium, deductible, or coinsurance charges or payments for health insurance coverage.
> b. For other incurred medical expenses, the expense must be for a medical or remedial care service and be medically necessary as specified in subsection 59G-1.010(166), F.A.C., and be recognized in state law. For medically necessary care, services and items not paid for under the Medicaid State Plan, the actual billed amount will be the amount of the deduction, not to exceed the maximum payment or fee recognized by Medicare, commercial

payors, or any other third party payor, for the same or similar item, care, or service.

2. The expense must have been incurred no earlier than the three month period preceding the month of application providing eligibility.

3. The expense must not have been paid for under the Medicaid State Plan.

4. Other health insurance policies, including long term care insurance, are considered to be the first payor for medical items, care, or services covered by such policies and the remaining items can be used as an uncovered medical expense deduction. Therefore, to be deducted from the individual's income, the individual must demonstrate that other insurance does not cover such medical items, care, or services.

5. The medical and remedial care expenses that were incurred as the result of imposition of a transfer of asset penalty is limited to zero.
(emphasis added)

27. In accordance with this legal authority, the ACCESS Florida Program Policy Manual specifies, in part, at Section 2640.0125.01 (**Uncovered Medical Expenses (MSSI)**):

Policies found in passages 2640.0125.01 through 2640.0125.05 apply to the ICP, ICP MEDS, ICP Hospice, Community Hospice, Long-Term Care Diversion Waiver Program, the Assisted Living Waiver Program, and PACE.

When an individual incurs medical expenses that are not Medicaid compensable and not subject to payment by a third party, the cost of these uncovered medical expenses must be deducted from the individual's income when determining his patient responsibility. To be deducted, the medical expense only needs to be incurred, not necessarily paid.
Uncovered medical expenses will be averaged and projected over a prospective period of, generally, no more than six-months.

The following types and amounts of medical expenses may be deducted from an individual's income available for patient responsibility:

1. The actual amount of health insurance (other than Medicare) payments an individual is responsible for paying. This includes premiums, deductibles, and coinsurance charges.

2. The actual amount (if reasonable) incurred for medical services or items that are recognized under state law and medically necessary.

A medical expense deduction is not budgeted when:

1. Medical expenses are paid by someone other than the recipient or other than someone acting on behalf of the recipient using the recipient's funds.

2. Payments are made to someone other than the provider.

> 3. The medical expense is for nursing facility services, including those incurred during a penalty period.
> (emphasis added)

28. Respondent's inclusion of Petitioner's BCBS monthly premium and his dental insurance as uncovered/unreimbursed medical expenses is clearly in compliance with the above-reference authority.

29. Petitioner, himself, admits that the invoice from Geriatrics and Internal Medicine Practices may be reimbursed after he submits same to Petitioner's BCBS or Long Term Care (Sunshine Health) coverage providers. As such, this invoice currently falls into the category of a medical expense that may be "Medicaid compensable" or "subject to payment by a third party." Absent further documentation, the invoice cannot be considered an uncovered medical expense.

30. With regard to Petitioner's prescriptions, however, Petitioner has shown that his Long Term Care plan, Sunshine Health, will *not* provide coverage or reimbursement. Petitioner is not currently enrolled in a Medicare prescription coverage plan, so said prescriptions will not be covered by Medicare, either. Petitioner's BCBS insurance is contributing to the cost of prescription drugs, insofar as it reduces Petitioner's out-of-pocket costs to monthly co-pays. However, Petitioner has submitted documentation which clearly shows that he, himself (i.e., through the QIT, on his behalf) is paying these monthly co-pays, and is not receiving reimbursement for same. This situation falls squarely within the parameters of Fla. Admin. Code R. 65A-1.7141(1)(i)(4) and The Department's Program Policy Manual at Section 2640.0125.01.

31. To budget for Petitioner's uncovered prescription expenses, the undersigned has followed the requirements of Section 2640.0125.01, averaging the prescription

costs by adding the six months of bills provided ($107.68 + $219.50 + $258.50 + $105.95 + $81.11 + $82.22 = $854.96) and dividing the total by six. This results in a monthly uncovered medical expense for prescriptions (only) of $142.49.

33. Adding this additional $142.49 uncovered medical expense to the $3,406.22 expenses (including dental) already calculated by Respondent results in total monthly uncovered medical expenses of $3,548.71 for months during which Petitioner paid a dental insurance premium – i.e., March through July, 2015. For January and February 2015, when the dental premium was not paid, Petitioner's total uncovered medical expenses are $3,316.22 +$142.49, or $3,458.71.

34. For the months of January and February of 2015, Petitioner's PR is calculated as follows:

$6,499.85 (total gross income)
- $105.00 (personal needs allowance)
- $3,458.71 (total uncovered medical expenses + spousal support)

$2,936.14 Patient Responsibility

For the months of March through July, 2015 (and ongoing), the PR Is:

$6,499.85 (total gross income)
- $105.00 (personal needs allowance)
- $3,548.71 (total uncovered medical expenses, including dental + spousal support)

$2,846.14 Patient Responsibility

35. Respondent is directed to adjust Petitioner's monthly Patient Responsibility according to the calculations set forth, above, and to continue calculating the budget in this manner until such time as Petitioner no longer pays out-of-pocket co-payments to obtain his prescription drugs.

36. Petitioner is reminded that he must report to DCF any change in coverage of his

prescriptions -- particularly if he obtains Medicare coverage, such that he no longer pays an out-of-pocket co-pay. Should Petitioner wish for any other unpaid medical expenses to be considered, he must supply these to the Department for consideration.

37. Although the undersigned acknowledges Petitioner's frustration with the Department's non-appeal unit caseworkers and the difficulty he has obtained in attempting to communicate with Department to resolve issues without necessitating hearing, the hearing officer has no jurisdiction over these customer service issues. The undersigned commends Mr. Lynn for his dedication to this case, and for encouraging Petitioner to reach out to him, directly, or to utilize the client relations number provided at hearing, should future problems arise.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Petitioner's appeal is hereby GRANTED.

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 agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 24 day of November, 2015,

in Tallahassee, Florida.

Patricia C. Antonucci
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: appeal.hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency
[redacted]

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

[redacted]

APPEAL NO. 15F-02618

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 Dade
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 19, 2015 and September 10, 2015.

APPEARANCES

For the Petitioner: [redacted] Petitioner's son.

For the Respondent: Dianna Chirino, Senior Program Specialist, Agency for Health Care Administration (AHCA).

STATEMENT OF ISSUE

At issue is the denial of the Petitioner's request for adult diapers and Petitioner's request for a bathroom modification. The Petitioner has the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

Appearing as witnesses for the Respondent were the following individuals from Sunshine Health, which is Petitioner's managed health care organization: India Smith, Grievance and Appeals Coordinator; Mayra Infantone, Case Management Director; Rosa Brugal, Case Manager; Mike Thomas, PDO Supervisor; Dr. John Carter, Medical Director; Karel Fernandez, Case Manager; and Rolande Francois, Case Manager Supervisor. Also present as representatives for Sunshine were Catherine Dorvil, Esq. and Mamie Joeveer, Esq.

The Agency's evidence packet was entered into evidence as Respondent's composite Exhibit 1. After the hearing was concluded, the record was left open for Sunshine to submit additional evidence concerning the denial of the bathroom modification. This document was subsequently received and marked as Respondent Exhibit 2. The hearing was re-convened on September 10, 2015 to address the additional documents. On or about August 25, 2015, Petitioner received another denial notice regarding diapers. This document was marked Petitioner Exhibit 1 and this denial notice was also addressed at the September 10, 2015 hearing.

Also present for each hearing was a Spanish language interpreter from Propio Language Services – [redacted] Interpreter number [redacted] and [redacted] Interpreter number [redacted]

Petitioner also had pending issues concerning the nutritional supplement Glucerna and personal care assistance hours, which were addressed in Appeal Hearing Case Number 14F-10949.

FINDINGS OF FACT

1. The Petitioner is ninety years of age and lives with her son. Her medical conditions include [redacted] She is wheelchair-bound and utilizes adult diapers for incontinence.

2. The Petitioner is a Medicaid recipient who was enrolled in the Statewide Medicaid Managed Care (SMMC) – Long Term Care (LTC) plan. She began receiving services under the plan from Sunshine on February 1, 2014.

3. The Agency For Health Care Administration (AHCA) is responsible for management of the managed long-term care plan contracts; statewide policy decisions and interpretation of all federal and state laws; and rules and regulations governing the contract. Managed Care Organizations such as Sunshine provide services to Medicaid recipients pursuant to a contract with AHCA, a partial copy of which is included in Respondent Exhibit 1.

4. On March 2, 2015, Sunshine sent a notice to Petitioner stating her February 26, 2015 request for a bathroom modification had been denied. The notice stated the reason for the denial, which was the following:

> The request to approve a 02/23/2015 Construction Proposal (for bathroom modification, with total $9200) is denied. This request exceeds the maximum benefit as per Florida Medicaid guidelines for home modifications (since the present proposal for home modification is over the limit of $1000 per job, for a maximum of 5 jobs per year). Florida Medicaid guidelines for Home Modifications were used in making this decision.

5. On March 16, 2015, Sunshine sent a notice to Petitioner stating her request for disposable diapers would be denied as of March 26, 2015 and the service terminated. However, the notice also stated "[b]ased on my clinical judgment, approved as medically necessary."

6. The apparent inconsistency in the notice regarding the disposable diapers was explained at the hearing by one of the Sunshine witnesses, Ms. Infantone. She stated a different type of diaper was approved for the Petitioner in March, 2015, which caused the supply of the other diapers to be terminated effective March 26, 2015. She stated the new diapers are considered a premium diaper due to their size and Petitioner has been approved to receive 128 diapers monthly (2 cases of 64 diapers each).

7. Petitioner's son stated the correct diapers for his mother are overnight diapers and she started receiving that type of diaper in mid-2014. He stated his mother began receiving a new type of diaper in March, 2015 which were not overnight diapers. She received the correct diapers on April 23, 2015 and two cases were delivered.

8. During the pendency of this hearing, Petitioner received another denial notice dated August 24, 2015 regarding diapers. This notice stated that overnight adult pull-ups would be terminated on September 3, 2015 since it was no longer a covered item per the Florida Medicaid Fee Schedule. Both parties had an opportunity to address this denial notice at the hearing held on September 10, 2015.

9. Ms. Francois from Sunshine explained that there was a change in providers and this is what caused the August 24, 2015 notice to be sent to the Petitioner. The

diapers are to be supplied by a different provider, but the Petitioner will continue receiving diapers.

10. Petitioner's son confirmed his mother received a supply of diapers recently and his chief complaint seems to be that the Sunshine providers have been sending different types of diapers at different times. He claims his mother went without diapers for a four month period due to no diapers or the wrong diapers being provided to her.

11. Regarding the bathroom modification, Petitioner's son stated the first proposed modification was for grab bars only, which were insufficient to meet his mother's needs due to her condition. He also stated that due to the age of the home, additional remodeling of the bathroom is required to meet current building codes. He also said he submitted other remodeling estimates for $4,900 and $6,200, which were lower than the $9,200 estimate that was denied. He claims the $9,200 estimate was inflated so that it would not be approved by Sunshine.

12. Sunshine's witness, Ms. Smith, stated a bathroom remodeling estimate of $3,395 had been previously approved by Sunshine, but rejected by Petitioner's son. This estimate was for installation of a ramp, shower, and bath rails. She stated the $9,200 estimate was denied based on a limitation of $1,000 per remodeling project contained in the AHCA Aged and Disabled Adult Services Waiver Handbook. She also stated the $3,395 estimate had been previously approved because Sunshine was not aware of the $1,000 limitation at the time of that approval.

13. Respondent's representative stated the Aged and Disabled Adult Services Waiver was terminated in 2014 and that Waiver Handbook was repealed.

14. Following the conclusion of the hearing, Sunshine submitted information acknowledging the $1,000 limit was no longer applicable (Respondent Exhibit 2) and asserting that medically necessary home modifications would be approved. The hearing was thereafter reconvened to address the issue of medical necessity for the bathroom modifications.

15. Dr. Carter from Sunshine testified that medically necessary bathroom modifications have been approved for the Petitioner. This estimate ($3,395) includes removal of the bathtub and installation of a shower and grab-bars.

16. Petitioner's position is that one of the higher estimates should be approved because additional remodeling is required to make the bathroom handicap accessible.

PRINCIPLES OF LAW AND ANALYSIS

17. By agreement between the Agency for Health Care Administration (AHCA) 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. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

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

19. The standard of proof in an administrative hearing is a preponderance of the evidence, in accordance with Rule 65-2.060 (1), Fla. Admin. Code. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

20. Fla. Stat. § 409.979 sets forth eligibility requirements for the Long-Term Care Program and states:

> (1) Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:
>
> (a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.
>
> (b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).

21. As stated in the Findings of Fact, the Petitioner was determined to be eligible and enrolled in the Long Term Care Program.

22. Covered services under the AHCA contract for LTC plans include medical supplies and home adaptation services, among other services.

23. The AHCA contract describes Home Accessibility Adaptation Services as follows:

> Physical adaptations to the home required by the enrollee's plan of care which are necessary to ensure the health, welfare and safety of the enrollee or which enable the enrollee to function with greater independence in the home and without which the enrollee would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems to accommodate the medical equipment and supplies, which are necessary for the welfare of the enrollee. Excluded are those adaptions or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the enrollee, such as carpeting, roof repair or central air conditioning.

24. Sunshine initially approved a bathroom modification estimate of $3,395 for the Petitioner, which included replacement of a bathtub with a shower and installation of grab-bars. Petitioner's son submitted other estimates which were higher in cost. Sunshine's denial letter referenced an Aged and Disabled Adult Services Waiver provision which placed a $1,000 limit on modification services. This provision is no longer applicable since that Waiver was eliminated in 2014. Sunshine acknowledged its error in its supplemental filing and asserted the approval standard for modification services is medical necessity.

25. Fla. Admin. Code R. 59G-1.010 defines medical necessity:

> (166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider...
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services do not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

26. The hearing officer concludes that the $3,395 estimate provides medically necessary bathroom modifications for the Petitioner since it includes

replacement of the bathtub with a shower as well as grab-bars. Petitioner has not demonstrated medical necessity for the higher estimates.

27. Regarding the issue of the diapers, that issue is now moot since Petitioner began receiving the correct diapers on April 23, 2015 and also continued receiving diapers after the August 24, 2015 denial notice. Petitioner's son also complained that the diapers always arrive late and there have been constant changes in the types of diapers provided to his mother. However, this is not an issue that can be addressed by the hearing officer since it is in the nature of a customer service complaint. Petitioner's son should seek assistance from AHCA concerning customer service issues if he is unable to resolve them directly with Sunshine.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is 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 9th day of November, 2015,

in Tallahassee, Florida.

Rafael Centurion

Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal_Hearings@dcf.state.fl.us

Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 20 Lee
UNIT: 88326

RESPONDENT.
_____/

APPEAL NO. 15F-03845

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on July 28, 2015 at 11:00 a.m. and September 15, 2015 at 8:00 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the petitioner: [redacted] pro se.

For the respondent: Christine McKee, Economic Self Sufficiency Specialist II, and Ed Poutre, Economic Self Sufficiency Specialist II.

STATEMENT OF ISSUE

Petitioner is appealing the Department's action to terminate her full Medicaid benefits effective February 28, 2015 and enroll her in the Medically Needy (MN) Program with a Share of Cost (SOC) effective March 1, 2015. The respondent carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

On February 13, 2015, the Department sent a Notice of Case Action (NOCA) informing the petitioner that her Medicaid would end effective February 28, 2015 and that she would be enrolled in the MN Program with a $1,038 estimated SOC effective March 2015. The petitioner timely appealed the Department's actions on April 28, 2015.

The hearing was originally scheduled for June 12, 2015. The petitioner failed to appear. The hearing was rescheduled for July 28, 2015 at the petitioner's request. The Department requested a continuance to further evaluate new information that developed during the hearing. The petitioner had no objection to continuing the hearing, so the undersigned rescheduled the hearing for August 12, 2015. The petitioner requested a continuance on August 12, 2015; the undersigned granted her request and rescheduled the hearing for September 1, 2015 at 9:00 a.m. The petitioner requested an earlier hearing to accommodate her work schedule. The hearing was rescheduled for September 2, 2015 at 8:00 a.m. On September 2, 2015, the parties requested a continuance. The undersigned granted the request for continuance until September 15, 2015.

The petitioner indicated she also had an issue regarding payment of a prescription bill. The respondent submitted a Motion for Dismissal explaining this issue was not within the scope of Department of Children and Families (DCF), as it only determines eligibility. The Agency for Healthcare Administration (AHCA) is responsible for issues concerning Medicaid payments; therefore, another appeal was set up to address this issue as the respondent on that appeal will be AHCA. Since the petitioner

also has an issue with the Department's actions, the respondent's Motion for Dismissal is denied.

The petitioner presented no evidence during the hearing for the undersigned to consider. The Department presented a total of 82 pages of evidence for the undersigned to consider, which was admitted into evidence as Respondent's Composite Exhibits 1 and 2. The record was held open until September 22, 2015 for the petitioner to submit additional evidence. The petitioner submitted 2 pages of evidence on September 16, 2015, which was admitted into evidence as Petitioner's Exhibit 1. The record was closed on September 22, 2015.

FINDINGS OF FACT

1. On February 11, 2015, the petitioner submitted an application to recertify for FAP and Medicaid benefits for herself and her child. She reported earned income from Global Prospects. She also reported rent of $400 and electric with heating and cooling.

2. On February 11, 2015, the petitioner sent the following paystubs to verify her gross income: January 16, 2015 $337.95; January 23, 2015 $348.89; January 30, 2015 $396.88, and February 6, 2015 $342.00. The Department added these paystubs to calculate the petitioner's total gross earned income of $1,425.72 per month. The income limit for a parent in a two person household to receive full Medicaid is $241. As the petitioner's income was over this limit, the Department closed her full Medicaid benefits and enrolled her in the MN program with a SOC of $1,038 effective March 1, 2015.

3. The Department calculated the SOC by subtracting the Medically Needy Income Limit (MNIL) of $387 for a two person household from the total gross income of $1,425.72. This resulted in a monthly SOC of $1,038 for the petitioner.

4. The Department explained that she had full Medicaid prior to receiving earned income and met the eligibility criteria at that time. When the petitioner started working, the Department determined she was eligible to receive twelve months of Transitional Medicaid benefits (full Medicaid) through January2015. The petitioner received an extra month of full Medicaid coverage over the guaranteed one year.

5. The petitioner's income varies and her employer changed during the hearing process. As such, the Department agreed to consider the change in income and recalculate her SOC amount. The petitioner returned the following paystubs: May 5, 2015 $696.20; May 20, 2015 $589.92; July 3, 2015 $601.53 and August 5, 2015 $209.38. The Department used the Year to Date (YTD) to determine the gross amounts of the missing paystubs. The Department enrolled the petitioner with the following SOC amounts:

Month	Income	MNIL	SOC
May 2015	$1,285.12	$387	$898
June 2015	$1,011.84	$387	$624
July 2015	$1,244.67	$387	$857

The same methodology used previously was used to calculate each month's SOC.

6. The petitioner does not believe that she should be in the MN program with a SOC. The petitioner will file a tax return this year with her daughter as her tax dependent.

CONCLUSIONS OF LAW

7. 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 Fla. Stat. § 409.285.

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

9. The Department publishes a policy manual to interpret the state and federal laws. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 2030.0203 Transitional Coverage (MFAM) states in part:

> Transitional coverage provides extended coverage for up to 12 months, beginning with the month of ineligibility. Changes during this period, other than the child turning 18 or loss of state residence, do not affect the transitional Medicaid period. An ex parte determination must be completed prior to cancellation at the end of the transitional period.
> Conditions that must be met:
> 1. The parents and other caretaker relatives' assistance group must be ineligible for Medicaid based on initial receipt of earned income or receipt of increased earned income by the parent or caretaker relative. If more than one budget change is being acted on at the same time, a test budget(s) will be necessary to determine if the change in earned income is the sole cause of ineligibility.
> 2. At least one member of the assistance group was eligible for and received Medicaid in at least three of the preceding six months. The three months can include one month in which Medicaid was received in another state, or a retroactive month. All SFU members are eligible, even if they were not a part of the original assistance group.

10. The Fla. Admin. Code R. 65A-1.702 Special Provisions states in part:

> (4) Ex Parte Process.
> (a) When a recipient's eligibility for Medicaid ends under one or more coverage groups, the department must determine their eligibility for medical assistance under any other Medicaid coverage group(s) before terminating Medicaid coverage. Both Family-related Medicaid and SSI-

> related Medicaid eligibility are determined based on available information. If additional information is required to make an ex parte determination, it can be requested from the recipient, or, for SSI-related Medicaid eligibility, from the recipient or from the Social Security Administration.
> (b) All individuals who lose Medicaid eligibility under one or more coverage groups will continue to receive Medicaid until the ex parte redetermination process is completed. If the department determines that the individual is not eligible for Medicaid, the individual will be sent a notice to this effect which includes appeal rights. The individual may appeal the decision and, if requested by the individual within 10 days of the decision being appealed, Medicaid benefits will be continued pending resolution of the appeal.

11. The above policies show that an individual who loses his/her full Medicaid eligibility, due to receipt or increase in earned income, is eligible for Transitional Medicaid benefits for up to one year. It further states that an Ex Parte process must be completed. The Department gave the petitioner 12 months of Transitional Medicaid and completed the required Ex Parte determination which afforded the petitioner an additional month of Transitional Medicaid benefits. As the petitioner received over twelve months of Transitional Medicaid benefits, the undersigned concludes that the Department followed rule in terminating the petitioner's Transitional Medicaid benefits effective February 28, 2015.

12. The Code of Federal Regulations 42 C.F.R. § 435.110 defines Medicaid Mandatory Coverage of Families and Children:

> ...
> (c) Income standard. The agency must establish in its Sate plan the income standard as follows:
> (1) The minimum income standard is a State's AFDC income standard in effect as of May 1, 1988 for the applicable family size converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act...

13. The Fla. Admin. Code R. 65A-1.707 Family-Related Medicaid Income and Resource Criteria states in part:

> (1) (a) Income. Income is earned or non-earned cash received at periodic intervals from any source such as wages, self-employment, benefits, contributions, rental property, etc. Cash is money or its equivalent, such as a check, money order or other negotiable instrument. Total gross income includes earned and non-earned income from all sources…For Medically Needy coverage groups, the amount by which the gross income exceeds the applicable payment standard income level is a share of cost as defined in Rule 65A-1.701, F.A.C. For the CNS criteria, refer to subsection 65A-1.716(1), F.A.C. For the payment standard income levels, refer to subsection 65A-1.716(2), F.A.C.

14. The above authority defines earned income and states that it must be used to determine Medicaid eligilibility. The undersigned concludes that the Department was correct to include the petitioner's gross earned income in the determination process.

15. The Federal Regulations at 42 C.F.R. § 435.603 "Application of modified gross income (MAGI)" states in relevant part:

> (a) Basis, scope, and implementation.
> (1) This section implements section 1902(e)(14) of the Act.
> (2) Effective January 1, 2014, the agency must apply the financial methodologies set forth in this section in determining the financial eligibility of all individuals for Medicaid, except for individuals identified in paragraph (j) of this section and as provided in paragraph (a)(3) of this section…
> (b) Definitions. For purposes of this section—
> Child means a natural or biological, adopted or step child.
> Code means the Internal Revenue Code.
> Family size means the number of persons counted as members of an individual's household…
> Parent means a natural or biological, adopted or step parent…
> (c) Basic rule. Except as specified in paragraph (i), (j), and (k) of this section, the agency must determine financial eligibility for Medicaid based on "household income" as defined in paragraph (d) of this section.
> (d) Household income-(1) General rule. Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the

MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household.
(2) Income of children and tax dependents. (i) The MAGI-based income of an individual who is included in the household of his or her natural, adopted or step parent and is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined, is not included in household income whether or not the individual files a tax return.
(ii) The MAGI-based income of a tax dependent described in paragraph (f)(2)(i) of this section who is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined is not included in the household income of the taxpayer whether or not such tax dependent files a tax return.
(3) In the case of individuals described in paragraph (f)(2)(i) of this section, household income may, at State option, also include actually available cash support, exceeding nominal amounts, provided by the person claiming such individual as a tax dependent.
(4) Effective January 1, 2014, in determining the eligibility of an individual using MAGI-based income, a state must subtract an amount equivalent to 5 percentage points of the Federal poverty level for the applicable family size only to determine the eligibility of an individual for medical assistance under the eligibility group with the highest income standard using MAGI-based methodologies in the applicable Title of the Act, but not to determine eligibility for a particular eligibility group.
(e) MAGI-based income. For the purposes of this section, MAGI-based income means income calculated using the same financial methodologies used to determine modified adjusted gross income as defined in section 36B(d)(2)(B) of the Code,
(f) Household—(1) Basic rule for taxpayers not claimed as a tax dependent. In the case of an individual who expects to file a tax return for the taxable year in which an initial determination or renewal of eligibility is being made, and who does not expect to be claimed as a tax dependent by another taxpayer, the household consists of the taxpayer and, subject to paragraph (f)(5) of this section, all persons whom such individual expects to claim as a tax dependent....

16. The Policy Manual, CFOP 165-22, passage 2230.0400, Standard Filing Unit (MFAM), states:

For tax filers, the Standard Filing Unit (SFU) is the tax filing group for the tax year in which eligibility is being determined. Eligibility is determined by each individual using the tax filing group's income. Individuals cannot

> receive Medicaid benefits under more than one coverage group, but can have their income included in more than one SFU.

17. The above policy explains that Family-Related Medicaid is determined by how the family files federal taxes. The family's eligibility is determined by grouping certain individuals together and counting those members' income; this is called the Standard Filing Unit or SFU. Eligibility is determined for each individual using the tax filing group's income. According to the above policy, all persons filing taxes together are included in the SFU. The undersigned concludes that the Department was correct to include the petitioner and her child in the SFU.

18. The Policy Manual, CFOP 165-22, passage 2630.0108, Budget Computation (MFAM) sets forth the budgeting process and states:

> Financial eligibility for Family-Related Medicaid is determined using the household's Modified Adjusted Gross income (MAGI). The MAGI is the household's adjusted gross income as calculated by the Internal Revenue Service plus any foreign earned income and interest income exempt from tax.
> In computing the assistance group's eligibility, the general formula is:
> Step 1 - (Gross Unearned + Gross Earned) = (Total Gross Income).
> Step 2 - Deduct any allowable income tax deductions (lines 23-35 from 1040). Deduct any allowable deductions for financial aid or self-employment to obtain the Modified Adjusted Gross Income.
> Step 3 - Deduct the appropriate standard disregard. This will give the countable net income.
> Step 4 - Compare the total countable net income to the coverage group's income standard.
> If less than or equal to the income standard* for the program category, STOP, the individual is eligible. If greater than the income standard for the program category, continue to Step 5.
> Step 5 - Apply a MAGI deduction (5% of the FPL based on SFU size).
> If the 5% disregard would make the individual eligible, include the disregard. Otherwise the individual is ineligible for Medicaid.
> Individuals determined ineligible for Medicaid will be enrolled in Medically Needy and referred, as appropriate, to Florida KidCare and/or the Federally Facilitated Marketplace (FFM).

19. The Policy Manual at Appendix A-7 indicates that for a household size of two, the income limit for a parent to receive full Medicaid is $241 per month and the MNIL is $387. It also indicates "the Medically Needy Income Limit (MNIL) includes the appropriate standard disregard. No additional disregards should be applied to establish a share of cost."

20. The undersigned completed a manual budget to determine if the Department's calculations were correct. For the month of July 2015 and ongoing, a standard disregard of $146 was subtracted from the gross income of $1,244.67, to result in a countable income of $1,098.67. The MAGI disregard (5% of federal poverty limit) deduction for a household size of two is $66. The adjusted income would be $1,032.67 after the MAGI disregard was subtracted. As the petitioner's countable income of $1,032.67 is over the income limit of $241 per month, the undersigned concludes that the Department was correct in its action to remove her from full Medicaid and enroll her in the MN program with a SOC. The same methodology was used for all months calculated and the petitioner is over the income limit for full Medicaid for each month.

21. The above-cited authorities state that the MN SOC is determined by the amount by which the gross income exceeds the MNIL for the household size. In this instant case, the petitioner's gross income is $1,244.67 for July 2015 and ongoing, and the MNIL for a household size of two is $387. Therefore, the Department was correct in its calculation of a SOC amount of $857 for the petitioner. The undersigned completed manual budgets for each month at issue

using the above methodology and found no error in the Department's calculation of the petitioner's MN SOC amount.

22. The above-cited authorities were used by the Department in determining the petitioner's eligibility for full Medicaid and the Medically Needy Program. As the petitioner's countable income exceeded the income limit for full Medicaid, the undersigned concludes that the respondent correctly evaluated the petitioner for the Medically Needy Program with a SOC effective March 2015. The undersigned cannot conclude a more favorable outcome for the petitioner.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the Department's action is 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 30 day of November, 2015,

in Tallahassee, Florida.

BrandyRicklefs

Brandy Ricklefs
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

PETITIONER,

Vs.

APPEAL NO. 15F-4216

CASE NO. [redacted]

FLORIDA DEPT OF CHILDREN AND FAMILIES
CIRCUIT: 10 POLK
UNIT: 88222

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on September 3rd, 2015 at 1:00 p.m.

APPEARANCES

For the Petitioner: Petitioner was not present, but was represented by [redacted] and [redacted]

For the Respondent: Stephanie Camfield, Esq., District Legal Counsel for the Department of Children and Families.

STATEMENT OF ISSUE

The petitioner is appealing the denial of Institutional Care Program (ICP) benefits for June 2014 through November 2014. The petitioner carries the burden of proving his position by a preponderance of the evidence.

PRELIMINARY STATEMENT

Appearing as a witness for the petitioner was [redacted] the petitioner's legal guardian.

Appearing as a witness for the respondent was Kane Lamberty, Senior Human Services Program Specialist for the Department of Children and Families.

The petitioner submitted documents pre-marked A-F which were moved into evidence as exhibits 1 through 6.

Respondent's Exhibits 1 through 6 were moved into evidence. (The respondent also submitted copies of excerpts from the Department's Manual Policy Manual to support its position at the hearing. Administrative note was made of these documents, but they were not marked as exhibits.)

The hearing was originally scheduled for June 17th, 2015. Continuances were granted for July 30th, and September 3rd, 2015, both times at the request of the petitioner.

The record was held open until the close of business September 18th, 2015 to allow counsel for both parties to submit proposed orders. Petitioner submitted a proposed order within the allowed time frame. Respondent did not submit a proposed order, and did not request an extension to do so.

By way of a Notice of Case Action dated August 12th, 2014, the respondent informed the petitioner that his Medicaid application/review dated June 12th, 2014 was

denied for June 2014 through September 2014. The reason stated on the notice is "We did not receive all the information requested to determine eligibility."

By way of a Notice of Case Action dated October 3rd, 2014, the respondent informed the petitioner that his Medicaid application/review dated September 2nd, 2014 was denied for September 2014. The reason stated on the notice is "We did not receive all the information requested to determine eligibility."

By way of a Notice of Case Action dated November 18th, 2014, the respondent informed the petitioner that his Medicaid application/review dated October 17th, 2014 was denied for July 2014 through December 2014. The reason stated on the notice is "We did not receive proof of the value of assets."

By way of a Notice of Case Action dated December 29th, 2014, the respondent informed the petitioner that his Medicaid application/review dated November 24th, 2014 was denied for August 2014 through February 2015. The reason stated on the notice is "The value of your assets is too high for this program."

By way of a Notice of Case Action dated January 30th, 2015, the respondent informed the petitioner that his Medicaid application/review dated December 30th, 2014 was denied for September 2014 through March 2015. The reason stated on the notice is "We did not receive all the information requested to determine eligibility."

The respondent subsequently established eligibility for the petitioner for ICP benefits effective December 2014 and ongoing. With this last action, the petitioner was also seeking, and still seeks, eligibility for June 2014 through November 2014. However,

no Notice of Case Action to this effect was submitted into evidence. The petitioner was seeking eligibility for June 2014 through November 2014.

On May 7th, 2015, the petitioner filed an appeal to challenge the respondent's position that eligibility could not be established for June 2014 through November 2014. Absent evidence to the contrary, the appeal is considered to have been filed timely.

FINDINGS OF FACT

1. The petitioner, then [redacted] years of age, was admitted to [redacted] on [redacted] At the time of admittance, the petitioner was found to be [redacted] and not capable of either acting for himself or making his own decisions. There was nobody known, family or non-family, who could either act or make decisions in the petitioner's stead.

2. On June 12th, 2014, a representative of [redacted] submitted an application for ICP Medicaid benefits on the petitioner's behalf. (ICP Medicaid covers the cost of nursing home residence.)

3. As part of the application process, the respondent is required to explore and verify all factors of eligibility which include, but are not limited to, the value of all countable assets.

4. The respondent issued a Notice of Case Action dated August 12th, 2014 notifying the [redacted] representative that the petitioner's application was denied. The reason stated on the notice was "We did not receive all the information requested to

determine eligibility." The respondent did not submit any evidence that any information had been requested.

5. On September 2nd, 2014, a representative of [redacted] submitted an application for ICP Medicaid benefits on the petitioner's behalf.

6. The respondent issued a Notice of Case Action dated October 3rd, 2014 notifying the [redacted] representative that the petitioner's application was denied. The reason stated on the notice was "We did not receive all the information requested to determine eligibility." The respondent did not submit any evidence that any information had been requested.

7. On October 17th, 2014, a representative of [redacted] submitted an application for ICP Medicaid benefits on the petitioner's behalf.

8. The respondent issued a Notice of Case Action dated November 18th, 2014 notifying the [redacted] representative that the petitioner's application was denied. The reason stated on the notice was "We did not receive proof of the value of assets." The respondent did not submit any evidence that proof of any assets had been requested.

9. On November 18th, 2014, the petitioner's witness was granted Letters of Plenary Guardianship of the Person and Property of the petitioner.

10. On November 24th, 2015, an application for ICP Medicaid benefits was submitted on the petitioner's behalf.

11. The respondent received an alert dated November 19th, 2014 from its Data Exchange system (the system that collects data from various sources to be used in

determining an individual's eligibility for benefits) indicating that the petitioner was the owner of a bank account at [redacted] (account ending in [redacted]. The alert ("DEAV") indicates that in June 2014, the account had an ending balance of $14,526.13; in July, 2014 $14,517.88; in August and September 2014, $14,370.94, and October and November 2014, $14,362.69. The information contained in the system alert is considered to be verified upon receipt.

12. As the monthly balance(s) exceed the asset limit of $2,000, the respondent determined that the petitioner was ineligible for ICP Medicaid benefits, irrespective of its position that it had not received any verification of assets from the petitioner.

13. The respondent issued a Notice of Case Action dated December 29th, 2014 notifying [redacted] that the petitioner's application of November 24th, 2014 was denied. The reason stated on the notice was "The value of your assets is too high for this program."

14. Upon appointment as the petitioner's legal guardian (as described above), the petitioner's witness was allowed access to the petitioner's bank account and was able to transfer the money into a "pooled special needs fund" and spend the balance down, to the extent that the petitioner has since been found eligible for ICP Medicaid funds effective December 2014.

15. As established above, the petitioner seeks eligibility for June 2014 through November 2014. The petitioner contends that because the petitioner was found to be [redacted] and not capable of either acting for himself or making his own decisions from the time of his admission into [redacted] the assets in question should have been considered to be unavailable to the petitioner. Assets considered to be unavailable are

excluded as countable assets; therefore, the petitioner should have been determined eligible for ICP Medicaid benefits.

PRINCIPLES OF LAW AND ANALYSIS

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

17. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

18. The Fla. Admin. Code R. 65A-1.712, SSI-Related Medicaid Resource Eligibility Criteria, sets forth: "(1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C..."

19. The Fla. Admin. Code R. 65A-1.716 sets forth, "(5) SSI-Related Program Standards. (a) SSI (42 U.S.C. §§ 1382 – 1383c) Resource Limits: 1. $2000 per individual. 2. $3000 per eligible couple."

20. The Department's Program Policy Manual, 165-22, section 1640.0319 Comatose Individual (MSSI, SFP), states, "Any asset owned by a **comatose** individual will be excluded when there is no known legal guardian or other individual who can access the asset." *[Emphasis added.]*

21. The above guidelines stipulate that in order to qualify for SSI-related Medicaid, an individual must own no more than $2,000 in countable assets. The undisputed evidence shows that from at least June 2014 through at least November 2014, the petitioner owned at least one bank account that carried monthly balances in excess of $14,000.

22. The above guidelines also stipulate that an asset will be excluded from consideration if said asset is owned by a comatose individual and there is no legal guardian or other individual who can access the asset. The hearing officer reviewed the regulations and finds nothing to support excluding an asset in any other circumstance. A review of the evidence in its totality indicates that although the petitioner had medical impairments that prevented him from accessing the bank account in question, the petitioner submitted no evidence to indicate that the petitioner was, specifically, comatose. Therefore, the hearing officer affirms the respondent's consideration of this asset in determining the petitioner's eligibility.

23. The hearing officer notes that the stated reason for the respondent's denial of ICP Medicaid benefits for the period of June 2014 through November 2014 was that the petitioner failed to provide proof of the value of his assets. As the respondent submitted no evidence to verify that such proof was properly requested, the hearing officer does not affirm the respondent's reason for denial of these benefits.

24. However, because the evidence shows that the petitioner's assets exceeded the limit as described above, the hearing officer concludes that the petitioner was, in fact, ineligible, and therefore, concludes that the denial of ICP Medicaid from June 2014 through November 2014 is correct.

DECISION

Based on the foregoing Findings of Fact and Principles of Law, this appeal is denied, and the respondent's action is upheld.

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 indigence to waive those fees. The Department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 3rd day of November, 2015, in Tallahassee, Florida.

Justin Enfinger
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.hearings@myFLfamilies.com

Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency
[redacted]

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

[redacted]

APPEAL NO. 15F-04442

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 01 Okaloosa
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 30, 2015 at 1:02 p.m.

APPEARANCES

For the Petitioner: [redacted]
Petitioner's mother

For the Respondent: Cindy Henline
Medical Health Care Program Analyst

ISSUE

Whether respondent's denial of a partial upper and lower denture (Procedures D5213 and D5214) was proper. The burden of proof was assigned to the petitioner.

PRELIMINARY STATEMENT

A telephonic hearing was first scheduled for July 6, 2015. Petitioner failed to appear. On July 23, 2015 the hearing request was closed as abandoned. On August

10, 2015 petitioner's representative contacted the Office of Appeal Hearings and inquired about the hearing.

On August 11, 2015 the undersigned issued an Order to Show Good Cause. Petitioner was allowed 10 calendar days to submit written information to support good cause for failure to appear. A response was timely received. The undersigned thereafter determined good cause existed.

The matter was then rescheduled for September 24, 2015. Due to difficulty securing evidence, petitioner's representative requested a continuance. A continuance was granted.

Petitioner was not present for the October 30, 2015 hearing but was represented by her mother. Petitioner's exhibit "1" was entered into evidence.

Ms. Henline appeared as both a representative and witness for the respondent. Present from Humana was Mindy Aikman, Grievance and Appeals Specialist. Present from DentaQuest were Dr. Susan Hudson, Dental Consultant and Jackelyn Salcedo, Appeals and Grievance Specialist. Respondent's exhibits "1" and "2".

The record was held open through November 4, 2015 for respondent to provide updated eligibility information. Information was timely received and entered as respondent's exhibit "3"

Administrative notice was taken of Florida Statutes § 409.963; § 409.965; § 409.971; § 409.972; § 409.973; § 409.913; §409.815; Fla. Admin. Code Rules 59G-1.010; and the Dental Services Coverage and Limitations Handbook (Dental Handbook).

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. Petitioner's date of birth is July 5, 1959. At all times relevant to this proceeding, petitioner was eligible to receive Medicaid services.

2. Petitioner receives Medicaid services through respondent's Statewide Medicaid Managed Care Program. From August 1, 2014 through August 30, 2015 Humana was the managed care entity providing petitioner's Medicaid services. For the period September 1, 2015 through October 31, 2015 petitioner was enrolled with the Integral Health Plan. Effective November 1, 2015 Molina Healthcare of Florida provides petitioner's Medicaid services.

3. DentaQuest is Humana's dental vendor. All requests for dental services are reviewed by DentaQuest. DentaQuest determines whether the requested procedure is medically necessary and in compliance with pertinent rules and regulations.

4. Both Humana and DentaQuest must be in compliance with respondent's Dental Handbook.

5. On May 9, 2015 DentaQuest received from petitioner's dentist an x-ray and prior authorization request for:

- Upper Arch partial denture (Procedure D5213)
- Lower Arch partial denture (Procedure D5214)

6. On May 12, 2015 DentaQuest issued a Notice of Action to the petitioner which denied both the partial upper and lower denture as not being medically necessary. In regard to the upper partial, the notice stated:

> In order to get a partial denture, you must have at least 50% bone support for the tooth that is still in your mouth. Our dentist looked at the x-rays sent by your dentist. You have less than 50% bone support. We have also told your dentist this. Please talk to your dentist about other choices to fix your teeth.

7. In regard to the lower partial, the notice stated: "You still have enough teeth to properly chew your food, therefore, you do not qualify for a partial denture ..."

8. In separate correspondence to petitioner's dentist, a DentaQuest dentist stated a resin base upper partial would be considered as would a full upper denture. The dental reviewer also commented a lower partial was not warranted as petitioner's masticatory function was not severely impaired.

9. On May 19, 2015 petitioner contacted the Office of Appeal Hearings and timely requested a fair hearing.

10. Dr. Hudson is a licensed dentist. In review of the submitted x-rays, she estimates petitioner's upper arch bone loss to be approximately 10% to 20%.

11. Occlusion is the contact between the upper and lower teeth when they approach each other for chewing.

12. Regarding the request for a lower partial, submitted x-rays show there were eight teeth in occlusion for chewing.

13. An undated letter from petitioner's dentist states petitioner has experienced two [redacted] and is diagnosed with a [redacted] Petitioner is now missing eleven teeth and has difficulty chewing and digesting food.

14. An updated x-ray was not presented to establish the current number of missing teeth.

15. Dr. Hudson opines the above narrative suggests there are now seven teeth in occlusion for chewing.

16. Petitioner's representative cooks separate meals for her daughter. The meals consists of soft food to facilitate chewing and digestion.

CONCLUSIONS OF LAW

17. 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.

18. This is a final order pursuant to § 120.569 and § 120.57, Fla. Stat.

19. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

20. The standard of proof in an administrative hearing is by a preponderance of the evidence. (See Fla. Admin. Code R. 65-2060(1).) The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

21. The Florida Medicaid Provider General Handbook (Provider Handbook) – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code R. 59G-4. The Provider Handbook states on page 1-27:

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.

> Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

22. Page 1-30 of the Provider Handbook continues by stating: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

23. Respondent's Dental Handbook – November 2011 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code R. 59G-4.060.

24. The Dental Handbook states "Medicaid reimburses for services that are determined medically necessary ..."

25. The definition of "medically necessary" is found in the Fla. Admin. Code R. 59G-1.010, which states, in part:

> (166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
>
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider...
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

26. The Dental Handbook states on page 2-3:

> Covered Adult Services (Ages 21 and over):
>
> The adult dental program provides for the reimbursement of full and removable partial dentures. Extractions and other surgical procedures essential to the preparation of the mouth for dentures are reimbursable if the patient is to receive dentures. Procedures relating to dentures such as repairs, relines and adjustments are reimbursable.

27. In regard to partial dentures, pages 2-30 through 2-33 the Dental Handbook states, in part:

> For all eligible Medicaid recipients, Medicaid may reimburse for the fabrication of full and removable partial dentures ...
>
> **The standard for all dentures**, whether seated immediately after extractions or following alveolar healing, **is that the denture be fully functional** [Emphasis Added].
> ...
>
> Partial dentures refer to the prosthetic appliance that replaces missing teeth and is on a framework that is removed by the patient. Prior authorization is required for reimbursement of removable partial dentures and must be submitted to the dental consultant for determination of medically necessity prior to the procedure being performed.
>
> Medicaid will not reimburse for:
>
> • **Partial dentures where there are at least eight posterior teeth in occlusion**; ... [Emphasis Added]

28. Regarding the upper partial denture, persuasive evidence was not presented that sufficient bone support exists to adequately support the partial. As such, the requirement that a partial be fully functional has not been satisfied.

29. Regarding the lower partial, new evidence suggests there may now be less than eight posterior teeth in occlusion. The Findings of Fact establish, however, an updated x-ray has not been submitted to substantiate the number of missing teeth.

30. As previously noted, this hearing is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056. A de novo proceeding allows the hearing officer to consider new evidence not previously available to the respondent. It does not mean, however, the hearing officer is tasked with conducting a review more properly conducted by the respondent or the appropriate managed care entity.

31. The respondent is the single state agency authorized to operate the Medicaid Program in Florida[1]. It must be noted, however, the only denial in this matter is from Humana's dental vendor, DentaQuest. Since the denial, petitioner's managed care plan has changed an additional two times. Not only has the managed care plan changed, but the number of petitioner's teeth in occlusion may have also changed.

32. At the time of denial on May 12, 2015 petitioner had eight teeth in occlusion. It is not clear if these teeth could all be classified as posterior. Regardless, petitioner is afforded the opportunity to submit new diagnostic information to her current managed care plan for both an upper and lower partial. If unhappy with the actions taken in response to the request, fair hearing rights can once again be exercised.

33. At the time of denial of upper and lower partials on May 12, 2015, petitioner has not demonstrated respondent's action in this matter was improper. The following conditions of medical necessity have not been satisfied:

> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
>
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

[1] See Fla. Stat. §409.963.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, petitioner's appeal is 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 19 day of November, 2015, in Tallahassee, Florida.

Frank Houston
Hearing Officer
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Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: [redacted] Petitioner
Marshall Wallace, Area 1, AHCA Field Office Manager

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

[redacted]

PETITIONER,

vs.

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 05 Marion
UNIT: 88000

RESPONDENT.
_____/

APPEAL NO. 15F-04880

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice and agreement, administrative hearing in the above-captioned matter first convened before Hearing Officer Patricia Antonucci on August 5, 2015 at approximately 3:00 p.m. All participants appeared via teleconference.

APPEARANCES

For the Petitioner: [redacted] Petitioner

For the Respondent: Evelyn Ross, ESS Supervisor,
Department of Children and Families

STATEMENT OF ISSUE

At issue is whether Respondent, the Department of Children and Families (DCF or 'the Department'), was correct to deny Petitioner's request for disability-based Medicaid. Petitioner bears the burden of proving, by a preponderance of the evidence, that this denial was improper.

PRELIMINARY STATEMENT

During all administrative proceedings in the above-captioned matter, Petitioner appeared as her own representative. Petitioner noted that she was represented by an attorney in her appeal to the Social Security Administration (SSA), and by a separate attorney in a private law suit resulting from an [redacted] however, she confirmed that she had not retained counsel for the instant appeal. Respondent was represented by Evelyn Ross, Supervisor with DCF. No additional witnesses appeared on behalf of either party.

This matter was initially scheduled to convene on July 7, 2015 at 1:00 p.m. Just prior to hearing, Respondent noted that the Department conferred with Petitioner and received information of new/worsening conditions (reported on Petitioner's application for benefits), which the Department had yet to consider. Respondent requested a continuance to receive and review documentation of Petitioner's alleged new/worsening conditions, and Petitioner agreed. The case was rescheduled to convene for hearing on August 5, 2015.

On August 5, 2015 at 3:00 p.m., both parties appeared, as scheduled. At that time, Respondent noted that in reviewing Petitioner's case for hearing, it was discovered that the Department had never actually processed Petitioner's application. More specifically, although the Department issued a denial letter, the Department had not pended the case for more information, had not requested or reviewed Petitioner's records, and had not forwarded her review to the Division of Disability Determination (DDD). Respondent noted the denial letter was thus issued in error.

As Respondent had not received any medical records from Petitioner prior to August 5, 2015, the Department took no further action on Petitioner's case in preparation for the August 5th hearing. As such, the parties agreed to exchange documentation and convene for a telephonic status conference on August 25, 2015 at 1:00 p.m.

At the status conference on August 25, 2015, Respondent noted it had received the requested information from Petitioner, forwarded same to DDD, and only received the Disability Determination Transmittal (the decision) from the Department's DDD office just prior to the conference call. Respondent forwarded this documentation to the undersigned and to Petitioner for use at final hearing. The parties agreed to convene for final hearing on September 10, 2015 at 1:00 p.m.

At final hearing on September 10, 2015, Respondent's Exhibits 1 through 8, inclusive, were entered into evidence. Testimony was secured, and the record was held open to allow Petitioner opportunity to supplement the record with documentation she had attempted to submit to Respondent, but which was only partially transmitted via facsimile. Petitioner also requested and was granted permission to file an [redacted]record submitted to the Department on or about August 21, 2015.

The initial record, an October 17, 2014 Psychological Evaluation by [redacted] [redacted](9 pages) was timely received and copied to Respondent, and has been entered into evidence as Petitioner's Exhibit 1. No further proposed evidence was received from either party. This Order follows.

FINDINGS OF FACT

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

1. Petitioner is a [redacted], born [redacted] She has a medical history that includes, but is not limited to, [redacted] and [redacted]

2. Prior to the state/Medicaid action at issue, Petitioner applied for disability benefits with the Social Security Administration (SSA). On or about May 2, 2014, SSA issued to Petitioner a letter denying her application. This letter stated, in pertinent parts:

> The following evidence was used to decide your claim:
> [redacted] report received 02/28/2014
> [redacted] report received 02/26/2014
> [redacted] report received 03/11/2014
>
> We have determined that your condition is not severe enough to keep you from working. We considered the medical record and other information, your age, education, training and work experience in determining how your condition affects your ability to work.
>
> You state that you are disabled and unable to work because of [redacted]

3. On or about August 5, 2014, Petitioner filed an appeal of SSA's determination. Petitioner advises that she is represented by an attorney in her SSA case, which is currently pending hearing.

4. On December 21, 2014, Petitioner was involved in an automobile accident. Petitioner states that said accident both generated new medical conditions (specifically with regard to her neck) and worsened those already in existence at the time of the

incident. Petitioner is represented by separate legal counsel in a lawsuit over this accident.

5. On or about May 26, 2015, Petitioner's application for disability-based Medicaid was filed with DCF. No copy of this application was submitted into evidence; however, Respondent notes that Petitioner advised the Department at the time of application that new/worsening conditions had emerged since her most recent SSA denial.

6. In reviewing Petitioner's case in preparation for hearing, Respondent discovered that Petitioner's application for benefits was not processed according to standard Department procedure. Per Respondent, the Department denied Petitioner's application without requesting a copy of her SSA denial letter or any/all medical records, to assist in its evaluation of her case. Although no copy of the Department's initial Notice of Case Action/denial of Medicaid was proffered into evidence, the Department concedes that said Notice was issued in error and thus, Respondent does not rely upon same.

7. Following continuation of the initial hearing, Respondent contacted Petitioner to request additional information for review. The Department received 11 total pages from Petitioner, including the following (page numbers as shown on the fax stamp):

- An Authorization to Disclose Information to the Department, signed May 7, 2015;
- Faxed Page 10: First page of a Psychological Evaluation conducted on October 17, 2014;
- Faxed Page number undecipherable (likely Page 01): additional page of Psychological Evaluation, marked in the heading with Petitioner's name and "October 17, 2014 Page 4 of 9";
- Faxed pages 02 through 09: pages from a May 2, 2014 SSA denial letter (some duplicates included).

8. Review of the Department's Running Record Comments from August 10, 2015 reflects the notation, "CLT SENT IN PAPERWORK FROM PSYCHOLOGIST AND FROM SS... INFO SENT TO ODD FOR REVIEW TO SEE IF CLT MEETS DISABILITY REQUIREMENTS ABOVE SS DENIAL."

9. On August 20, 2015, Lauren Coe of DDD affixed her stamp to a DDD Determination and Transmittal (Transmittal), denying Petitioner's Medicaid application with the handwritten notation "Hankerson 7/14 same allegations, hearing pending." Ms. Coe also checked a box to indicate that DDD staff had not found Petitioner disabled after reviewing a primary diagnosis of [redacted] and secondary diagnosis of [redacted] Although DDD notated that the claim was received on August 8, 2015, both the Running Records Comments and the top portion of the Transmittal (completed by Department staff) reflect that the claim was not forwarded to DDD until August 10, 2015.

10. At hearing, Petitioner testified that she had also sent to the Department copies of an MRI report regarding [redacted] Respondent confirmed that these were received on August 21, 2015, but stated that because DDD issued its Transmittal on August 20th, the Department did not review the MRI and would not consider it unless Petitioner applied for benefits again, at least 90 days from the date of Respondent's denial.

11. On or about August 20, 2015, the Department completed its "Elderly/Incap/Disab Information" screen, based upon the DDD Transmittal. This screen reflects that Petitioner's case was sent to DDD on August 10, 2015 and was reviewed on August 18, 2015. All of the following questions on the screen were answered with an indication of "N" (No):

- Has disability already been established?

- Has SSA determined individual qualified working disabled (QDWI)?
- Has individual applied for and been denied disability be SSA/SSI?
- If Denied for disability, has timely appeal been filed with SSA/SSI?
- Has it been more than one year since denial?
- Does individual have a new condition not considered by SSA/SSI?
- Has individual been terminated for disability by SSA/SSI?
- Will incap/disab exceed 30 days? 12 months?

12. At hearing, DCF clarified that the question "Will incap/disab exceed 30 days? 12 months?" is answered "No" whenever the Department has not made a specific determination regarding duration. As such, an answer of "No" in this section does not necessarily mean the condition will *not* exceed these time frames, but rather, that DCF has not reached a conclusion one way or the other. With regard to the rest of the screen, the Department noted that it had completed some of the fields with erroneous responses.

13. Via Notice of Case Action dated August 21, 2015, Respondent notified the Petitioner, "Your Medicaid application/review dated May 26, 2015 is **denied**... Reason: You or a member(s) of your household do not meet the disability requirement" (emphasis original). A separate copy of this Notice was issued to Petitioner for each month from May to September of 2015.

14. At hearing, Respondent explained that because SSA denied disability, and because a final decision is still pending on Petitioner's SSA appeal, the Department did not make an independent determination with regard to establishing disability. In reviewing the Petitioner's medical records, the Department decided there were no new/worsened conditions. Therefore, instead of conducting a new review, DCF adopted Social Security's decision that the Petitioner is not disabled.

15. When asked how DDD could make a determination that no new/worsening conditions exist based upon two pages of what is clearly marked as a nine-page document, Respondent indicated that because DDD had all it needed to reach its decision, it did not request the remaining pages of the Psychological Evaluation.

16. Petitioner contends that she has provided the attorney handling her SSA appeal with additional records, but that they have not yet been filed with SSA. It is her understanding that the attorney plans to bring them to the attention of SSA when Petitioner's appeal is heard.

17. Following hearing, Petitioner supplemented the record with a full copy of the Psychological Evaluation, conducted by [redacted] on [redacted] Of particular import, page 6 of 9 notes that Petitioner presents with [redacted] (these are not necessarily diagnoses). Page 8 of 9 notes that "she may require services from Social Security Disability to be successful," and page 9 of 9 lists the following:

Diagnostic Impressions

Axis I	296.5
	300.00
	304.90
	315.9
Axis II	V71.09
Axis III	
Axis IV	
Axis V	

[redacted]

CONCLUSIONS OF LAW

18. 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 Fla. Stat. § 409.285.

19. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code R. 65 2.056. While *de novo* indicates that the hearing officer may consider new evidence, not previously available to either party, it does not mean that the hearing officer is tasked with conducting reviews more properly conducted by the Respondent, itself.

20. In accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof is assigned to Petitioner, who seeks coverage under Florida's disability-based Medicaid.

21. Federal Regulations at 42 C.F.R. § 435.541, "Determinations of disability," state in part:

> (a) *Determinations made by SSA.* The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.
>
> (1) If the agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act, the agency may not make a determination of disability when the only application is filed with SSA.
>
> (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.911 ['Timely Determination of Eligibility'] on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under § 435.909.
>
> (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.
>
> (2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.
>
> (c) *Determinations made by the Medicaid agency.* The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:
>
> ...
>
> (4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA, and--
> (i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination....
> (underlined emphasis added)

22. The Department's ACCESS Program Policy Manual, 165-22 section 1440.1204 Blindness/Disability Determinations (MSSI, SFP) states, in part:

> State disability determinations for disability-related Medicaid applications must be done for all applicants with pending Title II or Title XVI claims unless SSA has denied their disability within the past year. If SSA has denied disability within the past year and the decision is under appeal with SSA, do not consider the case as pending. Use the decision SSA has already rendered. The SSA denial stands while the case is pending appeal.
>
> When the individual files an application within 12 months after the last unfavorable disability determination by SSA and provides evidence of a new condition not previously considered by SSA, the state must conduct an independent disability determination. Request a copy of the SSA denial letter. The SSA denial letter contains an explanation of all the conditions considered and the reason for denial.
>
> (emphasis added)

23. Petitioner's application for disability-based Medicaid (May 26, 2015) was filed more than 12 months after her most recent SSA denial (May 2, 2014).

Additionally, Petitioner specified that she had new/worsening conditions which needed to be reviewed. In this situation, the above-cited authority clearly indicates that the Department must conduct its own review.

24. DDD/DCF contend that they had sufficient information to determine the conditions Petitioner was alleging were the same as those reviewed by SSA; however, this determination was made based on review of a partial document – i.e., two pages of a Psychological Evaluation, which was clearly marked as nine pages long. Importantly, DDD did not receive or request the last page of the report, which, like with most psychological evaluations, is the page that actually lists the Petitioner's diagnoses.

25. Respondent had in its possession Petitioner's contact information, as well as a signed Authorization to Disclose Information form, dating back to May 7, 2015. No reasonable explanation was proffered for the Department's failure to obtain the full Psychological Evaluation, in order to conduct a thorough review. Had DDD done so, they would have seen that [redacted] amongst others, is one of Petitioner's diagnoses – one that was *not* reviewed by SSA, and one which Petitioner contends has not been presented to SSA, to date.

26. The undersigned notes that the Department must meet certain time standards in processing applications for disability-based Medicaid. However, as noted in 42 CFR 435.911:

> (e) The agency must not use the time standards—
> (1) As a waiting period before determining eligibility; or
> (2) As a reason for denying eligibility (because it has not determined eligibility within the time standards).

27. In Petitioner's case, the Department initially denied her application without any sort of processing, whatsoever. Once this error was discovered, the Department reviewed and reached disposition on her application by relying on incomplete information. This lack of thoroughness is in contravention to the governing legal authority.

28. The undersigned hearing officer does not have sufficient information to complete an independent evaluation. The Department, which holds Petitioner's Authorization to Disclose, and may thus request medical documents and/or speak to the attorney representing Petitioner in her SSA appeal, is in the best position to undertake this task.

29. The undersigned thus concludes that Respondent's disability denial is the result of a prematurely concluded review. Respondent, DCF/ DDD, must be given the opportunity to thoroughly review Petitioner's case. If said review again results in a Medicaid denial, Petitioner will be notified of her right to appeal that, specific decision.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this case is REMANDED to Respondent for further review, consistent with the legal requirements and policy, cited herein.

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 4th day of November, 2015,

in Tallahassee, Florida.

Patricia C. Antonucci

Patricia C. Antonucci
Hearing Officer
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Office of Economic Self Sufficiency

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

[redacted]

APPEAL NOs. 15F-05419, 15F-05420,
15F-05479, 15F-05480

PETITIONER,

vs.

CASE NO. [redacted]

FLORIDA DEPT OF CHILDREN AND FAMILIES
CIRCUIT: 08 Levy
UNIT: 02555

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing in the above-referenced matter convened before Patricia C. Antonucci on October 7, 2015 at approximately 10:30 a.m. and October 29, 2015 at approximately 3:00 p.m. Both parties appeared via teleconference. As Petitioner is a Spanish-speaker, an interpreter was also present on the line to translate the entire proceeding.

APPEARANCES

For the Petitioner: [redacted] Petitioner

For the Respondent: Ernestine Bethune, Eligibility Specialist, Special Services Unit II, Department of Children and Families

STATEMENT OF ISSUE

At issue is whether Respondent, the Department of Children and Families (DCF or 'the Department') properly calculated Petitioner's monthly Share of Cost in the Medicaid Program (for Petitioner, only), and whether her request for temporary cash

assistance (TCA) was properly denied. Petitioner bears the burden of proving, by a preponderance of the evidence, that Respondent's actions are incorrect.

PRELIMINARY STATEMENT

Petitioner filed multiple requests for hearing in June of 2015. During a pre-hearing conference in advance of hearing on August 4, 2015, Petitioner disconnected from the conference line and did not contact the Office of Appeal Hearings to explain why she terminated the call. Via Preliminary Order of Dismissal, Petitioner was given opportunity to object to dismissal of her case. As Petitioner responded to this Order, her hearing was rescheduled for October 7, 2015. The Department was not ready to proceed with all issues (and was not sure why Petitioner requested hearing) on October 7, 2015; however, the parties agreed to begin proffering testimony and reviewing evidence. When the October 7, 2015 hearing ran overtime, the Department noted it would review Petitioner's case for any Department-based errors, and both parties agreed to reconvene and finish testimony on October 29, 2015.

When Petitioner first requested hearing, she wished to contest Respondent's determination of her food assistance program (FAP) benefits, in addition to benefits in the above-referenced programs. At hearing October 29, 2015, Respondent explained that a sanction had improperly been applied to Petitioner's case, and had since been removed. The Department had recalculated FAP benefits, as well Petitioner's Medicaid benefits, based upon information provided at the prior hearing. Petitioner confirmed that the FAP matter had been resolved to her satisfaction, but that she still wished to contest the newly calculated Share of Cost (SoC), and the denial of TCA. The undersigned

accepted this as a withdrawal of the FAP case, and issues this Final Order to dispose of all appeals.

Petitioner appeared as her own representative and provided testimony to support her case. Ernestine Bethune, ESS II with DCF, represented the Respondent. Hearing Officer Greg Watson, with the Office of Appeal Hearings, observed the proceedings.

Respondent's Composite Exhibit 1, as discussed on the record on October 7, 2015, is hereby moved into evidence. Respondent's Composite Exhibit 2, as accepted into evidence on October 29, 2015, is also moved. It should be noted that Respondent's Composite Exhibit 1 contains documentation initially submitted as part of Petitioner's mother's case (a separate appeal that was closed out as abandoned), and has largely been corrected via the documentation contained within Respondent's Composite Exhibit 2.

FINDINGS OF FACT

1. Petitioner is a 39-year-old, non-disabled female, born [redacted] She moved from Puerto Rico to Florida around May of 2015 to care for her ailing mother. She now resides in the family home with her mother [redacted] her husband [redacted] one mutual child [redacted] and one non-mutual child [redacted]

2. On or about May 19, 2015, Petitioner submitted to the Department an electronic application for assistance, requesting benefits through FAP, TCA for G.B., and Medicaid. Within this application, Petitioner noted that her household's income included monthly social security payments for her mother, husband, and daughter, [redacted] No other income was noted.

3. On or about May 28, 2015, the Department conducted a telephone interview

with Petitioner, based upon her application. The Department's Running Record Comments reflect that very little information was sought regarding the household's tax filing status and/or determination of mandatory filing unit/assistance group members.

4. Following review of Petitioner's application, the Department generated a Notice of Case Action (NOCA) with regard to FAP and Medicaid on June 3, 2015, and a NOCA denying TCA on June 15, 2015. The June 3, 2015 NOCA reflected a monthly SoC for Petitioner and V.M. of $328.00 per month.

5. Petitioner requested a hearing to challenge the determination of SoC for herself, only (not for V.M.), and the denial of TCA. She noted at hearing on October 29, 2015 that her FAP benefits issue was resolved.

6. At hearing on October 7, 2015, Petitioner clarified her families' tax filing status: Petitioner plans to file taxes, claiming her husband and both children as dependents. Petitioner's mother files her own, separate, taxes.

7. Upon review of Petitioner's case, the Department determined that for Medicaid/SoC purposes, Petitioner's assistance group was a household of four (Petitioner, [redacted] and [redacted], with unearned income from [redacted] of $815.70 per month. For purposes of TCA, Petitioner's assistance group is also a household of four, with unearned income of $815.70 (Social Security for [redacted]) *plus* $76.20 (Social Security for [redacted])

8. The November 2015 Medicaid budget that Respondent submitted at hearing on October 29, 2015 shows that the Department used [redacted] Social Security as the household's unearned monthly income of $815.70. As this amount is higher than the maximum monthly income for an adult within a four-person household ($364.00),

Petitioner is not eligible for "full Medicaid" through the family Medicaid program. However, since the income is below the total maximum income for a four-person household ($2,021.00), the Department continued to process Petitioner's case to determine her SoC. To this end, the Department subtracted a Medically Needy Income Level (MNIL) of $585.00 from Petitioner's countable income of $815.70, to arrive at a SoC of $230.00 per month.

9. It is the $230.00 SoC – not the originally noticed SoC of $328.00 – which the Department stands by as the proper benefit calculation.

10. The June/July 2015 TCA budget prepared by Respondent shows that the Department calculated Petitioner's monthly income as $815.70 (V.M.) + $76.20 (D.M) = $891.90. The Department determined that Petitioner was ineligible for TCA benefits, as the $891.90 figure exceeds the payment standard of $364.00 for a four-person household.

11. Petitioner contests the SoC, noting that she is unable to afford medical care because practitioners will not schedule appointments or send her for testing (such as ultrasounds) since she does not have full Medicaid. Petitioner notes that in July of 2005, [redacted] and has had medical complications ever since. She is concerned that whenever she needs medical assistance, she will have to go to the emergency room. She believes this is an inefficient use of the State's resources, when a lower SoC might allow her greater access to less expensive healthcare.

12. Petitioner also contests the denial of TCA. She states that in addition to

caring for her children, she is now caring for an ailing, disabled mother. As such, she is not able to work outside the home, and cannot afford to take care of her family, solely on the unearned income received by her husband and daughter.

CONCLUSIONS OF LAW

13. 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.

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

15. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof is assigned to the Petitioner, who submitted an application for FAP, Medicaid, and TCA benefits.

16. Pursuant to Petitioner's statement on the record, her appeal regarding FAP benefits is dismissed.

Medicaid

17. Eligibility Standards for family Medicaid are found in Appendix A-7 of the Department's Policy Manual (July 2014), CFOP 165-22, which reflects a maximum, four-person monthly income of $2,021.00. For a single, non-disabled adult under the age of 65 within the four-person household to qualify for full Medicaid, the income standard is $364.00 per month (see third column of Appendix A-7 and Fla. Admin. Code R. 65A-1.716(2)).

18. As Petitioner's household income/Modified Adjusted Gross Income (MAGI) of $815.70 exceeds this standard, she is not eligible for full Medicaid. Even when a standard deduction ($221) or MAGI disregard ($101.00) are deducted from her MAGI, her income is greater than the income standard of $364.00, and she fails the test for full Medicaid (See Appendix A-7). However, per Fla. Admin. Code 65A-1.707(1)(a), "For Medically Needy coverage groups, the amount by which the gross income exceeds the applicable payment standard income level is a share of cost as defined in Rule 65A-1.701, F.A.C."

19. Fla. Admin. Code R. 65A-1.701(30) defines share of cost as:

> Share of Cost (SOC): SOC represents the amount of recognized medical expenses that a Medically Needy enrolled individual or family must incur each month before becoming eligible to receive Medicaid benefits for medical expenses incurred during the remainder of the month.

20. Per Fla. Admin. Code 65A-1.702:

> (2)(b) Individuals applying for the Medically Needy program become eligible on the date their incurred allowable medical expenses, excluding payments by all third party sources except state or local governments not funded in full be federal funds, equal their share of cost, provided that all other conditions of eligibility are met. Any bill used in full to meet the individual's share of cost (SOC) shall not be paid by Medicaid....
> (13) Determining Share of cost. The SOC is determined by deducting the Medically Needy Income Level from an individual's or family's income.

21. In the instant case, the Department utilized Petitioner's income of $815.70, then subtracted the $585.00 Medically Needy Income Limit (MNIL), as determined by the Appendix A-7 of the Policy Manual, to obtain a SoC of ($815.70 - $585.00) $230.00.

22. Potential deductions for Medically Needy budgeting purposes include those which result from expenses incurred to obtain income, earned income (work expenses,

federal/state income taxes, and related deductions), Part B Medicare premiums (paid by the family), and health or life insurance premiums. (See Policy Manual sections 2440.0300 – 2440.0371). There is no evidence to indicate that Petitioner pays any of these expenses.

23. If, at any point, Petitioner discovers unpaid medical expenses, begins to pay a Medicare premium, or incurs additional expenses not previously considered by the Department, she is encouraged to report these for review.

Cash Assistance

24. Section 414.095 Fla. Stat, Determining eligibility for temporary cash assistance, states, in part:

> (10) DETERMINATION OF LEVEL OF TEMPORARY CASH ASSISTANCE.—Temporary cash assistance shall be based on a standard determined by the Legislature, subject to availability of funds. There shall be three assistance levels for a family that contains a specified number of eligible members, based on the following criteria:
> (a) A family that does not have a shelter obligation.
> (b) A family that has a shelter obligation greater than zero but less than or equal to $50.
> (c) A family that has a shelter obligation greater than $50 or that is homeless.
>
> The following chart depicts the levels of temporary cash assistance for implementation purposes:

THREE-TIER SHELTER PAYMENT STANDARD

Family Size	Zero Shelter Obligation	Greater than Zero Less than or Equal to $50	Greater than $50 Shelter Obligation
4	$254	$309	$364

> (11) DISREGARDS.—

(a) As an incentive to employment, the first $200 plus one-half of the remainder of earned income shall be disregarded. In order to be eligible for earned income to be disregarded, the individual must be:
1. A current participant in the program; or
2. Eligible for participation in the program without the earnings disregard.
(b) A child's earned income shall be disregarded if the child is a family member, attends high school or the equivalent, and is 19 years of age or younger.

(12) CALCULATION OF LEVELS OF TEMPORARY CASH ASSISTANCE.—
(a) Temporary cash assistance shall be calculated based on average monthly gross family income, earned and unearned, less any applicable disregards. The resulting monthly net income amount shall be subtracted from the applicable payment standard to determine the monthly amount of temporary cash assistance.
(emphasis added)

25. The Department's Florida Program Policy Manual, 165-22 at section 2420.0315 Eligibility for $200 and 1/2 Disregard (TCA) states:

In order for a member of a Temporary Cash Assistance (TCA) standard filing unit (SFU) to receive the $200 and 1/2 disregard, the individual must:
1. have been eligible for and received TCA in one of the past four months; or
2. have gross countable income (including earned and unearned income), less the $90 standard earned income disregard, which is less than the applicable payment standard.

26. Petitioner's filing unit/assistance group for TCA purposes was determined, in part, based on Policy Manual Section 2220.0404.06, which notes:

Minor Siblings (TCA)
All minor siblings (including half-brothers and half-sisters) living with the child for whom assistance is requested or if away from home, meeting the conditions of temporary absence, must have their needs included, provided the sibling meets all Temporary Cash Assistance eligibility criteria.
Minor siblings are those brothers and sisters under the age of 18 or under age 19 and a full-time student in secondary school or at the equivalent level of vocational or technical training who have never been married or whose marriage was annulled. The needs of these children must be included through the month of their 18th birthday or 19th birthday if a full-time student, unless born on the first

> day of the month. If born on the first day of the month, their needs must be removed effective the birth month.
>
> Two-parent families containing at least one mutual child must be considered as one standard filing unit (SFU) due to the sibling relationships of mutual and nonmutual children. If the family is ineligible for Temporary Cash Assistance benefits as one SFU, Temporary Cash Assistance is not available to the nonmutual children or their parents.
> (emphasis added)

27. With an assistance group of two adults and two children, the Department looked to the unearned household income (Social Security) of $815.70 received by [redacted] and $76.20 received by G.B. (for whom TCA is sought). This amount totals to $891.90. No income disregards were applied because there is no earned income in the filing unit, and the total income exceeds the highest possible income standard ($364.00) for a family of four.

28. If, at any point, Petitioner's family income changes, she is encouraged to re-apply for TCA.

29. Petitioner's opinion regarding limitations to her access of healthcare and the inefficiency of a SoC is noted; however, the undersigned hearing officer has no authority to rule on public policy argument. Petitioner is encouraged to contact the Department for assistance with bill tracking, so as to better manage her healthcare needs and increase her chances for meeting the SoC each month. As she is notably concerned about her ailing mother, she is further encouraged to contact the Department to discuss whether the mother might qualify for additional assistance or any waiver programs, so as to meet her medical and caregiving needs. Should Petitioner apply for additional

programs, and be denied same, she will reserve the right to appeal those, specific denials.

30. Based upon the totality of the evidence, the Department has shown that its revised calculations of Petitioner's Medicaid SoC benefits, and its decision to deny TCA were proper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner's appeal regarding FAP is DISMISSED as moot. Her appeals regarding Medicaid and TCA are DENIED. Respondent is hereby directed to apply its revised, correctly calculated SoC retroactive to Petitioner's date of application.

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 09 day of December, 2015, in Tallahassee, Florida.

Patricia C. Antonucci
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: appeal.hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

FILED
Nov 30, 2015
Office of Appeal Hearings
Dept. of Children and Families

[redacted]

PETITIONER,

Vs.

APPEAL NO. 15F-05610

CASE NO. [redacted]

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 02 Leon
UNIT: 88113

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on September 29, 2015 at 3:06pm.

APPEARANCES

For the Petitioner: [redacted]
Managing Partner
[redacted]
Processing Manager
[redacted] processor

For the Respondent: Christine Frier, Northwest ACCESS Program Office, Senior Human Services Program Specialist.

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of May 26, 2015 denying Institutional Care Program (ICP) benefits between October 2014 and May 2015. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The Department submitted evidence on August 10, 2015, which was entered as Respondent Exhibit 1. The Department submitted additional information on September 25, 2015. This was entered as Respondent Exhibit 2. The petitioner submitted evidence on September 29, 2015, which was entered as Petitioner Exhibit 1.

The record was held open until October 23, 2015. The Department submitted additional information on October 20, 2015. This was entered as Respondent Exhibit 3. The petitioner requested an additional seven days to review and respond to the supplemental evidence. The deadline for petitioner's response was extended to October 30, 2015. The petitioner submitted a written response to the Department's supplemental evidence on October 29, 2015. This was entered as Petitioner Exhibit 2.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. The petitioner was admitted to [redacted] on March 26, 2013 following a brief hospital stay.

2. At the time of admission to the [redacted] the petitioner was already receiving Institutional Care Program (ICP) Medicaid.

3. The petitioner had an Income Trust established in 2010. The Trustee for the income trust was a law firm.

4. During the recertification completed in April 2014, the Department discovered that the deposits into the petitioner's income trust ceased sometime between March 2013 and April 2014.

5. [redacted] filed an application for Medicaid on October 15, 2014. On the last page of the application a note stated, "QIT and Proof of funding to be submitted, Applying for UMED for June/July August, and September. (facility bills with application verification docs" *[sic]*

6. The Department found the petitioner's income was diverted from the Income Trust sometime after his admission to [redacted] to a patient trust account at the facility. A statement of this account shows the petitioner's income was utilized to meet his needs in the facility.

7. The petitioner's ICP Medicaid was closed effective May 31, 2014.

8. The petitioner is [redacted] years old.

9. The petitioner's monthly income consists of a [redacted] pension of $917, Social Security retirement (SS) of $1,396, and an annuity of $177.53 for a total gross income of $2,490.53.

10. The parties do not dispute the petitioner's income is over the income limit for ICP Medicaid. The parties disagree on the availability of the income to the petitioner.

11. [redacted] explained to the Department in October 2014 that the petitioner's health conditions at the time of admission to [redacted] in 2013 rendered him as incapacitated and unable make decisions or communicate with staff regarding his

income, assets or resources. [redacted] asserts the petitioner has no family to assist him with his finances.

12. The Department pointed out that the facilities' admission record (Respondent Exhibit 1, page 18) lists the petitioner's contacts as a son and three daughters, two of whom reside in [redacted] where the facility is located.

13. [redacted] further submitted a Certificate of Incapacity to the Department on October 27, 2014 showing a physician's medical opinion of, "It is my medical opinion that there is no reasonable probability that the resident/patient will recover competency to make health care decisions." The Certificate of Incapacity is dated May 1, 2013.

14. [redacted] also submitted a letter to the Department on January 26, 2015 from [redacted] The purpose of this letter was to notify the Department of the petitioner's inability to sign any documents or provide any documentation to assist with his application for ICP Medicaid. The letter states the petitioner has no Attorney in Fact or guardian to assist with the ICP application or finances.

15. The Department issued a Notice of Case Action on November 17, 2014 denying the petitioner's application for Medicaid citing "We did not receive proof of the value of assets" and "No appropriate placement" as the reasons for denial.

16. [redacted] submitted another application for ICP Medicaid for the petitioner on November 20, 2014.

17. The Department issued a Notice of Case Action on December 23, 2014 denying the petitioner's application as "Fail – financial consent not received for all

required individuals", "We did not receive proof of the value of assets", and "We did not receive all information needed to determine eligibility."

18. [redacted] filed a new application for ICP Medicaid for the petitioner on December 31, 2014.

19. The Department issued a Notice of Case Action on February 2, 2014 denying the December 2014 application, as "We did not receive proof of the value of assets".

20. [redacted] submitted an application for ICP Medicaid for the petitioner on February 4, 2015.

21. The Department issued a Notice of Case Action on March 9, 2015 denying the February 2015 application, as "We did not receive proof of the value of assets".

22. [redacted] filed a new application on April 1, 2015 for ICP Medicaid for the petiioner.

23. The petitioner's daughter was appointed Plenary Guardian for him on April 7, 2015. This daughter is listed on the petitioner's admission record.

24. The Department issued a Notice of Case Action on May 4, 2015 denying the petitioner's application, as "We did not receive proof of the value of assets".

25. The Department has opened the petitioner's ICP coverage effective May 1, 2015.

26. [redacted] is seeking Medicaid benefits for the petitioner from October 2014 through April 2015.

27. The Department asserts part of the information requested was proof of funding the original Income Trust. The Department believes there was no assistance it could provide in verifying the trust account was funded as no deposits were made to the account.

28. The Department's position is that there were no deposits made into a qualifyied income trust between at least April 2014 and April 2015 causing the petitioner to exceed the income limit resulting in ineligibility for ICP coverage.

29. [redacted] argues the Department is required by law to assist with obtaining verification of assets. [redacted] further argues the Department erred in denying the applications based on unverified assets when the Department could obtain the information on behalf of the customer and did not.

30. The Department explained although the Notices read the petitioner was denied due to failure to verify assets the petitioner is actually ineligible because his income exceeded the income limit for ICP Medicaid. Having a properly executed and funded income trust would be the only way the petitioner could be eligible for ICP Medicaid.

31. [redacted] believes that due to the Notices showing ICP Medicaid benefits being denied due to failure to verify assets, the Department incorrectly denied the petitioner's case.

32. [redacted] asserts the [redacted] must be complied with in the determination of the petitioner's Medicaid benefits. [redacted] asserts the [redacted] was not complied with in regards to this petitioner's Medicaid application.

CONCLUSIONS OF LAW

33. 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.

34. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code § 65-2.056.

35. Fla. Admin. Code § 65A-1.710 SSI-Related Medicaid Coverage Groups defines Institutional Care Program (ICP) as follows: "(2) Institutional Care Program (ICP). A coverage group for institutionalized aged, blind or disabled individuals (or couples) who would be eligible for cash assistance except for their institutional status and income as provided in 42 C.F.R. §§ 435.211 and 435.236. Institutional benefits include institutional provider payment or payment of Medicare coinsurance for skilled nursing facility care."

36. The Department's ACCESS Program Policy Manual (165-22) Appendix 9 "Eligibility Standards for SSI-Related Programs" effective July 2014 shows the Income Limit for an individual for ICP Medicaid at $2,163. Effective January 2015 the Income Limit increased to $2,199.

37. Fla. Admin. Code § 65A-1.713 "SSI-Related Medicaid Income Eligibility Criteria" (1)(d) states: "For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in subsection 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional

care services by establishing an income trust which meets criteria set forth in subsection 65A-1.702(15), F.A.C."

38. Fla. Admin. Code § 65A-1.702 "Special Provisions" states:

(15) Trusts.
(a) The department applies trust provisions set forth in 42 U.S.C. § 1396p(d).
(b) Funds transferred into a trust or other similar device established other than by a will prior to October 1, 1993 by the individual, a spouse or a legal representative are available resources if the trust is revocable or the trustee has any discretion over the distribution of the principal. Such funds are a transfer of a resource or income, if the trust is irrevocable and the trustee does not have discretion over distribution of the corpus or the client is not the beneficiary. No penalty can be imposed when the transfer occurs beyond the 36 month look back period. Any disbursements which can be made from the trust to the individual or to someone else on the individual's behalf shall be considered available income to the individual. Any language which limits the authority of a trustee to distribute funds from a trust if such distribution would disqualify an individual from participation in government programs, including Medicaid, shall be disregarded.
(c) Funds transferred into a trust, other than a trust specified in 42 U.S.C. § 1396p(d)(4), by a person or entity specified in 42 U.S.C. § 1396p(d)(2) on or after October 1, 1993 shall be considered available resources or income to the individual in accordance with 42 U.S.C. § 1396p(d)(3) if there are any circumstances under which disbursement of funds from the trust could be made to the individual or to someone else for the benefit of the individual. If no disbursement can be made to the individual or to someone else on behalf of the individual, the establishment of the trust shall be considered a transfer of resources or income.
(d) The trustee of a qualified income trust, qualified disabled trust or pooled trust shall provide quarterly statements to the department which identify all deposits to and disbursements from the trust for each month.
(e) Undue Hardship. A period of ineligibility shall not be imposed if the department determines that the denial of eligibility based on counting funds in an irrevocable trust according to provisions in paragraphs 65A-1.702(12)(b) and (c), F.A.C., would work an undue hardship on the individual. Undue hardship exists when application of a trust policy would deprive an individual of food, clothing, shelter or medical care such that their life or health would be endangered. This can be caused by legal restrictions or illegal actions by a trustee. All efforts by the individual,

> spouse or representative to access the resources or income must be exhausted before this exception applies.

39. The findings show the petitioner has income of [redacted]pension of $917, Social Security retirement (SS) of $1,396, and an annuity of $177.53 for a total gross income of $2,490.53. The undersigned concludes the Department correctly included all of the petitioner's income. This amount exceeds the limit for ICP eligibility without a Qualified Income Trust (QIT) properly executed and funded.

40. The petitioner previously had a properly executed and funded income trust which allowed for ICP eligibility. The findings show this changed when the petitioner's income was no longer deposited into the trust and was diverted to the facility instead. The undersigned concludes once the QIT was no longer funded, the petitioner lost eligibility for ICP Medicaid due to being over the income limit.

41. The fact the petitioner had a Qualified Income Trust (QIT) previously, acknowledges the petitioner's total monthly gross income exceeded the ICP income limit. The undersigned concludes for the petitioner to be eligible for ICP Medicaid, the petitioner could fund a QIT sufficiently to reduce his countable income. Although the Department's denial notices show denials for "failure to verify assets", it does not change the fact that there was no QIT funded for the months of October 2014 through April 2015 causing petitioner to exceed the ICP income limit.

42. Federal Regulations found at 20 C.F.R. § 416.1201 "Resources; general" states in relevant part:

> (a) Resources; defined. For purposes of this subpart L, resources means cash or other liquid assets or any real or personal property that an

individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance.

(1) If the individual has the right, authority or power to liquidate the property or his or her share of the property, it is considered a resource. If a property right cannot be liquidated, the property will not be considered a resource of the individual (or spouse).

(2) Support and maintenance assistance not counted as income under §416.1157(c) will not be considered a resource.

(3) Except for cash reimbursement of medical or social services expenses already paid for by the individual, cash received for medical or social services that is not income under §416.1103 (a) or (b), or a retroactive cash payment which is income that is excluded from deeming under §416.1161(a)(16), is not a resource for the calendar month following the month of its receipt.

43. 42 C.F.R. § 435.945 "General Requirements" states in relevant part:

(b) The agency must request and use information relevant to verifying an individual's eligibility for Medicaid in accordance with §§435.948 through 435.956 of this subpart.

(c) The agency must furnish, in a timely manner, income and eligibility information, subject to regulations at part 431 subpart F of this chapter, needed for verifying eligibility to the following programs:

(1) To other agencies in the State and other States and to the Federal programs both listed in §435.948(a) of this subpart and identified in section 1137(b) of the Act;

...

(d) All State eligibility determination systems must conduct data matching through the Public Assistance Reporting Information System (PARIS).

(e) The agency must, as required under section 1137(a)(7) of the Act, and upon request, reimburse another agency listed in §435.948(a) of this subpart or paragraph (c) of this section for reasonable costs incurred in furnishing information, including new developmental costs.

(f) Prior to requesting information for an applicant or beneficiary from another agency or program under this subpart, the agency must inform the individual that the agency will obtain and use information available to it

> under this subpart to verify income and eligibility or for other purposes directly connected to the administration of the State plan.

44. The petitioner's bank verifications were requested by the Department.

The undersigned concludes the request to the petitioner was an attempt to verify if the previous QIT was still being funded.

45. Fla. Admin. Code § 65A-1.712 "SSI-Related Medicaid Resource Eligibility Criteria" states in relevant part:

> (2) Exclusions. The Department follows SSI policy prescribed in 20 C.F.R. § 416.1210 and 20 C.F.R. § 416.1218 in determining resource exclusions, with the exceptions in paragraphs (a) through (g) below, in accordance with 42 U.S.C. § 1396a(r)(2).
> (a) Resources of a **comatose applicant (or recipient)** are excluded when there is no known legal guardian or other individual who can access and expend the resource(s). (emphasis added)

46. The Department's ACCESS Program Policy Manual (165-22) section 1640.0320 "Legally Incompetent Individuals" (MSSI, SFP) states:

> Under the Florida Guardianship Law, only a guardian of the property is authorized to dispose of assets on behalf of a legally incompetent individual. Until a legal guardian is assigned, real property owned by a legally incompetent individual is not available.
> **Liquid assets (for example, patient fund accounts and checking accounts) are included as available if the individual has free access to the funds.**
> If a legal guardian must petition the court in order to dispose of the individual's property, the asset is still included for the individual. The fact that the guardian must petition the court does not make the property an unavailable asset. (emphasis added)

47. The Department's Policy Manual section 1640.0321 "Assets Unavailable – Circumstances Beyond Control (MSSI, SFP)" states:

> Assets unavailable due to circumstances beyond the individual's control are not considered in the determination of eligibility.

> The individual must present convincing evidence to prove the asset is unavailable to him due to circumstances beyond his control. The eligibility specialist will make an independent assessment of the availability based on the evidence presented. Additional guidance can be requested from the Region or Circuit Program Office, Circuit Legal Counsel, or Headquarters through the Region or Circuit Program Office.

48. The representative argued that petitioner's health issues, which rendered him incompetent, should be taken into consideration in the determination of his eligibility. [redacted] further asserted the eligibility determination should exclude all of the petitioner's resources. The above controlling authorities address restrictions on when assets can be considered unavailable. There was no evidence petitioner was in a comatose state; therefore, the assets could not be excluded from consideration under the Florida Administrative Code. The Department's Policy Manual regarding legally incompetent individuals specifically addresses liquid assets such as patient fund accounts and checking accounts. The petitioner was not declared legally incompetent until April 2015. [redacted] argued the petitioner was incompetent to handle his financial affairs. There was no argument that he had no access to his finances. The above controlling authorities also indicate that assets can be considered unavailable due to a circumstance beyond his control. However, the authorities make it clear that the petitioner's liquid assets are available if the individual has free access to the funds. The statement from the petitioner's physician states he is unable to handle his health care information. There is no evidence that he was unable to handle his financial affairs.

49. The undersigned can find no authority that excludes the petitioner's income from being included in the eligibility determination. The petitioner's income exceeded the limit established for ICP Medicaid. [redacted] took steps to

ensure the petitioner's income was available. The undersigned concludes although the Notice contained a faulty reason for denial, the petitioner remains ineligible based on his income exceeding the income limit.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the Department's action is 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 30 day of November, 2015, in Tallahassee, Florida.

Melissa Roedel

Melissa Roedel
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: [redacted] Petitioner

Office of Economic Self Sufficiency
[redacted]

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 05 Hernando
UNIT: 88003

RESPONDENT.
_____/

APPEAL NO. 15F-05746

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 8:15 a.m. on September 21, 2015.

APPEARANCES

For the Petitioner: [redacted] pro se

For the Respondent: Marilyn Ficke, ACCESS Supervisor

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny petitioner Medicaid benefits is proper. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

By notice dated June 11, 2015, the respondent notified petitioner application dated June 8, 2015 for Medicaid was denied. Petitioner timely requested a hearing to challenge the denial.

Petitioner submitted one exhibit, entered as Petitioner Exhibit "1". Respondent submitted four exhibits, entered as Respondent Exhibits "1" through "4". The record was held open until end of business day on September 21, 2015, for the respondent to submit an additional exhibit. The exhibit was received timely and entered as Respondent Exhibit "5".

FINDINGS OF FACT

1. Petitioner, [redacted] submitted a Food Assistance and Medicaid application for herself on June 8, 2015. The application indicates petitioner is not disabled. Medicaid is the only issue.

2. Petitioner did not mention she was disabled when she was interviewed by the Department on June 10, 2015.

3. To be eligible for Family Medicaid, petitioner must have minor children living in the home or be pregnant. To be eligible for Adult Medicaid, petitioner must be age 65 or older or considered blind or disabled.

4. Petitioner does not have minor children, is not pregnant, is not age 65 or older, and has not been considered blind or disabled. Therefore, she is not eligible for Family or Adult Medicaid.

5. On June 11, 2015, the respondent mailed petitioner a Notice of Case Action notifying she was denied Medicaid benefits, due to not being "eligible for this program".

6. Petitioner did not dispute that she did not indicate she was disabled on the June 8, 2015 application or during the Department interview on June 10, 2015.

7. Petitioner has [redacted] Petitioner believes that since she has "paid into the program she would now like Medicaid to pay for her [redacted]

8. Petitioner applied for disability through the Social Security Administration (SSA) in June 2015 and was denied in July 2015. Petitioner is appealing the SSA denial.

9. Petitioner submitted another Medicaid application in September 2015.

10. Respondent's representative explained the September 2015 application indicates petitioner is disabled. Therefore, the application will be processed for Medicaid disability eligibility. A new Notice of Case Action with Medicaid eligibility results will be mailed to petitioner. The notice will include appealable rights.

CONCLUSIONS OF LAW

11. 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 Fla. Stat. § 409.285.

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

13. Medicaid eligibility is based on federal regulations. There are two categories of Medicaid that the Department determines eligibility for: (1) Family-Related Medicaid for parents and children, and pregnant women, and (2) Adult-Related (referred to SSI-Related Medicaid) for disabled adults and adults 65 or older.

14. Florida Administrative Code R. 65A-1.703 Family-Related Medicaid Coverage Groups in part states:

> (1) The department provides mandatory Medicaid coverage for individuals, families and children described in Section 409.903, F.S., Section 1931 of the Social Security Act and other relevant provisions of Title XIX of the Social Security Act. The optional family-related Title XIX and Title XXI

> coverage groups served by the department are stated in each subsection of this rule...
> (5) Medicaid for pregnant women...

15. Florida Administrative Code R. 65A-1.711 SSI-Related Medicaid Non Financial Eligibility Criteria in part states:

> (1) For MEDS-AD Demonstration Waiver, the individual must be age 65 or older, or disabled as defined in 20 C.F.R. §416.905...

16. Title 20 Code of Federal Regulations § 416.903 address disability and blindness determinations and in part states:

> (b) Social Security Administration. The Social Security Administration will make disability and blindness determinations...

17. In accordance with the above authorities, to be eligible for Medicaid petitioner must have minor children or be pregnant or be age 65 or older or be considered disabled or blind.

18. The evidence establishes that petitioner has no minor children, is not pregnant, is not age 65 or older and has not been determined disabled or blind. Therefore, petitioner is not eligible for Medicaid.

19. In careful review of the cited authorities and evidence, the undersigned concludes the respondent followed Rule in denying petitioner Medicaid.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the respondent's action is 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 3 day of November, 2015,

in Tallahassee, Florida.

Priscilla Peterson

Priscilla Peterson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

FILED
Dec 01, 2015
Office of Appeal Hearings
Dept. of Children and Families

[redacted]

APPEAL NO. 15F-05898

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 Dade
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 16, 2015 at 8:30 a.m.

APPEARANCES

For the Petitioner: [redacted] Petitioner

For the Respondent: Monica Otalora, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the Respondent's denial of the Petitioner's request for dental services was correct. The Petitioner has the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The Petitioner did not submit any documents as evidence for the hearing. However, a letter from the Petitioner was included among the Respondent's exhibits.

Appearing as witnesses for the Respondent were Dr. Susan Hudson, Dental Director, and Jackeline Salcedo, Grievance Specialist, from DentaQuest, which is the Petitioner's dental services organization. Also present as a witness for the Respondent was Mindy Aikman, Grievance and Appeals Specialist, from Humana, which is Petitioner's managed health care organization.

Also present for the hearing was a Spanish language interpreter, [redacted] Interpreter Number [redacted] from Propio Language Services.

Respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Exhibits: Exhibit 1 – Member Information; Exhibit 2 – Claim Form; Exhibit 3 – X-rays; Exhibit 4 – Denial Letters; and Exhibit 5 – Letter from Petitioner.

FINDINGS OF FACT

1. The Petitioner is a fifty-nine (59) year-old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. She receives services under the plan from Humana, which utilizes DentaQuest for review and approval of dental services.

2. On or about May 5, 2015, the Petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from DentaQuest to perform installation of

upper and lower partial metal dentures. DentaQuest denied this request on May 7, 2015.

3. DentaQuest's denial notice to the Petitioner advised her of the following reason for the denial of her request for the dentures:

> In order to get a partial denture, you must have at least 50% bone support for the tooth that is still in your mouth. Our dentist looked at the x-rays sent by your dentist. You have less than 50% bone support. We have told your dentist this. Please talk to your dentist about other choices to fix your teeth.

4. Petitioner testified that she needs the dentures because she has problems with chewing her food and is afraid to smile in front of other people because of the condition of her teeth.

5. Ms. Salcedo from DentaQuest testified that Petitioner's request for the lower partial dentures had been subsequently approved; therefore, the current denial is for the upper partial dentures.

6. The Respondent's expert witness, Dr. Hudson, testified that the denial of the Petitioner's request for the upper partial metal dentures was appropriate because of the moderate to advanced bone loss in most of her upper teeth. Dr. Hudson explained that metal dentures require healthy bone support in the mouth. Dr. Hudson also advised that a resin-based denture would be more appropriate because metal dentures cannot have teeth added to the denture to replace the patient's teeth.

7. Services under the Medicaid State Plan in Florida are provided in accordance with the Respondent's Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012 and the Dental Services Coverage and Limitations Handbook ("Dental Handbook"), effective November 2011.

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CONCLUSIONS OF LAW

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

9. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

10. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

11. The standard of proof in an administrative hearing is a preponderance of the evidence, in accordance with Rule 65-2.060 (1), Florida Administrative Code. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

12. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the Respondent. The Medicaid Handbooks are incorporated by reference in Chapter 59G-4, Florida Administrative Code.

13. Florida Statute § 409.912 requires that Respondent "purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care."

14. The Medicaid Handbook and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

> "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:

> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide;
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
> . . .
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

15. Partial dentures are covered services for adults under the Medicaid Program.

The Dental Handbook, on page 2-31, describes partial dentures as follows:

> Partial dentures refer to the prosthetic appliance that replaces missing teeth and is on a framework that is removed by the patient. Prior authorization is required for reimbursement of removable partial dentures and must be submitted to the dental consultant for determination of medically necessity prior to the procedure being performed.
>
> Removable partial dentures are reimbursable for all eligible Medicaid recipients regardless of age.

16. Petitioner testified she needs the partial dentures because she has problems chewing her food and she is afraid to smile in front of others due to the condition of her teeth. Although the Petitioner's treating dentist has requested the partial metal dentures, this does not in itself establish that this service is medically necessary according to the rule provisions outlined above.

17. Respondent's witness testified resin-based dentures are more appropriate for the Petitioner than metal dentures due to bone loss and the condition of her existing teeth.

18. After considering the evidence and testimony presented, the undersigned concludes the Respondent correctly denied Petitioner's request for the upper partial metal dentures. The evidence demonstrates that resin-based dentures are a more appropriate alternative, and Petitioner should explore this option with her provider.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is 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 agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 01 day of December, 2015,

in Tallahassee, Florida.

Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662

Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

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

FILED
Nov 30, 2015
Office of Appeal Hearings
Dept. of Children and Families

[redacted]

PETITIONER,

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 05 Hernando
UNIT: AHCA

RESPONDENT.
_____/

APPEAL NO. 15F-05931

FINAL ORDER

Pursuant to notice and agreement, Hearing Officer Patricia Antonucci convened an administrative hearing in the above-referenced matter on September 24, 2015 at approximately 1:00 p.m. All parties and witnesses appeared via teleconference.

APPEARANCES

For Petitioner: [redacted] Petitioner
[redacted] Petitioner's wife

For Respondent: Selwyn Gossett, Medical/Health Care Program Analyst, Agency for Health Care Administration

Bonnie Taylor, Program Administrator, Agency for Health Care Administration

ISSUE

At issue is whether Respondent, the Agency for Health Care Administration (AHCA or 'the Agency'), through its contracted Health Maintenance Organization, Sunshine Health, properly terminated provision of Petitioner's medical/wound care

supplies. Respondent bears the burden of proving, by a preponderance of the evidence, that this termination was proper.

PRELIMINARY STATEMENT

This matter was initially scheduled for telephonic hearing on August 26, 2015. Due to erroneous information received by the Office of Appeal Hearings, the August 26th hearing was cancelled. When Petitioner contacted the Office of Appeal Hearings to correct this information, the matter was set for a telephonic status conference on September 2, 2015 at 10:00 a.m.

All parties appeared, as scheduled, on September 2, 2015. At that time, it was determined that hearing based on certain items of durable medical equipment (DME) and wound care/consumable medical supplies (CMS) – collectively referenced as medical supplies (MS) – would convene on September 24, 2015 at 1:00 p.m. Although Sunshine had also advised Petitioner that additional wound care supplies (two types of AG patches and Medipore tape) might be terminated, Sunshine had yet to generate a Notice of Case Action for these items. As such, Petitioner was advised to await denial and request a separate hearing if the AG patches and Medipore tape were not approved.

Petitioner was present at hearing, and was represented by his wife, [redacted] Petitioner presented one witness: [redacted] Senior Human Services Program Specialist with AHCA. As Petitioner subpoenaed [redacted] as a witness, David Nam, Esq., also with AHCA, appeared to ensure [redacted] was not being questioned in her personal capacity.

AHCA Medical/Health Care Program Analyst, Selwyn Gossett, represented Respondent at the telephonic status conference and engaged in substantial correspondence with Petitioner regarding his appeal; however, at hearing on September 24, 2015, Mr. Gossett was unavailable. Respondent was represented by his supervisor, Bonnie Taylor. Pat Brooks and Ingrid Paige, also with AHCA, observed the final hearing. Respondent presented the following witnesses from Petitioner's Long Term Care (LTC) plan, Sunshine Health:

- □ Donna Melogy, Executive Director (status conference, only);
- □ John Carter, M.D., Medical Director;
- □ Jennifer Arteaga, Grievance and Appeals Coordinator;
- □ Donna Laber, R.N., Grievance and Appeals Manager;
- □ Tammi Swan, Case Manager Supervisor;
- □ Angela Blue, Case Manager; and
- □ Tiffany Smith, Grievance and Appeals Coordinator II (observed hearing).

Petitioner had no objection to the three noted individuals observing the proceedings. Petitioner's Exhibits 1 through 8, inclusive, and Respondent's Exhibits 1 through 3, inclusive, were accepted into evidence. The record was held open to receive from Respondent supplemental documentation referenced at hearing but not previously filed in the case, as well any response from Petitioner thereto. Respondent's supplement was timely received and confirmed received by Petitioner. It has been entered as follows:

- Respondent's Exhibit 4: single-page cover sheet + six pages of the AHCA, Attachment II Core Contract Provisions, effective April 15, 2015 (7 pages total).

FINDINGS OF FACT

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

1. Petitioner is a 63-year-old male, born [redacted] He has multiple medical needs, which include wound care and home management of three separate wound sites. The Petitioner visits a wound care center approximately once every 2 weeks (if he is healthy enough to attend), but the center does not provide supplies for at-home use. Petitioner's wife provides in-home wound care every two days, for all three wounds.

2. The Petitioner was previously enrolled in a Medicaid Waiver Program, but transferred to Sunshine Health's LTC "Tango" Plan, with an effective enrollment date of March 1, 2014. AHCA contracts with Sunshine Health, a managed care/HMO company, to provide Long Term Care services to eligible Medicaid recipients. Petitioner also receives Medicare through a separate HMO, United Healthcare.

3. Upon enrollment with Sunshine, and in accordance with the requirements of their contract with AHCA, Petitioner's services continued, unaltered, until Sunshine conducted its own assessment of Petitioner's needs.

4. Sunshine conducted an assessment of Petitioner on or about January 30, 2015, and completed a care plan review in April of 2015. Per Petitioner's care plan, at least as early as April 27, 2015 (and noted as "ongoing"), he was authorized to receive monthly supplies of medical equipment including, but not limited to, these seven items:

- A6454, Co-band (self-adhesive): 31 units;
- A6402, 4x4 gauze: 200 units;

- A5120, Skin barrier/prep: 50 units;
- A6446, Self-conforming gauze: 31 units;
- A4216, Saline solution 10ML (sterile): 6 units;
- T5999, Cotton tip applicators: 1 box; and
- E0325, Male urinals: 2 units.

5. Via Notice of Case Action dated July 6, 2015, Sunshine informed Petitioner, in pertinent part:

> Sunshine Health has reviewed your request for Coban (self-adhesive bandage), 4x4 Gauze, Skin Barrier, Conforming Gauze, Sterile Saline, and Cotton Tipped Applications, which we received on 6/29/15. After our review, this service has been TERMINATED as of 7/16/15.
> ...
> We made our decision because:
> _X__ We determined that your requested services are **not medically necessary** because the services do not meet the reason(s) checked below: (See Rule 59G-1.010)
> ...
> _X__ **Other authority: Medicare is the primary payor.**
> **The wound care supplies: Coban (self-adhesive bandage), 4x4 Gauze, Skin Barrier, Conforming Gauze, Sterile Saline, and Cotton Tipped Applicators, have been terminated (stopped). Your Medicare policy is the primary payor for these items.**
> (emphasis original)

6. By a separate Notice of Case Action, also dated July 6, 2015, Sunshine informed the Petitioner that his male urinals would also be terminated, effective July 16, 2015, noting, "**You are getting Male Urinals, this has been terminated (stopped). Your Medicare policy is the primary payor for these items**," (emphasis original).

7. As Petitioner timely requested a hearing to challenge the termination of these seven medical supplies, Sunshine reinstated and has continued to supply the equipment, pending the outcome of this appeal.

8. On or about July 9, 2015, Sunshine completed an additional care plan review. Although the draft version of the care plan still lists the seven medical supplies in dispute, it is not clear whether Petitioner's case manager recommended continued authorization of same.

9. At hearing, Petitioner explained that he has requested certain supplies from Medicare, but has not requested coverage of all the medical supplies at issue. Petitioner did receive one denial letter from his Medicare HMO (United), on or about June 24, 2015. Said letter notes that Petitioner's request was denied as out-of-network, since the supplier he was using at the time (Prism) was not a participating provider.

10. In multiple attempts to coordinate his own care, Petitioner sought assistance from AHCA, the Department of Elder Affairs, Medicaid personnel, and his current MS supplier (Medline), regarding receipt of the supplies he needs. Petitioner was advised by Medline that Medicare would cover variations on some of the supplies; however, Petitioner has no further correspondence or denials from Medicare.

11. Sunshine argues that Petitioner must first request coverage of the MS from United, as Medicare is Petitioner's primary coverage provider. Sunshine does not specifically contend that the requested medical supplies are not necessary to treat Petitioner's wounds, nor does Sunshine contend that the supplies are non-covered items. It is Sunshine's position, however, that they will not authorize the supplies until they receive written notification from United as to what United/Medicare will and will not provide.

12. Mr. Gossett, on behalf of AHCA, argued that, per the Florida Medicaid Provider General Handbook (July 2012), Petitioner must submit all requests first to his Medicare

HMO. It was Mr. Gossett's position (per status conference and written correspondence with Petitioner) that Sunshine would not be required to provide medical supply coverage absent both a denial and an unsuccessful appeal from Petitioner's Medicare plan.

13. Ms. Taylor, on behalf of AHCA, posited that AHCA's contract with Sunshine LTC requires coordination of care. It was her position that Sunshine is responsible for providing case management and care coordination consistent with this contract. As such, she stated AHCA's position as requiring Sunshine to communicate with Petitioner's Medicare HMO to determine coverage of his medical supply needs.

CONCLUSIONS OF LAW

14. By agreement between AHCA and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction to conduct this hearing pursuant to Florida Statutes Chapter 120.

15. Legal authority governing the Florida Medicaid Program is found in Florida Statutes, Chapter 409, and in Chapter 59G of the Florida Administrative Code. Respondent, AHCA, administers the Medicaid Program.

16. This is a Final Order, pursuant to § 120.569 and § 120.57, Fla. Stat.

17. This hearing was held as a *de novo* proceeding, in accordance with Fla. Admin. Code R. 65-2.056.

18. The burden of proof in the instant case is assigned to Respondent, who proposes to terminate medical supply coverage.

19. The standard of proof in an administrative hearing is "preponderance of the evidence." (See Fla. Admin. Code R. 65-2.060(1).)

20. Florida Statutes §409.905 addresses mandatory Medicaid services under the State Medicaid Plan, noting, in part:

> Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law....
>
> (4) HOME HEALTH CARE SERVICES.—The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home. An entity that provides such services must be licensed under part III of chapter 400. These services, equipment, and supplies, or reimbursement therefor, may be limited as provided in the General Appropriations Act and do not include services, equipment, or supplies provided to a person residing in a hospital or nursing facility. (emphasis added)

21. Also with regard to managed care, per Fla. Stat. § 409.965:

> All Medicaid recipients shall receive covered services through the statewide managed care program, except...The following Medicaid recipients are exempt from participation in the statewide managed care program:
> (1) Women who are eligible only for family planning services.
> (2) Women who are eligible only for breast and cervical cancer services.
> (3) Persons who are eligible for emergency Medicaid for aliens.

22. Fla. Stat. § 409.972 adds to the list of those exempt, noting:

> (1) The following Medicaid-eligible persons are exempt from mandatory managed care enrollment required by s. 409.965, and may voluntarily choose to participate in the managed medical assistance program:
> (a) Medicaid recipients who have other creditable health care coverage, excluding Medicare.
> (b) Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice or mental health treatment facilities as defined by s. 394.455(32).
> (c) Persons eligible for refugee assistance.
> (d) Medicaid recipients who are residents of a developmental disability center, including Sunland Center in Marianna and Tacachale in Gainesville.

(e) Medicaid recipients enrolled in the home and community based services waiver pursuant to chapter 393, and Medicaid recipients waiting for waiver services.
(f) Medicaid recipients residing in a group home facility licensed under chapter 393.
(g) Children receiving services in a prescribed pediatric extended care center.
(2) Persons eligible for Medicaid but exempt from mandatory participation who do not choose to enroll in managed care shall be served in the Medicaid fee-for-service program as provided under part III of this chapter.
(3) The agency shall seek federal approval to require Medicaid recipients enrolled in managed care plans, as a condition of Medicaid eligibility, to pay the Medicaid program a share of the premium of $10 per month.

23. No evidence was presented to demonstrate that Petitioner may opt-out of managed care for his Long-Term Care needs.

24. Section 409.978, Florida Statutes, provides that the "Agency shall administer the long-term care managed care program," through the Department of Elder Affairs and through a managed care model. Fla. Stat. § 409.981(1), authorizes AHCA to bid for and utilize provider service networks to achieve this goal. In the instant case, the provider network/HMO is Sunshine Health.

25. Sunshine contends that its decision to terminate Petitioner's seven pieces of medical equipment is due not to the fact that they are not "medically necessary" to treat Petitioner's wounds, but rather, because Petitioner must first seek coverage of these supplies through his Medicare HMO. Although Sunshine's Notice references medical necessity, Sunshine did not rely upon this argument at hearing, nor contend that the items requested are uncovered items under Sunshine's LTC plan.

26. The July 2012 Florida Medicaid Provider General Handbook ("Provider General Handbook"), is incorporated into rule via Fla. Admin. Code R. 59G-5.020, as follows:

> All Medicaid providers enrolled in the Medicaid program and billing agents who submit claims to Medicaid on behalf of an enrolled Medicaid provider must comply with the provisions of the Florida Medicaid Provider General Handbook, July 2012…
> (emphasis added).

27. Per page 1-12 of the Provider General Handbook:

> Third Party Liability (TPL) is the obligation of any entity other than Medicaid or the recipient to pay all or part of the cost of the recipient's medical care. If the recipient has other coverage through a TPL source, the provider must bill the TPL source prior to billing Medicaid.
> …
> Florida Medicaid and Title 42, Code of Federal Regulations, Part, 447.20 (b), prohibit a provider from refusing to furnish a covered Medicaid service to a Medicaid recipient solely because of the presence of other insurance, including Medicare. Although providers can choose which Medicaid recipients they will serve, they cannot refuse services to recipients solely due to third party coverage.
> …
> **Responsibility For Exhausting TPL Sources**
> Medicaid is the payer of last resort. If a recipient has other insurance coverage through a third party source, such as Medicare, TRICARE, insurance plans, AARP plans, or automobile coverage, the provider must bill the primary insurer prior to billing Medicaid.
>
> If the amount of the third party payment meets or exceeds the Medicaid fee for the service, Medicaid will not reimburse for the service. If the third party payment amount is less than the Medicaid fee, Medicaid will reimburse the difference between the Medicaid fee and the third party payment minus any Medicaid copayment or coinsurance.
> (underline emphasis added)

28. This above-cited authority clearly sets forth a duty on behalf of the *provider* to bill/submit claims to Medicare before balance-billing to Medicaid. However, the authority does *not* specify that it is the responsibility of a Medicaid recipient/member to

request services from a Medicare HMO before requesting same from his Medicaid health plan.

29. According to AHCA's LTC plan contract with Sunshine Health (see AHCA, Attachment II Core Contract Provisions, Effective 11/15, page 90 of 214)[1]:

> Managing Mixed Services
> a. The Managed Care Plan shall provide case management and care coordination with other Managed Care Plans for enrollees with both MMA benefits and LTC benefits to ensure mixed services are not duplicative but rather support the enrollee in an efficient and effective manner. When a recipient is enrolled in both the LTC and MMA programs, the LTC case manager is primarily responsible for care coordination and case management to enrollees. LTC Managed Care Plans shall provide mixed services to enrollees with LTC benefits, regardless of an enrollee's enrollment in an MMA Managed Care Plan.
> ...
> b. Managed Care Plans shall coordinate with any other third party payor sources to ensure mixed services are not duplicative.
>
> (emphasis added)

30. Page 13 of 90 of the AHCA model contract, Attachment II, Exibit II-B, Effective 11/1/15 lists the descriptions for required LTC case management, noting:

> Care Coordination/Case Management — Services that assist enrollees in gaining access to needed waiver and other State plan services, as well as other needed medical, social, and educational services, regardless of the funding source for the services to which access is gained. Case management services contribute to the coordination and integration of care delivery through the ongoing monitoring of service provision as prescribed in each enrollee's plan of care.
> (emphasis added)

31. Although it is acknowledged that Petitioner's Medicare plan, United, may indeed be the payor of first resort, Sunshine initially authorized Petitioner's medical supplies as medically necessary. As Sunshine now seeks to terminate what it previously

[1] This corresponds to page 92 of 220 of the AHCA contract, effective April 15, 2015, which was entered as Respondent's Composite Exhibit 4.

authorized, Sunshine bears the burden of proving that its decision to terminate Petitioner's medical supplies is proper. Absent verification that United *will* cover the seven items at issue, and absent evidence to show that Sunshine has diligently attempted to coordinate this care with United, as required by its contract with AHCA, Sunshine cannot meet this burden.

32. Petitioner is cautioned that the undersigned makes no determination with regard to future requests for services or items, for which *Petitioner* might bear the burden of proof. As such, Petitioner is encouraged to keep in contact with his Sunshine case manager and request coordination of benefits, as needed.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner's appeal is hereby GRANTED.

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 30 day of November, 2015,

in Tallahassee, Florida.

Patricia C. Antonucci
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: appeal.hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Debbie Stokes, Area 4, AHCA Field Office Manager

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

[redacted]

APPEAL NO. 15F-05976

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 15 Palm Beach
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 8, 2015, at 1:00 p.m.

APPEARANCES

For the Petitioner: [redacted] pro se.

For the Respondent: Lisa Sanchez, Senior Program Specialist, Agency for Health Care Administration (AHCA).

STATEMENT OF ISSUE

At issue is the Agency's action, through Sunshine Health, in denying prescription coverage for [redacted] and [redacted] on April 15, 2015 due to the petitioner not meeting the criteria for Stage 3 or Stage 4 [redacted] The petitioner carries the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

Present as a witness for the petitioner was [redacted] Pharmacist.

Present as witnesses for the Agency were Paula Daley, Grievance and Appeals Coordinator II; Jill Hanson, Pharmacist; Richard Plymel, Pharmacy Manager; and Dr. David Gilchrist, Medical Director, all with Sunshine Health.

Present as an observer was Stephanie Smith with Sunshine Health.

The respondent submitted into evidence Respondent Exhibit 1 through 3.

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 lives in [redacted] County, Florida and is a Managed Medical Assistance Program (MMA) recipient. Sunshine Health Plan is the managed care agency authorized by AHCA to provide Medicaid services. The petitioner has [redacted] based on her condition of [redacted]

2. On or about April 15, 2015, the petitioner's treating physician requested prior authorization for the drugs Sovaldi 400mg and Ribavirin 200mg. It should be noted that Ribavirin is a drug provided in conjunction with Sovaldi and is not a stand-alone drug.

3. On April 15, 2015, Sunshine Health denied this request and mailed a Notice of Action to the petitioner stating:

> There was no evidence of stage 3 or 4 [redacted] in the clinical information provided. The APRI score provided was 0.522. Evidence of Stage 3 or 4 [redacted] is defined as: [redacted] confirming a MATAVIR score of F3 or F4; OR Transient elastography (Fibroscan) score > 9.5 kPa; OR FibroTest score of greater than or equal to 0.58; OR APRI score greater than 1.5; OR Radiological imaging consistent with [redacted]

(e.g., evidence of portal hypertension); OR Physical findings or clinical evidence consistent with [redacted] as attested by the prescribing physician.

4. The respondent's pharmacist witness indicated this decision was made after reviewing all of the medical information provided by the petitioner's treating physician and provider. She indicated that the decision was made by following AHCA criteria.

5. The petitioner meets stage 2, or F2, criteria for her level of [redacted] This is not in dispute. The petitioner and her witness argued that the drugs denied are needed to enhance the petitioner's quality of life. The petitioner argued that she needs the drugs now as it will be too late for her when she reaches stage 4. She argued that she is the best candidate for the denied drugs as she has had interferon treatment and she does not have many options at this time. She argued her liver is already enlarged.

6. The respondent reiterated that the decision remains correct based on the AHCA criteria and the petitioner's current level of liver function. She also indicated that if the petitioner meets the criteria of F3 or F4, she can then be approved for Sovaldi.

CONCLUSIONS OF LAW

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

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

9. In accordance with Fla. Admin. Code R. 65-2.060 (1), the party having the burden shall establish his/her position by a preponderance of the evidence, to the satisfaction of the hearing officer.

10. 42 C.F.R § 438.210 Coverage and authorization of services addresses the contractual requirements of agreements between states and managed care organizations and explains as follows:

> (b) *Authorization of services.* For the processing of requests for initial and continuing authorizations of services, each contract must require—
> ...
> (3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

11. Section 409.912 (8)(a), Florida Statutes states in relevant parts:

> (14) **The agency may require prior authorization for Medicaid-covered prescribed drugs. The agency may prior-authorize the use of a product**:
> a. For an indication not approved in labeling;
> b. **To comply with certain clinical guidelines**; or
> c. If the product has the potential for overuse, misuse, or abuse.
>
> The agency may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug. The agency shall post prior authorization, step-edit criteria and protocol, and updates to the list of drugs that are subject to prior authorization on the agency's Internet website within 21 days after the prior authorization and step-edit criteria and protocol and updates are approved by the agency.

12. Fla. Admin. Code R. 59G-1.010 states in part:

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service…

13. The Agency for Health Care Administration's Prior Authorization Criteria for Sovaldi to treat [redacted] (treatment naïve with or without [redacted] treatment experienced without [redacted] requires, among other criterion:

Documentation of concurrent (or planning to start) therapy with ribavirin and peg-interferon when starting SOVALDI for a 12-week duration

Evidence of Stage 3 or Stage 4 [redacted] including one of the following:

- Liver biopsy confirming a METAVIR score of F3 or F4; OR
- Transient elastography (Fibroscan) score greater than or equal to 9.5 kPa; OR
- Fibro Test score of greater than or equal to 0.58; OR
- APRI score greater than 1.5; OR
- Radiological imaging consistent with [redacted] (e.g., evidence of portal hypertension); OR
- Physical findings or clinical evidence consistent with cirrhosis as attested by the prescribing physician.

14. As shown in the Findings of Fact, Sunshine Health denied the petitioner's request for Sovaldi and Ribavirin on April 15, 2015 due to not meeting the criteria for Stage 3 or Stage 4 [redacted]

15. For the case at hand, the petitioner has not presented evidence of Stage 3 or Stage 4 [redacted] nor has she demonstrated that she meets the requirements set forth in AHCA's Prior Authorization Criteria noted above. Since the petitioner does not meet the preauthorization requirements for the approval of Sovaldi or Ribavirin, the respondent correctly denied prescription coverage for these drugs.

16. After careful review of the evidence submitted and the relevant laws set forth above, the undersigned concludes the Agency's action to deny prescription coverage for Sovaldi and Ribavirin was proper, and the Petitioner's burden was not met.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is denied and the Agency action affirmed.

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 16 day of December, 2015,

in Tallahassee, Florida.

Robert Akel

Robert Akel
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
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Judy Jacobs, Area 7, AHCA Field Office

[redacted]
Beverly Smith, Esq.

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

[redacted]

PETITIONER,

Vs.

APPEAL NO. 15F-06184

CASE NO. [redacted]

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 12 Manatee
UNIT: 883CF

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter on October 5, 2015 at 8:31 a.m. All parties appeared from different locations. One continuance was granted for both the petitioner and the respondent.

APPEARANCES

For Petitioner: [redacted] pro se

For Respondent: Ed Poutre, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether respondent's action to deny petitioner's application for SSI-Related Medicaid is correct. The burden of proof is assigned to the petitioner.

PRELIMINARY STATEMENT

Petitioner was present and testified; however, petitioner was represented by [redacted] [redacted] testified. Petitioner

submitted five exhibits, which were accepted into evidence and marked as Petitioner's Exhibits "1" through "5". Respondent was represented by Ed Poutre with the Department of Children and Families (hereafter "DCF", "Respondent" or "Agency"). Respondent provided one witness who testified: Lauren Coe, Program Office Administrator with Department of Health's Division of Disability Determinations (hereafter "DDD"). Respondent submitted eight exhibits, which were accepted into evidence and marked as Respondent's Exhibits "1" through "8". The record closed on October 5, 2015.

FINDINGS OF FACT

1. On October 15, 2013, the petitioner applied for Supplemental Security Income (SSI) benefits from the Social Security Administration (SSA). On April 15, 2014, SSA denied petitioner's SSI application using the code N32. N32 means "Non-pay-Capacity for substantial gainful activity – other work, no visual impairment". Petitioner is currently appealing the denial of his SSI application.

2. Petitioner is a [redacted] male who had his first [redacted] in 2005; furthermore, he had [redacted] one in 2005 and the other in 2012, to place [redacted]

3. On May 15, 2015, the petitioner was admitted to the hospital and required [redacted] during his hospital stay.

4. On May 22, 2015, the petitioner submitted an application for SSI-Related Medicaid benefits on the basis that he was disabled.

5. On June 4, 2015, the respondent reviewed petitioner's request for SSI-Related Medicaid benefits and submitted the necessary paperwork to DDD to determine if petitioner is disabled and eligible for SSI-Related Medicaid benefits.

6. On June 2015, DDD received the Disability Determination and Transmittal form along with medical evidence and other documentation. DDD determined it required additional information from petitioner to determine if he was disabled.

7. On several occasions, DDD tried contacting petitioner to inform him he was required to speak with a representative from DDD. The representative wanted to speak with petitioner to "see how he was doing after the operation"; to discuss his work history; and to discuss his ability to complete his Activities of Daily Living (ADLs).

8. Petitioner never contacted DDD, so on July 13, 2015, DDD determined petitioner not disabled as there was insufficient evidence in the file to make an independent determination. Petitioner's application with DDD resulted in an unfavorable decision of N36. Decision code N36 indicates there is insufficient evidence to assess claimant's allegations.

9. On July 16, 2015, the respondent mailed petitioner a Notice of Case Action indicating his May 22, 2015 Medicaid application was denied as "you or a member(s) of your household do not meet the disability requirement".

10. Petitioner received a [redacted] and never attended college.

11. Petitioner is currently unable to work and last worked in 2013. He worked as a [redacted] was self employed (doing manual labor) from June 2009 through January 2012; and worked as a [redacted]

12. Petitioner asserted he could not return to work as a [redacted] as those jobs require lifting, which he is unable to perform due to his medical condition.

13. Petitioner is able to complete some ADLs, such as bathing, grooming, and brushing his teeth. He does not cook or complete chores around the home. Petitioner's surgery has not affected his ability to socialize outside of the home.

14. Petitioner asserted some days are better than others as some days he has trouble breathing and cannot walk and other days he can breathe and walk.

CONCLUSIONS OF LAW

15. 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.

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

17. The Fla. Admin. Code R. 65A-1.705(7)(c) Family-Related Medicaid General Eligibility Criteria, in part states:

> If assistance is requested for the parent of a deprived child, the parent and any deprived children who have no income must be included in the SFU. Any deprived siblings who have income, or any other related fully deprived children, are optional members of the SFU. If the parent is married and the spouse lives in the home, income must be deemed from the spouse to the parent. For the parent to be eligible, there must be at least one child under age 18, with or without income, in the SFU, or who would be in the SFU if not receiving SSI...

18. According to the above authority, to be eligible for Family-Related Medicaid, petitioner must have a minor child under age 18 living in the household with him. Since

petitioner does not have any children under the age of 18 living in the home, he does not meet the technical requirement to be eligible for Family-Related Medicaid benefits.

19. Fla. Admin. Code R. 65A-1.710 sets forth the rules of eligibility for SSI-Related Medicaid Coverage Groups. The MEDS-AD Demonstration Waiver is a coverage group for aged and disabled individuals (or couples), as provided in 42 U.S.C. § 1396a(m). For an individual less than 65 years of age to receive benefits, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905 which states, in part:

> (a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see § 416.960(b)) or any other substantial gainful work that exists in the national economy.

20. Pursuant to the above authority, to be eligible for SSI-Related Medicaid, petitioner must be determined disabled as he is under the age of 65 and not considered disabled by the Social Security Administration.

21. Federal Regulation 42 C.F.R. § 435.541 provides that a state Medicaid determination of disability must be in accordance with the requirements for evaluating evidence under the SSI program specified in 20 C.F.R. §§ 416.901 through 416.998.

22. Federal Regulation 20 C.F.R. § 416.920, Evaluation of Disability of Adults, explains the five-step sequential evaluation process used in determining disability; however, DDD did not complete the five-step evaluation process as it determined the petitioner's medical evidence was insufficient to be able to complete an independent

determination. Since petitioner never contacted DDD, it (DDD) determined he was not disabled as there was insufficient evidence to support his allegation of disability.

23. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner has not met his burden of proof in establishing the respondent incorrectly denied his application for SSI-Related Medicaid benefits.

24. The respondent was correct in denying petitioner's application for SSI-Related Medicaid benefits effective May 2015 and ongoing. Petitioner and his representative are encouraged to submit a new application for SSI-Related Medicaid benefits as petitioner is now available to speak with DDD.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the SSI-Related Medicaid appeal is DENIED.

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 16th day of November, 2015,

in Tallahassee, Florida.

Mary Jane Stafford
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency
[redacted]

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

[redacted]

APPEAL NO. 15F-06213

PETITIONER,

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 06 Pasco
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing in the above-styled matter convened on October 29, 2015 at approximately 1:00 p.m. All parties and witnesses appeared via teleconference.

APPEARANCES

For the Petitioner: [redacted] Petitioner

For the Respondent: Stephanie Lang, Registered Nurse Specialist,
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is a decision by Respondent, the Agency for Health Care Administration (AHCA or "the Agency), through its contracted health plans, to deny Petitioner's request for Magnetic Resonance Imaging (MRI) scans of the cervical and lumber spine. Petitioner bears the burden of proving, by a preponderance of the evidence, that this denial was improper.

PRELIMINARY STATEMENT

The Agency for Health Care Administration is responsible for administering Florida's Medicaid Program. In the instant case, AHCA has contracted with the Managed Care Organization (MCO), Amerigroup, to provide services to enrolled Medicaid recipients. Amerigroup, in turn, contracts with AIM Specialty Health (AIM) to conduct prior authorization reviews of requests for diagnostic imaging.

This matter was initially scheduled to convene for hearing on September 17, 2015 at 10:00 a.m. Petitioner failed to appear for hearing, but later called the Office of Appeal Hearings to request rescheduling. Both parties were notified in advance of the rescheduled hearing date.

Petitioner appeared as her own representative. Respondent was represented by Stephanie Lang, RN, AHCA Registered Nurse Specialist/Fair Hearing Coordinator, who presented two witnesses: Laura Winthrow, Manager in Amerigroup's Quality Management Department, and Jennifer Eklund, M.D., Associate Medical Director of Government Programs with AIM.

Although Petitioner had not received her copy of Respondent's evidence packet prior to hearing, she opted to proceed, as scheduled. Respondent's Exhibits 1 through 6, inclusive, were accepted into evidence. Administrative Notice was taken of pertinent legal authority. The record was held open until November 6, 2015, so that Respondent might furnish Petitioner with a copy of the evidence, and Petitioner might file any needed response to same. The undersigned received a certificate of service that the evidence was furnished to Petitioner, but has not received any further correspondence or any responsive filing thereto.

FINDINGS OF FACT

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

1. Petitioner is an adult female (57 years old at the time of hearing) with a medical history including back pain as the result of an automobile accident. She works as a hair-dresser, but has had to cut down on her hours, as she is unable to stand for long periods of time. She feels the pain is getting worse and worries she might need surgery. She is also concerned that if she is unable to work, she will lose her Medicaid coverage.

2. On June 18, 2015, Petitioner's treating physician called in to AIM a request for cervical and lumbar MRIs, noting a diagnosis of [redacted]" Later that same day, the physician called AIM, again. Per AIM's records and testimony, the diagnoses provided were [redacted], and the following additional information was obtained:

> No ddx [differential diagnosis]. No physician supervised conservative treatment for 4 weeks. Unknown if the patient is a potential candidate for epidural injection or surgery. No XR. No hx of malignancy, fever, or unexplained weight loss. No focal neuroglial deficits.

3. Also on June 18, 2015, the reviewing AIM nurse sent a request to the prescribing physician, asking that he participate in a peer-to-peer review. After the physician failed to respond, the MRI request was transferred to AIM's physician consultants for a medical necessity review.

4. On June 22, 2015, AIM denied the request as failing to meet clinical criteria; however, this denial was transferred to holding so as to await participation in a peer-to-peer conference. When the prescribing physician failed to return AIM's correspondence by June 24, 2015, the MRI denial was finalized.

5. Via Amerigroup Notices of Case Action (NOCAs) dated June 24, 2015, Petitioner was informed that her requests for lumbar spine and cervical spine MRIs were denied because they were not "individualized, specific and consistent with symptoms or diagnosis or illness or injury and not... in excess of the patient's needs." The cervical NOCA stated:

> Our records show that you are being treated for [redacted]. This test is medically necessary when the pain has not improved after 3 to 4 weeks of treatment by your doctor. Your doctor needs to have seen you in the office after treatment. You also need to be a candidate for surgery or steroid injection. Our records do not show that this is the case for you. We used AIM Specialty Health Guideline for Magnetic Resonance Imaging (MRI)... to make this decision. You may view this guideline at http://www.aimspecialtyhealth.com/marketing/guidelines/185/index.html.

The lumbar NOCA utilized the same language, but referenced [redacted] and 4 to 6 weeks of unsuccessful treatment.

6. The above-referenced guidelines were submitted into evidence, and reflect the following criteria for MRIs:

> **Non-specific** [redacted]
> • In a patient where focused history and physical exam suggest non-specific cervical pain and/or referred upper extremity pain and all of the following are met:
> ○ Patient is a potential candidate for surgery or epidural steroid injection; **AND**
> ○ Patient has, following clinical examination, completed a minimum of 3-4 consecutive weeks of physician supervised conservative therapy for the current episode of pain, including but not limited to any of the following:

■ NSAIDs
■ Muscle relaxants
■ Steroids
■ Physical therapy; **AND**
○ After trial of conservative therapy as listed above, patient fails to show substantial improvement on clinical re-evaluation; **OR**
● In the pediatric population, pain in the cervical spine region may not require completion of the 3-4 week course of conservative treatment; **OR**
● [redacted] not meeting the above criteria but associated with "red flag" symptoms such as unexplained weight loss, history of malignant disease, fever, abnormal serum electrophoresis suggestive of multiple myeloma, history of drug abuse or tuberculosis

...

Non-specific [redacted]
● In a patient where focused history and physical exam suggest non-specific lumbar pain and/or referred buttock or lower extremity pain and all of the following are met:
○ Patient is a potential candidate for surgery or epidural steroid injection; **AND**
○ Patient has, following clinical examination, completed a minimum of 4-6 consecutive weeks of physician supervised conservative therapy for the current episode of pain, including but not limited to any of the following:
■ NSAIDs
■ Muscle relaxants
■ Steroids
■ Physical therapy; **AND**
○ After trial of conservative therapy as listed above, patient fails to show substantial improvement on clinical re-evaluation; **OR**
● In the pediatric population, pain in the lumbar spine region may not require completion of the 4-6 week course of conservative treatment; **OR**
● [redacted] not meeting the above criteria but associated with "red flag" symptoms such as unexplained weight loss, history of malignant disease, fever, abnormal serum electrophoresis suggestive of multiple myeloma, history of drug abuse or tuberculosis.
(emphasis original)

7. With regard to appeal rights, both NOCAs read:

How to Ask for an Appeal:
You can ask for an appeal in writing or by calling us. Your case manager can help you with this, if you have one. We must receive the request *within 30 days* of the date of this letter. Here is where to call or send your request:

Medical Appeals

> Greivance and Appeals Coordinator
> Amerigroup
> ...
> PHONE: 1-800-600-441 (TTY 1-800-855-2880)
> ...
> Within five days of getting your appeal, we will tell you in writing that we got your appeal unless you ask for an expedited (fast) appeal. We will give you an answer to your appeal within 45 days of you asking for an appeal.
> (all emphasis original)

8. On or about July 2, 2015, Petitioner filed a verbal request for an appeal with Amerigroup.

9. On July 20, 2015, Amerigroup administratively closed this request for appeal because "the required written follow up was not received within the allotted time (10 calendar days)."

10. On July 22, 2015, Petitioner filed an appeal with the Office of Appeal Hearings.

11. At hearing, Dr. Eklund (AIM) explained that without any supporting information from the prescribing physician, AIM was unable to determine if the clinical criteria were met, and was thus unable to approve the MRIs.

12. Petitioner stated that her physician told her he does not participate in peer-to-peer conversations. She explained that she has had difficulty locating participating physicians since enrolling with Amerigroup, and her former physician, who has her medical records, does not accept the plan. She knows her diagnosis is a [redacted] but is unable to obtain the records to show this is the case. She does not experience any of the symptoms noted in the guidelines as "red flags," but does experience pain.

13. Amerigroup noted that, had Petitioner followed her verbal request for appeal with a written request, they could have assisted her in obtaining medical records; however, since she did not, they closed out her grievance without any further action. It is Amerigroup's position that the requirement to follow a verbal request with a written one is contained within their member handbook. Said handbook is not part of the record.

CONCLUSIONS OF LAW

14. By agreement between AHCA and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction to conduct this hearing, pursuant to Florida Statutes Chapter 120.

15. Legal authority governing the Florida Medicaid Program is found in Fla. Stat. Chapter 409, and in Chapter 59G of the Florida Administrative Code. Respondent, AHCA, administers the Medicaid Program.

16. This is a Final Order, pursuant to Sections 120.569 and 120.57, Florida Statutes.

17. This hearing was held as a *de novo* proceeding, in accordance with Florida Administrative Code Rule 65-2.056.

18. The burden of proof was assigned to Petitioner in accordance with Florida Administrative Code Rule 65-2.060(1).

19. The standard of proof in an administrative hearing is by a preponderance of the evidence (See Fla. Admin. Code R. 65-2060(1)), which requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

20. Section 409.905, Florida Statutes, addresses mandatory Medicaid

services under the State Medicaid Plan:

> Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law....

21. Florida Administrative Code Rule 59G-1.010(166) defines medical necessity, as follows:

> "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
>
> (a) Meet the following conditions:
>
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
>
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
>
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
>
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
>
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. ...
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

22. The medical necessity rule, cited above, incorporates a requirement that the service requested be consistent with the generally accepted professional medical standards, as determined by the Medicaid program. The Medicaid Practitioner Services Coverage and Limitations Handbook (April 2014) ("the Handbook") is promulgated into

law by Florida Administrative Code Rule 59G-4.205(2). At page 2-99, the Handbook explains that radiology and nuclear medicine requests, such as Petitioner's request for an MRI, require prior authorization, noting:

> Prior authorization (PA) is the approval process required prior to providing certain Medicaid services to recipients. Medicaid will not reimburse for the designated, outpatient, non-emergent diagnostic imaging services without prior authorization.

23. In conducting its PA reviews, Amerigroup, through AIM, utilizes guidelines to determine the medical necessity of a requested service. Said guidelines, as outlined in paragraph 6, above, require that a patient requesting an MRI, who is not in the pediatric population and does not exhibit "red flag" symptoms, must document unsuccessful trials of more conservative treatment, such as drug or physical therapy, before an MRI will be authorized. No such documentation was submitted in Petitioner's case.

24. With regard to Amerigroup's handling of Petitioner's internal appeal/grievance, the undersigned sees no indication within Amerigroup's NOCA that an appeal filed with Amerigroup via telephone must be followed up in writing. Instead, the NOCA very clearly states that a member may file an appeal "in writing or by calling us" (emphasis added). Regardless of what may be written in Amerigroup's member handbook, the instructions set forth in their NOCA are clear, and were properly followed by Petitioner. Amerigroup prematurely terminated the grievance process; however, while this is poor customer service, it ultimately has no bearing on the outcome of this appeal.

25. It is unfortunate that Petitioner's prescribing physician is resistant to peer-to-peer conferences and does not seem amenable to assisting Petitioner in obtaining the

services she desires. As Petitioner has noted her frustration in finding physicians who participate in Amerigroup, the Amerigroup witness provided the following customer call center number, to assist in Petitioner's search: 1-800-600-4441. If Petitioner is still unable to locate providers, or experiences any other frustration with her health plan, she is encouraged to call the Medicaid Managed Care Complaint Line at 1-877-254-1055.

26. Based upon review of the entire record, Petitioner has not met her burden to show that Respondent's denial was improper. Should she wish to resubmit a request for MRIs with additional supporting documentation, she is encouraged to do so. If said request is denied, Petitioner will reserve the right to appeal that, distinct, denial.

DECISION

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

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 11 day of December, 2015,

in Tallahassee, Florida.

Patricia C. Antonucci
Hearing Officer
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Email: appeal.hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Don Fuller, Area 5, AHCA Field Office Manager

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

[redacted]

PETITIONER,

Vs.

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

RESPONDENT.
_____/

APPEAL NO. 15F-06221

CASE NO.

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on November 10, 2015, at 3:10 p.m.

APPEARANCES

For the Petitioner: [redacted]
Petitioner's mother

For the Respondent: Linda Latson, R.N.
Registered Nurse Specialist/Fair Hearing Coordinator
Agency for Health Care Administration

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the Agency for Health Care Administration incorrectly denied his request for an increase in his speech therapy services from one hour per week to three hours per week?

PRELIMINARY STATEMENT

[redacted] the petitioner's mother, appeared on behalf of the petitioner, [redacted] ("petitioner"), who was not present. [redacted] may sometimes hereinafter be referred to as the petitioner's "representative".

Linda Latson, R.N., Registered Nurse Specialist and Fair Hearing Coordinator for the Agency for Health Care Administration ("AHCA" or "Agency"), appeared on behalf of the Agency for Health Care Administration. The following individuals from Better Health appeared as witnesses on behalf of the Agency: Jeannette Rios, D.O., Medical Director; Carrie Jordan, C.C.C., M.S., S.L.P., Speech Language Pathologist; and Diana Anda, Grievance and Appeals Supervisor.

The respondent introduced respondent's Exhibits "1" through "8", inclusive, at the hearing, which were accepted into evidence and marked accordingly. At the request of the respondent, the hearing officer took administrative notice of the Florida Medicaid Therapy Services Coverage and Limitations Handbook – August 2013.

FINDINGS OF FACT

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

1. Petitioner is a four year old male diagnosed with [redacted] and [redacted] disorder and [redacted] disorder.

2. The petitioner was eligible to receive Medicaid at all times relevant to this proceeding.

3. The petitioner is an enrolled member of Better Health. Better Health is a health maintenance organization ("HMO") contracted by the State of Florida to provide

services to certain Medicaid-eligible individuals in the State of Florida. The petitioner's effective date of enrollment with Better Health is July 1, 2014. Within Better Health, the petitioner is enrolled in the Managed Medical Assistance ("MMA") Program.

4. The petitioner was previously approved to receive four units of speech therapy services per week.

5. One unit of speech therapy is equivalent to 15 minutes; hence, four units equals one hour.

6. On or about August 12, 2015, KID SPOT, the petitioner's speech therapy provider, submitted a request to Better Health for 228 units of speech therapy. This therapy was to be provided in the amount of 12 units (three 60 minute sessions) weekly.

7. The petitioner's request for speech therapy services was accompanied by a Re-evaluation and a Plan of Care.

8. In a Notice of Action dated August 13, 2015, Better Health informed the petitioner it was approving 76 units of speech therapy and denying the remaining 152 units. The 76 units of speech therapy approved allow for one hour of speech therapy to be provided per week.

9. The Notice of Action states, in part:

> X We determined that your requested services are **not medically necessary** because the services do not meet the reason(s) checked below: *(See Rule 59G-1.040)*
>
> X Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs.

10. Speech consists of multiple individual components, including receptive language skills, expressive language skills, fluency, and articulation.

11. Receptive language abilities are skills that enable a child to understand the meaning of sound and spoken language.

12. Expressive language skills enable a child to produce spoken language.

13. Fluency refers to the degree of stuttering present during speech, if any.

14. Articulation relates to speech production and the system of individual sounds that are produced to create words.

15. The petitioner's Re-evaluation submitted along with his preauthorization request indicates he was administered the Preschool Language Scale -5 ("PLS-5") (3rd Edition) by his speech language provider, [redacted]

16. The Preschool Language Scale-5 is an assessment used to measure auditory comprehension and expressive communication for children from birth to age 7-11.

17. The Preschool Language Scale-5 has a mean of 100 and a standard deviation +/- 15. This means that standard scores between 85 and 115 are considered to be within the average range.

18. The petitioner received a score of 75 on the portion of the assessment designed to measure his receptive language abilities. This indicates the petitioner's receptive language skills are below average for his age.

19. The petitioner received a score of 80 on the portion of the assessment designed to measure his expressive language abilities. This indicates the petitioner's expressive language skills are below average for his age.

20. The petitioner's mother testified the petitioner's stutters and is difficult to understand.

21. Stuttering relates to fluency and indicates a lack thereof. Being difficult to understand indicates the petitioner has difficulty with articulation.

22. The petitioner's Re-evaluation contains no formal or informal information regarding fluency or articulation. Formal information is generally presented in the form of test results. Informal information may include case notes from an individual's speech language pathologist.

23. There are standardized evaluations designed to measure fluency and articulation.

24. If the petitioner was tested for fluency and articulation, these test results are not included in the Re-evaluation, nor were they provided to Better Health during the review process or the hearing officer during the appeal process.

25. The petitioner's Plan of Care does not list any goals with respect to fluency and articulation.

26. Based on the information provided to it, Better Health determined the petitioner's receptive and expressive language deficits are mild and an increase in his speech therapy services is not medically necessary.

27. The speech language pathologist testifying on behalf of the respondent explained Better Health considers the petitioner's receptive and expressive language deficits as mild because they are less than two standard deviations from the average. The petitioner received scores of 75 and 80 on the relevant portions of the Preschool Language Scale-5. A score of 70 is required for a result to be considered two standard deviations from the mean.

28. The speech language pathologist testifying for the respondent explained to the petitioner's mother that she can request [redacted] to evaluate the petitioner for fluency and articulation. She explained that if difficulties in these areas are documented and forwarded to Better Health along with a request for additional speech therapy, the petitioner may be approved to receive additional speech therapy services.

CONCLUSIONS OF LAW

29. 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 Fla. Stat. § 120.80.

30. The Florida Medicaid Program is authorized by Chapter 409, Fla. Stat., and Chapter 59G, Florida Administrative Code. The Program is administered by AHCA.

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

32. The petitioner is requesting an increase in his speech therapy services. Therefore, in accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof is assigned to the petitioner.

33. 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.).

34. The Florida Medicaid Therapy Services Coverage and Limitations Handbook – August 2013 is incorporated by reference in the Medicaid Services Rules by Fla. Admin. Code R. 59G-4.320.

35. Fla. Admin. Code R. 59G-4.320 implements certain limitations for therapy services covered by Medicaid. These limitations are defined in the Florida Medicaid Therapy Services Coverage and Limitations Handbook.

36. Page 2-2 of the Therapy Services Coverage and Limitations Handbook states services are to be provided only when medically necessary.

37. Fla. Admin. Code R. 59G-1.010(166), defines medical necessity as:

> (166) "Medically necessary" or "medical necessity" means that medical or allied care, goods or services furnished or ordered must:
>
> (a) Meet the following conditions:
>
> 1. Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patent's needs;
> 3. Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational;
> 4. Be reflective of the level of service that can safely be furnished, for which no equally effective and more conservative or less costly treatment is available statewide; and,
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. . .
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods or services medically necessary, or a medical necessity, or a covered service.

38. Since petitioner is under 21, a broader definition of medically necessary applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPDST) requirements. Section 409.905, Fla. Stat., Mandatory Medicaid Services defines Medicaid services for children to include:

> (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

39. Section 409.913, Fla. Stat. governs the oversight of the integrity of the Florida Medicaid Program. Section (1)(d) sets forth the "medical necessity or medically necessary" standards, and states in pertinent part as follows

> "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice....
> Section (1)(d) goes on the further state:
>
> ...For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

40. Section (1)(d) highlights that the Agency makes the final decision regarding whether or not a requested service is medically necessary; however, the hearing officer is the final decision making authority for the Agency. See § 120.80, Fla. Stat.

41. The Therapy Services Coverage and Limitations Handbook defines speech therapy on Page 1-4. It states as follows:

> Speech-language pathology services involve the evaluation and treatment of speech-language disorders.
>
> Services include the evaluation and treatment of disorders of verbal and written language, articulation, voice, fluency, phonology, mastication, deglutition, cognition, communication (including the pragmatics of verbal communication), auditory processing, visual processing, memory comprehension and interactive communication as well as the use of instrumentation, techniques, and strategies to remediate, maintain communication functioning, acquire a skill set, restore a skill set, and enhance the recipient's communication needs, when appropriate. Services also include the evaluation and treatment of oral pharyngeal and laryngeal sensorimotor competencies.

42. The Therapy Services Coverage and Limitations Handbook, on Page 2-2, states: "Medicaid reimburses for services that are determined medically necessary and do not duplicate another provider's service."

43. In the present case, the petitioner did not provide any evidence to support that an increase in his speech therapy services is medically necessary. Therefore, the petitioner has not met his burden of proof that the Agency incorrectly denied his request for additional speech therapy.

44. This Order does not purport to state that the petitioner would not benefit from additional speech therapy services, only that there is no evidence to support an increase at this time. If the petitioner still feels additional speech therapy services are medically necessary, he is encouraged to undergo the additional testing discussed at the hearing and submit the results of those evaluations to Better Health along with a new request for additional services.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is 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 14 day of December, 2015, in Tallahassee, Florida.

Peter J. Tsamis

Peter J. Tsamis
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

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

[redacted]

APPEAL NO. 15F-06480
APPEAL NO. 15F-06481

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 13 Hillsborough
UNIT: 883DT

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter on September 16, 2015 at 1:02 p.m. All parties appeared from different locations.

APPEARANCES

For Petitioner: [redacted] pro se

For Respondent: Ed Poutre, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

At issues are whether the respondent's action to (1) deny petitioner and her husband's application for full Medicaid benefits and instead enroll them in the Medically Needy (MN) program effective May 1, 2015 and ongoing; and to (2) deny petitioner and her husband's application for the Medicare Savings Program (MSP) effective May 1,

2015 and ongoing are correct. The burden of proof for both issues is assigned to the petitioner.

PRELIMINARY STATEMENT

Petitioner was present and testified. Petitioner did not submit any exhibits at the hearing. Respondent was represented by Ed Poutre with the Department of Children and Families (hereafter "DCF", "Respondent" or "Agency"). Respondent submitted five exhibits, which were entered and marked as Respondent's Exhibits "1" through "5".

The record was left open until September 23, 2015 to allow all parties the opportunity to provide additional information. On September 22, 2015, the respondent submitted additional information, which was entered and marked as Respondent's Exhibits "6" through "13". The record closed on September 23, 2015.

FINDINGS OF FACT

1. On March 26, 2015, the respondent terminated petitioner's full Medicaid benefits and Qualifying Individual 1 (QI1) benefits as she began receiving Medicare effective May 1, 2015.

2. On March 25, 2015, petitioner submitted an interim contact letter to apply for SSI-Related Medicaid benefits. The application listed petitioner and her husband as residents in the household, petitioner's Social Security Disability Insurance (SSDI) income as $879 per month; and husband's SSDI income as $987 per month.

3. On March 27, 2015, the respondent mailed petitioner a Notice of Case Action indicating petitioner's QI1 benefits would end for her and her husband effective April 30, 2015 as "Your household's income is too high for this program".

4. On March 31, 2015, the respondent mailed petitioner a Notice of Case Action indicating petitioner and her husband's MN application dated March 25, 2015 was approved with a monthly estimated share of cost (SOC) of $1,605. Furthermore, the notice indicated petitioner and her husband's March 25, 2015 QI1 application was denied as "Your household's income is too high to qualify for this program".

5. On April 1, 2015, the petitioner submitted an application for SSI-Related Medicaid and MSP Benefits. The application listed petitioner and her husband as residents in the household, petitioner's SSDI income as $879.90 per month; husband's SSDI income as $987 per month; and petitioner and husband as receiving Medicare Part A and B.

6. On April 3, 2015, the respondent mailed petitioner a Notice of Case Action indicating petitioner's April 1, 2015 QI1 application was denied for her and her husband effective April 2015 as "Your household's income is too high for this program".

7. On April 8, 2015, the respondent mailed petitioner a Notice of Case Action indicating petitioner and her husband's estimated monthly SOC amount was reduced from $1,605 to $1,500 effective May 1, 2015.

8. On May 21, 2015, the petitioner submitted an application for SSI-Related Medicaid and MSP Benefits. The application listed petitioner and her husband as residents in the household, petitioner's SSDI income as $879.90 per month; husband's SSDI income as $987 per month; and petitioner and husband as receiving Medicare Part A and B.

9. On June 3, 2015, the respondent mailed petitioner a Notice of Case Action indicating petitioner and her husband's estimated monthly SOC amount was reduced

from $1,500 to $1,395 effective July 1, 2015. The notice also indicated petitioner's May 21, 2015 QI1 application was denied for her and her husband effective May 2015 as "Your household's income is too high for this program".

10. On July 6, 2015, the petitioner filed a hearing concerning the respondent's determination of her Food Assistance (FA) benefit amount. FA benefit amounts are not at issue during this proceeding.

11. On July 30, 2015, the petitioner indicated she was also appealing her and husband's denial for full Medicaid benefits and the termination of their QI1 benefits. On July 30, 2015, the respondent filed petitioner's hearing request for SSI-Related Medicaid and QI1 benefits.

12. On July 31, 2015, the respondent mailed petitioner a Notice of Case Action indicating petitioner's July 30, 2015 QI1 application was denied for her and her husband effective July 2015 as "Your household's income is too high for this program". The July 30, 2015 application was not submitted into evidence.

13. On August 13, 2015, the respondent mailed petitioner a Notice of Case Action indicating petitioner's August 12, 2015 QI1 application was denied for her and her husband effective July 2015 as "Your household's income is too high for this program". The August 12, 2015 application was not submitted into evidence.

14. On August 31, 2015, the petitioner submitted an application for SSI-Related Medicaid and MSP Benefits. The applications listed petitioner and her husband as residents in the household and petitioner's SSDI income as $879.90 per month; husband's SSDI income as $986.90 per month; and petitioner and husband as receiving Medicare Part A and B.

15. On September 3, 2015, the respondent mailed petitioner a Notice of Case Action indicating petitioner's August 31, 2015 QI1 application was denied for her and her husband effective July 2015 as "Your household's income is too high for this program".

16. Respondent determined petitioner and her husband's MN SOC amount as $1,395 per month effective October 2015 and ongoing as follows:

$1865.00	petitioner's and husband's SSDI income
-$ 20.00	unearned income disregard
$1845.00	total countable income
-$ 241.00	MNIL for a household of two
-$ 209.80	Med. Insurance Premium
$1394.00	share of cost

17. Respondent determined petitioner and her husband over the income standard for QI1 effective October 2015 and ongoing as follows:

$1865.00	petitioner's and husband's SSDI income
-$ 20.00	unearned income disregard
$1845.00	total countable income
$1793	QI1 income standard for a household of two

18. Petitioner does not dispute her SSDI income as $879.90 per month or her husband's SSDI income as $986.90 per month. Respondent did not submit any MN or QI1 budgets for months prior to October 2015.

19. Petitioner does not agree with the respondent's determination that she and her husband are not eligible for full SSI-Related Medicaid benefits and are not eligible for the QI1 benefits. She and her husband both need full Medicaid benefits due to their severe medical illnesses. Furthermore, they do not have enough money to pay for their medical expenses, Medicare premiums, as well as all of their other household expenses.

20. All of the aforementioned Notices of Case Actions and applications have petitioner's address listed as [redacted]

CONCLUSIONS OF LAW

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

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

23. Prior to discussing the merits of the case, the undersigned has to determine if petitioner timely requested her appeal for the notices dated March 27, 2015 through September 3, 2015.

24. The Fla. Admin. Code R.65-2.046, Time Limits in Which to Request a Hearing states:

> (1) The appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs. Additionally, in the Food Stamp Program, a household may request a fair hearing at any time within a certification period to dispute its current level of benefits. The time period begins with the date following:
> ...
> (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

25. The Department's Program Policy Manual, 165-22, section 0440.0603 Time Limits to Request Hearing (MSSI) states:

> The Department or its partner agency must receive the individual's appeal of an action, decision or current level of benefits within 90 days of the date a notice is mailed or hand delivered to the individual.
>
> **Exceptions:**
>
> 1. The time limit does not apply when the Department fails to send required notification, takes no action on a specific request or denies a request without informing the individual appealing.
>
> 2. A hearing request made outside the 90-day limit may only be rejected or dismissed by the Office of Appeal Hearings.
>
> Consider a request received after the 90-day time limit as a request for restoration of lost benefits.

26. Pursuant to the above authorities, an individual must file a request for an appeal within 90 calendar days of the date of any written notification that denies or terminates an individual's Medicaid benefits. The notice dated March 27, 2015 indicated petitioner's full Medicaid benefits and her husband's QI1 benefits were terminated effective April 30, 2015; the 90th day of the notice was June 25, 2015. The notice dated March 31, 2015 indicated petitioner and husband's QI1 application dated March 25, 2015 was denied and also indicated they were enrolled in MN Medicaid program with a monthly estimated SOC of $1,605; the 90th day of the notice was June 29, 2015. The notice dated April 3, 2015 indicated petitioner and husband's QI1 application dated April 1, 2015 was denied; the 90th day of the notice was July 2, 2015. The earliest date petitioner requested a hearing concerning her Medicaid benefits was July 6, 2015.

27. There are exceptions to the 90 day rule; however, petitioner does not meet any of the aforementioned exceptions as the petitioner's address was the same on all notices submitted for the period of March 2015 through August 2015. Since the appeal for the notices dated March 27, 2015 through April 3, 2015 were requested beyond the

required 90-day timeframe, the appeal regarding the aforementioned notices of case action must be dismissed as untimely. The undersigned does not have jurisdiction to review the merits of these notices as they were not requested timely by the petitioner. Therefore, the respondent prevails in regards to the termination of petitioner's full Medicaid benefits; husband's QI1 benefits; and the calculation that her and husband's estimated SOC amount was $1,605.

28. Since the 90th day for the notice dated April 8, 2015 was July 7, 2015 and since petitioner requested her appeal on July 6, 2015, any notice dated on or after April 8, 2015 is within 90 days timeframe. The notices dated on or after April 8, 2015 discuss petitioner and husband's enrollment in the Medically Needy Medicaid program and petitioner and husband's denial of their application for QI1 benefits.

Petitioner and husband's eligibility for full SSI-Related Medicaid benefits

29. The Fla. Admin. Code R. 65A-1.709 SSI-Related Medicaid Coverage states "SSI-related Medicaid provides medical assistance to eligible individuals who are aged, blind or disabled in accordance with Titles XVI and XIX of the Social Security Act and Chapter 409, F.S."

30. Pursuant to the above authority, petitioner and her husband are eligible for the SSI-Related Medicaid programs as they are both considered to be disabled.

31. The Fla. Admin. Code R. 65A-1.701(20) defines MEDS-AD Demonstration Waiver as:

> Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and **are not receiving Medicare** [emphasis added] or if receiving Medicare are also eligible for

> Medicaid covered institutional care services, hospice services or home and community based services.

32. The Department's Program Policy Manual, CFOP 165-22, passage 2040.0813.03, Technical Requirements for MEDS-AD (MSSI) states:

> The individual must meet all of the following criteria:
> 1. Age or disability,
> 2. U.S. residency,
> 3. Citizenship,
> 4. Welfare enumeration,
> 5. Third party liability,
> 6. Application for other benefits they may be eligible to receive,
> 7. **Not be receiving Medicare** [emphasis added]...

33. Pursuant to the above authorities, an individual who receives Medicare is not eligible to receive full Medicaid. The undersigned conludes the respondent correctly denied petitioner and her husband for full Medicaid benefits as both receive Medicare benefits through SSA and do not meet one of the technical requirements receive full Medicaid benefits.

Petitioner and husband's eligibility for the Medicare Savings Programs benefits effective May 2015

34. The Fla. Admin. Code R. 65A-1.702, Medicaid Special Provisions, states in relevant part:

> ...
> (12) Limits of Coverage
> (a) Qualified Medicare Beneficiary (QMB). Under QMB coverage, individuals are entitled only to Medicare cost-sharing benefits, including payment of Medicare premiums.
> (b) Special Low-Income Medicare Beneficiary (SLMB). Under SLMB coverage, individuals are entitled only to payment of the Part B Medicare premium...
> ...
> (d) Part B Medicare Only Beneficiary (QI1). Under QI1 coverage, individuals are only entitled to payment of their Medicare part B premium. (This is coverage for individuals who would be eligible for QMB or SLMB coverage except their income exceeds time limits for those programs.)

35. The Fla. Admin. Code R. 65A-1.713(1) further addresses the SSI-Related Medicaid Income Eligibility Criteria as follows:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
> ...
> (b) For QMB, income must be less than or equal to the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.
> ...
> (g) For SLMB, income must be greater than 100 percent of the federal poverty level but equal to or less than 120 percent of the federal poverty level.
> ...
> (j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. QI1 is eligible only for payment of the Part B Medicare premium through Medicaid.

36. The Policy Manual, Appendix A-9 lists the SSI-Related Income Limits for a household size of two as follows: the Income Standard for Qualified Medicare Beneficiaries (QMB) as $1,328; the Income Standard for Special Low Income Medicare Beneficiary (SLMB) as $1,593; and the Income Standard for QI1 as $1,793.

37. Federal Regulations at 20 C.F.R. 416.1124(c)(12) sets forth income that is not counted in this program and states, "The first $20 of any unearned income in a month other than...income based on need."

38. Petitioner and husband's monthly SSDI incomes exceed the income limits for all three Medicare Savings Programs; therefore, the respondent correctly denied petitioner and her husband's QI1 benefits effective May 2015 and ongoing.

39. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner did not meet the burden of proof that indicates the respondent

incorrectly denied petitioner and her husband's applications for the Qualified Individual 1 program effective May 1, 2015 and ongoing.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeals for full SSI-Related Medicaid benefits and the Medicare Savings Programs are DENIED.

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 3rd day of November, 2015, in Tallahassee, Florida.

Mary Jane Stafford

Mary Jane Stafford
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 66292

RESPONDENT.
_____/

APPEAL NO. 15F-06547
15F-09347

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter on September 3, 2015, and reconvened on September 15, 2015, at 2:45 p.m.

APPEARANCES

For the petitioner: [redacted] pro se

For the respondent: Katherine Ambrose, ACCESS Supervisor

STATEMENT OF ISSUE

At issue is whether the respondent properly terminated petitioner's SSI-Related Medically Needy (MN) Share of Cost (SOC) and Qualified Medicare Beneficiary (QMB) Medicaid benefits. The respondent carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

By notice dated July 20, 2015, the respondent notified the petitioner that her MN SOC and QMB benefits would end on July 31, 2015 citing "The value of your assets is too high for these Programs."

During the September 3, 2015 hearing, it was determined that testimony was needed from ACCESS Policy Program Office; therefore, the parties agreed to reconvene the hearing.

Appearing as witness for the respondent on September 15, 2015, was Reginald Schofield, ACCESS Senior Human Services Program Specialist.

Petitioner submitted one exhibit, entered as Petitioner Exhibit "1". Respondent submitted six exhibits, entered as Respondent Exhibits "1" through "6". The record closed on September 15, 2015.

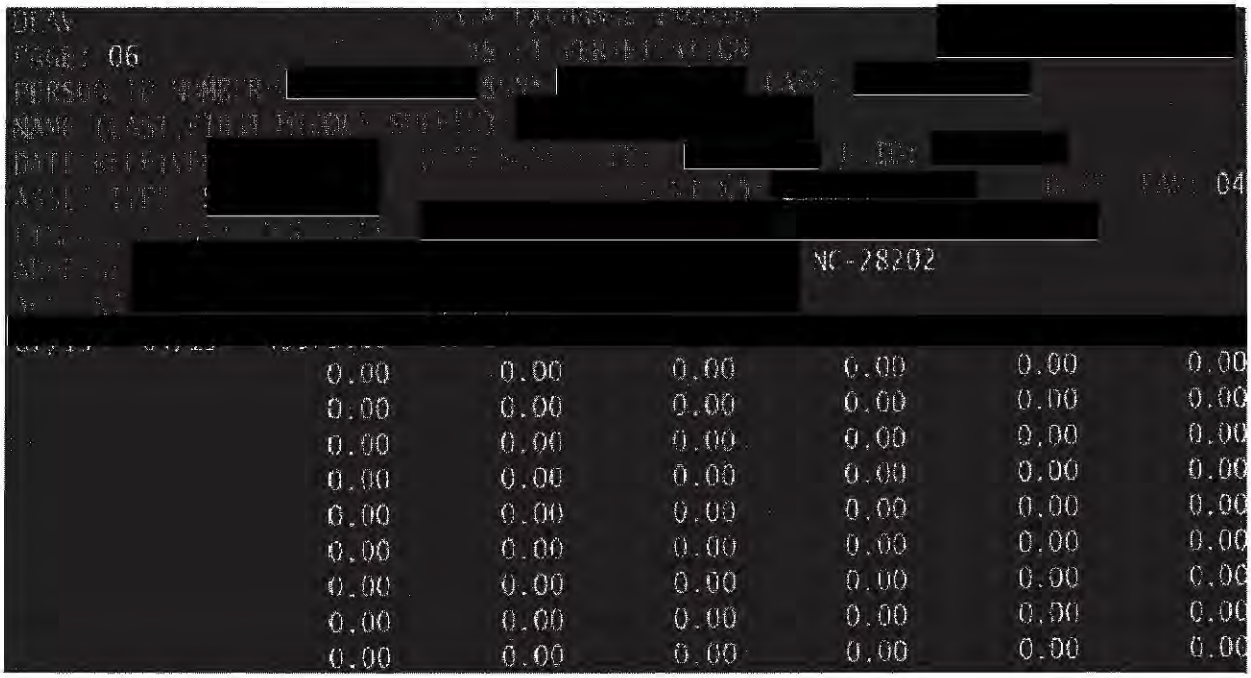
FINDINGS OF FACT

1. Prior to the action under appeal, petitioner was receiving SSI-Related MN SOC, QMB, and Food Assistance benefits for herself.

2. On July 6, 2015, the petitioner recertified for Food Assistance, MN SOC and Medicare Savings Plan (QMB). Food Assistance is not the issue.

3. Respondent explained that during the recertification process, the Department discovered the petitioner's financial account balance was greater than reported on her previous application.

4. Respondent referenced information obtained by the Department through the data exchange inquiry asset verification system. The information reflects balance summaries for the financial account jointly owned by the petitioner and her mother as follows:



5. Petitioner and her mother have a [redacted] with the financial institution [redacted] The data exchange inquiry asset verification system showed a balance of $45,375.55 on July 2015.

6. Respondent determined the petitioner's joint account showing a balance of $45,375.55 puts her over the asset limit for both the MN SOC and QMB Medicaid Programs.

7. On July 20, 2015, the respondent mailed the petitioner a Notice of Case Action ending her MN SOC and QMB as of July 31, 2015, due to the household assets were too high for these Programs.

8. Petitioner did not contest the balance on the account; she confirmed the account is unrestricted and that she has access to the account. During the hearing, the petitioner submitted a [redacted] statement from June 27, 2015 through July 29, 2015, showing a balance of $43,378.73. Petitioner explained the respondent was aware of the joint financial account with her mother for the last three years. Petitioner argued that all the funds in the account belong to her mother.

9. The respondent mailed the petitioner a pending notice allowing the petitioner an opportunity to rebut the presumption of ownership/control of the asset.

10. The petitioner submitted documentation to the respondent to confirm the funds in the account belong only to the petitioner's mother. The petitioner was successful in proving the asset did not belong to her; however, she must also remove her name from the account. Once the petitioner's name is removed from the financial account, it will not be included in the petitioner's MN SOC and QMB Medicaid eligibility determination.

11. Petitioner did not wish to remove her name from the joint financial account and argued that her mother is [redacted] Petitioner explained that she is in charge of paying the house bills and any improvements or repairs in the house. Petitioner believes she should be eligible for MN SOC and QMB Medicaid benefits because she is [redacted]

12. The respondent's witness explained petitioner must remove her name from the joint [redacted] account, and suggested other options such as obtaining power of attorney (POA) or payable on death (POD) for her mother so that she can continue to manage her mother's finances. The respondent explained there are no exceptions

identified in the Department's policy to suggest not counting financial institution accounts with no legal restrictions as an asset.

CONCLUSIONS OF LAW

13. 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.

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

15. Fla. Admin. Code R. 65A-1.710(5) defines the Medically Needy Program as, "A Medicaid coverage group, as allowed by 42 U.S.C. 139a and §1963d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance due to their level of income or resources." Fla. Admin. Code R. 65A-1.702(12)(a), the QMB program entitles eligible recipients "...only to Medicare cost-sharing benefits, including payment of Medicare premiums." Petitioner was receiving Medicaid benefits under these two programs.

16. Eligibility Standards for these Medicaid Programs are found in Appendix A-9 of the Department's Program Policy Manual, which reflects the maximum asset value for a Medically Needy individual is $5,000.00, and the maximum asset value for a QMB individual is $7,280.00.

17. Fla. Admin. Code R. 65A-1.303 explains considerations on assets involved:

> (2) Any individual who has the legal ability to dispose of an interest in an asset owns the asset.

> (3) Once the individual's ownership interest of an asset(s) is established, the availability of that asset must be determined. Asset(s) determined not to be available are not considered in determining eligibility. Assets are considered available to an individual when the individual has unrestricted access to it. Accessibility depends on the legal structure of the account or property. An asset is countable, if the asset is available to a representative possessing the legal ability to make the asset available for another's support or maintenance, even though the representative chooses not to do so. Assets not available due to legal restrictions are not considered in determining total available assets unless the legal restrictions were caused or requested by the individual or another acting at their request or on their behalf.

18. The Code of Federal Regulations, 20 C.F.R. § 416.1208, explains how funds held in financial institution accounts are counted:

> (a) General. Funds held in a financial institution account (including savings, checking, and time deposits, also known as certificates of deposit) are an individual's resource if the individual owns the account and can use the funds for his or her support and maintenance. We determine whether an individual owns the account and can use the funds for his or her support and maintenance by looking at how the individual holds the account. This is reflected in the way the account is titled...
> (b) Individually-held account. If an individual is designated as sole owner by the account title and can withdraw funds and use them for his or her support and maintenance, all of the funds, regardless of their source, are that individual's resource. For as long as these conditions are met, we presume that the individual owns 100 percent of the funds in the account. This presumption is non-rebuttable.
> (c) Jointly-held account—(1) Account holders include one or more SSI claimants or recipients. If there is only one SSI claimant or recipient account holder on a jointly held account, we presume that all of the funds in the account belong to that individual. If there is more than one claimant or recipient account holder, we presume that all the funds in the account belong to those individuals in equal shares...
> (2) Account holders include one or more deemors. If none of the account holders is a claimant or recipient, we presume that all of the funds in a jointly-held account belong to the deemor(s), in equal shares if there is more than one deemor. A deemor is a person whose income and resources are required to be considered when determining eligibility and computing the SSI benefit for an eligible individual (see §§ 416.1160 and 416.1202).

(3) Right to rebut presumption of ownership. If the claimant, recipient, or deemor objects or disagrees with an ownership presumption as described in paragraph (c)(1) or (c)(2) of this section, we give the individual the opportunity to rebut the presumption. Rebuttal is a procedure as described in paragraph (c)(4) of this section, which permits an individual to furnish evidence and establish that some or all of the funds in a jointly-held account do not belong to him or her. Successful rebuttal establishes that the individual does not own some or all of the funds. The effect of successful rebuttal may be retroactive as well as prospective.
Example: The recipient's first month of eligibility is January 1993. In May 1993 the recipient successfully establishes that none of the funds in a 5-year-old jointly-held account belong to her. We do not count any of the funds as resources for the months of January 1993 and continuing.
(4) Procedure for rebuttal. To rebut an ownership presumption as described in paragraph (c)(1) or (c)(2) of this section, the individual must:
(i) Submit his/her statement, along with corroborating statements from other account holders, regarding who owns the funds in the joint account, why there is a joint account, who has made deposits to and withdrawals from the account, and how withdrawals have been spent;...
(iii) Correct the account title to show that the individual is no longer a co-owner if the individual owns none of the funds; or, if the individual owns only a portion of the funds, separate the funds owned by the other account holder(s) from his/her own funds and correct the account title on the individual's own funds to show they are solely-owned by the individual. (emphasis added)

19. Department's Program Policy Manual, CFOP 165-22, passage 1640.0302.04, Proof Needed to Rebut Ownership (MSSI, SFP):

When an individual has unrestricted access to the funds in a joint account but does not consider himself an owner of part or all of the account funds, you must advise the individual that:
1. the funds are presumed to be his; and
2. he may rebut the presumption of ownership by presenting proof the funds belong to someone else.
To rebut the presumption of ownership, the individual must provide the following information:
First, the individual must provide a written statement and corroborating evidence from the financial institution(s) and other sources to substantiate:
1. any claims about ownership of the funds or interest from the funds;
2. the reasons for establishing the joint account;
3. whose funds were deposited into the account;
4. who made withdrawals from the account; and

5. information on how withdrawals were spent.
Second, the individual must provide a written statement from the joint owner(s) explaining their understanding of the ownership of the account(s); that is, claims of ownership, why the account was set up, who deposited funds, withdrew funds and used the account.
When an individual is a co-owner of an account with someone who is incompetent or a minor, the corroborating co-owner statement is not necessary. You must obtain a corroborating statement from a third party who has knowledge of the circumstances. (emphasis added)
If there is no third party or the individual is unable to provide all bank verification, you must make a rebuttal determination based on the evidence submitted. Enter an explanation on CLRC why no written corroborating statement was obtained from the joint owner.
To successfully rebut ownership of a joint account, the evidence must clearly support that the individual is not a joint owner of the funds.

20. The Department's Program Policy Manual, CFOP 165-22, passage 1640.0302.05

Evaluating Evidence for Rebuttal (MSSI, SFP):

When all proof (per 1640.0302.04) is received, you must evaluate the evidence to determine if it supports the individual's claim that someone other than the individual owns the asset. The evidence must clearly corroborate that the funds deposited to the account did not belong to the individual and were not used to meet his needs.
If the rebuttal evidence proves that the account funds (all or partially) were deposited, withdrawn and used by the other joint owner(s) only, the individual has successfully proven that he does not own (all or part of) the funds.
If the individual successfully rebuts ownership of all the funds in the joint account, the individual's name must be removed from the account, so he no longer has access to the funds in the account. (This is not considered a transfer of assets.) Do not consider the funds in the account as an asset to the individual for any month (even for months prior to the month the individual's access to the account is removed). **The individual must submit documentation of the original and revised (if any) account records showing his name has been removed. Photocopies are necessary for the case file.(emphasis added)**
If the individual does not successfully rebut ownership of the account, you must consider the total joint account balance as an asset to the individual.

21. The above authority indicates if the individual has the power to liquidate the resource it is to be considered a resource. An individual's resources (assets) must be equal to or below the resource limit at some point during each time, that MN SOC and QMB Medicaid eligibility is determined. Petitioner was given the opportunity to rebut the presumption of ownership/control of the asset. Petitioner argued her mother was incompetent; therefore, the corroborating co-owner statement from the joint owner (mother) would not be necessary due to her current illness. The petitioner presented evidence from the financial institution – [redacted] to the respondent and demonstrated the money in said account does not belong to her. The petitioner successfully rebutted ownership of the joint account.

22. The authority and policy cited above explain that for an asset not to be considered in the Medicaid eligibility determination, an individual must successfully rebut ownership of the funds in a joint account **and** must also provide documentation from the financial institution showing his/her name has been removed from the account. As of the hearing date, petitioner had not removed her name from the joint financial account she has with her mother at [redacted]

23. Based upon the totality of the evidence, respondent has shown that both its decision to terminate SSI-Related Medically Needy SOC benefits and its decision to terminate QMB benefits were proper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are denied and the Department's action is 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 10th day of November, 2015,

in Tallahassee, Florida.

Cassandra Perez
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 13 Hillsborough
UNIT: AHCA

RESPONDENT.
_____/

APPEAL NO. 15F-06584

CASE NO.

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on September 8, 2015, at approximately 10:03 a.m.

APPEARANCES

For Petitioner: [redacted] Petitioner's fiancée

For Respondent: Stephanie Lang, RN Specialist
Agency for Healthcare Administration

STATEMENT OF ISSUE

Whether the Agency was correct in denying Petitioner's request for tooth cleaning of heavy deposits, deep gum and root cleaning. The burden of proof on this issue is assigned to the Petitioner by the preponderance of evidence.

PRELIMINARY STATEMENT

Appearing as witnesses for Respondent were Laura Withrow, Manager of Quality with Amerigroup; Jackie Salcedo with Amerigroup's Complaints and Grievance Department; and Dr. Susan Hudson, Florida Dental Director with DentaQuest.

Respondent admitted seven exhibits into evidence, which were marked and entered as Respondent's Exhibits 1 through 7. Petitioner submitted no exhibits. Administrative notice was taken of Florida Statutes §§ 409.910, 409.962 through 409.965, and 409.973. Administrative notice was also taken of Florida Administrative Code Rules 59G-1.001, 1.010, 59G-4.060.

FINDINGS OF FACT

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

1. Petitioner is a Medicaid recipient over 21 years of age. He has dental problems which cause bleeding gums and pain. He has periodontal disease. His dentist refuses to fill cavities or give a regular cleaning unless a deep cleaning is performed. Petitioner is worried about long term medical effects resulting from untreated teeth.

2. On or about June 19, 2015, Petitioner's dentist submitted a prior authorization request to Petitioner's managed care plan, Amerigroup. DentaQuest handles the prior authorization reviews for Amerigroup members. The dentist requested codes D4355 (full mouth debridement), D4341 (periodontal scaling and root planing), and D2392 (amalgam).

3. DentaQuest, by notice dated June 20, 2015, denied Petitioner's request for codes D4341 and D4355. The request was denied because these procedures are not a

covered benefit for Medicaid recipients over 21 years old. Code D2150 was not reviewed because authorization was not required for that service.

4. The procedure codes D4341 and D4355 are not listed on Amerigroup's benefit schedule. The procedure codes D4341 and D4355 are listed on the Medicaid Dental Fee Schedule but there is a maximum age of 20 years old to receive these services.

5. Petitioner's plan covers regular cleanings, but not deep cleanings. Medical need for the deep cleaning was not the reason for the denial. The deep cleaning was denied because it is not a covered service under Petitioner's plan.

CONCLUSIONS OF LAW

6. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80, Florida Statutes.

7. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.

8. This hearing was held as a de novo proceeding pursuant to Florida Administrative Code Rule 65-2.056.

9. Section 409.912, Florida Statutes, notes that AHCA shall purchase goods and services for Medicaid recipients in the most cost-effective manner possible, consistent with the delivery of quality medical care.

10. The Florida Medicaid Provider General Handbook (Provider Handbook) – July 2012 is incorporated by reference in Florida Administrative Code Rule 59G-5.020(1). In accordance with the Florida law, the Provider Handbook discusses managed care coverage, stating on page 1-27:

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee. Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

11. Page 1-30 of the Provider Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

12. According to page 2-3 of the Medicaid Dental Services Coverage and Limitations Handbook (Dental Handbook), Medicaid covers some dental services for adults over 21. The Dental Handbook is promulgated into law by Rule 59G-4.060(2), Florida Administrative Code. According to the Dental Handbook, Medicaid will cover dentures and denture related procedures, as well as:

> ...medically-necessary emergency dental procedures to alleviate pain and/or infection for eligible adults... Emergency dental care shall be limited to emergency problem-focused evaluations, necessary radiographs to make a diagnosis, extraction, and incision and drainage of abscess.

13. The question becomes whether Petitioner's request for services is a medically-necessary emergency dental procedure to alleviate pain and/or infection. Florida Administrative Code, 59G-1.010(166), defines medical necessity, as follows:

> "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

14. Covered dental services for adults are described on page 2-3 of the Dental Handbook, excerpted in paragraph 12 above. Deep cleaning services are not listed as a covered benefit for adults over 21, such as Petitioner, under fee-for-service Medicaid. Even if Petitioner showed that the cleaning was a medically necessary emergency treatment, Medicaid does not provide deep cleanings as a part of emergency care for adults. The HMO may provide services beyond what Medicaid provides, but in this case, the HMO does not provide deep cleanings.

15. After careful review of the relevant authorities, the testimony and the evidence in this matter, the hearing officer concludes that Petitioner's request for deep cleaning is outside the scope of services to which he is entitled under the benefit plan.

DECISION

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

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 2nd day of November, 2015,

in Tallahassee, Florida.

Danielle Murray
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Don Fuller, Area 6, AHCA Field Office Manager

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

[redacted]

APPEAL NO. 15F-06587

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 02 Leon
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on November 9, 2015 at 11:39am

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Dianne Soderlind, Registered Nurse Specialist

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of June 29, 2015 denying a replacement Cochlear processor. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

[redacted] father of the petitioner, appeared as a witness for the petitioner. Michael O'Donnell, Grievance and Appeals Coordinator, and Esther Pierre-Louis,

Supervisor Grievance and Appeals, from Prestige Health Choice appeared as witnesses for the Agency.

The Agency provided evidence, which included three parts, prior to the hearing. Part one of the evidence was from AHCA included 17 pages. AHCA added two pages during hearing and 19 pages were entered as Respondent Exhibit 1. Part two of the evidence was from Prestige and included 12 pages. This was entered as Respondent Exhibit 2. Part three of the evidence was information sent from the petitioner to the Agency. This was entered as Petitioner Exhibit 1. The petitioner provided additional information during the hearing. This was entered as Petitioner Exhibit 2.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. The petitioner is a (age 31) is a Florida Medicaid recipient. Prestige Health Choice is the contracted Medicaid services provider for the petitioner.

2. The petitioner is hearing impaired. He has cochlear implants and external processors for both ears.

3. The petitioner left his left external processor at Shands for repair approximately a year ago. He had an appointment to pick it up in late November 2015.

4. A request was submitted to Prestige Health Choice on June 18, 2015 for a new processor for the petitioner's right ear.

5. Prestige Health Choice issued a Notice of Action on June 29, 2015 denying the petitioner's request for an external speech processor and controller, integrated system replacement. The reason given for the decision was: "The requested

services is not a covered benefit." The notice also stated, "Request has been denied as a non-covered benefit under Medicaid Fee Schedule."

6. The petitioner is requesting new external processors for both ears; but would be happy just to receive one right now.

7. The petitioner has been taking course work for Heating, Ventilation and Air Conditioning (HVAC). He has one semester left to complete his coursework.

8. The petitioner believes he needs the new processors as opposed to having his current processors repaired. The requested processors are waterproof. His current processors are not waterproof. The petitioner explained that the current processors will not function properly if exposed to moisture or sweat.

9. The petitioner explained he is concerned his completion of HVAC will have him working in sweaty or damp environments where his processors could fail and cause a safety issue with him hearing motors running.

10. The petitioner is concerned that the HVAC companies that would hire him if he was not hearing impaired or had waterproof processors may not hire him without the waterproof processors.

11. Prestige approved the repair or refurbishment of the failing processor.

12. Prestige noted in the audiologist's letter she "fully expected a denial of an upgrade, since to her, all that is needed to restore functional hearing at this time would be a repair (replacement with a refurbished version) of the non-functioning left sided processor".

13. Prestige believes the petitioner's request for a new processor is a vocational issue not an issue of medical necessity. Prestige found no proof the member could not fully function with only a repaired or refurbished device.

14. Prestige advised that hearing-impaired individuals are allowed one device per ear every three years.

CONCLUSIONS OF LAW

15. 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.

16. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code § 65-2.056.

17. The standard of proof in an administrative hearing is by a preponderance of the evidence (See Fla. Admin. Code § 65-2.060(1)). The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

18. The Florida Medicaid program is authorized by Fla. Stat. Chapter 409 and Fla. Admin. Code Chapter 59G. The Medicaid program is administered by the Agency.

19. All Medicaid goods and services must be medically necessary. The definition of medically necessary is found in Fla. Admin. Code § 59G-1.010 and states:

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:

> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
> ...
> **(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.**(emphasis added)

20. The above controlling authority sets forth that medical necessity means the medical care, goods, or services furnished which meets **all** five of the above-cited criteria. One of the criteria is the service be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available.

21. Prestige denied the petitioner's request for a new upgraded processor for the right ear. Prestige approved repair of the current processor or replacement with a refurbished processor. The undersigned concludes the petitioner's request for a new processor does not rise to the level of medical necessity under Medicaid law, as repairing the unit or replacing with a refurbished unit will allow the petitioner to hear. The undersigned further concludes this would be considered an equally effective or less costly treatment as stated in the above cited Medicaid law.

22. The undersigned notes that the concern for safety in his future vocation of HVAC should his processors fail. However, the controlling authorities direct the undersigned to review current medical necessity, not a future or possible situation. The petitioner may desire to consult with the Department of Economic Opportunity's Vocational Rehabilitation local office to determine if that organization can assist with the upgrade requested.

23. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes the respondent's decision in this matter was correct. The petitioner did not prove by a preponderance of the evidence the request for new processors meets **all** the requirements for medical necessity requirements for Medicaid payment through its contracted HMO.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is 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 15 day of December, 2015,

in Tallahassee, Florida.

Melissa Roedel

Melissa Roedel
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Marshall Wallace, Area 2, AHCA Field Office Manager

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

[redacted]

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 20 Lee
UNIT: AHCA

RESPONDENT.
_____/

APPEAL NO. 15F-06588

CASE NO.

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on September 21, 2015, at 1:05 p.m.

APPEARANCES

For the Petitioner: [redacted]
Petitioner

For the Respondent: Stefanie Urban
Medical Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the respondent incorrectly denied his request for endodontic treatment in the form of a root canal?

PRELIMINARY STATEMENT

[redacted] ("petitioner"), the petitioner, appeared on his own behalf.

Stefanie Urban, Medical Health Care Program Analyst with the Agency for Health Care Administration ("AHCA" or "Agency"), appeared on behalf of the Agency for Health Care Administration. The following individuals appeared as witnesses on behalf of the Agency: Kelly Carr, Vendor Account Manager at Staywell; Stephanie Shupe, Grievance Coordinator for Staywell; Alta Recio, Ancillary Coordinator with Staywell; and John R. Singer, D.D.S., State Director at Liberty Health Plan.

The petitioner introduced petitioner's Exhibit "1", inclusive, at the hearing, which was accepted into evidence and marked accordingly. The respondent introduced respondent's Exhibits "1" through "7", inclusive, at the hearing, which were accepted into evidence and marked accordingly. At the respondent's request, the hearing officer took administrative notice of the Dental Services Coverage and Limitations Handbook.

The hearing record in this matter was left open until the close of business on September 25, 2015 for the respondent to provide the Staywell Member Handbook provisions pertinent to this case. The respondent did not provide this information to the hearing officer.

FINDINGS OF FACT

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

1. The petitioner is a 74-year-old male.

2. The petitioner was eligible to receive Medicaid at all times relevant to this proceeding.

3. The petitioner is enrolled in Staywell. Staywell is a health maintenance organization ("HMO") which is contracted by the Agency for Health Care Administration, the respondent, to provide services to certain Medicaid eligible persons in the State of Florida.

4. The petitioner was enrolled in Staywell effective June 1, 2014.

5. Humana has contracted with Liberty Dental Plan to review prior authorization requests for dental services.

6. The petitioner had an appointment to get his teeth cleaned at the [redacted] sometime in February 2015. At the time of his appointment, students/staff at the Clinic noticed an infection surrounding one of his wisdom teeth.

7. The petitioner subsequently saw a dentist at [redacted] due to tooth pain.

8. On or about July 23, 2015, the petitioner's dental provider submitted a request for the following services:

- Molar endodontic therapy (exclude final restoration) #31
- Gingival irrigation – per quadrant #31

Molar endodontic therapy is the medical term for a root canal.

9. In a Notice of Action dated July 28, 2015, Staywell informed the petitioner that his request was denied. The Notice of Action explains, in part:

> # 1 DG-2 Denied – This procedure appears to have a poor prognosis. Alternative treatment choices may be available.
> # 2 DG-5 Denied – This procedure is not listed as covered by the plan. Please refer to the Evidence of Coverage (EOC) booklet or Schedule of Benefits for details or you may call us for additional information.

10. On August 17, 2015, Liberty Dental completed an administrative review of the petitioner's request and all available documentation. Based on that review, Liberty Dental determined that the denial of the pre-treatment authorization was denied for the incorrect reason. Upon further review after the denial, Liberty Dental determined that a root canal is not a covered benefit according to the petitioner's Schedule of Benefits.

11. The dentist testifying for the respondent stated that tooth # 31 is a poor candidate for a root canal because the infection has encircled the entire tooth. He also testified that a root canal is not a covered benefit under the petitioner's dental plan.

12. The dentist testifying for the respondent testified that extracting tooth #31 is a better alternative for the petitioner and that extraction of the tooth will alleviate the petitioner's pain.

13. The Dental Fee Schedule is a complete list of the dental procedures for which benefits are payable under the petitioner's Plan. The Dental Fee Schedule states non-listed procedures are not covered.

14. The procedure code for a root canal is D3330.

15. Procedure code D3330 does not appear on the Dental Fee Schedule. A root canal is not a covered benefit under the petitioner's dental plan.

CONCLUSIONS OF LAW

16. 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.

17. This is a final order pursuant to § 120.569 and § 120.57, Fla. Stat.

18. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

19. The petitioner in the instant matter is requesting a new service. Therefore, in accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof is assigned to the petitioner.

20. The standard of proof in an administrative hearing is by a preponderance of the evidence. (See Fla. Admin. Code R. 65-2.060(1)). The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

21. The Florida Medicaid program is authorized by Fla. Stat. ch. 409 and Fla. Admin. Code R. 59G. The Medicaid program is administered by the respondent.

22. Fla. Admin. Code R. 59G-1.010(166) explains that medical or allied care, goods, or services furnished or ordered must meet the definition of medically necessary or medical necessity, and defines medical necessity as:

> (a) "Medical necessary" or "medical necessity" means that medical or allied care, goods or services furnished or ordered must meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patent's needs;
> 3. Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational;
> 4. Be reflective of the level of service that can safely be furnished, for which no equally effective and more conservative or less costly treatment is available statewide; and,
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. . .

> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods or services medically necessary, or a medical necessity, or a covered service.

23. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Chapter 59G-4. In accordance with the above Statute, the Handbook states on page 1-27:

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.
>
> Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

24. Pages 1-28 and 1-29 of the Florida Medicaid Provider General Handbook provide a list of HMO covered services.

25. Page 1-30 of the Florida Medicaid Provider General Handbook, Optional Services, explains: "Other services that plans may provide include dental services, transportation, nursing facility and home and community-based services. Plans may also provide services under their contracts that Medicaid does not cover, such as over-the-counter drugs."

26. Page 1-30 of the Florida Medicaid Provider General Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

27. The Dental Services Coverage and Limitations Handbook – November 2011 is incorporated by reference into the Medicaid Service Rules by Rule 59G-4.060, Florida Administrative Code.

28. The Dental Services Coverage and Limitations Handbook addresses Covered Adult Services (Ages 21 and Over) on Page 2-8. It explains:

> The adult dental program provides for the reimbursement of full and removable partial dentures. Extractions and other surgical procedures essential to the preparation of the mouth for dentures are reimbursable if the patient is to receive dentures. Procedures relating to dentures such as repairs, relines and adjustments are reimbursable.
>
> Medicaid will reimburse for medically-necessary emergency dental procedures to alleviate pain and or infection for eligible adult Medicaid recipients 21 years of age or older. Emergency dental care shall be limited to emergency problem-focused evaluations, necessary radiographs to make a diagnosis, extraction, and incision and drainage of abscess.

29. The Agency for Health Care Administration does not cover endodontic services for individuals 21 years of age and older.

30. The respondent's witness testified that endodontic services are not a covered benefit under the petitioner's health plan. The procedure code for a root canal is absent from the Staywell Dental Fee Schedule which sets forth a comprehensive list of the dental procedures for which benefits are payable under the petitioner's plan.

31. In the present case, a root canal is not a covered benefit under the petitioner's plan. Furthermore, the dentist who appeared at the hearing testified that a root canal is not the best alternative for petitioner because the infection has encircled

the entire tooth. The dentist also explained the petitioner's pain will stop when he has the tooth extracted.

32. The dentist appearing for the respondent stipulated to the approval of tooth # 31 for the petitioner.

33. Pursuant to the above, the petitioner has not met his burden of proof to demonstrate the respondent improperly denied his request for a root canal.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is 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 2nd day of November, 2015, in Tallahassee, Florida.

Peter Tsamis

Peter J. Tsamis
Hearing Officer
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Tallahassee, FL 32399-0700
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Copies Furnished To: [redacted] Petitioner
Dietra Cole, Area 8, AHCA Field Office Manager

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

[redacted]

PETITIONER,

Vs.

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

RESPONDENT.
_____/

APPEAL NO. 15F-06672

CASE NO.

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on September 21, 2015, at 3:30 p.m.

APPEARANCES

For the Petitioner: [redacted]
Petitioner

For the Respondent: Linda Latson, R.N.
Registered Nurse Specialist/Fair Hearing Coordinator
Agency for Health Care Administration

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the respondent incorrectly denied his request for a referral to a periodontist?

PRELIMINARY STATEMENT

[redacted] ("petitioner"), the petitioner, appeared on his own behalf. [redacted] Interpreter [redacted] with Language Service Associates, provided Creole-English translation for the hearing.

Linda Latson, R.N., Registered Nurse Specialist with the Agency for Health Care Administration ("AHCA" or "Agency"), appeared on behalf of the Agency for Health Care Administration. The following individuals appeared as witnesses on behalf of the Agency: Mindy Aikman, Grievance and Appeals Specialist with Humana; Jackelyn Salcedo, Complaints and Grievances Specialist with DentaQuest; and Susan Hudson, D.M.D., Dental Consultant with DentaQuest.

The respondent introduced Exhibits "1" through "5", inclusive, at the hearing, all of which were accepted into evidence and marked accordingly. The hearing record was left open until the close of business on September 28, 2015 for the respondent to provide additional documents. Once received, this information was accepted into evidence and marked as respondent's Composite Exhibit "6". The hearing record was then closed.

FINDINGS OF FACT

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

1. The petitioner is a 58-year-old male.

2. The petitioner was eligible to receive Medicaid at all times relevant to this proceeding.

3. The petitioner is enrolled in Humana Florida Medicaid Plan. Humana is a health maintenance organization ("HMO") which is contracted by the Agency for Health Care Administration, the respondent, to provide services to certain Medicaid eligible persons in the State of Florida.

4. The petitioner was enrolled in Humana effective July 1, 2015.

5. Humana has contracted DentaQuest to review prior authorization requests for dental services.

6. On or about July 7, 2015, the petitioner's dental provider submitted a prior authorization request to DentaQuest for a referral to a periodontist. The dental office submitted the request through the DentaQuest web-based portal.

7. The referral stated there was mobility on Teeth 25 and 26 and petitioner needed to see a periodontist as soon as possible; however, the referral contained no additional information explaining the need for a referral to a specialist. The petitioner's dentist did not provide a narrative along with the prior authorization request detailing the need for a referral, nor did the dentist provide radiographs or photographs of the affected areas.

8. The petitioner stated at the hearing the referral was for gum treatment but could provide no further information.

9. On July 23, 2015, DentaQuest sent a letter to the petitioner's dentist advising the referral was denied because it did not meet guidelines. The letter further stated the services should be completed by a general dentist.

10. Also on July 23, 2015, DentaQuest forwarded a Notice of Action to the petitioner explaining his request was denied. The Notice of Action states "The requested **service is not a covered benefit**" and goes on to explain:

> The facts that we used to make our decision are:
> You do not need to see a specialist because your services can be performed by a general dentist. Please talk to your primary care dentist about your dental care needs. We have told your dentist this also.

11. DentaQuest completed an internal review of its decision to deny the petitioner's request for a referral to a periodontist on August 20, 2015. The notes of the Dental Consultant who reviewed and upheld the initial decision state as follows:

> Appeal reviewed and upheld denial. At this point in time we cannot approve referral to the periodontist. Provider did not provide radiographs, proper narratives, reasons or a diagnosis that would lead us to refer to Periodontist. Swollen and pain are not sufficient for referral. It could be an Endodontic problem or a periodontal problem. We would need more information to determine proper course of treatment. Provider (GP) should have prescribed antibiotics and if there is that much mobility and bone loss then also it could lead to possible extraction.

12. DentaQuest contacted the petitioner's dental office after July 23, 2015 to request additional information that would clarify why the petitioner was being referred to a specialist. DentaQuest informed the dentist's office it would require a periodontal chart if the petitioner needed a deep cleaning. The dental office informed DentaQuest it does not perform deep cleanings. DentaQuest also inquired that, if the petitioner did require a deep cleaning, then why wasn't he referred to a different general dentist who does perform such cleanings.

13. At the time of the aforementioned conversation, the petitioner's dental office informed DentaQuest it would contact the petitioner to schedule an appointment

for him to have a periodontal chart completed and to provide him with information regarding a different general dentist.

14. The petitioner testified that, as of the date of the hearing in this matter, his dentist's office had not contacted him to schedule an appointment for the completion of a periodontal chart.

CONCLUSIONS OF LAW

15. 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.

16. This is a final order pursuant to § 120.569 and § 120.57, Fla. Stat.

17. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

18. The petitioner in the instant matter is requesting a new service. Therefore, in accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof is assigned to the petitioner.

19. The standard of proof in an administrative hearing is by a preponderance of the evidence. (See Fla. Admin. Code R. 65-2060(1).) The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

20. The Florida Medicaid program is authorized by Fla. Stat. ch. 409 and Fla. Admin. Code R. 59G. The Medicaid program is administered by the respondent.

21. Fla. Admin. Code R. 59G-1.010(166) explains that medical or allied care, goods, or services furnished or ordered must meet the definition of medically necessary or medical necessity, and defines medical necessity as:

> (a) "Medical necessary" or "medical necessity" means that medical or allied care, goods or services furnished or ordered must meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patent's needs;
> 3. Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational;
> 4. Be reflective of the level of service that can safely be furnished, for which no equally effective and more conservative or less costly treatment is available statewide; and,
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. . .
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods or services medically necessary, or a medical necessity, or a covered service.

22. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Chapter 59G-4. In accordance with the above Statute, the Handbook states on page 1-27:

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.

> Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

23. Pages 1-28 and 1-29 of the Florida Medicaid Provider General Handbook provide a list of HMO covered services.

24. Page 1-30 of the Florida Medicaid Provider General Handbook, Optional Services, explains: "Other services that plans may provide include dental services, transportation, nursing facility and home and community-based services. Plans may also provide services under their contracts that Medicaid does not cover, such as over-the-counter drugs."

25. Page 1-30 of the Florida Medicaid Provider General Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

26. The Dental Services Coverage and Limitations Handbook – November 2011 is incorporated by reference into the Medicaid Service Rules by Rule 59G-4.060, Florida Administrative Code.

27. The Dental Services Coverage and Limitations Handbook describes Periodontal Services on Page 2-24. It states, in part:

> Periodontal services may be reimbursed only for eligible recipients under 21 years of age who exhibit generalized periodontal pockets in excess of the 4-5 mm range. The fee for the service includes postoperative care. The nature of any condition must be documented on the periodontal chart (Appendix E) of the dental record.

28. Periodontal services are not available to individuals 21 years of age and older through the Agency for Health Care Administration. For those under age 21, a periodontal chart must be completed detailing the nature of the condition.

29. The DentaQuest Complaints and Grievances Specialist testifying for the respondent explained DentaQuest may approve periodontal services but that it requires a periodontal chart before a member may be considered for such services.

30. Humana dental policy with respect to periodontal services is not more restrictive than that of the Agency for Health Care Administration.

31. Page 1-30 of the Florida Medicaid Provider General Handbook addresses Exemptions from HMO Authorization and explains "All services may be prior authorized by the HMO plan except for the following...." Dental services do not appear on the list of services which do not require prior authorization.

32. The Humana Member Handbook addresses services which are available without a referral and prior authorization. Periodontal services are absent from the list of services that do not require prior authorization.

33. In the present case, the petitioner's dentist did not provide DentaQuest with a narrative detailing the petitioner's need for a referral to a periodontist, nor did he provide radiographs, photographs, or a periodontal chart. The petitioner's dentist did not provide DentaQuest with the pertinent information it needed to make a decision, nor was this information provided to the hearing officer. Therefore, there is no evidence to support a conclusion that DentaQuest improperly denied the request.

34. Pursuant to the above, the petitioner has not met his burden of proof to show the respondent improperly denied his request for a referral to a periodontist.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is 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 2nd day of November, 2015, in Tallahassee, Florida.

Peter Tsamis

Peter J. Tsamis
Hearing Officer
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1317 Winewood Boulevard
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Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

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

[redacted]

APPEAL NO. 15F-06691

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 09 Osceola
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on September 28, 2015 at approximately 10:30 a.m.

APPEARANCES

Petitioner: [redacted]

For Respondent: Lisa Sanchez
Senior Human Services Program Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is Respondent's denial of Petitioner's request for Lumbar Spine Fusion surgery. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

The following individuals were present as witnesses for Respondent:

- India Smith, Grievance and Appeals Coordinator, Sunshine Health.
- Donna Laber, Grievance and Appeals Manager, Sunshine Health.
- Dr. Ernest Bertha, Medical Director, Sunshine Health.

Tiffany Smith, Grievance and Appeals Coordinator with Sunshine Health ("Sunshine") was present as an observer. Petitioner gave oral testimony, but did not move any exhibits into evidence at the hearing. Respondent moved Exhibits 1 through 5 into evidence at the hearing. The record was held open until October 5, 2015 for both parties to submit additional evidence. Petitioner submitted additional evidence, entered as Exhibit 1. Respondent submitted additional evidence, entered as Exhibits 6 and 7.

The undersigned took administrative notice of the Florida Medicaid Provider General Handbook, July 2012 ("Handbook").

FINDINGS OF FACT

1. Petitioner is a 39-year-old female. At all times relevant to this proceeding, she was eligible to receive Medicaid services.
2. Petitioner is enrolled with Sunshine as her Managed Medical Assistance (MMA) program.
3. Petitioner has constant lower back pain. She is unable to stand for more than 10 minutes at a time without being in pain. Sitting and laying down causes her pain. The pain is so severe that Petitioner cannot even have her children rub BenGay on her lower back because it hurts her for them to touch it.
4. Petitioner had an MRI performed on her lower back on October 31, 2014, and an X-Ray performed on April 13, 2015. Both procedures found spondylolisthesis, which, according to Dr. Bertha, is slippage of vertebra bodies onto each other.
5. Petitioner was approved for three (3) visits of lumbar injections for pain management between June 8, 2015 and September 6, 2015. Petitioner received

one series of injections on June 18, 2015. Petitioner did not use her other authorized visits because the lumbar injections did not relieve the pain.

6. On July 29, 2015, Petitioner's neurosurgeon requested authorization for the Lumbar Spine Fusion surgery.

7. On August 4, 2015, Sunshine issued a Notice of Action denying the request. (Respondent's Composite Exhibit 3). The Notice stated the request did not meet paragraphs 2 and 4 of Florida Administrative Code Rule 59G-1.010, as well as "other authority". The reason for denial was listed as follows:

> Request for Lumbar Spine Fusion (a surgery to join bones together in the back) is DENIED. The medical records from your Doctor do not show you neither taking pain medication, nor receiving physical therapy (a special exercise to help make the muscles stronger) to try to take away pain.
>
> The facts that we used to make our decision are: InterQual Criteria Product: CP: Procedures Criteria Subset: Laminectomy, Lumbar, +/- Fusion Version: InterQual® 2014 Were used in making this decision.

8. After receiving the Notice of Action, Petitioner timely requested a Fair Hearing on August 7, 2015.

9. InterQual is the vendor product used by Sunshine to make medical necessity determinations. Dr. Bertha stated the criteria were not met because there was no documentation that Petitioner had any pain or paresthesia which were improved with forward flexion, no documentation that she had been on nonsteroidal anti-inflammatory drugs (NSAIDS) or acetaminophen for greater than or equal to three (3) weeks, no documentation of home exercise or physical therapy for greater than or equal to 12 weeks, and no documentation of activity modification for greater than or equal to 12 weeks.

10. Dr. Bertha stated examples of NSAIDS include ibuprofen and naproxen. After reviewing Petitioner's pharmaceutical history from USscript (Respondent's Exhibit 5), he conceded the drug meloxicam taken by Petitioner satisfied the NSAID requirement, leaving only the physical therapy and activity modification criteria to be met.

11. Per Dr. Bertha, if it was documented that physical therapy was attempted, but that Petitioner could not tolerate it, then he would take that into consideration. Petitioner testified she had tried physical therapy on her lower back in the past, but that it did not work.

12. On October 2, 2015, Petitioner's family physician wrote a letter stating she is unable to do physical therapy because of inability to manipulate her back and previous physical therapy never improved her condition. (Petitioner's Exhibit 1).

13. Dr. Bertha said proof of activity modification for greater than or equal to 12 weeks is also required. The Notice of Action letter dated August 4, 2015 states no such requirement. It only states the surgery was denied due to the medical records failing to show her taking pain medication and receiving physical therapy. Further, the Inpatient Authorization Summary states at page 7 of 8: "home exercise **or** physical therapy for greater than or equal to 12 weeks, **Or** activity modification for greater than or equal to 12 weeks" is what is required. (emphasis added)(Respondent's Exhibit 7).

PRINCIPLES OF LAW AND ANALYSIS

14. By agreement between the Agency for Healthcare Administration ("AHCA" or "Agency") and the Department of Children and Families ("DCF"), the Office of

Appeal Hearings has jurisdiction to conduct this hearing pursuant to Section 120.80, Fla. Stat.

15. The hearing was held as a *de novo* proceeding, in accordance with Florida Administrative Code Rule 65-2.056.

16. This is a Final Order, pursuant to Sections 120.569 and 120.57, Fla. Stat.

17. The standard of proof in an administrative hearing is a preponderance of the evidence. Fla. Admin. Code R.65-2.060(1). The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

18. Legal authority governing the Florida Medicaid Program is found in Fla. Stat. Chapter 409, and in Chapter 59G of the Florida Administrative Code. AHCA is the single state agency that administers the Medicaid Program.

19. In the instant matter, the Notice of Action states Petitioner's request for the Lumbar Spine Fusion surgery does not meet paragraphs 2 and 4 of Fla. Admin. Code R.59G-1.010, and is therefore not medically necessary.

20. Florida Administrative Code Rule 59G-1.010 states as follows:

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and

> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
>
> . . . .
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods, or services medically necessary or a medical necessity or a covered service.

21. Regarding paragraph 2, the surgery is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs. Dr. Bertha conceded Petitioner has attempted NSAIDS for a minimum of three (3) weeks. The letter from her family physician, along with Petitioner's testimony, indicates physical therapy has been tried in the past and is not feasible at this time due to her current condition. While Dr. Bertha asserts that she also needs to show evidence of attempted activity modification, the undersigned concludes the plain language in the Inpatient Authorization Summary only requires one of the following: home exercise, physical therapy, or activity modification, and does not require all three.

22. Regarding paragraph 4, the surgery can be safely furnished, and there is no equally effective and more conservative or less costly treatment available statewide. Petitioner tried physical therapy and it did not work. Petitioner tried the lumbar injection and it did not help. Petitioner has tried having her children rub BenGay on her back and it is too painful for her to tolerate. The surgery is medically necessary at this time.

DECISION

Based upon the foregoing, Petitioner's appeal is GRANTED. Respondent is directed to provide Petitioner the Lumbar Spine Fusion surgery, consistent with her neurosurgeon's request.

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 4th day of November, 2015, in Tallahassee, Florida.

Rick Zimmer

Rick Zimmer
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Judy Jacobs, Area 7, AHCA Field Office

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

[redacted]

PETITIONER,

APPEAL NO. 15F-06731

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 04 Duval
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 9, 2015 at 10:16 a.m.

APPEARANCES

For the Petitioner: pro se

For the Respondent: Sheila Broderick, registered nurse specialist

STATEMENT OF ISSUE

Whether the respondent's denial of the petitioner's request for dental services through Medicaid was correct. The burden of proof was assigned to the petitioner.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (Agency or AHCA or respondent) administers the Florida Medicaid Program. Medicaid rules require that most recipients receive their Medicaid services through the Managed Care Plan. The Agency contracts

with numerous health care organizations to provide medical services to its program participants. Molina Healthcare (Molina) is the contracted health care organization in the instant case. Molina subcontracts its dental services to DentaQuest of Florida (DentaQuest).

By notice dated July 29, 2015, Molina informed the petitioner that his request for tooth cleaning of heavy deposits, partial lower denture, partial upper denture, other drugs and/or medicines, and alveoloplasty with extractions was denied because the services were not medically necessary.

The petitioner timely requested a hearing to challenge the denial decision.

The petitioner's wife, [redacted] was present as a witness. The petitioner did not submit exhibits.

Present as witnesses for the respondent were Natalie Fernandez, government contracts specialist with Molina; Jackelyn Salcedo, grievance and compliance officer with DentaQuest; and Dr. Daniel Dorrego, dental consultant with DentaQuest. Respondent's Composite Exhibit 1 was admitted into evidence.

The record was held open until close of business on October 13, 2015 for the submission of additional evidence. Evidence was received from the respondent and admitted as Respondent's Composite Exhibit 2.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. The petitioner (age 48) is a Florida Medicaid recipient. The petitioner is enrolled in Molina HMO. Molina subcontracts with DentaQuest to provide its dental services, including completing prior service authorizations.

2. The petitioner's dentist requested prior authorization for extraction/surgical removal of several teeth, tooth cleaning of heavy deposits, partial lower denture, partial upper denture, other drugs and/or medicines, and alveoloplasty (filing down of bone in the mouth) in July 2015.

3. DentaQuest approved the extraction/surgical removal of the requested teeth.

4. DentaQuest denied the tooth cleaning of heavy deposits (procedure code D4355), other drugs and/or medicines (procedure code D9630), and alveoloplasty (procedure code D7311) as non-covered services.

5. DentaQuest denied the partial lower denture (D5214) and partial upper denture (procedure code D5213) because, per Dr. Danial Dorrego, dental consultant with DentaQuest, the petitioner's remaining teeth were so decayed they had to be extracted/surgical removed prior consideration of partial dentures. Dr. Dorrego testified that placing partial dentures in a mouth with decayed teeth was like "putting a new roof on a house with a cracked foundation."

6. Prior to the hearing, the petitioner's decayed teeth were extracted. DentaQuest reversed its prior denial and approved the request for partial lower denture and partial upper denture.

7. DentaQuest stands by its decision that the other services (tooth cleaning of heavy deposits, other drugs and/or medicines, and alveoloplasty) are not covered by Medicaid.

8. Medicaid provides only emergency dental services to enrollees age 21 and older. In addition, Medicaid provides denture and denture related services and oral and maxillofacial surgery services to all Medicaid enrollees. Covered dental services are listed by procedure code on the Medicaid Dental Fee Schedule. If dental service code does not appear on the Dental Fee Schedule, Medicaid will not reimburse for that service.

9. The petitioner and his wife argued that his "teeth are bad...does not know what caused them to go bad...teeth are falling...needs dentures."

PRINCIPLES OF LAW AND ANALYSIS

10. By agreement between the Agency for Health Care Administration (AHCA) 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.

11. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

12. The burden of proof is assigned to the petitioner. The standard of proof in an administrative hearing is by a preponderance of the evidence. (See Fla. Admin. Code R. 65-2060(1).) The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

13. The Florida Medicaid Provider Dental Services Coverage and Limitations Handbook (Dental Handbook) – November 2011 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code R. 59G-4.060.

14. The Dental Handbook states "Medicaid reimburses for services that are determined medically necessary ..."

15. The definition of "medically necessary" is found in the Fla. Admin. Code R. 59G-1.010, which states, in part:

> (166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
>
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider...
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

16. The Florida Medicaid Provider General Handbook (Provider Handbook) – July 2012 explains, on page 1-7, that "[o]nly those procedures that are not listed on the provider's Medicaid fee schedule (procedure code table) are non-covered services.

17. The Dental Fee Schedule shows that tooth cleaning of heavy deposits (procedure code D4355) is only covered for Medicaid enrollees under age 21. Other drugs and/or medicines (procedure code D9630) and alveoloplasty (procedure code D7311) are not listed on the Dental Fee Schedule.

18. The respondent denied the petitioner's (age 48) request for dental services (tooth cleaning of heavy deposits, other drugs and/or medicines, and alveoloplasty) as non-covered services. The controlling legal authorities show that the requested services are only covered for enrollees under age 21 or non- covered services.

19. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the respondent's decision in this matter was correct.

DECISION

The appeal is 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 5th day of November, 2015,

in Tallahassee, Florida.

Leslie Green
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Debbie Stokes, Area 4, AHCA Field Office Manager

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

[redacted]

PETITIONER,

Vs.

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

RESPONDENT.
_____/

APPEAL NO. 15F-06732

CASE NO.

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in this matter telephonically on September 24, 2015, at 3:10 p.m.

APPEARANCES

For the petitioner: [redacted]
Petitioner's son

For the Respondent: Linda Latson, R.N.
Registered Nurse Specialist/Fair Hearing Coordinator
Agency for Health Care Administration

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the respondent incorrectly denied her request for an additional five hours per week of Personal Care services?

PRELIMINARY STATEMENT

[redacted] the petitioner's son, appeared on behalf of the petitioner, [redacted] ("petitioner"). [redacted] may sometimes hereinafter be referred to as the petitioner's "representative".

Linda Latson, R.N., Registered Nurse Specialist and Fair Hearing Coordinator with the Agency for Health Care Administration ("AHCA" or "Agency"), appeared on behalf of the Agency for Health Care Administration. The following individuals from Amerigroup appeared as witnesses on behalf of the Agency: Mary Colburn, M.D., Long-Term Care Medical Director; and Carlene Brock, L.P.N., Quality Operations Nurse.

The respondent introduced Exhibits "1" through "5", inclusive, at the hearing, which were accepted into evidence and marked accordingly. The hearing record in this matter was left open until the close of business on September 28, 2015 in order for the respondent to submit the relevant portion of the contract between the Agency for Health Care Administration and Amerigroup and the Amerigroup Member Handbook provisions relating to personal care. Once received on September 25, 2015, this information was accepted into evidence and marked as respondent's Exhibit "6". The hearing record was then closed.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. The petitioner is a 76-year-old female residing in [redacted] Florida.

2. Petitioner was eligible to receive Medicaid services at all times relevant to this proceeding.

3. The petitioner is an enrolled member of Amerigroup. Amerigroup is a health maintenance organization ("HMO") contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in Florida.

4. The petitioner's effective date of enrollment with Amerigroup was November 1, 2013.

5. The petitioner is diagnosed with [redacted]

6. The petitioner had a spinal cord tumor surgically removed in 2012 which has affected her ability to walk. The petitioner can ambulate short distances using a walker but needs the assistance of a wheelchair for longer distances.

7. The petitioner requires total assistance with all of her activities of daily living including bathing, dressing, hair care, oral care, and hygiene.

8. The petitioner is partially incontinent. She sometimes requires assistance with the changing of incontinence products.

9. The petitioner lives in the family home with her adult son and his partner.

10. The petitioner's son is employed full-time. Although his normal work hours are from 8:00 a.m. to 4:30 p.m., he sometimes has to work late. The petitioner's son also has a part-time job which requires him to work from either 8:00 a.m. to 4:30 p.m. or 9:00 a.m. to 5:30 p.m. on Saturday and Sunday.

11. The son's partner is also employed full time. He works from 4:00 p.m. to 12:30 a.m., five days per week. The days of the week on which he works fluctuate.

12. Neither the petitioner's son nor his partner have any physical limitations which limit their ability to assist the petitioner.

13. The petitioner currently receives 21 hours per week (three hours per day) of personal care services.

14. The petitioner receives adult day health care services five days per week, Monday through Friday. The petitioner is at adult day health care six to seven hours per day.

15. On or about July 20, 2015, the petitioner's representative requested an additional five hours per week of personal care services, to be used one hour per day.

16. In a Notice of Action dated July 23, 2015, Amerigroup notified petitioner that her request for an additional five hours per week of personal care services was denied.

17. The Notice of Action states, in part:

> ■ We determined that your requested services are not medically necessary because the services do not meet the reasons(s) checked below: *(See Rule 59G-1.010)*
>
> > ■ Must be furnished in a manner not primarily intended for convenience of the recipient, caretaker, or provider. ...

18. The petitioner's aide arrives at approximately 6:30 a.m. Monday through Friday and stays with the petitioner until she is picked up for adult day health care at or around 8:30 a.m.

19. During that time, the petitioner's aide assists petitioner with her activities of daily living, including bathing, dressing and toileting. She also prepares breakfast for the petitioner and assists her with eating.

20. During the day, the petitioner receives a hot meal at her adult day health care program.

21. Attendants at the adult day health care program assist the petitioner with any toileting requirements during the day as well as with the changing of incontinence products if that becomes necessary.

22. The petitioner's private aide returns in the afternoon at approximately 4:00 p.m. or 4:30 p.m. to meet the petitioner as she arrives home from adult day health care. The petitioner's aide spends one hour with her in the afternoon. During that time, the aide attends to any toileting and hygiene requirements and provides the petitioner with a snack and water.

23. It is the position of the petitioner's representative that one additional hour of personal care services in the afternoon Monday through Friday will allow the aide to provide additional assistance to the petitioner.

24. It is the respondent's position that the services it is providing are meeting the petitioner's basic needs and are adequate.

PRINCIPLES OF LAW AND ANALYSIS

25. 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 Chapter 120.80, Fla. Stat.

26. This is a final order pursuant to § 120.569 and § 120.57, Fla. Stat.

27. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

28. In the present case, the petitioner is requesting additional services. Therefore, in accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof is assigned to the petitioner.

29. 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.).

30. The Florida Medicaid program is authorized by Chapter 409, Fla. Stat. and Chapter 59G, Fla. Admin. Code. The Medicaid program is administered by respondent.

31. Section 409.905, Fla. Stat. addresses mandatory Medicaid services under the State Medicaid Plan:

> Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law...

32. Under § 1915(c) of the Social Security Act (42 USC § 1396n(c)), a state may obtain a Medicaid waiver that allows the state to include in the state's Medicaid program the cost of home or community-based services (other than room and board) provided to individuals who otherwise would require care in a hospital, nursing facility, or intermediate care facility.

33. Home or community-based services include personal care services, habilitation services, and other services that are "cost effective and necessary to avoid institutionalization." See 42 CFR § 440.180.

34. Section 409.978, Florida Statutes, provides that the "Agency shall administer the long-term care managed care program," through the Department of Elder Affairs and through a managed care model. Fla. Stat. § 409.981(1), authorizes AHCA to bid for and utilize provider service networks to achieve this goal. In the instant case,

the provider network/HMO is Amerigroup.

35. The definition of medically necessary is found in the Fla. Admin Code. R. 59G-1.010 which states:

> (166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider...
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

36. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Chapter 59G-4. In accordance with the above Statute, the Handbook states on page 1-27

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.

> Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

37. Page 1-28 of the Florida Medicaid Provider General Handbook provides a list of HMO covered services. Page 1-30 of the Handbook explains "Other services that plans may provide include dental services, transportation, nursing facility and home and community-based services."

38. Page 1-30 of the Florida Medicaid Provider General Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

39. AHCA Contract No. FP021, Attachment II, Exhibit II-B, Effective 07/15/15, Page 15 of 91 (the Long-Term Care Program Contract between the Agency for Health Care Administration and Amerigroup) defines Personal Care as follows:

> A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

40. The Amerigroup Member Handbook, on Page 10, lists the following as appropriate personal care activities:

- Help at home with bathing, dressing, eating, personal hygiene and other activities
- Help with light cleaning, bed making and meals

41. The personal care services Amerigroup offers to its Long-Term Care Program participants are consistent with those outlined in its contract with the Agency for Health Care Administration.

42. In the present case, the petitioner proffered no evidence to support a conclusion that the three hours per day of personal care services she is currently receiving are not enough to complete the activities contemplated in the above paragraphs, and that additional services are medically necessary. The presently approved three hours per day are sufficient to assist the petitioner with eating, bathing, dressing, personal hygiene, meal preparation, light housekeeping, and any other activities of daily living.

43. Pursuant to the above, the petitioner has not met her burden of proof to demonstrate the respondent incorrectly denied her request for additional personal care services.

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 2 day of November, 2015,

in Tallahassee, Florida.

Peter Tsamis

Peter J. Tsamis
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal_Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

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

[redacted]

APPEAL NO. 15F-06745

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 09 Orange
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing on October 5, 2015 at approximately 10:30 a.m.

APPEARANCES

Petitioner: [redacted]

For Respondent: Doretha Rouse
Registered Nurse Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is Respondent's denial of Petitioner's request for pre-operative refractions for cataract surgery. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

Respondent presented the following witnesses:

- Stephanie Shupe, Senior Grievance Coordinator, Staywell.
- Alexandria Hicks, Senior Grievance Coordinator, Staywell.
- Carrie Jenkins, Vendor Account Manager, WellCare.
- Dr. Michael Hecht, O.D., Medical Director, Premier Eye Care.

- Liz Jackson, Director of Network Management, Premier Eye Care.

Petitioner moved Exhibits 1 and 2 into evidence at the hearing. Respondent moved Exhibits 1 through 7 into evidence at the hearing. Administrative notice was taken of the July 2012 Florida Medicaid Provider General Handbook. The record was held open for both parties to submit additional evidence. Respondent submitted additional evidence, entered as Exhibit 8, as well as excerpts from the May 2014 Optometric Services Coverage and Limitations Handbook.

FINDINGS OF FACT

1. Petitioner is a 61-year-old female. At all times relevant to this proceeding, Petitioner was eligible to receive Medicaid services.

2. Petitioner is enrolled with Staywell as her Managed Medical Assistance (MMA) plan. Premier Eye Care ("Premier") is Staywell's vision services vendor.

3. Petitioner wants cataract surgery. She testified the cataract surgery itself was approved, but the necessary pre-operative refractions were not. There is no dispute that cataract surgery is a covered benefit.

4. Dr. Hecht stated refractions, CPT code 92015, are always a non-covered service for medical eye exams. He stated refractions as part of a routine eye exam are covered.

5. Premier confirmed Petitioner received one (1) eye exam, with refraction, during the last 365 days. The exam took place on May 8, 2015. Staywell asserts: "Per Premier, there is no specific contract language in the Vendor contract that speaks to specific, defined services, such as refractions." (Respondent's Exhibit 8).

6. Dr. Hecht testified Premier has not issued any denial and only recommends denials to WellCare. He stated pre-operative refractions are a non-covered service. He also stated all surgeons require patients to have pre-surgical refractions before they will perform surgery.

7. Petitioner testified she cannot have the cataract surgery without the pre-operative refractions because the surgical center, Magruder Eye Institute ("Magruder") will not perform the surgery without it.

8. Petitioner said the cataract surgery was scheduled and when she got to Magruder's facility, they called her into the office and said she would have to pay $250.00 before she could go in for the pre-op or anything else. Dr. Hecht said this would be typical; a pre-operative refraction would be performed, and then a request to perform the surgery would be submitted and reviewed for medical necessity. He stated there was never a request to perform the surgery sent to Premier.

9. According to page 3 of Staywell's Grievance Notes, dated July 30, 2015, Staywell's Grievance Department spoke to an individual named Jenny at Premier. The notes state: "[Jenny] was under the impression that the appointment was set up and that Magruder was to contact the member to advise her of the appointment. Jenny stated that in the beginning the office wanted to charge the member for testing. Premier reviewed and it met the medical guidelines so all was covered but the refractions." (Respondent's Exhibit 4).

10. Petitioner testified the refractions were originally going to cost $250.00 out-of-pocket ($125.00 per eye), although the Grievance Notes indicate it was $200.00. Per page 2 of the Grievance Notes, Staywell "Contacted Premier and spoke to

Jenny...She stated they had already worked out with Magruders that the refractions would be a total of $90.00 for the refractions which is not a covered expense on the member's plan. Jenny and the medical director will follow up with Magruders regarding the refractions and then follow up with the member." (Respondent's Exhibit 4).

11. On July 30, 2015, Staywell sent a letter to Petitioner confirming the conversation with her and that she would have to pay a total of $90.00 to Magruder for the refractions. The letter stated Petitioner had the right to request a Fair Hearing if she disagreed.

12. Petitioner timely requested a hearing on August 10, 2015.

CONCLUSIONS OF LAW

13. By agreement between the Agency for Health Care Administration ("AHCA" or "Agency") and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction over this matter pursuant to § 120.80, Fla. Stat.

14. This hearing was held as a *de novo* proceeding, in accordance with Florida Administrative Code Rule 65-2.056.

15. This is a Final Order, pursuant to §§ 120.569 and 120.57, Fla. Stat.

16. 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.).

17. Legal authority governing the Florida Medicaid Program is found in Chapter 409 of the Florida Statutes, and in Chapter 59G of the Florida Administrative Code.

Respondent, AHCA, is the single state agency that administers the Medicaid Program.

18. The May 2014 Florida Medicaid Optometric Services Coverage and Limitations Handbook ("Optometric Handbook") is promulgated into law by Florida Administrative Code Chapter 59G-4.

19. According to ACHA's Medicaid MMA Contract with Staywell, "In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those in the Medicaid Optometric Services Coverage and Limitations Handbook and Medicaid Vision Services Coverage and Limitations Handbook." (Respondent's Exhibit 6).

20. On page 2-3 of the Optometric Handbook, it states: "Medicaid will reimburse only two refractions performed in the provider's office per recipient, per 365 days. The 365-day period begins with the date of the first refraction."

21. There is some dispute as to whether or not a formal request by Magruder for the cataract surgery has been submitted. Dr. Hecht said a request would not be submitted until after the refractions are performed, and that Premier does not have a request on file. Petitioner's testimony, and Staywell's Grievance Notes seem to indicate the cataract surgery itself has been approved, but she is being required to pay out-of-pocket for the refractions. Because the medical necessity of the cataract surgery is not currently under review, the undersigned will only address the refractions.

22. Both Dr. Hecht's testimony and Staywell's Grievance Notes indicate the medical necessity of the pre-operative refractions is not in dispute because they are required

in order for the cataract surgery to proceed. The only dispute is whether or not the refractions are a covered benefit.

23. Staywell confirmed Petitioner received one (1) eye exam with refraction on May 8, 2015. Per the Optometric Handbook, Petitioner is allowed up to two (2) refractions every 365 days.

24. Since Petitioner has only utilized one (1) eye exam with refraction within the past 365 days, the plain language of the Optometric Handbook leads the undersigned to conclude that she is entitled to one (1) additional refraction within the 365 day period beginning on May 8, 2015 and ending on May 7, 2016.

DECISION

Based upon the foregoing, Petitioner's appeal is GRANTED insofar as she is entitled to receive one (1) additional refraction at this time, pursuant to the Medicaid Handbooks.

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 10th day of November, 2015,

in Tallahassee, Florida.

Rick Zimmer
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Judy Jacobs, Area 7, AHCA Field Office

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

[redacted]

PETITIONER,

Vs.

APPEAL NO. 15F-06746

CASE NO.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on October 6, 2015, at 10:45 a.m., in Fort Lauderdale, Florida.

APPEARANCES

For the Petitioner: [redacted]
Petitioner's mother

For the Respondent: Linda Latson, R.N.
Registered Nurse Specialist/Fair Hearing Coordinator
Agency for Health Care Administration

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the Agency for Health Care Administration incorrectly denied her request to remove her wisdom teeth?

PRELIMINARY STATEMENT

[redacted] the petitioner's mother, appeared on behalf of the petitioner, [redacted] ("petitioner"), who was not present. [redacted] may sometimes hereinafter be referred to as the petitioner's "representative".

Linda Latson, R.N., Registered Nurse Specialist and Fair Hearing Coordinator for the Agency for Health Care Administration ("AHCA" or "Agency"), appeared on behalf of the Agency for Health Care Administration. The following appeared as witnesses on behalf of the Agency: Vincent Pantone, M.D., Chief Medical Officer of Better Health; Diana Anda, Grievance and Appeals Supervisor at Better Health; Susan Hudson, D.M.D., Dental Consultant with DentaQuest; and Haydee Penaranda, Complaints and Grievances Specialist with DentaQuest.

The respondent introduced respondent's Exhibits "1" through "3", inclusive, at the hearing, which were accepted into evidence and marked accordingly. The hearing record in this matter was left open until the close of business on October 13, 2015 for the petitioner to provide medical documentation supporting the need for the removal of the petitioner's wisdom teeth and the respondent to provide a copy of the Better Health Member Handbook. Once received, the petitioner's information was accepted into evidence and marked as petitioner's Exhibit "1". Although the respondent attempted to transmit the Better Health Member Handbook after the hearing, what was received by the Office of Appeal Hearings was an email attachment consisting of 46 blank pages. Since the respondent's witness proffered testimony at the hearing concerning the Better Health and DentaQuest criteria for the removal of wisdom teeth, the absence of the Better Health Member Handbook was not detrimental to arriving at a decision in this

matter. Therefore, the hearing record was closed on October 13, 2015 as set forth at the hearing with the absence of the Better Health Member Handbook.

At the respondent's request, the hearing officer took administrative notice of the Dental Services Coverage and Limitations Handbook.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. The petitioner is a 16-year-old female.

2. Petitioner was eligible to receive Medicaid services at all times relevant to this proceeding.

3. The petitioner is an enrolled member of Better Health. Better Health is a health maintenance organization ("HMO") contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in Florida.

4. The petitioner's effective date of enrollment with Better Health was July 1, 2014.

5. Better Health provides certain dental benefits to its members. With regard to its members under age 21, these benefits include the surgical extraction of wisdom teeth when such medical intervention is determined to be medically necessary.

6. Better Health has contracted DentaQuest to complete prior authorization reviews of requests for dental services by its members.

7. On or about August 3, 2015, the petitioner's dental provider submitted a prior authorization request to DentaQuest for the following services:

- general anesthetic – first 30 minutes

- extraction of impacted tooth covered by bone Tooth 17
- extraction of impacted tooth covered by bone Tooth 32
- extraction of impacted tooth covered by bone Tooth 1
- extraction of impacted tooth covered by bone Tooth 16
- general anesthesia – each additional 15 minutes
- general anesthesia – each additional 15 minutes

8. In a Notice of Action dated August 4, 2015, DentaQuest informed the petitioner it denied her request for the removal of her wisdom teeth. The Notice of Action (*Resp. Exhibit* 1) states, in part:

> We determined that your requested services are **not medically necessary** because the services do not meet the reason(s) checked below: *(See Rule 59G-1.010)*
>
> X Must be needed to protect life, prevent significant illness or disability, or alleviate severe pain.
> X Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs.
> X Must meet accepted medical standards and not be experimental or investigational.
>
> X The requested **service is not a covered benefit.**

9. The Notice of Action (*Resp. Exhibit* 1) goes on to explain:

The facts that we used to make our decision are:

- We cannot approve anesthesia, because the main treatment was denied. Please follow up with your dentist.
- The information your dentist sent shows your tooth does not need to be removed. Your tooth has no sign of infection and your dentist has not told us that you are in pain. Please follow up with your dentist.
- The information your dentist sent shows your tooth does not need to be removed. Your tooth has no sign of infection and your dentist has not told us that you are in pain. Please follow up with your dentist.
- The information your dentist sent shows your tooth does not need to be removed. Your tooth has no sign of infection and your dentist has not told us that you are in pain. Please follow up with your dentist.
- The information your dentist sent shows your tooth does not need to be removed. Your tooth has no sign of infection and your dentist has not told us that you are in pain. Please follow up with your dentist.
- We cannot approve anesthesia, because the main treatment was

denied. Please follow up with your dentist.
- We cannot approve anesthesia, because the main treatment was denied. Please follow up with your dentist.

10. Each of the lines in Paragraph 9 corresponds with the matching line in Paragraph 7.

11. DentaQuest completed an internal reconsideration of its decision to deny the petitioner's request on or about September 10, 2015. The Dental Consultant notes associated with that review (*Resp. Exhibit 2*) *state* as follows:

> Denial upheld. We received and reviewed all submitted documentation (radiographs, ADA form, Narrative, notes, etc.) for our final determination. No sign of infection or other medical reason for removal. No submitted narrative.

12. The note from the petitioner's dentist (*Pet. Exhibit* 1) provided by the petitioner's representative after the hearing explains as follows: "The patient presents with a history of pain and discomfort from the above listed teeth. These teeth are unable to erupt normally and surgical removal is indicated. The upper wisdom teeth are affecting the periodontal health of the surrounding dentition necessitating their removal." The note goes on to list the wisdom teeth, Teeth 1, 16, 17, and 32.

13. The dentist appearing for the respondent testified DentaQuest will approve the removal of a wisdom tooth if the tooth exhibits signs of infection or pathology, or if the individual is experiencing pain due to malpositioning of the tooth.

14. The note from the petitioner's dentist (*Pet. Exhibit 1*) does not indicate the presence of an infection associated with any of the wisdom teeth.

15. Pathology refers to a disease, such as when a cyst or tumor is associated with the wisdom tooth.

16. The note from the petitioner's dentist (*Pet. Exhibit 1*) does not indicate the presence of pathology associated with any of the wisdom teeth.

17. The dentist appearing for the respondent testified in order for DentaQuest to approve the extraction of a wisdom tooth due to malpositioning, at least one-half of the tooth's root must have formed. The reason for this is because the formation of the root may push the tooth into position.

18. The petitioner's wisdom teeth do not yet have the requisite root formation.

19. The petitioner's representative testified at the hearing that the petitioner is in severe pain and is prescribed pain medication; the petitioner's gums are swollen; the petitioner is sometimes unable to have dinner because of the pain in her mouth; and the petitioner is missing school due to pain associated with her wisdom teeth.

20. The dentist appearing for the respondent testified that some pain is normal with the formation and eruption of wisdom teeth. The pain that needs to be addressed is severe pain that lasts for an extended length of time.

21. The note from the petitioner's dentist (*Pet. Exhibit 1*) lists the medications the petitioner is presently taking as magnesium and propranolol. The note does not indicate the petitioner is currently prescribed or taking any pain medication.

22. The note from the petitioner's dentist (*Pet. Exhibit 1*) does not indicate the petitioner's gums are swollen. It documents no inflammation surrounding any of the petitioner's wisdom teeth.

23. The note from the petitioner's dentist (*Pet. Exhibit 1*) does not state the petitioner is unable to eat because of pain associated with her wisdom teeth.

24. The note from the petitioner's dentist (*Pet. Exhibit 1*) does not indicate the petitioner is missing school due to pain associated with her wisdom teeth.

CONCLUSIONS OF LAW

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

26. This is a final order pursuant to § 120.569 and § 120.57, Fla. Stat.

27. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

28. In the present case, the petitioner is requesting an additional service. Therefore, in accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof is assigned to the petitioner.

29. 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.).

30. The Florida Medicaid program is authorized by Chapter 409, Fla. Stat. and Chapter 59G, Fla. Admin. Code. The Medicaid program is administered by respondent.

31. Section 409.905, Fla. Stat. addresses mandatory Medicaid services under the State Medicaid Plan:

> Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law...

32. The definition of medically necessary is found in the Fla. Admin Code. R. 59G-1.010, which states:

> (166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider...
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

33. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Chapter 59G-4. In accordance with the above Statute, the Handbook states on page 1-27

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.

> Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

34. Page 1-28 of the Florida Medicaid Provider General Handbook provides a list of HMO covered services. Page 1-30 of the Handbook explains "Other services that plans may provide include dental services, transportation, nursing facility and home and community-based services."

35. Page 1-30 of the Florida Medicaid Provider General Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

36. The Dental Services Coverage and Limitations Handbook – November 2011 is incorporated by reference in the Medicaid Service Rules by Fla. Admin. Code Rule 59G-4.060.

37. The Dental Services Coverage and Limitations Handbook addresses Covered Child Services (Ages under 21) on Page 2-3 and states as follows:

> The Medicaid children's dental services program may provide reimbursement for diagnostic services, preventive treatment, restorative, endodontic, periodontal, surgical procedures and extractions, orthodontic treatment, and full and partial dentures (fixed and removable) for recipients under age 21.

The removal of wisdom teeth falls under the category of surgical procedures and extractions.

38. The respondent's witnesses testified that Better Health and DentaQuest will also approve the surgical extraction of wisdom teeth if certain criteria are met. Therefore, Better Health dental policy is not more restrictive than that of the Agency for Health Care Administration.

39. In the present case, the petitioner did not provide any specific information documenting the need for the removal of any of her four wisdom teeth. The information contained in the note from the petitioner's dentist (*Pet. Exhibit 1*) is general in nature and does not indicate the presence of an infection or pathology associated with any of the petitioner's wisdom teeth. There is no mention of any inflammation. It also does not document the presence of severe pain that is being treated with pain medication, nor does it state the petitioner is unable to eat and is missing school due to pain associated with her wisdom teeth.

40. Pursuant to the above, the petitioner has not shown by a preponderance of the evidence that the respondent incorrectly denied her request for the removal of her wisdom teeth.

41. Should the petitioner be able to secure more specific information from her dentist documenting the need for the removal of each of her four wisdom teeth, she may resubmit this information to Better Health and DentaQuest along with a new request to have her wisdom teeth extracted.

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 10th day of November, 2015,

in Tallahassee, Florida.

Peter J. Tsamis
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 07 Volusia
UNIT: 88371

RESPONDENT.
_____/

APPEAL NO. 15F-06749

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 8:30 a.m. on September 2, 2015.

APPEARANCES

For the Petitioner: [redacted] pro se

For the Respondent: Matthew Lynn
ACCESS Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's action to approve petitioner in the Medically Needy Program with an estimated $696 Share of Cost (SOC) is proper. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

By notice dated June 2, 2015, respondent notified petitioner he was approved in the Medically Needy Program with an estimated $696 SOC. Petitioner timely requested a hearing to challenge approval in the Medically Needy Program.

Petitioner did not submit exhibits. Respondent submitted three exhibits, entered as Respondent Exhibits "1" through "3". The record was closed on September 2, 2015.

FINDINGS OF FACT

1. Petitioner submitted an application for Food Assistance and Medicaid benefits for himself on May 21, 2015. Medicaid is the only issue.

2. As part of the eligibility process, the Department verified petitioner receives $896 in Social Security Disability Income (SSDI).

3. Petitioner does not have minor children; therefore, he is not eligible for Family Medicaid. To be eligible for Adult (SSI-Related) Medicaid, petitioner's income cannot exceed the $864 monthly Medicaid income limit. Petitioner's $896 SSDI exceeds the $864 income limit. The next program available is the Medically Needy Program with a SOC.

4. Respondent determined petitioner's SOC as follows:

$896	SSDI
-$ 20	unearned income disregard
-$180	Medically Needy Income Level (MNIL)
$696	SOC

5. On June 2, 2015, respondent mailed petitioner a Notice of Case Action notifying he was approved in the Medically Needy Program with a $696 estimated SOC.

6. Petitioner believes since he has worked all his life, he should now be allowed to receive full Medicaid.

CONCLUSIONS OF LAW

7. 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 Fla. Stat. § 409.285.

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

9. The Fla. Admin. Code R. 65A-1.713, SSI-Related Medicaid Income Eligibility Criteria states in part:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
> (a) For MEDS-AD Demonstration Waiver, income cannot exceed 88 percent of the federal poverty level...
> (h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses...
> (4)(c) Medically Needy. The amount by which the individual's countable income exceeds the Medically Needy income level, called the "share of cost", shall be considered available for payment of medical care and services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical costs. If countable income exceeds the Medically Needy income level the department shall deduct allowable medical expenses in chronological order, by day of service...To be deducted the expenses must be unpaid, or if paid, must have been paid in the month for which eligibility is being determined or incurred and paid during the three previous calendar months to the month for which eligibility is being determined but no earlier than the three retroactive application months...

10. The above authority explains to be eligible for full Medicaid; income cannot exceed 88 percent of the federal poverty level. And Medically Needy provides coverage for individuals who do not qualify for full Medicaid due to income.

11. The Department's Program Policy Manual, CFOP 165-22, appendix A-9 (April 2015), identifies $864 as 88 percent of the federal poverty level for a household size of one.

12. Petitioner's $896 SSDI exceeds the $864 income limit to be eligible for full Medicaid. Therefore, petitioner is not eligible for full Medicaid.

13. Federal Regulations at 20 C.F.R. § 416.1124 explain unearned income not counted and states in part "(c) Other unearned income we do not count... (12) The first $20.00 of any unearned income in a month..."

14. The Fla. Admin. Code R. 65A-1.716 sets forth the MNIL at $180 for a family size of one.

15. In accordance with the authorities, respondent deducted $20 unearned income and $180 MNIL from petitioner's $896 SSDI to arrive at $696 SOC.

16. In carefully review of the cited authorities and evidence, the undersigned concludes the respondent followed Rule in approving petitioner in the Medically Needy Program with $696 monthly SOC.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the respondent's action is approved.

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 4th day of November, 2015,

in Tallahassee, Florida.

Priscilla Peterson

Priscilla Peterson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished To [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

PETITIONER,

APPEAL NO. 15F-06972

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 telephonically in the above-referenced matter on October 12, 2015, at 3:12 p.m.

APPEARANCES

For the petitioner: [redacted]
Petitioner

For the Respondent: Sandra Moss
Program Administrator
Agency for Health Care Administration

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the Agency for Health Care Administration incorrectly denied her request for an additional nine tablets of [redacted] (100 mg) tablets.

PRELIMINARY STATEMENT

[redacted] ("petitioner"), the petitioner, appeared on her own behalf.

Sandra Moss, Program Administrator with the Agency for Health Care Administration ("AHCA" or "Agency"), appeared on behalf of the Agency for Health Care Administration. The following individuals from Sunshine Health appeared as witnesses on behalf of the Agency: India Smith, Grievance and Appeals Coordinator; David Gilchrist, D.O., Medical Director; and Richard Plymel, Pharm. D., Pharmacy Manager.

The hearing record in this matter was left open until the close of business on October 15, 2015 for the respondent to provide a copy of the Florida Medicaid Summary of Drug Limitations for [redacted] Once received, this information was accepted into evidence and marked as respondent's Exhibit "1". The hearing record was then closed.

FINDINGS OF FACT

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

1. The petitioner is an adult female.

2. The petitioner was eligible to receive Medicaid at all times relevant to this proceeding.

3. The petitioner is an enrolled member of Sunshine Health. Sunshine Health is a health maintenance organization ("HMO") contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in Florida.

4. [redacted] is a medication used for the treatment of migraine headaches.

5. The petitioner's doctor prescribes [redacted] (100 mg) for the petitioner.

6. The petitioner filled a prescription for [redacted] on August 12, 2015. The one-month supply of the medication consisted of nine tablets.

7. The petitioner returned to the pharmacy on August 15, 2015 to request an additional nine tablets of [redacted] The pharmacy rejected the petitioner's request for the additional nine tablets.

8. The petitioner has been prescribed [redacted] for an extended period of time.

9. A one-month supply of [redacted] previously consisted on 18 tablets.

10. The last time the petitioner's [redacted] prescription was filled with 18 tablets was October 31, 2014.

CONCLUSIONS OF LAW

11. 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.

12. This is a final order pursuant to § 120.569 and § 120.57, Fla. Stat.

13. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

14. The petitioner is requesting additional tablets of her medication. Therefore, in accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof is assigned to the petitioner.

15. The standard of proof in an administrative hearing is by a preponderance of the evidence. (See Fla. Admin. Code R. 65-2060(1).) The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.

16. The Florida Medicaid program is authorized by Fla. Stat. ch. 409 and Fla. Admin. Code R. 59G. The Medicaid program is administered by the respondent.

17. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference into the Medicaid Services Rules by Fla. Admin. Code Rule 59G-5.020.

18. Page 1-22 of the Florida Medicaid Provider General Handbook provides a list of Medicaid covered services. These services include prescribed drug services.

19. Fla. Admin. Code R. 59G-1.010(166) explains that medical or allied care, goods, or services furnished or ordered must meet the definition of medically necessary or medical necessity, and defines medical necessity as:

> (a) "Medical necessary" or "medical necessity" means that medical or allied care, goods or services furnished or ordered must meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patent's needs;
> 3. Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational;
> 4. Be reflective of the level of service that can safely be furnished, for which no equally effective and more conservative or less costly treatment is available statewide; and,
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. . .

> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods or services medically necessary, or a medical necessity, or a covered service.

20. Section 409.912 (37)(a), Florida Statutes states, in relevant parts:

> 14. The agency may require prior authorization for Medicaid-covered prescribed drugs. The agency may prior-authorize the use of a product:
> a. For an indication not approved in labeling;
> b. To comply with certain clinical guidelines; or
> c. If the product has the potential for overuse, misuse, or abuse.
> The agency may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug....

21. Fla. Admin. Code R. 59G-4.250 Prescribed Drug Services incorporates by reference the Florida Medicaid Prescribed Drug Services Coverage, Limitations, and Reimbursement Handbook, updated July 2014.

22. The Florida Medicaid Prescribed Drug Services Coverage, Limitations, and Reimbursement Handbook addresses Service Limitations on Page 2-8. It states as follows:

> Medicaid limits the quantity and number of refills that may be reimbursed for certain drug classes. Medicaid also limits reimbursement for certain drug classes to recipients based upon clinical considerations of the patient's age. A current list of drug limitations can be found on the Internet at: www.mymedicaid-florida.com. Click on Public Information for Providers, then Pharmacy, then Drug Limitations.

23. The link above leads to a Summary of Drug Limitations. On Page 17 of 43 of this summary appears [redacted] 25mg, 50mg and 100mg tablets. Next to the description, it states "Maximum of 9 tablets every 30 days".

24. The respondent correctly denied the petitioner's request for any additional tablets in excess of the nine she received for August based on the limitation set forth above.

25. Pursuant to the above, the petitioner has not met her burden of proof to demonstrate the respondent incorrectly denied her request for additional tablets of the prescription drug [redacted]

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this 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 10th day of November, 2015, in Tallahassee, Florida.

Peter Tsamis

Peter J. Tsamis
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

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

[redacted]

APPEAL NO. 15F-07034

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 (Dade)
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 9, 2015 at 2:30 p.m.

APPEARANCES

For the Petitioner: [redacted] Petitioner

For the Respondent: Monica Otalora, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the Respondent's reduction of the Petitioner's home health aide services was correct. Respondent bears the burden of proving its case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The Petitioner submitted his doctor's letter and medical records as evidence for the hearing, which were marked Petitioner Exhibits 1 and 2.

Appearing as witnesses for the Respondent were Mindy Aikman, Grievance Specialist, and Dr. Ian Nathanson, Medical Director, for Humana, which is the Petitioner's managed health care organization. Respondent submitted the following documents into evidence: Exhibit 1 – Service Request and Plan of Care; Exhibit 2: Denial Notice; and Exhibit 3: Medical Assessment Form.

FINDINGS OF FACT

1. The Petitioner is a forty-seven (47) year-old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. He receives services under the plan through Humana.

2. The Petitioner is blind in one eye and is non-ambulatory, although he can stand up and sit down by himself. He utilizes a wheelchair for mobility. He lives with his mother, who is sixty-seven (67) years of age and also wheelchair-bound.

3. On or about July 1, 2015, Petitioner's home health services provider submitted an authorization request to Humana for approval of two home health aide visits daily.

4. On or about August 25, 2015, Humana informed the Petitioner by written notice that his request for home health aide visits had been partially denied. Humana approved one home health aide visit daily for bathing. The following was stated as the reason for the partial denial: "You require some assistance with bathing. Medicaid home health aide visits do not cover light housekeeping or meal preparation."

5. The Petitioner had been previously receiving two home health aide visits daily – one in the morning and one in the afternoon.

6. The Petitioner testified he should continue receiving two home health aide visits daily because he needs assistance throughout the day. He states the aide helps bathe him during the morning visit, and this takes up to one and one-half hours. During the afternoon visit, the aide helps clean his room and wash his clothes and this visit takes approximately one-half hour. He also stated he needs help with walking to the toilet and preparing meals. Petitioner believes that one visit is the equivalent of one hour; therefore he believes two visits are necessary since the aide is providing two hours of assistance daily.

7. The Respondent's witness, Dr. Nathanson, testified that the partial denial of the Petitioner's request for home health services was appropriate because only one visit daily is medically necessary. He stated that home health aide visits do not include housekeeping or meal preparation, pursuant to Medicaid guidelines. He also stated that the Petitioner's primary needs were for bathing and skin care, and the medical records indicated he needed only minimal assistance with transfers and needed no assistance with toileting and elimination functions. He also pointed out that home health aide visits are not limited in time, so that one visit does not mean only one hour of service.

8. Home health services under the Medicaid State Plan in Florida are provided in accordance with the Respondent's Home Health Services Coverage and Limitations Handbook ("Home Health Handbook"), effective October, 2014.

PRINCIPLES OF LAW AND ANALYSIS

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

10. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

11. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

12. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the Respondent since it is seeking a reduction in Petitioner's services. 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.).

13. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the Respondent. The Home Health Handbook is incorporated by reference in Chapter 59G-4, Florida Administrative Code.

14. The Home Health Handbook, on page 2-18, describes home health aide visits as follows:

> Home health aide services help maintain a recipient's health or facilitate treatment of the recipient's illness or injury. The following are examples of home health aide services reimbursed by Medicaid:
>
> • Assisting with the change of a colostomy bag
> • Assisting with transfer
> • Reinforcing a dressing
> • Assisting the individual with prescribed range of motion

exercises that have been taught by the RN
• Measuring and preparing prescribed special diets
• Providing oral hygiene
• Bathing and skin care
• Assisting with self-administered medication

Home health aides must not perform any services that require the direct care skills of a licensed nurse.

15. The Home Health Handbook, on page 2-12, also describes the following exclusion which is not reimbursable as a Medicaid home health service:

Housekeeping (except light housekeeping), homemaker, and chore services, including any shopping except grocery shopping when provided as an IADL for recipients under the age of 21 years

16. The Handbook provision cited above states that Medicaid does not cover housekeeping and homemaker services as part of home health aide visits. Petitioner testified that the second daily home health aide visit consists of the aide cleaning his room and washing his clothes. In addition, meal preparation is in the nature of homemaker services.

17. After considering all the documentary evidence and witness testimony presented, the undersigned concludes Humana properly reduced Petitioner's home health services to one visit daily. Petitioner's primary needs are bathing and skin care and these needs can be addressed in one home health aide visit daily.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is 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 agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 25 day of November, 2015, in Tallahassee, Florida.

Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Rhea Gray, AHCA Area 11, Field Office Manager

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

[redacted]

PETITIONER,

Vs.

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

RESPONDENT.
_____/

APPEAL NO. 15F-07036

CASE NO.

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in this matter telephonically on October 1, 2015, at 1:05 p.m.

APPEARANCES

For the petitioner: [redacted]
Petitioner's daughter

For the Respondent: Linda Latson, R.N.
Registered Nurse Specialist/Fair Hearing Coordinator
Agency for Health Care Administration

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the Agency for Health Care Administration incorrectly denied a portion of her request for personal care services and homemaker services?

PRELIMINARY STATEMENT

[redacted] the petitioner's daughter, appeared on behalf of the petitioner, [redacted] ("petitioner"), who was not present. [redacted] may sometimes hereinafter be referred to as the petitioner's "representative".

Linda Latson, R.N., Registered Nurse Specialist and Fair Hearing Coordinator for the Agency for Health Care Administration ("AHCA" or "Agency"), appeared on behalf of the Agency for Health Care Administration. The following individuals appeared as witnesses on behalf of the Agency: Mary Colburn, R.N., Long-Term Care Medical Director for Amerigroup; and Carlene Brock, L.P.N., Quality Operations Nurse for Amerigroup.

The respondent introduced respondent's Exhibits "1" through "5", inclusive, at the hearing, which were accepted into evidence and marked accordingly. The hearing record in this matter was left open until the close of business on October 8, 2015 for the respondent to provide the Amerigroup Long-Term Care Member Handbook and the portions of the contract between the Agency for Health Care Administration and Amerigroup pertaining to personal care and homemaker services. Once received, this information was accepted into evidence and marked as respondent's Composite Exhibit "6". The hearing record was then closed.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. The petitioner is a 94-year-old female.

2. Petitioner was eligible to receive Medicaid services at all times relevant to this proceeding.

3. The petitioner is an enrolled member of Amerigoup. Amerigroup is a health maintenance organization ("HMO") contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in Florida.

4. The petitioner's effective date of enrollment with Amerigroup was July 1, 2015.

5. The petitioner is a participant of the Long-Term Care Program.

6. The petitioner's medical history is remarkable for the following: gait disorder; macular degeneration; chronic obstructive pulmonary disease ("COPS"); arthritis; hypertension; dyslipidemia (high cholesterol); and hearing loss.

7. The petitioner has a problem with short-term memory loss.

8. The petitioner ambulates with the assistance of a walker.

9. The petitioner is generally continent of bladder but incontinent of bowel. She uses incontinence products during the day but not during the night.

10. The petitioner presently has a privately paid aide with her from 10:30 a.m. to 5:00 p.m. daily.

11. When the petitioner wakes in the morning, she is able to turn-on a coffee maker prepared with coffee and water for her the previous evening by her aide.

12. The petitioner is able to make toast for breakfast independently.

13. The petitioner's aide prepares lunch and dinner for the petitioner.

14. The petitioner is unable to shop or cook for herself.

15. The petitioner requires assistance with her activities of daily living.

16. Activities of daily living include eating, bathing, dressing, oral care, skin care, toileting and elimination, incontinent care, and range of motion and positioning.

17. The petitioner's aide helps the petitioner get ready for bed before she leaves at 5:00 p.m.

18. The petitioner resides alone. She is alone from the time her aide leaves at 5:00 p.m. until the following day at 10:30 a.m. when her aide returns.

19. The petitioner is able to transfer independently during the evening and nighttime hours in order to meet her toileting needs.

20. The petitioner has a Personal Emergency Response System ("PERS") provided to her by Amerigroup. This system is intended to assist the petitioner with calling for help in the event of an emergency.

21. The petitioner's aide assists the petitioner with the following: taking her medication; using her nebulizer and oxygen concentrator; preparing lunch and dinner; laundry; food shopping; picking up prescriptions; and transportation to and from doctor's and other medical appointments.

22. On or about July 8, 2015, the petitioner submitted a request to Amerigroup for 18 hours per week of personal care and homemaker services. The request was unspecified as to how many hours of personal care and how many hours of homemaker services were being requested.

23. Personal care services and homemaker services may be performed by the same individual.

24. The petitioner intended to use the hours in the following manner: six hours per day on Friday, Saturday, and Sunday.

25. The petitioner's family intended to continue paying for a privately paid aide on the other days of the week.

26. Amerigroup reviewed the petitioner's request on July 14, 2015.

27. In a Notice of Action dated July 14, 2015, Amerigroup approved personal care services and homemaker services three hours per day, three days per week, and denied the remainder of the petitioner's request.

28. The Notice of Action states, in part:

> ■ We determined that your requested services are not medically necessary because the services do not meet the reasons(s) checked below: *(See Rule 59G-1.010)*
>
> > ■ Must be furnished in a manner not primarily intended for convenience of the recipient, caretaker, or provider. ...

29. The three hours per day, three days per week, of personal care services and homemaker services approved by the respondent were rejected by the petitioner.

30. It is the position of the petitioner's representative that three hours per day are insufficient to assist petitioner with all of the activities with which she requires help.

31. The Long-Term Care Medical Director set forth the respondent's position that the petitioner's needs may be met with three hours of personal care services per day. The Medical Director explained the hours may be bifurcated with two hours being provided in the morning to assist the petitioner with bathing, dressing, meal preparation, and toileting, and one hour being provided in the afternoon to assist the petitioner with any remaining activities of daily living and to assist with placing the petitioner safely in bed for the evening.

32. This appeal is the result of an initial application for services.

CONCLUSIONS OF LAW

33. 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 Chapter 120.80, Fla. Stat.

34. This is a final order pursuant to § 120.569 and § 120.57, Fla. Stat.

35. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

36. This appeal is the result of an initial application for services. Therefore, in accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof is assigned to the respondent.

37. 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.).

38. The Florida Medicaid program is authorized by Chapter 409, Fla. Stat. and Chapter 59G, Fla. Admin. Code. The Medicaid program is administered by respondent.

39. Section 409.905, Fla. Stat. addresses mandatory Medicaid services under the State Medicaid Plan:

> Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law...

40. Under § 1915(c) of the Social Security Act (42 USC § 1396n(c)), a state may obtain a Medicaid waiver that allows the state to include in the state's Medicaid

program the cost of home or community-based services (other than room and board) provided to individuals who otherwise would require care in a hospital, nursing facility, or intermediate care facility.

41. Home or community-based services include personal care services, habilitation services, and other services that are "cost effective and necessary to avoid institutionalization." See 42 CFR § 440.180.

42. Section 409.978, Florida Statutes, provides that the "Agency shall administer the long-term care managed care program," through the Department of Elder Affairs and through a managed care model. Fla. Stat. § 409.981(1), authorizes AHCA to bid for and utilize provider service networks to achieve this goal. In the instant case, the provider network/HMO is Amerigroup.

43. The definition of medically necessary is found in the Fla. Admin. Code. R. 59G-1.010 which states:

> (166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider...
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such

> care, goods or services medically necessary or a medical necessity or a covered service.

44. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Chapter 59G-4. In accordance with the above Statute, the Handbook states on page 1-27

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.
>
> Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

45. Page 1-30 of the Florida Medicaid Provider General Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

46. AHCA Contract No. FP021, Attachment II, Exhibit II-B, Effective 07/15/15, Page 15 of 91 defines Personal Care as follows:

> A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

47. The Amerigroup Long-Term Care Member Handbook discusses personal care services on Page 16. It explains these services include: help at home with bathing,

dressing, eating, personal hygiene and other activities; and help with light cleaning, bed making, meals, and chores.

48. AHCA Contract No. FP021, Attachment II, Exhibit II-B, Effective 07/15/15, Page 13 and 14 of 91 Homemaker Services as follows:

> General household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control may be included in this service.

49. The Amerigroup Long-Term Care Member Handbook discusses homemaker services on Page 15. It explains these services include: household help such as meal preparation and routine household care; a trained homemaker; and chore and pest-control services.

50. In the present case, the petitioner has not demonstrated that six hours per day of personal care services and homemaker services are medically necessary. The three hours per day of personal care services and homemaker services approved by the respondent are sufficient to assist petitioner with the activities that may be completed by a personal care assistant or professional homemaker.

51. Pursuant to the above, the petitioner has not met her burden of proof to show the respondent incorrectly denied her request for personal care and homemaker services in the amount of six hours per day.

52. A primary intent of the Long-Term Care Program is to promote care of the individual at home and to prevent institutionalization. If the petitioner requires assistance every day of the week, the petitioner is entitled to request services for every day of the week. The family may then choose to pay for a privately paid aide for any times they

feel the petitioner requires services but for which services have not been approved. In addition, the petitioner is not restricted to asking for only personal care and homemaker services. If the petitioner can potentially benefit from additional socialization, she may want to consider requesting companion services. The petitioner is also encouraged to review the Member Handbook carefully to determine if there are any additional services for which she may qualify. Any denial of a request for services by the petitioner is accompanied by independent fair hearing rights.

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 17th day of November, 2015,

in Tallahassee, Florida.

Peter Tsamis

Peter J. Tsamis
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

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

[redacted]

APPEAL NO. 15F-07046

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 12 Sarasota
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on September 15, 2015, at approximately 1:04 p.m.

APPEARANCES

For Petitioner: [redacted] Petitioner

For Respondent: Suzanne Chillari, Medical Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

Whether the Agency was correct in denying Petitioner's request for chiropractic visits beyond the allowed 24 visits per year. The burden of proof on this issue is assigned to the Petitioner.

PRELIMINARY STATEMENT

Petitioner's chiropractor, [redacted] appeared as a witness for Petitioner. Appearing as witnesses for Respondent were Robert Walker (Regulatory Research Coordinator with Staywell), Marlene Kraft (Vice President of Quality Management with Palladian Health), Ralph Hague (Network Services Manager with Chiro Alliance), Dr. Paul Seniw (Vice President of Chiropractic Clinical Services with Palladian Health). Sheila Folger, Vendor Account Manager with Staywell, observed the hearing.

Respondent admitted seventeen exhibits into evidence, which were marked and entered as Respondent's Exhibits 1 through 17. Petitioner submitted no documentary evidence. Administrative notice was taken of the Florida Medicaid Chiropractic Services Coverage and Limitations Handbook (January 2010).

FINDINGS OF FACT

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

1. Petitioner is a Medicaid recipient over 21 years of age. She has many musculoskeletal problems causing her constant pain which keeps her up at night. Her diagnoses include [redacted] She is unable to metabolize any common pain killers so she has no pain relief option beyond exercise and non-medical treatments such as acupuncture.

2. Petitioner saw her chiropractor more than 24 visits. She believes this care has helped her pain and she wants to continue the treatment. She cannot afford to pay out of pocket for massage, acupuncture, physical therapy, or chiropractic visits. She exercises at home as much as she can to help her conditions.

3. A subsection of Palladian Health known as Chiro Alliance, handles the chiropractic related prior authorization reviews and claims for Staywell members. Staywell (through its contractor, Chiro Alliance) processed 30 claims for Petitioner's chiropractic visits. After the 24th claim, it denied claims due to maximum benefit reached.

4. Staywell's Member Handbook, and the Medicaid policy on chiropractic care, limit the benefit to 24 visits per year without exception. Staywell apparently allows for extra visits if the visits are prior authorized as medically necessary, but this is not documented in its handbook.

5. On or about July 13, 2015, Petitioner's chiropractor submitted a prior authorization request to Chiro Alliance for one visit per week without an end date, beyond the allotted 24 visits (which Petitioner has exhausted for this year). The request included x-rays and MRI reports. Chiro Alliance denied this request on July 14, 2015, stating that there was not enough information to show medical necessity for ongoing treatments. Specifically, the records review noted a lack of objective care assessments and outcomes, functional assessments, updated findings, and no goals or expected outcomes in a treatment plan that suggests Petitioner's problems will be significantly improved by chiropractic care. The denial stated that the determination was based on

Palladian Chiropractic Guidelines for Spine and Spinal-Related Care for the Neck, Mid Back and Low Back. The guidelines were not submitted as evidence in this case.

6. The Office of Appeal Hearings received Petitioner's fair hearing request on August 12, 2015. In response to Petitioner's hearing request, Chiro Alliance requested more information from the treating chiropractor, and received SOAP Notes for each of Petitioner's past visits. After reviewing the additional information, Chiro Alliance upheld the denial based on the same reasons: lack of defined goals and expected outcomes, lack of interim outcome measurements or functional assessments, lack of updated goals and objectives based on progress.

7. Petitioner's chiropractor uses the activator technique to treat his patients. This technique restores movements to joints. He does not use typical measurement tools, but does "functional outcome assessments" to Petitioner before and after each treatment to see progress. Each visit lasts approximately thirty minutes.

8. Petitioner reports her pain levels at each visit, but not using the standardized 1 through 10 pain scale that most medical professionals refer to. Her provider documents her pain complaints during each visit as "improved" or "worse." During the hearing, Petitioner self-reported her pain on an average day as between five and six, sometimes eight or nine (assuming 10 is the equivalent of childbirth pain).

9. The provider's goal is to help Petitioner's pain and restore her range of motion so that she may exercise at home and continue progress. The visit notes indicate "subjective" findings reported by the patient, "objective" assessments done along with the findings for each assessment ("improved", "worse", or "not examined") compared to

the last note, and "assessment" indicating his overall impression of the patient's condition as of the note date.

CONCLUSIONS OF LAW

10. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80, Florida Statutes.

11. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.

12. This hearing was held as a de novo proceeding pursuant to Florida Administrative Code Rule 65-2.056.

13. In accordance with Florida Administrative Code Rule 65-2.060(1), the burden of proof was assigned to the Petitioner. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Florida Administrative Code Rule 65-2.060(1).

14. Section 409.912, Florida Statutes, notes that AHCA shall purchase goods and services for Medicaid recipients in the most cost-effective manner possible, consistent with the delivery of quality medical care.

15. The Florida Medicaid Provider General Handbook (Provider Handbook) – July 2012 is incorporated by reference in Florida Administrative Code Rule 59G-4. In accordance with the Florida law, the Provider Handbook discusses managed care coverage, stating on page 1-27:

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee. Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

16. Page 1-30 of the Provider Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

17. As of August 16, 2015, there is no longer a Chiropractic Services Coverage and Limitations Handbook for Florida Medicaid. Florida Administrative Code Rule 59G-4.040(2) promulgates the new Chiropractic Services Coverage Policy ("Policy") which superseded the Handbook and is the applicable policy for this case. The policy notes on page 3, section 4.0 Coverage Information that:

> 4.1 General Criteria
> Florida Medicaid reimburses services that:
> • Are determined medically necessary.
> • Do not duplicate another service.
> • Meet the criteria as specified in this policy.
>
> 4.2 Specific Criteria
> Florida Medicaid reimburses for the following:
> • One new patient visit plus 23 established patient visits per year or 24 established patient visits per year
> • X-rays

18. There are no exceptions to this limitation found in the Policy. As excerpted in paragraphs 15 and 16 above, HMOs may choose to offer more than state Medicaid (also known as "fee-for-service") but are not permitted to be more restrictive or offer fewer services than state Medicaid.

19. Regarding authorization for the service, under section 7.1 on page 4, the Policy states: "[f]or recipients enrolled in a managed care plan, providers should request authorization through the recipient's managed care plan."

20. All services reimbursed by Florida Medicaid, whether through fee-for-service or through a managed care plan, must meet the definition of medical necessity. Florida Administrative Code, 59G-1.010(166), defines medical necessity as follows:

> "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

21. Petitioner followed procedure in requesting prior authorization for chiropractic treatment through her managed care plan. The plan covers 24 visits per year, in compliance with the Policy. The plan may authorize additional visits beyond the required 24 covered visits under Medicaid policy, as an expanded benefit specific to the plan. In this case, the plan will authorize visits in excess of the allotted 24 visits if those visits are prior authorized as medically necessary. The plan is obligated to follow the

definition of "medically necessary" as excerpted above, but may institute utilization guidelines to assist with the prior authorization review. Prior authorizations are subject to the plan's internal policies, guidelines, and procedures. The plan did not submit its internal guidelines for review during this proceeding, but there was testimony that the submitted documentation does not meet the guidelines for various reasons.

22. In order to meet medical necessity, the service must "be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain." Testimony confirmed that this service is to alleviate severe pain and Petitioner believes it is helping her.

23. Next, it must "be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs." The service appears to be consistent with Petitioner's diagnosed musculoskeletal symptoms. However, it cannot be determined from the records whether continued chiropractic treatment would be appropriate or in excess of her needs. The documentation does not adequately explain the progress made or what the desired end result of the treatment is.

24. Petitioner's provider testified that the goal is to give Petitioner pain relief and allow her to exercise to further help her pain. This is a vague goal and cannot be measured objectively.

25. Petitioner received chiropractic visits over the course of approximately one year. During that time, her progress has been inconsistent. The notes indicate "slightly improved" or "slightly worse" on a daily basis. Overall, it appears there are more "slightly improved" notes, but this doesn't indicate how much she has improved since

treatment began. There is no objective assessment of her abilities at the onset of treatment, during treatment, or at the end, to determine whether this treatment is actually working. The daily assessment is entirely based on the provider's opinion as of the date of the note and cannot be objectively verified, unlike (as an example) a degree of measurement showing a marked change in range of motion between current status and a month prior. There are no goals and no metrics to see if there is any progress being made, besides the provider's opinion. As it cannot be determined whether or not the service is in excess of her needs, the remaining prongs of the medical necessity determination do not require analysis.

26. The medical necessity definition explains that just because a provider prescribed or recommends something, it does not automatically make it medically necessary under Medicaid's rules. There is simply not enough information to make an objective assessment of whether or not this treatment is likely to have desired results in any set period of time. The treating provider's opinion, without any documented objective rationale, is the only clinical information as to the need for this treatment. An opinion does not allow for any substantial prior authorization review in compliance with any legal definitions or clinical guidelines.

27. The undersigned acknowledges Petitioner's unique situation and need for some relief. Petitioner is entitled to all the care that the applicable rules, regulations, and policies allow. There is not enough evidence in this case to support medical necessity of the requested treatment in compliance with the applicable rules.

28. After careful review of the relevant authorities, the testimony and the evidence in this matter, the hearing officer concludes that Petitioner did not meet her burden of

proof in this case. She is not precluded from re-submitting her request with any additional documentation to the plan. Any subsequent denials on future requests would give her new fair hearing appeal rights.

DECISION

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

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 10th day of November, 2015, in Tallahassee, Florida.

Danielle Murray

Danielle Murray
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Dietra Cole, Area 8, AHCA Field Office Manager

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

[redacted]

APPEAL NO. 15F-07047

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 Dade
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 2, 2015, at 10:00 a.m.

APPEARANCES

For the Petitioner: [redacted] Petitioner's wife

For the Respondent: Dianna Chirino, Senior Program Specialist

STATEMENT OF ISSUE

At issue is the Agency action denying the Petitioner's request for additional respite services, companion services, and personal care services under the Long Term Care Program. Petitioner bears the burden of proof in this matter.

PRELIMINARY STATEMENT

The Petitioner did not submit any documents as evidence for the hearing.

Appearing as witnesses for the Respondent were Dr. John Carter, Medical Director; Paula Daley, Grievance and Appeals Coordinator; Cynthia Morisaki, Case Manager Supervisor; and Gretchen Curtis, Case Manager, from Sunshine Health, which is Petitioner's managed health care organization.

The Respondent submitted documents as evidence for the hearing consisting of the following which were marked as Respondent Exhibits: Exhibit 1 – Denial letters; Exhibit 2 – Medical Assessment Form; Exhibit 3 – Plan of Care; Exhibit 4 – Letter from Petitioner's wife; Exhibit 5 – Letter from Petitioner's physician; Exhibit 6 – Long Term Care Plan Policy and Procedures.

Also present for the hearing was a Spanish language interpreter, [redacted] Interpreter Number [redacted] from Propio Language Services.

FINDINGS OF FACT

1. The Petitioner is seventy-four (74) years of age and lives with his wife, who is sixty-nine years of age and is his sole caregiver. He is ambulatory, incontinent, and needs assistance with personal hygiene and activities of daily living (ADLs). He suffers from [redacted] and [redacted]

2. The Petitioner is a Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Long Term Care (LTC) Plan. He receives services under the plan from Sunshine Health.

3. The Agency For Health Care Administration (AHCA) is responsible for management of the managed long-term care plan contracts; statewide policy decisions and interpretation of all federal and state laws; and rules and regulations governing the contract. Managed Care Organizations such as Sunshine Health provide services to Medicaid recipients pursuant to a contract with AHCA.

4. The Petitioner currently receives the following LTC services through Sunshine Health: fourteen (14) hours weekly of personal care assistance, seven (7) hours weekly of homemaker services, and five (5) days weekly of adult day care services.

5. The Petitioner made a request to Sunshine for additional home care services consisting of eight (8) hours weekly of respite care and three (3) hours weekly of companion care services. On July 16, 2015, Sunshine sent a letter to Petitioner denying his request for the additional home care services. The letter stated the requested services were denied because the currently approved services were sufficient to meet his care needs.

6. The Petitioner also made a request to Sunshine for an additional thirty (30) minutes daily of personal care services. On August 27, 2015, Sunshine sent a letter to Petitioner denying his request for the additional personal care services. The letter stated the additional service was denied because the currently approved services were sufficient to meet his care needs.

7. Petitioner's wife stated he utilizes the currently approved twenty-one hours of weekly home services as follows: 1.5 hours in the morning and 1.5 hours in the afternoon. She states her husband needs an additional thirty minutes of assistance in

the afternoon visit because he becomes more agitated later in the day and it becomes more difficult to take care of him. His behavior problems include trying to eat soap and dishwashing liquid. The Petitioner goes to bed at approximately 6:00 p.m. every day.

8. Petitioner's wife stated she is requesting the companion services so that someone can accompany her when she takes her husband to doctor's appointments because he sometimes tries to abscond from the office. She is requesting respite services to be used on the weekends so she can travel to visit her grandchildren and someone can watch her husband at home. She utilizes the time her husband is at the adult day care facility on Monday to Friday to run errands, clean the home, and go to her own medical appointments.

9. At the time of the hearing, Petitioner had been hospitalized for the past two weeks due to a [redacted] and was expected to return home within another two weeks. At that time, Sunshine Health indicated it would conduct a re-evaluation of the Petitioner's needs after he returns to the home.

CONCLUSIONS OF LAW

10. 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.

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

12. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the Petitioner since the issue involved a request for an increase in services. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

13. Fla. Stat. § 409.979 sets forth eligibility requirements for the Long-Term Care Program and states:

> (1) Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:
>
> (a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.
>
> (b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).

14. As stated in the Findings of Fact, the Petitioner was determined to be eligible and enrolled in the Long Term Care Program.

15. The Petitioner requested a fair hearing because he believes his services under the Program should be increased.

16. Fla. Stat. § 409.98 lists the services which must be covered by Long-Term Care plans. Respite care, companion care, personal care assistance, homemaker services, and adult day care services are among the services available from Long-Term Care plans and are addressed in the AHCA contract.

17. Respite Care services are defined in the contract as:

> Services provided to enrollees unable to care for themselves furnished on a short-term basis due to the absence or need for relief of persons normally providing the care. Respite care does not substitute for the care usually provided by a registered nurse, a licensed practical nurse or a therapist. Respite care is provided in the home/place of residence, Medicaid licensed hospital, nursing facility or assisted living facility.

18. Adult companion care is defined in the contract as:

> Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discreet services. The provision of companion services does not entail hands-on nursing care. This service includes light housekeeping tasks incidental to the care and supervision of the enrollee.

19. The Petitioner currently receives Homemaker services, which are defined in the contract as:

> General Household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. chore services, including heavy chore services and pest control are included in this service.

20. The Petitioner also currently receives Personal Care services, which are defined in the contract as follows:

> A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

21. The Petitioner also currently receives Adult Day Care services, which are defined in the contract as follows:

> Services furnished in an outpatient setting which encompass both the health and social services needed to ensure optimal functioning of an enrollee, including social services to help with personal and family

> problems and planned group therapeutic activities. Adult day health care includes nutritional meals. Meals are included as a part of this service when the patient is at the center during meal times. Adult day health care provides medical screening emphasizing prevention and continuity of care, including routine blood pressure checks and diabetic maintenance checks. Physical, occupational and speech therapies indicated in the enrollee's plan of care are furnished as components of this service. Nursing services, which include periodic evaluation, medical supervision and supervision of self-care services directed toward activities of daily living and personal hygiene, are also a component of this service.

22. The AHCA contract also provides that a Plan "may place appropriate limits on a service on the basis of such criteria as medical necessity, as defined by the Agency, or for utilization control, consistent with the terms of this Contract, provided the services furnished can be reasonably expected to achieve their purpose."

23. Fla. Stat. § 409.912 requires that Respondent "purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care."

24. The Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012, and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

> "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide;
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
> . . .
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

25. After considering the evidence and testimony presented, the hearing officer concludes that the Petitioner has not demonstrated that his services under the LTC Program should be increased by adding eight hours weekly of respite care, three hours weekly of companion care, and an additional thirty minutes daily of personal care.

26. The Petitioner clearly needs assistance with all his activities of daily living (ADLs). The evidence presented, however, establishes that the Petitioner's needs can be met with the twenty-one (21) hours weekly of in-home assistance which has already been approved by Sunshine, as well as the adult day care facility which the Petitioner attends Monday to Friday. The in-home assistance is being provided in the morning and afternoon each day. Petitioner's attendance at the adult day care facility also provides his wife with respite from having to provide his care during those hours. Any additional services would appear to be in excess of Petitioner's needs and more for the convenience of the caregiver.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is 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 18 day of November, 2015, in Tallahassee, Florida.

Rafael Centurion

Rafael Centurion
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

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

[redacted]

APPEAL NOS. 15F-7050
15F-7097
15F-7098

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPT OF CHILDREN AND FAMILIES
CIRCUIT: 11 DADE
UNIT: 88653

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened telephonic administrative hearing in the above-referenced matter on October 19th, 2015 at 10:00 a.m.

APPEARANCES

For the Petitioner: [redacted] pro se.

For the Respondent: Sylvia Stokes, Operations Management Consultant for the Economic Self-Sufficiency program.

STATEMENT OF ISSUE

The petitioner is appealing the amount of Food Assistance authorized by the respondent based on the removal of his minor son from his case (appeal number 15F-7097). The petitioner is also appealing the respondent's action to deny his application for Temporary Cash Assistance (TCA) (appeal number 15F-

7050). The petitioner carries the burden of proving his position in these appeals. The petitioner is furthermore appealing the respondent's action to remove his minor son from his Medicaid assistance group (appeal number 15F-7098). The respondent carries the burden of proving its position in this appeal. In all appeals, the standard of proof is a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing was originally scheduled for September 9th, 2015. On that date, the parties convened; however, the petitioner had not received the respondent's evidence, which had been properly and timely issued, per the accompanying Certificate of Service. A continuance was granted, and the respondent agreed to reissue its documents.

At the October 19th hearing, the petitioner acknowledged having received the respondent's documents.

Respondent's Exhibits 1 through 5 were moved into evidence.

The petitioner did not submit any documents in time for the hearing.

The record was held open until the close of business November 2nd, 2015 to allow both parties to submit additional evidence. During this time, the petitioner submitted one document which was moved into evidence as Petitioner's Exhibit 1. Also during this time, the respondent submitted 27 pages of additional documents. Pages 13 through 22 were excluded, as these were duplicative of

documents included in the respondent's original submission. The remaining pages were marked as Respondent's Exhibits 6 through 15.

By way of a Notice of Case Action dated July 23rd, 2015, the respondent informed the petitioner that his application for FA dated July 9th, 2015 was approved in the amount of $139 effective August 2015 and ongoing. The same notice informs the petitioner informs the petitioner that his Medicaid benefits will end on August 31st, 2015. The reason stated on the notice is "We received your verbal request to remove an individual from this program."

No Notice of Case Action regarding denial of the petitioner's application for TCA was submitted into evidence.

On August 14th, 2015, the petitioner filed appeals to challenge the respondent's actions. The appeals are considered to be timely-filed.

FINDINGS OF FACT

1. Prior to the actions under appeal, the petitioner was certified to receive FA and Medicaid for himself and his minor son through July 2015.

2. On July 9th, 2015, the petitioner submitted an application to recertify for benefits. The recertification was to be effective August 2015. As part of the recertification process, the respondent is required to re-explore, and if deemed necessary, re-verify certain factors of eligibility which include, but are not limited to household size and composition.

3. On the above-mentioned application, the petitioner reported that his household consisted of himself and his minor son, [redacted] (See Respondent's Exhibit 1, page 2 of the exhibits.)

4. The petitioner pays $600 for rent, plus utilities. Accordingly, the respondent considered $600 for rent. The respondent also considered the Standard Utility Allowance (SUA) in the amount of $337 through September 2015, and $347 effective October 2015. The petitioner's shelter expenses are undisputed.

5. The respondent considered $305 monthly in Child Support expenses paid by the petitioner for [redacted] (See Respondent's Exhibit 2.)

6. On the application, the petitioner reported zero income for his household. (See Respondent's Exhibit 1, page 5 of the exhibits.)

7. On July 10th, 2015, the respondent issued an Appointment for Interview and Pending Notice requesting of the petitioner "proof of worker's comp and child support payment made out to [petitioner's son]. The notice provided a deadline of July 20th, 2015 by which to comply with the request. The notice went on to say that failure to comply with the request would result in denial of the petitioner's application or cancellation of the petitioner's benefits.

8. The respondent considered as income for this household a total of $1,130.12 monthly in Workman's Compensation (WC) benefits. However, while on the record, the respondent explained that during the petitioner's previous

certification process, he had submitted two WC paystubs dated January 14th, 2015 and January 28th, 2015, both in the amount of $1,130.12. Therefore, this income should have been multiplied by the bi-weekly factor of 2.15 to derive a monthly figure of $2,429.76.

9. The petitioner asserted that he stopped receiving WC in February 2015, but acknowledged that he had not reported this information to the respondent. The petitioner has a roommate (a non-related person) who has been assisting him in covering his expenses.

10. During the post-hearing open-record period, the petitioner submitted a Notice of Action/Change from the Division of Worker's Compensation which informs the petitioner that "all indemnity [will be] suspended" effective March 16th, 2015. It was not clear why the petitioner did not report this information at the time of occurrence. It was also not clear why the petitioner did not reply with this information to the respondent's notice of July 10th, 2015 cited above.

11. Regarding the removal of [redacted] from the petitioner's case, the respondent's position is that [redacted] is currently included in his mother's case as an active household member and therefore, cannot receive benefits as a member of the petitioner's case.

12. The petitioner contends that the respondent should not have taken action to remove [redacted] from his case as he and his ex-wife ([redacted] share custody of him. The respondent countered that policy does not make any

allowances for "shared custody". The respondent must determine custody on a "51/49" basis, and absent any other evidence, the respondent looks to which parent claimed the child as a dependent on the last income tax report in order to determine the household in which the child should be considered. The petitioner acknowledged that his ex-wife claimed [redacted] as a dependent during 2014. This information, coupled with the fact that the petitioner is credited for making Child Support payments for [redacted] led the respondent to conclude that [redacted] must be removed from the petitioner's case and included in that of [redacted]

CONCLUSIONS OF LAW

13. The Department of Children and Families Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to § 120.80, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

14. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056 which states, in relative part as follows:

> (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.

The hearing officer will first address the respondent's inclusion of Worker's Compensation benefits in determining the petitioner's FA eligibility.

15. The evidence shows that the petitioner submitted an application to recertify for his FA benefits on July 9th, 2015, wherein he reported that his household did not have any income. The evidence shows that the respondent

issued a notice on July 10th, 2015, requesting that the petitioner submit verification of his WC benefits. The evidence shows that the respondent continued to budget WC benefits upon authorizing the petitioner's FA for August. However, the evidence also shows that the petitioner ceased receiving WC on March 16th, 2015. Therefore, the case is hereby remanded to the respondent for corrective action. The respondent will, within ten days from the date of this order, recalculate the petitioner's FA benefits without inclusion of his WC benefits.

The hearing officer will first address the respondent's exclusion of the petitioner's son in determining the petitioner's eligibility for Food Assistance.

16. The Code of Federal Regulation 7 C.F.R. § 273.6 refers to the use of Social Security numbers and states in relevant part:

> (f) Use of SSNs. The State agency is authorized to use SSNs in the administration of the Food Stamp Program. To the extent determined necessary by the Secretary and the Secretary of Health and Human Services, State agencies shall have access to information regarding individual Food Stamp Program applicants and participants who receive benefits under title XVI of the Social Security Act to determine such a household's eligibility to receive assistance and the amount of assistance, or to verify information related to the benefit of these households. State agencies shall use the State Data Exchange (SDX) to the maximum extent possible. **The State agency should also use the SSNs to prevent duplicate participation,** to facilitate mass changes in Federal benefits as described in Sec. 273.12(e)(3) and to determine the accuracy and/or reliability of information given by households. In particular, SSNs shall be used by the State agency to request and exchange information on individuals through the IEVS as specified in Sec. 272.8. *(Emphasis added.)*

17. The Code of Federal Regulation §273.2, office operations and application processing, states as follows:

(x) *Household composition.* State agencies shall verify factors affecting the composition of a household, if questionable.

18. The findings show that the petitioner received FA benefits for his minor son without question through July 2015. The findings show that the respondent took action to include the petitioner's son in his mother's FA assistance group effective August. However, no evidence was submitted at the hearing to prove that such action was justified. The regulation cited above states that the State agency (the respondent) shall verify factors affecting the composition of a household, if questionable. There was no evidence submitted that the petitioner was afforded the opportunity to resolve the discrepancy regarding his son's residence during the recertification process.

19. Therefore, the case is hereby remanded to the respondent for corrective action. The respondent will, within ten days of this order, issue notice to the petitioner allowing him a minimum of ten days to provide evidence that his son currently resides with him. The petitioner will need to cooperate in this process. The respondent may also use its own means of verification (such as third-party contacts, etc), as allowed by policy. Should the respondent determine that the petitioner's child is residing with him, the respondent will take action to remove him from his mother's case and re-add him to that of his father's (ensuring that benefits are not simultaneously authorized in both cases).

The hearing officer will now address the respondent's action to deny the petitioner's application, as well as the respondent's action to terminate his Medicaid benefits.

20. The Florida Administrative Code R. 65A-1.705 (7)(c) Family-Related

Medicaid General Eligibility Criteria states, in pertinent relative part:

> If assistance is requested for the parent of a deprived child, the parent and any deprived children who have no income must be included in the SFU *[standard filing unit]*. Any deprived siblings who have income, or any other related fully deprived children, are optional members of the SFU. If the parent is married and the spouse lives in the home, income must be deemed from the spouse to the parent. For the parent to be eligible, there must be at least one child under age 18, with or without income, in the SFU, or who would be in the SFU if not receiving SSI.

21. According to the above authority, to be eligible for Family-Related Medicaid, an individual must have a child under age 18 in the household. Although the undisputed fact is that the petitioner's minor son is receiving Medicaid in his (petitioner's son's) mother's case, the evidence that the petitioner's son resides with his mother was disputed and inconclusive. As established above, the respondent did not afford the petitioner an opportunity to verify that the petitioner's son resided with him at the time of application.

22. Therefore, the case is hereby remanded to the respondent. The respondent will, within ten days of this order, issue notice to the petitioner allowing him a minimum of ten days to provide evidence that his son currently resides with him. The petitioner will need to cooperate in this process. The respondent may also use its own means of verification (such as third-party contacts, etc), as allowed by policy. Should the respondent determine that the petitioner's child is residing with him, the respondent will take action to remove him from his mother's case and re-add him to that of his father's (ensuring that benefits are not simultaneously authorized in both cases).

The hearing officer will now address the respondent's action to deny TCA

benefits.

23. Fla. Stat. Ch. 414.095 establishes:

> Determining eligibility for temporary cash assistance...
> (2) ADDITIONAL ELIGIBILITY REQUIREMENTS.—
> (a) To be eligible for ...cash assistance... : ...
> 4. A minor child must reside with a parent or parents, with a caretaker relative who is within the specified degree of relationship as specified in 45 C.F.R. part 233...
> (14) PROHIBITIONS AND RESTRICTIONS.—(a) A family without a minor child living in the home is not eligible to receive temporary cash assistance...

24. Fla. Stat. Ch. 414.0252 defines a minor child as follows:

> (8) "Minor child" means a child under 18 years of age, or under 19 years of age if the child is a full-time student in a secondary school or at the equivalent level of career training, and does not include anyone who is married or divorced.

25. According to the above authority, to be eligible for TCA, an individual must have a child under age 18 in the household. Although the undisputed fact is that the petitioner's minor son is receiving Medicaid in his (petitioner's son's) mother's case, the evidence that the petitioner's son resides with his mother was disputed and inconclusive. As established above, the respondent did not afford the petitioner an opportunity to verify that the petitioner's son resided with him at the time of application.

26. Therefore, the case is hereby remanded to the respondent. The respondent will, within ten days of this order, issue notice to the petitioner allowing him a minimum of ten days to provide evidence that his son currently resides with him. The petitioner will need to cooperate in this process. The respondent may also use its own means of verification (such as third-party

contacts, etc), as allowed by policy. Should the respondent determine that the petitioner's child is residing with him, the respondent will take action to remove him from his mother's case and re-add him to that of his father's (ensuring that benefits are not simultaneously authorized in both cases).

27. In sum, the hearing officer hereby remands the case to the respondent for corrective action as described above. This instruction is not a guarantee of eligibility. Should the respondent determine that the petitioner's son is, in fact, residing with the petitioner, the respondent will take action to remove the petitioner's son and authorize benefits as appropriate in the petitioner's case; the respondent will then notify the petitioner of action taken in this regard, and the notice will contain appeal rights should the petitioner disagree with the outcome.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, all three appeals are partially granted in that the respondent will take corrective action as described above.

ANY FOOD STAMP BENEFITS DUE APPELLANT PURSUANT TO THIS ORDER MUST BE AVAILABLE WITHIN (10) TEN DAYS OF THIS DECISION OR WITHIN (60) SIXTY DAYS OF THE REQUEST FOR THE HEARING. ANY BENEFITS DUE WILL BE OFFSET BY PRIOR UNPAID OVERISSUANCES.

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 indigence to waive those fees. The Department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 23 day of November, 2015,

in Tallahassee, Florida.

Justin Enfinger

Justin Enfinger
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

APPEAL NO. 15F-07086

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 18 Seminole
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing on October 1, 2015 at approximately 10:30 a.m.

APPEARANCES

For Petitioner: [redacted]
Petitioner's Primary Caregiver

For Respondent: Doretha Rouse
Registered Nurse Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is Respondent's denial of Petitioner's request to continue receiving Ensure nutritional supplements. The burden of proof is assigned to Respondent.

PRELIMINARY STATEMENT

Respondent presented the following witnesses:

- Jennifer Arteaga, Grievance and Appeals Coordinator II, Sunshine Health.
- Dr. Ernest Bertha, Medical Director, Sunshine Health.

- Courtney Crawford, Case Manager, Sunshine Health.
- Kritzia Torres-Rodriguez, Supervisor of Case Management, Sunshine Health.
- Carolyn Smith, Director of Case Management, Sunshine Health.

Tiffany Smith, Grievance and Appeals Coordinator with Sunshine Health ("Sunshine") observed the hearing. [redacted] gave oral testimony, but did not move any exhibits into evidence. Respondent moved Exhibits 1 through 7 into evidence.

Administrative notice was taken of the following:

- The Florida Medicaid Provider General Handbook, July 2012.
- The Florida Medicaid Category Lists for the HCPCS Codes for Enteral Formula Effective July 1, 2014.

FINDINGS OF FACT

1. Petitioner is a 63-year-old female. At all times relevant to this proceeding, Petitioner was eligible to receive Medicaid services.

2. Petitioner became enrolled with Sunshine as her Long-Term Care (LTC) plan on August 1, 2013, and is currently active with the plan.

3. Petitioner's health conditions include:

- [redacted]

4. Petitioner's physician submitted an authorization request for Ensure. The request was for a supply of three (3) cans per day of Ensure administered orally.

The request form asks for a projected length of therapy of zero (0) to six (6) months, however, the physician listed that she would need the Ensure for her lifetime. The request indicated the Ensure would provide 660 calories per day, constituting 50% of Petitioner's daily nutrition. The qualifying diagnosis was listed as "calorie malnutrition," and Petitioner's body mass index (BMI) was listed as [redacted] (Respondent's Exhibit 4).

5. [redacted] testified Petitioner had previously been receiving Ensure supplements for years until Sunshine took over as her LTC plan.

6. Sunshine received the request on May 27, 2015. On May 29, 2015, Sunshine issued a Notice of Action denying the request for two (2) cases of Ensure per month for six (6) months, which corresponds to the three (3) cans per day requested for the maximum length of time listed on the request from, which is six (6) months.

7. The reason given for the denial was the Ensure is not medically necessary, specifically under the requirements of paragraph 2 of Fla. Admin. Code R.59G-1.010(166). The letter stated:

> The request for Ensure is denied. The information given to Sunshine Health does not show that the member's condition fits the Medicaid criteria for Enteral Formula. The Authorization Request form for Enteral Formula states the member's BMI, or body mass index which is a measure of nutrition status, is in the normal range. There is no medical note saying the member is not able to swallow, absorb, and digest regular food.
>
> The facts we used to make our decision are: This decision was made with Florida Medicaid criteria for Enteral Formula (Respondent's Exhibit 3).

8. On June 16, 2015, Petitioner received a 701B Comprehensive Assessment ("701B Assessment"). (Respondent's Exhibit 5). Per the assessment form, Petitioner answered the questions and Mr. Figley was present and also provided

answers to questions. Under the Memory Section, Petitioner is listed as not suffering from any [redacted] and presented as alert and oriented. [redacted] testified that she has some [redacted] loss.

9. Although [redacted] testified at the hearing that Petitioner has a low appetite, Petitioner's answer to question 78(e) states she does not have poor appetite or overeating. Petitioner's answer to question 87 indicates she eats at least two (2) meals per day. [redacted] testified he has known her for 18 years and she does not eat two (2) meals per day.

10. Petitioner's answer to question 88 is that, on a typical day, she has coffee for breakfast; a sandwich, chips, and soup for lunch; ribs, coleslaw, and beans for dinner; and chocolate and pudding for snacks. On question 93, Petitioner estimated her height to be 5' 5" and her weight to be 145 pounds. Dr. Bertha said that height and weight is a BMI of [redacted]

11. Dr. Bertha said a normal BMI ranges from 19 to 25. A BMI of over 25 means an individual is overweight. Petitioner's answer to question 96 was that she does have difficulty chewing and swallowing. [redacted] testified that her medications are rotting her teeth.

12. On September 14, 2015, Petitioner received another 701B Assessment. (Respondent's Exhibit 6). Again, Petitioner answered the questions and [redacted] was present. Petitioner was deemed alert and oriented.

13. Petitioner's answer to question 78(3) again stated she does not suffer from poor appetite or overeating.

14. Petitioner's answers to question 88 changed from the prior 701B Assessment. She said on a typical day she has coffee for breakfast, soup or Ensure for lunch, and a sandwich for dinner. She reported not eating any snacks. [redacted] said that's not true. Despite being present for the assessment, he said she has trouble remembering things and probably gave incorrect answers regarding how much she eats in a typical day. He said he can get her to eat some junk food, like apple pie, but otherwise not much nutrition. He also said that she drinks one (1) or two (2) cans of Ensure per day.

15. Her estimate of her height and weight was again 5' 5," [redacted] which would again be a BMI of [redacted] Dr. Bertha testified it would be impossible for her to maintain that BMI if she is only drinking one (1) or two (2) cans of Ensure per day and not also eating solid food.

16. The Notes & Summary of the Nutritional Section, on page 21 of the 701B Assessment states: "[Member] was recently denied Ensure because the BMI is normal. However, the member does not agree with that because she reports a very poor appetite, saying despite that the caregiver prepares meals she unable to eat but she is able to drink an Ensure." There is no indication she is unable to absorb and digest solid food.

17. Sunshine's internal policy regarding oral nutritional supplements allows for Ensure to be provided even if the recipient is able to eat solid food, as long as they are unable to eat enough food to maintain health, including due to decreased appetite. The criteria for adults over the age of 21 are a BMI of less than 18.5 kg/m,

or, a BMI of less than 20 kg/m that is also associated with unintentional weight loss of greater than 5% within the prior three (3) months. (Respondent's Exhibit 7).

18. Dr. Bertha said there may be an over-the-counter allotment of $25.00-$40.00 per month available to Petitioner that could be used to purchase Ensure if she wanted. She can get the information about obtaining the allotment from Sunshine's member services or from her Case Manager. Ensure costs approximately $20.00 for 16 cans, so a $40.00 allotment would cover 32 cans per month, which is enough to have one (1) can every day.

PRINCIPLES OF LAW AND ANALYSIS

19. By agreement between the Agency for Health Care Administration ("AHCA" or "Agency") and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction over this matter pursuant to § 120.80, Fla. Stat.

20. This hearing was held as a *de novo* proceeding, in accordance with Florida Administrative Code Rule 65-2.056.

21. This is a Final Order, pursuant to §§ 120.569 and 120.57, Fla. Stat.

22. 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.).

23. Legal authority governing the Florida Medicaid Program is found in Chapter 409 of the Florida Statutes, and in Chapter 59G of the Florida Administrative Code. Respondent, AHCA, is the single state agency that administers the Medicaid Program.

24. The July 2010 Durable Medical Equipment/Medical Supply Services Coverage and Limitations Handbook ("DME Handbook") has been promulgated into law by Fla. Admin. Code R. 59G-4.070.

25. Page 1-2 of the DME Handbook states: "Medical supplies are defined as medically necessary medical or surgical items that are consumable, expendable, disposable, or non-durable and appropriate for use in the recipient's home." The DME Handbook requires any medical supplies provided to the Medicaid recipient to be medically necessary. Nutritional supplements are a consumable medical supply.

26. The definition of medically necessary is found in Fla. Admin. Code R. 59G-1.010 which states:

> 166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
> . . .
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods, or services medically necessary or a medical necessity or a covered service.

27. Under AHCA's Category Lists for the HCPCS Codes for Enteral Formula, Ensure is indicated for increased caloric needs.

28. Sunshine denied Petitioner's request for Ensure for not meeting the requirements of paragraph 2 of the definition of medical necessity. The undersigned agrees. Three (3) cans of Ensure per day are in excess of her needs. Petitioner has a normal BMI. Indeed, her BMI is at the high end of the normal range. Further, Petitioner's own responses to both 701B Assessments indicate she consumes solid food.

29. The second 701B Assessment does indicate Petitioner has decreased appetite, which is a potential reason to require a nutritional supplement such as Ensure. However, [redacted] testimony is that Petitioner typically consumes one (1) or two (2) cans per day of Ensure. Her prescription is for three (3) cans per day.

30. At the present time, Petitioner does not require three (3) cans per day of Ensure. In the event Petitioner experiences significant, unintentional weight loss, she can submit a new request for Ensure at that time.

31. Dr. Bertha suggested Petitioner contact Sunshine's member services or her Case Manager to look into receiving an over-the-counter allotment that would allow her to purchase one (1) can per day.

DECISION

Based upon the foregoing, Petitioner's appeal is DENIED and the Agency's action is AFFIRMED.

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 13th day of November, 2015,

in Tallahassee, Florida.

Rick Zimmer
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Judy Jacobs, Area 7, AHCA Field Office

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

[redacted]

APPEAL NO. 15F-07090

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 10 Polk
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing on October 19, 2015 at approximately 10:00 a.m.

APPEARANCES

For Petitioner: [redacted]
Petitioner's Mother

For Respondent: Stephanie Lang
Registered Nurse Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is Respondent's termination of Petitioner's Prescribed Pediatric Extended Care Services ("PPEC"). The burden of proof is assigned to Respondent.

PRELIMINARY STATEMENT

Dr. Rakesh Mittal, Physician Reviewer with eQHealth Solutions ("eQHealth") appeared as a witness for Respondent. Petitioner's mother gave oral testimony, but did not move any exhibits into evidence. Respondent moved Exhibits 1 through 8 into evidence.

Administrative notice was taken of the following:

- Section 409.905, Florida Statutes.
- Florida Administrative Code Rules 59G-1.001, 59G-1.010, and 59G-4.260.
- The Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook, September 2013.

FINDINGS OF FACT

1. Petitioner is a 23-month-old female. At all times relevant to this proceeding, Petitioner was eligible to receive Medicaid services.

2. Petitioner's health conditions include:

- [redacted]
- [redacted]
- [redacted]
- [redacted]

3. Petitioner had been receiving PPEC services prior to this request. Petitioner is continuing to receive PPEC services, pending the outcome of this appeal.

4. Petitioner's Physician Plan of Care for PPEC Services indicates she eats a normal, age-appropriate diet, "has made progress over the last 180 days, as evidenced by her ability to pull up and cruise around furniture," and that discharge from PPEC should be considered once she no longer requires skilled nursing care (Respondent's Exhibit 4).

5. Petitioner receives speech therapy, occupational therapy, and physical therapy as part of her PPEC services. Dr. Mittal noted that only the PPEC services were under review at hearing, not the other therapies. Those services can be provided on an outpatient basis.

6. PPEC is for children who need special medical care, such as skilled-nursing care, throughout the day, that ordinary day care cannot provide. Ordinary day care cannot administer medications.

7. Petitioner's mother said some of her medications need to be taken twice per day. Other medications are provided to Petitioner on an as-needed basis, such as Pulmicort and Albuterol, because of her fragile respiratory system. Petitioner's mother sends extra medications to the PPEC provider to be administered as needed. If Petitioner was in ordinary day care, her mother would have to leave work to administer the medications. Petitioner's mother works between eight (8) to ten (10) hours per day.

8. Because Petitioner was born prematurely, she is more prone to illness than other children. Petitioner's mother has had to miss work a significant amount of time in order take care of her when she is ill. She also stated when one twin gets sick, the other also catches it. Petitioner and her sister have had hand, foot, and mouth disease twice this year, and also had vomiting and diarrhea. Petitioner can attend the PPEC center when she has a fever or other illness, as long as she is not contagious, because someone can provide her medication. An ordinary day care would not allow her to come when she is sick.

9. Dr. Mittal said the various illnesses, such as fever or gastroenteritis, cannot be foreseen, and that PPEC is not appropriate for temporary illnesses. PPEC is for someone who needs care every day for a chronic illness. Temporary illnesses can be dealt with when they occur, but PPEC cannot be provided every day, just in case something might happen. Petitioner's mother stated she does have chronic lung disease, but that it is treated on an as-needed basis.

10. Petitioner's PPEC provider submitted a request for 12 hours per day, five (5) days per week of PPEC services, for a period of 180 days.

11. On August 10, 2015, eQHealth issued a Notice of Outcome – Partial Denial Prescribed Pediatric Extended Care Services. One month of PPEC services were approved in order for Petitioner to transition into ordinary day care, but the rest of the request was denied. The Clinical Rationale for the Decision was as follows:

> The patient is a 1 year old with a history of twin birth and prematurity. The patient has a history of a grad IV IVH. The clinical information provided does not support the medical necessity of the requested services; however, 1 month will be approved to provide the caregiver time to transition the patient out of PPEC. The clinical information provided does not support the medical necessity of the additional services. The patient appears to no longer require skilled nursing services and does not meet the medical complexity requirement of PPEC services. The additional services are deemed excessive. 1 hour per day from 8.6.15 thru 9.4.15, Monday through Friday are approved. (Respondent's Composite Exhibit 8).

12. Petitioner timely requested a hearing on August 17, 2015.

CONCLUSIONS OF LAW

13. By agreement between the Agency for Health Care Administration ("AHCA" or "Agency") and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction over this matter pursuant to § 120.80, Fla. Stat.

14. This hearing was held as a *de novo* proceeding, in accordance with Florida Administrative Code Rule 65-2.056.

15. This is a Final Order, pursuant to §§ 120.569 and 120.57, Fla. Stat.

16. 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.).

17. Legal authority governing the Florida Medicaid Program is found in Chapter 409 of the Florida Statutes, and in Chapter 59G of the Florida Administrative Code. Respondent, AHCA, is the single state agency that administers the Medicaid Program.

18. The Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook, September 2013 ("PPEC Handbook") is promulgated into law by Florida Administrative Code Rule 59G-4.260.

19. Page 2-1 of the PPEC Handbook lists the requirements for receiving PPEC services. Page 2-1 states:

> To receive reimbursement for PPEC services, a recipient must meet all of the following criteria:
>
> - Be Medicaid eligible
> - Diagnosed with a medically-complex or medically fragile condition as defined in Rule 59G-1.010, F.A.C.
> - Be under the age of 21 years
> - Be medically stable and not present significant risk to other children or personnel at the center
> - Require short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care due to a medically complex condition.

20. Fla. Admin Code R.59G-1.010 defines "medically complex" and "medically fragile" as follows:

(164) "Medically complex" means that a person has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention.

(165) "Medically fragile" means an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, e.g., requires total parenteral nutrition (TPN), is ventilator dependant, or is dependent on a heightened level of medical supervision to sustain life, and without such services is likely to expire without warning.

21. Section 409.905, Florida Statutes, "Mandatory Medicaid services," states, in pertinent part: "Any service provided under this section shall be provided only when medically necessary and in accordance with state and federal law...."

22. The definition of medically necessary is found in Fla. Admin. Code R.59G-1.010, which states:

(166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods or services furnished or ordered must:
(a) Meet the following conditions:
1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
. . .

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods, or services medically necessary or a medical necessity or a covered service.

23. Since the Petitioner is under 21 years of age, a broader definition of medical necessity applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPDST) requirements. § 409.905, Fla. Stat., Mandatory Medicaid services, provides that Medicaid services for children include:

> (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

24. The United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in *Moore v. Reese*, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, which involved a dispute over private duty nursing:

> [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.
> (2) A state Medicaid plan must include "reasonable standards ... for determining eligibility for and the extent of medical assistance" ... and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.
> (3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."
> (4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both

> the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."
> (5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. **The state is not required to provide medically unnecessary, albeit desirable, EPSDT services.** However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."
> (6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and my present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)) (emphasis added).

25. Consistent with these requirements, the state is obligated to provide services to recipients under 21 years of age, but only to the extent such services are medically necessary. The definition of medical necessity for services provided under the EPSDT benefit is established by the state and the state is authorized to establish the amount, duration, and scope of such services.

26. In the instant matter, the testimony and documentary evidence fails to establish the medical necessity of PPEC services for Petitioner. While it is true Petitioner has chronic lung disease, her mother's testimony indicates that treatment is only given on an as-needed basis. Petitioner does not require skilled nursing care throughout the entire day, every day.

27. Petitioner is more susceptible to illness than an ordinary child of her age. However, while it is certainly an inconvenience for her mother to have to leave work in order to attend to her medical needs, her situation is no different than that of any other parent of a small child. Small children in ordinary day care sometimes get sick and their parents have to find an alternative method of care. The only difference here is that Petitioner is likely to be ill more frequently than the other children.

28. Petitioner's level of illness does not reach the level of "medically complex" or "medically fragile," as defined in the Florida Administrative Code. PPEC services are only provided when the recipient's condition is severe.

29. The undersigned has reviewed EPSDT and medical necessity requirements and concludes Respondent has met its burden of proof, by the greater weight of the evidence, in terminating Petitioner's PPEC services.

30. Dr. Mittal made it clear that Petitioner's needs for speech therapy, occupational therapy, and physical therapy are not at issue in this appeal. Petitioner's mother is encouraged to work with the Agency to address any needs for services that can be provided on an outpatient basis.

DECISION

Based upon the foregoing, Petitioner's appeal is DENIED and the Agency's action is AFFIRMED.

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 20 day of November, 2015,

in Tallahassee, Florida.

Rick Zimmer

Rick Zimmer
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Don Fuller, Area 6, AHCA Field Office Manager

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

[redacted]

APPEAL NO. 15F-07091

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 10 Polk
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing on October 19, 2015 at approximately 10:00 a.m.

APPEARANCES

For Petitioner: [redacted]
Petitioner's Mother

For Respondent: Stephanie Lang
Registered Nurse Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is Respondent's termination of Petitioner's Prescribed Pediatric Extended Care Services ("PPEC"). The burden of proof is assigned to Respondent.

PRELIMINARY STATEMENT

Dr. Rakesh Mittal, Physician Reviewer with eQHealth Solutions ("eQHealth") appeared as a witness for Respondent. Petitioner's mother gave oral testimony, but did not move any exhibits into evidence. Respondent moved Exhibits 1 through 8 into evidence.

Administrative notice was taken of the following:

- Section 409.905, Florida Statutes.
- Florida Administrative Code Rules 59G-1.001, 59G-1.010, and 59G-4.260.
- The Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook, September 2013.

FINDINGS OF FACT

1. Petitioner is a 23-month-old female. At all times relevant to this proceeding, Petitioner was eligible to receive Medicaid services.

2. Petitioner's health conditions include:

[redacted]

3. Petitioner had been receiving PPEC services prior to this request. Petitioner is continuing to receive PPEC services, pending the outcome of this appeal.

4. Petitioner's Physician Plan of Care for PPEC Services indicates she eats a normal, age-appropriate diet, "has made progress over the last 180 days, as evidenced by advancing to a regular diet for age and she is now pulling up and cruising around furniture," and that discharge from PPEC should be considered once she no longer requires skilled nursing care (Respondent's Exhibit 3).

5. Petitioner receives speech therapy, occupational therapy, and physical therapy as part of her PPEC services. Dr. Mittal noted that only the PPEC services were under review at hearing, not the other therapies. Those services can be provided on an outpatient basis.

6. PPEC is for children who need special medical care, such as skilled-nursing care, throughout the day, that ordinary day care cannot provide. Ordinary day care cannot administer medications.

7. Petitioner's mother said some of her medications need to be taken twice per day. Other medications are provided to Petitioner on an as-needed basis, such as [redacted] and [redacted] because of her fragile respiratory system. Petitioner's mother sends extra medications to the PPEC provider to be administered as needed. If Petitioner was in ordinary day care, her mother would have to leave work to administer the medications. Petitioner's mother works between eight (8) to ten (10) hours per day.

8. Because Petitioner was born prematurely, she is more prone to illness than other children. Petitioner's mother has had to miss work a significant amount of time in order take care of her when she is ill. She also stated when one twin gets sick, the other also catches it. Petitioner and her sister have had hand, foot, and mouth disease twice this year, and also had vomiting and diarrhea. Petitioner can attend the PPEC center when she has a fever or other illness, as long as she is not contagious, because someone can provide her medication. An ordinary day care would not allow her to come when she is sick.

9. Dr. Mittal said the various illnesses, such as fever or gastroenteritis, cannot be foreseen, and that PPEC is not appropriate for temporary illnesses. PPEC is for someone who needs care every day for a chronic illness. Temporary illnesses can be dealt with when they occur, but PPEC cannot be provided every day, just in case something might happen. Petitioner's mother stated she does have chronic lung disease, but that it is treated on an as-needed basis.

10. Petitioner's PPEC provider submitted a request for 12 hours per day, five (5) days per week of PPEC services, for a period of 180 days.

11. On August 10, 2015, eQHealth issued a Notice of Outcome – Partial Denial Prescribed Pediatric Extended Care Services. One month of PPEC services were approved in order for Petitioner to transition into ordinary day care, but the rest of the request was denied. The Clinical Rationale for the Decision was as follows:

> The patient is a 21 month old with a history of twin gestation, prematurity, GERD, and reactive airway disease. The clinical information provided does not support the medical necessity of the additional services. The patient appears to no longer require skilled nursing services and does not meet the medical complexity requirement of PPEC services. The additional services are deemed excessive. However, 30 days will be approved to provide the caregiver time to transition the patient out of PPEC. Partial approval PPEC: Mon thru Fri 8/18/15 thru 9/16/15. (Respondent's Composite Exhibit 7).

12. Petitioner timely requested a hearing on August 17, 2015.

CONCLUSIONS OF LAW

13. By agreement between the Agency for Health Care Administration ("AHCA" or "Agency") and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction over this matter pursuant to § 120.80, Fla. Stat.

14. This hearing was held as a *de novo* proceeding, in accordance with Florida Administrative Code Rule 65-2.056.

15. This is a Final Order, pursuant to §§ 120.569 and 120.57, Fla. Stat.

16. 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.).

17. Legal authority governing the Florida Medicaid Program is found in Chapter 409 of the Florida Statutes, and in Chapter 59G of the Florida Administrative Code. Respondent, AHCA, is the single state agency that administers the Medicaid Program.

18. The Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook, September 2013 ("PPEC Handbook") is promulgated into law by Florida Administrative Code Rule 59G-4.260.

19. Page 2-1 of the PPEC Handbook lists the requirements for receiving PPEC services. Page 2-1 states:

> To receive reimbursement for PPEC services, a recipient must meet all of the following criteria:
>
> - Be Medicaid eligible
> - Diagnosed with a medically-complex or medically fragile condition as defined in Rule 59G-1.010, F.A.C.
> - Be under the age of 21 years
> - Be medically stable and not present significant risk to other children or personnel at the center
> - Require short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care due to a medically complex condition.

20. Fla. Admin Code R.59G-1.010 defines "medically complex" and "medically fragile" as follows:

> (164) "Medically complex" means that a person has chronic debilitating diseases or conditions of one or more physiological or organ systems that

generally make the person dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention.

(165) "Medically fragile" means an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, e.g., requires total parenteral nutrition (TPN), is ventilator dependant, or is dependent on a heightened level of medical supervision to sustain life, and without such services is likely to expire without warning.

21. Section 409.905, Florida Statutes, "Mandatory Medicaid services," states, in pertinent part: "Any service provided under this section shall be provided only when medically necessary and in accordance with state and federal law...."

22. The definition of medically necessary is found in Fla. Admin. Code R.59G-1.010, which states:

(166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods or services furnished or ordered must:
(a) Meet the following conditions:
1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
. . .

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods, or services medically necessary or a medical necessity or a covered service.

23. Since the Petitioner is under 21 years of age, a broader definition of medical necessity applies to include the Early and Periodic Screening, Diagnosis, and

Treatment Services (EPDST) requirements. § 409.905, Fla. Stat., Mandatory Medicaid services, provides that Medicaid services for children include:

> (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

24. The United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in *Moore v. Reese*, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, which involved a dispute over private duty nursing:

> [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.
> (2) A state Medicaid plan must include "reasonable standards ... for determining eligibility for and the extent of medical assistance" ... and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.
> (3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."
> (4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."
> (5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. **The state is not required to provide medically unnecessary, albeit desirable,**

> **EPSDT services.** However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."
> (6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and my present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)) (emphasis added).

25. Consistent with these requirements, the state is obligated to provide services to recipients under 21 years of age, but only to the extent such services are medically necessary. The definition of medical necessity for services provided under the EPSDT benefit is established by the state and the state is authorized to establish the amount, duration, and scope of such services.

26. In the instant matter, the testimony and documentary evidence fails to establish the medical necessity of PPEC services for Petitioner. While it is true Petitioner has chronic lung disease, her mother's testimony indicates that treatment is only given on an as-needed basis. Petitioner does not require skilled nursing care throughout the entire day, every day.

27. Petitioner is more susceptible to illness than an ordinary child of her age. However, while it is certainly an inconvenience for her mother to have to leave work in order to attend to her medical needs, her situation is no different than that of any other parent of a small child. Small children in ordinary day care sometimes get sick and their parents have to find an alternative method of care. The only difference here is that Petitioner is likely to be ill more frequently than the other children.

28. Petitioner's level of illness does not reach the level of "medically complex" or "medically fragile," as defined in the Florida Administrative Code. PPEC services are only provided when the recipient's condition is severe.

29. The undersigned has reviewed EPSDT and medical necessity requirements and concludes Respondent has met its burden of proof, by the greater weight of the evidence, in terminating Petitioner's PPEC services.

30. Dr. Mittal made it clear that Petitioner's needs for speech therapy, occupational therapy, and physical therapy are not at issue in this appeal. Petitioner's mother is encouraged to work with the Agency to address any needs for services that can be provided on an outpatient basis.

DECISION

Based upon the foregoing, Petitioner's appeal is DENIED and the Agency's action is AFFIRMED.

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 20 day of November, 2015,

in Tallahassee, Florida.

Rick Zimmer

Rick Zimmer
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Don Fuller, Area 6, AHCA Field Office Manager

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

[redacted]

APPEAL NO. 15F-07092

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 01 Walton
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 30, 2015 at 9:36 a.m.

APPEARANCES

For the Petitioner: [redacted]
Pro Se

For the Respondent: Cindy Henline
Medical Health Care Program Analyst

ISSUE

Whether respondent's denial of petitioner's request for 12 companion hours per week through the Statewide Long Term Managed Care Program (LTMC Program) was proper. The burden of proof was assigned to the respondent.

PRELIMINARY STATEMENT

A telephonic hearing was first scheduled for September 25, 2015. On September 22, 2015 petitioner's request for a continuance was granted.

At the hearing, petitioner entered no exhibits into evidence.

Ms. Henline appeared as both a representative and witness for the respondent. Present from Sunshine Health were: Melissa Wookey, Long Term Care Case Manager; India Smith, Grievance and Appeals Coordinator; Shannon Leon, Long Term Care Case Manager Supervisor; and Dr. John Carter, Long Term Care Medical Director. Respondent's exhibits "1" and "2" were entered into evidence.

The record was held open through November 6, 2015 for respondent's response to:

- Whether the burden of proof was correctly assigned.
- Whether companion hours should have been continued at 12 hours per week pending the outcome of the hearing process.
- Whether notices addressing a reduction of companion services from 12 hours to nine hours per week were issued.

A response was received and entered as respondent's exhibit "3".

Administrative notice was taken of Florida Statutes §409.963; §409.965; §409.978; §409.979; §409.98; §409.984; §409.913; and Fla. Admin. Code R. 59G-1.010 (166)

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. Petitioner is 68 years of age and resides by herself. She is diagnosed with [redacted] and [redacted] Petitioner also reports stage [redacted]

2. Petitioner is independent with activities of daily living. These activities include: bathing; dressing; eating; toileting; transferring; and walking.

3. At all times relevant to this proceeding, petitioner was Medicaid eligible.

4. Respondent administers Florida's Medicaid Program and contracts with Health Maintenance Organizations (HMOs) to provide comprehensive, cost-effective medical services to Medicaid recipients in the LTMC Program.

5. Respondent does not have a promulgated Coverage and Limitations Handbook for the LTMC Program. LTMC services descriptions are defined by contract.

6. Petitioner's LTMC services are provided by Sunshine Health. At the time of hearing, petitioner was authorized to receive nine hours per week of companion and four hours per week of homemaker services.

7. Sunshine Health issued the following authorizations to petitioner's companion provider:

- July 10, 2015: For the period July 1, 2015 through August 31, 2015 authorized 4 hours per day/ three times per week.
- August 12, 2015: Companion services were authorized for nine hours per week as of August 1, 2015.
- August 31, 2015: Companion service authorized from September 1, 2015 through February 28, 2016 at nine hours per week[1].

8. Petitioner was not copied on the above service authorizations.

9. On June 24, 2015 petitioner formally requested 12 hours per week of companion services.

10. On July 1, 2015 Sunshine Health issued a Notice of Action denying petitioner's request as not being medically necessary. The notice also stated, in part:

> Sunshine Health has reviewed your request for 3 more hours each week of Companion Care Services ... which we received on 6/24/15. After our review, this service has been: DENIED as of 7/10/15.

[1] This notice corrected the end date for companion at 12 hours/week from August 1, 2015 to August 31, 2015

...

> You asked your Case Manager to increase your Companion Care (The person that helps assist and watch over you) from 3 hours per day x3 days per week to 4 hours per day x3 days per week. The extra hours have been denied. Sunshine Health has looked at your care needs and the current hours you are getting for Companion Care ... 3 hours per day x3 days per week (12 hours per week)[2], meets your needs.

11. The above notice informed the petitioner she could request an appeal with Sunshine Health and/or request a Medicaid Fair Hearing. For services to continue at the current level pending the outcome of either an appeal or fair hearing, the notice stated:

> If you are now receiving the service that was reduced, suspended or terminated, you have the right to keep getting those services until a final decision is made in an appear or fair hearing. You MUST file your appeal or request for a fair hearing AND ask for continued services within these time frames:
>
> For an appeal:
>
> File the appeal with Sunshine Health no later than 10 days after this letter was mailed OR no later than 10 days after the first day our action will take place, whichever is later. You can ask for an appeal by phone. If you do this, you must than also make a request in writing. Be sure to tell us that you want your services to continue.
>
> For a fair hearing:
>
> File the request with the Office of Appeal Hearings no later than 10 days after this letter was mailed or before the first day our action will take place, whichever is later. Be sure to tell the hearing officer that you want your services to continue.

12. On July 13, 2015 Sunshine Health received petitioner's written request for an internal appeal. Petitioner requested the 12 hours of companion services be continued.

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[2] It is not clear how 3 hours per day/3 days per weeks equals 12 hours per week.

13. On July 31, 2015 Sunshine Health issued a notice upholding the decision to deny 12 hours per week of companion services. The notice stated, in part:

> The member currently receives 4 hours of homemaking per week and 9 hours of companion care per week, for a total of 13 hours per week. She is able to perform all activities of daily living without assistance. She is able to perform all instrumental activities of daily living without assistance, except for chores, in which she needs total assistance.

14. On August 17, 2015 petitioner contacted the Office of Appeal Hearings and requested a fair hearing.

15. The undersigned finds at the time of notices issued by Sunshine Health on July 1, 2015 and July 31, 2015 petitioner was receiving 12 hours per week of companion services. As such, respondent's action represents a reduction in service hours.

16. Petitioner argues she was recently in a car accident and received a concussion. Her other medical conditions cause poor [redacted] and [redacted] She has multiple out of town medical appointments and must go by ambulance. The companion is a backup when a transportation issue emerges. The companion also picks up prescriptions from the pharmacy.

17. Petitioner also argues additional companion services are needed to help with medical related paperwork; faxes; and telephone calls.

18. A letter from petitioner's physician, [redacted] states, in part: "While medication management and fall avoidance in her home are important reasons for assistance, I suspect her need for transportation trumps all others, and is indeed specific to this individual's unusual needs, not in excess thereof."

19. Respondent states the July 31, 2015 notice upheld the original denial. As such, an additional 10 day advance notice was not required.

CONCLUSIONS OF LAW

20. By agreement between the Agency for Health Care Administration (AHCA) 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. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

22. The standard of proof in an administrative hearing is by 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.).

23. Analysis is first directed to notices issued by Sunshine Health.

24 42 C.F.R. requires the following:

> §431.211 Advance notice.
> The State or local agency must send a notice at least 10 days before the date of action, except as permitted under §§431.213 and 431.214.

25. Respondent's notice of July 1, 2015 identifies July 10, 2015 as the date of action. The notice of July 31, 2015 does not identify a date of action. The focus of that notice was to uphold the original decision. Regardless, the Findings of Fact establish 12 hours per week of companion services were approved through August 31, 2015. No notice was provided which notified the petitioner that, effective September 1, 2015, companion services would return to nine hours per week.

26. 42 C.F.R. continues by stating:

> §431.213 Exceptions from advance notice.
> The agency may send a notice not later than the date of action if—
> (a) The agency has factual information confirming the death of a beneficiary;

(b) The agency receives a clear written statement signed by a beneficiary that—
(1) He no longer wishes services; or
(2) Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;
(c) (d) The beneficiary's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address (See §431.231 (d) of this subpart for procedure if the beneficiary's whereabouts become known);
(e) The agency establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;
(f) A change in the level of medical care is prescribed by the beneficiary's physician;
(g) The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; or
(h) The date of action will occur in less than 10 days, in accordance with §483.12(a)(5)(ii), which provides exceptions to the 30 days notice requirements of §483.12(a)(5)(i).

§431.214 Notice in cases of probable fraud.
The agency may shorten the period of advance notice to 5 days before the date of action if—
(a) The agency has facts indicating that action should be taken because of probable fraud by the beneficiary; and
(b) The facts have been verified, if possible, through secondary sources.

27. The greater weight of evidence does not establish there is an exception from advance notice.

28. 42 C.F.R. §431.230 further requires:

Maintaining services

(a) If the agency sends the 10-day or 5-day notice as required under §431.211 or §431.214 of this subpart, and the beneficiary requests a hearing before the date of action, the agency may not terminate or reduce services until a decision is rendered after the hearing unless—
(1) It is determined at the hearing that the sole issue is one of Federal or State law or policy; and
(2) The agency promptly informs the beneficiary in writing that services are to be terminated or reduced pending the hearing decision.

29. 42 C.F.R. further requires:

> §431.231 Reinstating services.
> (a) The agency may reinstate services if a beneficiary requests a hearing not more than 10 days after the date of action.
> (b) The reinstated services must continue until a hearing decision unless, at the hearing, it is determined that the sole issue is one of Federal or State law or policy.
> **(c) The agency must reinstate and continue services until a decision is rendered after a hearing if—**
> (1) **Action is taken without the advance notice required under §431.211 or §431.214 of this subpart** [Emphasis Added];

30. Sunshine Health's actions are not in compliance with 42 C.F.R. §431.211. Petitioner was not provided a 10 day notice regarding the reduction of companion services to 9 hours per week effective September 1, 2015. The only advance notice provided was in association with the July 1, 2015 notice. It is noted, however, that petitioner's companion provider was authorized to provide 12 hours of companion services per week through August 31, 2015.

31. It is noted petitioner's request for a fair hearing was received 17 days after the last notice was issued on July 31, 2015. Petitioner, however, was not afforded the opportunity to challenge the September 1, 2015 reduction from 12 to 9 hours a week of companion services. A notice was not issued regarding this revised date of action.

32. Although notice concerns exist, the undersigned lacks jurisdiction to order services be reinstated for a timeframe which has passed. In this instant appeal, the provider did not continue providing 12 hours of uncompensated companion services a week. This frequency ended August 31, 2015.

33. Regarding the LTMC Program, § 409.978, Fla. Stat. states:

> (1) ... the agency shall administer the long-term care managed care program ...
>
> (2) The agency shall make payments for long-term care, including home and community-based services, using a managed care model.

34. In this instant appeal, the managed care plan is Sunshine Health.

35. Regarding the LTMC Program, Sunshine Health and the respondent entered into a contractual relationship. The contract both enumerates and defines required services. The contractual definition relevant to this proceeding is:

> Adult Companion Care – Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discreet services. The provision of companion services does not entail hands-on nursing care. The service includes light housekeeping tasks incidental to the care and supervision of the member. The provision of services may be provided at the member's residence or anywhere in the community where supervision and care is necessary. The services cannot be provided by a family member.

36. Florida Medicaid, which includes the LTMC Program, only covers those services determined to be medically necessary. See § 409.905 (4) (c), Fla. Stat.

37. The definition of medical necessity is found in Fla. Admin Code. R. 59G-1.010 and states:

> (166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider...
> . . .
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

38. Petitioner's need for 12 hours per week of companion does not focus on socialization activities. Petitioner does not require either assistance or supervision with activities of daily living. The companion provider is picking up prescriptions from the pharmacy and provides back up transportation.

39. The greater weight of evidence does not establish petitioner requires an elevated level of supervision.

40. In addition to companion services, Sunshine Health approved four hours a week of homemaker services.

41. Petitioner's need for assistance with medically related paperwork; faxes; and telephone calls is noted. This type of assistance, however, does not fall under the general guidelines of meal preparation; laundry; shopping; housekeeping; or general supervision. Rather, the duties are clerical in nature.

42. After considering all evidence and testimony, respondent has met its evidentiary burden. Petitioner's request for 12 hours per week of companion services fails to satisfy the following conditions of medical necessity:

> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, petitioner's appeal is 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 19 day of November, 2015, in Tallahassee, Florida.

Frank Houston
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Marshall Wallace, Area 1, AHCA Field Office Manager

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

[redacted]

APPEAL NO. 15F-07159
APPEAL NO. 15F-07357

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 06 Pinellas
UNIT: 88342

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened one administrative hearing in the above-referenced matter on September 23, 2015 at 1:06 p.m. in [redacted] and convened one administrative hearing by telephone on October 19, 2015 at 1:02 p.m. All parties appeared from different locations during the telephonic hearing. One continuance was granted for both the petitioner and the respondent.

APPEARANCES

For Petitioner: [redacted] pro se

For Respondent: Ed Poutre, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

At issues are whether the respondent's action to (1) decrease petitioner's Food Assistance (FA) benefits to $16.00 per month for June 2015 through August 2015; (2) to terminate petitioner's full Medicaid benefits and instead enroll him in the Medically

Needy (MN) program effective July 1, 2015; and (3) to terminate petitioner's wife's Medicaid benefits effective July 1, 2015 are correct. The burden of proof for the Food Assistance appeal is assigned to the petitioner and the burden of proof for petitioner and his wife's Medicaid appeals are assigned to the respondent.

PRELIMINARY STATEMENT

At both hearings, the petitioner was present and testified. Petitioner provided one witness who testified at both hearings: [redacted] petitioner's wife. Petitioner submitted four exhibits, which were accepted into evidence and marked as Petitioner's Exhibits "1" through "4". At both hearings, the respondent was represented by Ed Poutre with the Department of Children and Families (hereafter "DCF", "Respondent" or "Agency"). Respondent submitted ten exhibits, which were accepted into evidence and marked as Respondent's Exhibits "1" through "10". At the September 23, 2015 hearing, Daniel Graycheck, supervisor with DCF, observed the proceedings. The record closed on October 19, 2015.

FINDINGS OF FACT

1. On May 4, 2015, the petitioner completed a recertification application for Food Assistance (FA) and SSI-Related Medicaid benefits. The application listed petitioner and his wife as the only household members; no income for the household; property taxes of $89 per month; mortgage of $860 per month; electric of $181 per month; and no ongoing medical expenses.

2. Petitioner's Social Security Disability Insurance (SSDI) amount is $1,841 (gross) per month.

3. On May 27, 2015, the respondent mailed petitioner a Notice of Case Action indicating petitioner's May 4, 2015 FA application was approved for $16 per month effective June 2015; and his May 4, 2015 Medically Needy application was approved with a monthly SOC amount of $1,641. The notice also indicated petitioner and his wife's full Medicaid benefits ended effective June 30, 2015.

4. On August 27, 2015, the respondent mailed petitioner a Notice of Case Action indicating his FA benefits were increasing to $183 effective October 2015 and ongoing as he had a change in his household's circumstances.

5. Petitioner received FA benefits in the amount of $16 per month for the period of June 2015 through August 2015. Although the aforementioned notice indicated petitioner's FA benefits increased effective October 2015, the respondent explained petitioner's FA benefits actually increased effective September 2015. Petitioner's only issue in regards to his FA benefit amount is the $16 per month he received for period of June 2015 through August 2015. He is not appealing the FA benefit amount of $183 per month effective September 2015 and ongoing.

6. Respondent calculated the petitioner's FA budget for June 2015 through August 2015 as follows:

Expenses/Income	**Dollar Amount**
Unearned Income	$1841.00
Total household income	**$1841.00**
Standard deduction for a household of 1	-$ 155.00
Adjusted income after deductions	**$1686.00**
Rent/shelter	$ 949.00
Standard utility allowance	+$ 337.00
Total rent/utility costs	**$1286.00**
Shelter standard (50% adjusted income)	-$ 843.00

Excess shelter deduction	**$ 443.00**
Adjusted income	$1686.00
Excess Shelter Deduction	-$ 443.00
Adjusted income after shelter deduction	**$1243.00**

7. Respondent took 30% of $1,243 to calculate the benefit reduction of $373, which exceeds $357 or the maximum FA benefit amount for a household of two. Petitioner was eligible for the minimum monthly FA benefit amount of $16 as he resided in a two-person household and received disability income.

8. For the period of June 2015 through August 2015, the respondent determined petitioner's household's expenses as the expenses listed on his May 4, 2015 application and verified his SSDI income through the State of Florida SSA State On-Line Query system. The interview type for petitioner's May 4, 2015 application was passive.

9. Respondent determined petitioner's MN SOC amount as $1,641 effective July 2015 and ongoing as follows:

$1841.00	petitioner's SSDI income
-$ 20.00	unearned income disregard
$1821.00	total countable income
-$ 180.00	MNIL for a household of one
$1641.00	share of cost

10. Respondent determined petitioner not eligible for full SSI-Related Medicaid benefits as his monthly SSDI income is over the SSI-Related Medicaid income standard of $864.00.

11. Petitioner's wife does not receive any income from the Social Security Administration (SSA); is not over the age of 65; and has not been deemed disabled by SSA.

12. Petitioner does not agree with the respondent's determination that he is not eligible for full SSI-Related Medicaid benefits as he has a terminal illness requiring hospitalization, multiple medications, regular physician visits, and various ongoing medical tests.

CONCLUSIONS OF LAW

13. 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.

14. This proceeding is a de novo proceeding pursuant to Florida Administrative Code R. 65-2.056.

As to the monthly FA benefit amount for the period of June 2015 through August 2015

15. The Code of Federal Regulations 7 C.F.R. § 273.9 define income and deductions and states, in part:

> 2) Unearned income shall include, but not be limited to:
>
> (ii) Annuities; pensions; retirement, veteran's, or disability benefits; worker's or unemployment compensation including any amounts deducted to repay claims for intentional program violations as provided in §272.12; old-age, survivors, or social security benefits; strike benefits; foster care payments for children or adults who are considered members of the household. . .
>
> (d) Income deductions. Deductions shall be allowed only for the following household expenses. . .
>
> (1) *Standard deduction*—(i) *48 States, District of Columbia, Alaska, Hawaii, and the Virgin Islands.* Effective October 1, 2002, in the 48 States and the District of Columbia, Alaska, Hawaii, and the Virgin Islands, the standard deduction for household sizes one through six shall be equal to 8.31 percent of the monthly net income eligibility standard for each

> household size established under paragraph (a)(2) of this section rounded up to the nearest whole dollar...
>
> (6) *Shelter costs*...
>
> (ii) Excess shelter deduction. Monthly shelter expenses in excess of 50 percent of the household's income after all other deductions in paragraphs (d) (1) through (d)(5) of this section have been allowed...If the household does not contain an elderly or disabled member, as defined in § 271.2 of this chapter, the shelter deduction cannot exceed the maximum shelter deduction limit established for the area.
>
> (iii) *Standard utility allowances.* (A) With FNS approval, a State agency may develop the following standard utility allowances (standards) to be used in place of actual costs in determining a household's excess shelter deduction: an individual standard for each type of utility expense; a standard utility allowance for all utilities that includes heating or cooling costs (HCSUA)...

16. Pursuant to the above authority, petitioner's monthly SSDI income must be included in the determination of his household's monthly FA benefit amount. Furthermore, shelter costs, utilities, and a standard deduction must also be included in the determination of his household's monthly FA benefit amount.

17. The ACCESS Customer Service Center Guide (page 14) defines the passive (re)determination process as "determine eligibility based on the application and information the customer provides; there is no interview requirement. Contact the customer to discuss unclear or inconsistent information".

18. Pursuant to the above policy, since petitioner's May 2015 recertification period was a passive redetermination, the respondent was allowed to determine petitioner's expenses based on the information listed on his May 4, 2015 application and was allowed to verify his SSDI income through the State of Florida SSA State On-Line Query

system. Therefore, the respondent correctly calculated petitioner's expenses and income for the period of June 2015 through August 2015.

19. For June 2015 through September 2015, the ACCESS Florida Program Policy Manual Appendix A-1 sets forth the following Eligibility Standard for Food Assistance benefits:

> (1) $357 maximum FA benefit for a household size of two; (2) $337.00 standard utility allowance; (3) $155.00 standard deduction for a household size of two; (4) uncapped shelter deduction for AGs with elderly or disabled members; and (5) $16 per month for the minimum allotment for one or two member household.

20. Since petitioner's gross income ($1,841) was less than the 200% gross income limit of $2,622 for a household of two for the period of June 2015 through August 2015, he is potentially eligible to receive the monthly minimum FA benefit amount if his household meets all regular eligibility requirements.

21. The Department's Policy transmittal numbered C-13-10-0007, Food Assistance Minimum Benefit dated October 11, 2013 shows in pertinent part that:

> ...all one and two member assistance groups (AGs) are eligible for the minimum monthly food assistance benefit allotment, which is 8% of the maximum allotment for a one person household....The AG is eligible for the minimum monthly food assistance benefit allotment if the assistance group meets all regular eligibility requirements and....the AG has income less than or equal to the 200% gross income limit or the AG contains an elderly or disabled member and does not pass the 200% gross income test but does have income less than or equal to the 100% of the net income limit...

22. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 2610.0106.02, Minimum Benefits (FS) states in part, "Recurring months: Issue a minimum of eight percent of the maximum benefit for a one-person assistance group

to one or two person assistance groups who meet the net income test or are categorically eligible".

23. Pursuant to the above transmittal and policy, a two person household, which passes the gross income test or has an elderly or disabled member with income below the net income limit, is entitled to receive a minimum FA benefit amount that equals to eight percent of the maximum amount for a one person household. Petitioner's FA group is a two-person household, with a disabled member, and passes the gross income test; therefore, he and his wife are eligible to receive the monthly minimum FA benefit amount for the period of June 2015 through August 2015.

24. Pursuant to the various aforementioned authorities, the respondent correctly calculated petitioner and his wife's monthly FA benefit amount for the period of June 2015 through August 2015 by including all the required income, expenses, and deductions allowed in the determination of FA benefits.

25. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner has not met his burden of proof in establishing the respondent incorrectly calculated his monthly Food Assistance benefit amount for the period of June 2015 through August 2015.

As to the petitioner's eligibility for full SSI-Related Medicaid benefits

26. Fla. Admin. Code R. 65A-1.710 sets forth the rules of eligibility for SSI-Related Medicaid Coverage Groups. The MEDS-AD Demonstration Waiver is a coverage group for aged and disabled individuals (or couples), as provided in 42 U.S.C. § 1396a(m). For an individual less than 65 years of age to receive benefits, he or she must meet the

disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905 and states, in part:

> (a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see § 416.960(b)) or any other substantial gainful work that exists in the national economy.

27. Pursuant to the above authority, since petitioner is [redacted] he is eligible for Medicaid benefits under the SSI-Related Medicaid program.

28. The Policy Manual, CFOP 165-22, passage 2240.0610 Couple/One Requests Medicaid (MSSI) states:

> The following policy is applicable only to MEDS-AD, QMB, SLMB, QI-1, EMA, Protected Medicaid, Medically Needy and Working Disabled Programs.
>
> If an individual is living with their spouse and only one is requesting or receiving Medicaid (or the spouse does not meet the technical criteria for the program), the income and assets must be deemed from the spouse who is not requesting assistance (or who does not meet the technical criteria). If there is not enough income to be deemed, the income standard for one is used. If there is enough income to deem, the individual must first pass the individual test for one. If they pass the individual income test, they must also pass the couple standard using deemed income from the spouse.

29. Pursuant to the above authority, since petitioner's wife does not have any income to deem, the income standard for one person is utilized when determining the husband's eligibility for SSI-Related Medicaid benefits.

30. The Fla. Admin. Code R. 65A-1.713, SSI-Related Medicaid Income Eligibility Criteria defines income limit for the SSI-Related Medicaid Program as income that is at or below 88 percent of the federal poverty level.

31. The Policy Manual, Appendix A-9, lists the SSI-Related Income Standards for a household size of one for MEDS-AD or full SSI-Related Medicaid program as $864 for July 2015 and ongoing.

32. Federal Regulations at 20 C.F.R. 416.1124(c)(12) sets forth income that is not counted in this program and states, "The first $20 of any unearned income in a month other than...income based on need."

33. The Fla. Admin. Code R. 65A-1.716(2) indicates the Medically Needy Income Level (MNIL) for a family size of one as $180.

34. Petitioner's monthly SSDI income exceeds the Medicaid income standard for him to receive full SSI-Related Medicaid benefits; therefore, he is correctly enrolled in the Medically Needy Program with a monthly share of cost.

35. In careful review of the cited authorities and evidence, the undersigned concludes the respondent correctly terminated petitioner's full SSI-Related Medicaid benefits and correctly enrolled him in the Medically Needy Program with a monthly share of cost amount effective July 1, 2015.

As to the wife's eligibility for Medicaid Benefits

36. The Fla. Admin. Code R. 65A-1.705(7)(c) Family-Related Medicaid General Eligibility Criteria, in part states:

> If assistance is requested for the parent of a deprived child, the parent and any deprived children who have no income must be included in the SFU. Any deprived siblings who have income, or any other related fully deprived children, are optional members of the SFU. If the parent is married and the spouse lives in the home, income must be deemed from the spouse to the parent. For the parent to be eligible, there must be at least one child under age 18, with or without income, in the SFU, or who would be in the SFU if not receiving SSI...

37. According to the above authority, to be eligible for Family-Related Medicaid benefits, petitioner's wife must have a minor child under age 18 living in the household with her or she must be pregnant. Since petitioner's wife does not have a minor child under age 18 living in the household and since she is not pregnant, she does not meet the technical requirement to receive Medicaid benefits under the Family-Related Medicaid program.

38. Fla. Admin. Code R. 65A-1.710 sets forth the rules of eligibility for SSI-Related Medicaid Coverage Groups. The MEDS-AD Demonstration Waiver is a coverage group for aged and disabled individuals (or couples), as provided in 42 U.S.C. § 1396a(m). For an individual less than 65 years of age to receive benefits, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905 and states, in part:

> (a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see § 416.960(b)) or any other substantial gainful work that exists in the national economy.

39. Pursuant to the above authority, to be eligible for SSI-Related Medicaid benefits, petitioner's wife must be over the age of 65 or considered disabled by the Social Security Administration. Since petitioner's wife is not over the age of 65 and is not considered disabled, she does not meet the technical requirement to receive Medicaid benefits under the SSI-Related Medicaid program.

40. In careful review of the cited authorities and evidence, the undersigned concludes the respondent correctly terminated petitioner's wife's full SSI-Related Medicaid benefits effective July 1, 2015.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, petitioner's Food Assistance and SSI-Related Medicaid appeals are DENIED.

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 17th day of November, 2015,

in Tallahassee, Florida.

Mary Jane Stafford
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 66292

RESPONDENT.
_____/

APPEAL NO. 15F-07204

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on September 22, 2015 at 9:45 a.m.

APPEARANCES

For the petitioner: [redacted] pro se

For the respondent: Clara Ford, ACCESS Supervisor

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to increase the petitioner's husband's Medically Needy Program with a share of cost (SOC) from $735.00 to $788.00 beginning July 2015. Petitioner is seeking full Medicaid for her husband. The respondent carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

On June 5, 2015, the respondent notified the petitioner that her husband's SOC increased from $735.00 to $788.00 beginning July 2015.

Serving as interpreter for a portion of the hearing was [redacted] translator for Language line. For another portion of the hearing, [redacted] ACCESS Economic Self-Sufficiency Specialist 1 (ESS1) translated the proceedings.

Petitioner did not present any exhibits. Respondent submitted five exhibits, entered as Respondent Exhibits "1" through "5". The record closed on September 22, 2015.

FINDINGS OF FACT

1. Prior to the action under appeal, petitioner was receiving Food Assistance and Medically Needy Program with a SOC benefits for herself, her husband and Family-Related full Medicaid for their two minor children, ages [redacted] Food Assistance and Medicaid for herself and the children are not the issue.

2. On June 1, 2015, petitioner submitted an online application to recertify for Food Assistance and Medicaid benefits for the next certification period. On the application, petitioner listed the source of income for her household was her employment at [redacted] she is paid bi-weekly. The application did not indicate any disabled individuals.

3. During the application process, the petitioner submitted to the respondent her earned income paystubs dated May 7, 2015, gross pay $686.67 and May 21, 2015, gross pay $686.76. Both pays were used in determining the household's eligibility because both pays are considered representative of petitioner's earnings. The respondent calculated the petitioner's monthly income as $1,373.44 by adding her bi-weekly earnings ($686.67 + $686.76).

4. To determine the SOC amount, the respondent determined the Medically Needy Income Level (MNIL) for a household size of four was $585.00, this amount was

subtracted from the gross monthly income of $1,373.44, resulting in a SOC amount of $788.00. The respondent calculated the petitioner's husband's SOC amount as follows:

[redacted]

EARNED INCOME:+	1373.44	SFU SIZE:	4
UNEARNED INCOME:+	.00	INCOME STANDARD:	.00
TOTAL REPORTED INCOME:=	1373.44	MNIL:-	585.00
ALLOWABLE TAX DEDUCTIONS:-	.00	SHARE OF COST:=	788.00
MODIFIED ADJUSTED GROSS INC:=	1373.44	MED INSURANCE PREMIUM:-	.00
STANDARD DISREGARD:-	.00	RECURRING MED EXPENSE:-	.00
MAGI DISREGARD(5% OF FPL):-	.00	REMAINING SOC:=	788.00
COUNTABLE NET INCOME:=	1373.44	COUNT OF OOTHS:	0

AG HAS PASSED THE FAM RELATED MEDICAID/MED NEEDY BENEFIT DETERMINATION BUDGET

5. The petitioner argued that her husband needs full Medicaid because of his chronic illness. Petitioner's husband was receiving Supplemental Security Income (SSI); however; his SSI was suspended and later terminated on June 2014 due to Social Security Administration alleging he had committed fraud when he alleged to be disabled. Petitioner explained her husband is disabled. No evidence was presented at the hearing to indicate that petitioner's husband has been declared to be disabled.

6. For a parent to be eligible for full Family-Related Medicaid, the income cannot exceed the $364.00 Medicaid income limit for a household size of four. Petitioner's household income of $1,373.44 exceeds the $364.00 full Medicaid income limit.

CONCLUSIONS OF LAW

7. 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 Fla. Stat. § 409.285.

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

9. The Code of Federal Regulations at 42 C.F.R. 435.110 sets forth the Medicaid budgeting criteria for parents:

> (a) Basis. This section implements sections 1931(b) and (d) of the Act.
> (b) Scope. The agency must provide Medicaid to parents and other caretaker relatives, as defined in §435.4, and, if living with such parent or other caretaker relative, his or her spouse, whose household income is at or below the income standard established by the agency in the State plan, in accordance with paragraph (c) of this section.
> (c) Income standard. The agency must establish in its State plan the income standard as follows:
> (1) The minimum income standard is a State's AFDC income standard in effect as of May 1, 1988 for the applicable family size converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act.
> (2) The maximum income standard is the higher of—
> (i) The effective income level in effect for section 1931 low-income families under the Medicaid State plan or waiver of the State plan as of March 23, 2010 or December 31, 2013, if higher, converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act; or
> (ii) A State's AFDC income standard in effect as of July 16, 1996 for the applicable family size, increased by no more than the percentage increase in the Consumer Price Index for all urban consumers between July 16, 1996 and the effective date of such increase.

10. The Department's Program Policy Manual, CFOP 165-22, passage 2030.0200 Coverage Groups (MFAM):

> The following are the Medicaid coverage groups:
> 1. Parents and other caretaker relatives

2030.0201 Parents and Other Caretaker Relatives (MFAM)
Parents (including step-parents), caretaker relatives, and spouses living together may receive Medicaid coverage when household income is equal to or below the appropriate income limit.

2430.0100 INCOME LIMITS (MFAM)
Eligibility for Medicaid is determined by comparing the SFU's countable income to the appropriate income standard. Refer to Appendix A-7 for the standard tables.

2430.0204 Determining Monthly Income (MFAM)
Several factors are involved in determining a gross amount of monthly income to be budgeted. These are anticipating and projecting income, averaging income, and converting the income to a monthly amount. When income is received more often than monthly, it will be converted to a monthly amount. When averaging income, use the most recent consecutive four weeks or the best available information when it is representative of the individual's future income

11. Fla. Admin. Code R. 65A-1.716 Income and Resource Criteria explains:

(2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows:

Family Size	Income Level
1	$180
2	$241
3	$303
4	$364

12. Appendix A-7 of the Department's Program Policy Manual sets forth the maximum income for parents to receive full Family-Related Medicaid Program benefits, at $364 for a household size of four, and the MNIL for a household size of four at $585.00.

13. Fla. Admin. Code R. 65A-1.707 Family-Related Medicaid Income and Resource Criteria, states in part:

(1) Family-related Medicaid income is based on the definitions of income, resources (assets), verification and documentation requirements as follows:
(a) Income. Income is earned or non-earned cash received at periodic intervals from any source such as wages, self-employment, benefits, contributions, rental property, etc. Cash is money or its equivalent, such

> as a check, money order or other negotiable instrument. Total gross income includes earned and non-earned income from all sources...For Medically Needy coverage groups, the amount by which the gross income exceeds the applicable payment standard income level is a share of cost as defined in Rule 65A-1.701, F.A.C. For the CNS criteria, refer to subsection 65A-1.716(1), F.A.C. For the payment standard income levels, refer to subsection 65A-1.716(2), F.A.C.
>
> ...
>
> (2) The department considers income in excess of the medically needy income level available to pay for medical care and services. Available income from a one month period is used to determine the amount of excess countable income available to meet medical care and services. To be allowable, a paid expense may not have been previously deducted from countable income during a period of eligibility.

14. Pursuant to the above authorities, to be eligible for Family-Related Medicaid, an individual must have a minor child under 18 living in the household. Petitioner and her husband have minor children living in the home. Therefore, petitioner's husband was evaluated under the Family-Related Medicaid coverage group.

15. The authority cited sets forth the income limits for full Medicaid. The undersigned concludes petitioner's total countable gross income of $1,373.44 exceeds the $364.00 income standard for a household size of four.

16. The above authority explains that the Medically Needy Program is coverage for individuals who meet the technical requirements of the particular coverage groups but whose income exceeds the income limit.

17. According to the above authorities, the SOC is determined by subtracting the MNIL from the individual or family's income. In this case, the respondent used the petitioner's $1,373.44 household countable income less the MNIL for a family size of four, which is $585, resulting in a monthly share of cost of $788.00.

18. The evidence presented did not show petitioner's husband has been declared to be disabled; therefore, the Department correctly enrolled the petitioner's husband in the Family-Related Medically Needy Program with a SOC.

19. The undersigned concludes the Department followed its controlling authorities and policies to determine the petitioner's husband does not qualify for full Medicaid due to the household's income exceeding the income standard. The Department was correct to enroll him in the Medically Needy Program with an estimated SOC of $788.00 beginning July 2015.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and action 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 18 day of November, 2015,

in Tallahassee, Florida.

Cassandra Perez
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

APPEAL NO. 15F-07213

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 Dade
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 1, 2015, at 9:15 a.m.

APPEARANCES

For the Petitioner: [redacted] pro se

For the Respondent: Dianna Chirino, Senior Program Specialist, Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is the Agency action of August 19, 2015, through Simply Health Plan, to deny the petitioner's request for a Bariatric Surgery Procedure based on the request not being medically necessary. The burden of proof is assigned to the petitioner.

PRELIMINARY STATEMENT

Present as witnesses for the respondent were Diana Anda, Grievance and Appeals Supervisor, and Dr. Vincent Pantone, Chief Medical Officer, both from Simply Health Care. Present as an interpreter was [redacted] id number [redacted], from Propio Language Services.

The respondent submitted into evidence Respondent Composite Exhibit 1 and 2.

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 is fifty years of age and is a Managed Medical Assistance Program (MMA) recipient living in [redacted] County, Florida. Simply Health Plan is the managed care agency authorized by AHCA to provide Medicaid services.

2. The petitioner is five foot two inches tall and currently weighs about 244 pounds. Her treating physician considers her morbidly obese. On or about August 13, 2015, the petitioner's treating physician submitted a pre-authorization request to Simply Health Plan for Bariatric Surgery.

3. Simply Health Plan determined the request for the bariatric surgery was not medically necessary based on the information received. On August 19, 2015, Simply Health Care provided a Notice of Action to the petitioner stating:

> We determined that the requested services are not medically necessary because the services...
>
> Must be individualized, specific, consistent with symptoms or diagnosis or illness or injury and not in excess of the patient's needs.
>
> ....

> The facts that we used to make the decision are: Your request for bariatric surgery is denied because according to the information received you have not made a diligent effort to achieve healthy body weight. There is no documentation that you have been following a consistent medically supervised weight loss diet plan prior to the decision to operate.

4. The respondent's physician witness indicated that Simply Health uses InterQual standards in helping to determine the approval or non-approval of weight loss surgery for Medicaid recipients. He indicated there was no consistent medically supervised weight loss and exercise program that was completed for at least six months prior to considering Bariatric Surgery for the petitioner.

5. The respondent's physician witness also reiterated that all of the medical information submitted for the request for the surgery was reviewed. He indicated that the February 4, 2015 report from the petitioner's treating physician provides no clear plan or documentation for the requested surgery. He indicated that another report from the petitioner's treating physician dated March 27 2015 does not show a dietary plan with instructions for the petitioner to follow. He indicated that a May 25, 2015 note from the petitioner's physician indicates the petitioner is compliant with a diet; however, there is no evidence that the "diet" was part of a supervised weight loss program. He indicated that a July 28, 2015 form titled "Diet History" was provided; "blank", as it did not indicate any physician supervised diet for the petitioner.

6. The petitioner argued that she has physical problems, such as knee and spinal problems that make it hard for her to exercise. She argued her treating physicians have authorized the weight loss surgery. She argued that she has been trying to eat as healthy as possible. She argued that she has had problems following any diet based on her medical issues.

7. The respondent physician witness agreed that the petitioner has medically proven orthopedic issues that would prevent her from exercising. He indicated that the main eligibility criteria for weight loss surgery is related to diet, and the petitioner has not met the criteria for the weight loss surgery based on the lack of a medically supervised diet or weight loss program.

PRINCIPLES OF LAW AND ANALYSIS

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

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

10. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence as provided by Rule 65-2.060(1), Florida Administrative Code.

11. § 409.912, Fla. Stat. states, in relevant parts:

> Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program.
>
> ....
>
> (2) The agency may contract with a provider service network, which may be reimbursed on a fee-for-service or prepaid basis.

12. The Florida Medicaid Provider General Handbook, incorporated by reference in the Medicaid Services Rules under Fla. Administrative Code Chapter 59G-4, states on Page 1-27, in part:

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.

13. Fla. Admin. Code R. 59G-1.010 states:

(166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods, or services medically necessary or a medical necessity or a covered service.

14. The InterQual standards used by the Agency as a guideline states:

Before surgery is considered, patients should undergo an adequate trial of inoperative weight loss. Dieting could have occurred at any time in the course of the patient's medical management and should incorporate nutritional counseling, behavioral modification, and appropriate physical activity. The goal is weight loss of 0.5 kg/week and to reduce weight 5% to 10%.

15. As shown in the Findings of Fact, the Agency, through Simply Health Plan, determined the request for Bariatric Surgery was not medically necessary based on the information provided.

16. For the case at hand, the evidence presented does not indicate the petitioner followed or was prescribed a medically supervised weight loss program that was completed for at least six months prior to considering Bariatric Surgery; thus, the hearing officer agrees with the respondent's arguments that petitioner's request for the Bariatric Surgery did not meet medical necessity criteria. The controlling authorities make clear that services should be excluded whenever a less costly, equally effective, service can be safely furnished.

17. After considering the evidence and all of the appropriate authorities set forth in the findings above, the hearing officer affirms the Agency's action to deny the petitioner's request for the Bariatric Surgery procedure for the reason noted above. The petitioner has not met her burden of proof.

DECISION

This appeal is denied and the Agency action affirmed.

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 17th day of November, 2015,

in Tallahassee, Florida.

Robert Akel

Robert Akel
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Email: Appeal_Hearings@dcf.state.fl.us

Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

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

[redacted]

APPEAL NO. 15F-07241
15F-07284

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 20 Lee
UNIT: 88287

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on October 9, 2015 at 9:19 a.m. in Fort Myers, Florida.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Signe Jacobson, Economic Self-sufficiency Specialist II

STATEMENT OF ISSUE

The petitioner is appealing two actions taken by the Department. First, although the petitioner agrees with the amount of Food Assistance Program (FAP) benefits that the Department determined for the months from September 2015 and ongoing of $357, the petitioner disagrees with the amount of FAP benefits determined for the month of August 2015, as he believes that he is entitled to the full FAP benefit for two people of

$357. Secondly, although the petitioner agrees with the Department's determination of the Qualified Medicare Beneficiaries (QMB) Program for the months of July 2015 and ongoing, the petitioner is seeking the same benefits for the three months prior to his application for QMB benefits. The three months of QMB benefits that the petitioner is seeking are for April 2015, May 2015 and June 2015.

During the determination of which parties held the burden of proof, the undersigned determined that, in regards to the FAP benefits, the petitioner held the burden of proof. In regards to the QMB benefits, the undersigned reserved his decision as to who held the burden of proof. As both sides have presented their case, the undersigned has determined that the petitioner holds the burden of proof regarding the QMB benefits. For both issues, the petitioner is asserting the affirmative and bears the burden of proving his case by a preponderance of the evidence.

PRELIMINARY STATEMENT

This appeal had been originally scheduled for September 23, 2015 and was continued at the request of the petitioner.

The petitioner submitted seven (7) exhibits which were accepted into evidence and marked as Petitioner's Exhibits "1" through "7" respectively.

The respondent submitted twelve (12) exhibits which were accepted into evidence and marked as Respondent's Exhibits "1" through "12" respectively. The record was held open until the close of business on October 12, 2015 for the respondent to supplement the record. The petitioner declined an opportunity to review any addition evidence provided by the respondent prior to closing the record. The respondent timely provided the additional documentation, which were accepted into

evidence and marked as Respondent's Exhibits "13" through "30". The record closed on October 12, 2015.

FINDINGS OF FACT

1. On October 1, 2014, the Customer Call Center received a telephone call from the petitioner. The petitioner reported that "he is leaving the country and not sure when hes (sic) to the (sic) back." On October 2, 2014, a Notice of Case Action, for case number [redacted] was mailed to the petitioner indicating that the FAP benefits, the Medically Needy Program, and the QMB Program would end on October 31, 2014 for both the petitioner and the petitioner's wife [redacted] *See Respondent's Exhibit 30*. The reason stated on the notice, for all programs, was "(a) household member has left the home and can no longer be included in this program." The notice was mailed to the petitioner's address in [redacted]

2. The petitioner's wife returned to Florida and began receiving FAP benefits effective December 11, 2014 in case number [redacted] from an application submitted on 12/11/2014, *See Petitioner's Exhibit 7*. The ongoing FAP benefits were approved for $194 per month for the petitioner's wife.

3. Due to medical issues, he remained out of the country and resided in Egypt until July 19, 2015.

4. On July 20, 2015, the petitioner applied for the Medicaid Savings Plan (MSP) for himself via the Medicaid/Medicare Buy-in Application. He further alleged that he "checked" the box on the application that asked: Do you want eligibility determined for the three months before the month of application?"

5. MSP is a Medicaid Buy-In Program which pays for Medicare premium(s). There are three types of Buy-In Programs; of which, the QMB Program is one of them. The Department indicated that the QMB program is the only MSP program that does not allow for a three-month retroactive determination of benefits.

6. The two-person household consist of the petitioner and his wife. The petitioner, age 72, receives $929 in Social Security (SSA) benefits and he is receiving Medicare Parts A and B benefits. The Department presented a Data Exchange printout from SSA confirming the income. The petitioner's wife, age [redacted] has no income.

7. The respondent determined the petitioner's total countable income of $908 (SSA income of $928 minus the $20 unearned income disregard) did not exceed the income limit for the QMB Program of $981.

8. On July 23, 2015, a Notice of Case Action, for case number 124486063, was mailed to the petitioner indicating that the QMB benefits were approved effective July 2015 and ongoing.

9. The petitioner submitted an electronic application for FAP benefits on August 18, 2015 for case number [redacted]

10. The petitioner's wife received FAP benefits of $194 for the month of August 2015 in case number [redacted]

11. The petitioner stated that the household's shelter expenses are $825 rent and that he has utility expenses that include the ability to heat and cool.

12. On August 11, a Notice of Case Action, for case number [redacted] was mailed to the petitioner indicating that the FAP benefits of $11 were approved for August 2015 and $134 were approved for September 2015 and ongoing.

13. The petitioner timely requested a hearing on August 18, 2015 to challenge the amount of FAP benefits determined by the Department.

14. On August 21, 2015, another Notice of Case Action for case [redacted] was mailed indicating that the monthly FAP benefits would be $357 effective September 2015. The maximum monthly allotment for a two-person FAP household is $357.

15. The petitioner requested a hearing on August 25, 2015, regarding the QMB benefits.

16. On October 12, 2015, the Department determined that the petitioner was entitled to the maximum allotment of FAP benefits for two people of $357 for the month of August 2015. As there were already two FAP issuances for the household issued for the month of August 2015 ($194 (August 10, 2015 in case [redacted] *See Respondent's Exhibit 15*, and $11 (August 11, 2015 in case [redacted] an additional $152 in FAP benefits, for case 1244786063, were issued for a total of $357 for the month of August 2015, *See Respondent's Exhibit 22*. The respondent provided the Food Stamp Issuance History screens from their eligibility system, for case [redacted] and [redacted] to show that a total of $357 in FAP benefits was issued for the month of August 2015 for the household.

17. The petitioner alleges that he should still be eligible for QMB benefits as he did not have a closure notice for the QMB benefits. The petitioner submitted as evidence a page from a Notice of Case Action, date unknown that alleged he was eligible for continued benefits for the QMB Program, *See Petitioner's Exhibit 3*. The petitioner provided the first page of a Notice of Case Action, dated October 2, 2014, indicating that the FAP benefits would end on October 31, 2014. It is the same Notice

of Case Action that the Department presented showing the Medically Needy and QMB benefits would end; the notice provided information regarding the petitioner's appeal rights that included time limits for which to request an appeal. The undersigned finds that the petitioner received the Notice of Case Action that terminated the QMB benefits.

PRINCIPLES OF LAW AND ANALYSIS

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

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

Food Assistance Program

20. The FAP standards for income and deductions appear in the Department's Policy Manual, CFOP 165-22 at Appendix A-1. Effective October 1, 2014, the maximum FAP allotment for a household size of two is $357.

21. From two different FAP cases, [redacted] and [redacted] three separate deposits were made in the Electronic Benefit Transfer (EBT) account of $194, $152 and $11, for total of $357 for the month of August 2015.

22. The Code of Federal Regulations appearing in 7 C.F.R. § 273.10, "determining household eligibility and benefit levels" states in part:

> (a) Month of application—(1) Determination of eligibility and benefit levels.
> (i) A household's eligibility shall be determined for the month of application by considering the household's circumstances for the entire month of application.
> (2) *Eligibility and benefits*...

> (ii)(A) Except as provided in paragraphs (a)(1), (e)(2)(iii) and (e)(2)(vi) of this section, the household's monthly allotment shall be equal to the maximum food stamp allotment for the household's size...

23. As the Department took action to issue the maximum allotment of FAP benefits of $357 for a household of two for the month of August 2015 and this is the remedy that the petitioner was seeking, the undersigned concludes that there is no better outcome for the August 2015 FAP benefits. Therefore, the undersigned is dismissing the FAP appeal as moot.

Medicare Savings Plan

24. Fla. Admin. Code § 65-2.046 "Time Limits in Which to Request a Hearing" states:

> (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:
> (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.

25. The above authority explains that for all programs, an individual must file a request for an appeal within 90 calendar days of the date of the written notification of an action which aggrieves the petitioner. In this case, the petitioner did not request an appeal for his QMB benefits, until August 25, 2015 for the action that was taken on October 2, 2014, which was not within the specified timeframe. Therefore, the undersigned concludes that he does not have jurisdiction to rule on the petitioner's assertion that his QMB should not have been closed.

26. Fla. Admin. Code R. 65A-1.709 "SSI-Related Medicaid Coverage" states, "SSI-related Medicaid provides medical assistance to eligible individuals who are aged, blind or disabled in accordance with Titles XVI and XIX of the Social Security Act and Chapter 409, F.S."

27. The above authority sets forth that the SSI-Related Medicaid program provides medical assistance to those who are aged or disabled according to the Social Security Act.

28. Fla. Admin. Code R. 65A-1.709(9), Retroactive Medicaid, states in part:

> Retroactive Medicaid is based on an approved, denied, or pending application for ongoing Medicaid benefits.
> (a) Retroactive Medicaid eligibility is effective no later than the third month prior to the month of application for ongoing Medicaid if the individual would have been eligible for Medicaid at the time of application for Medicaid covered services... However, **Qualified Medicare Beneficiaries (QMB's) are not eligible for retroactive Medicaid benefits under the QMB coverage group as indicated in 42 U.S.C. § 1396a(e)(8). (emphasis added)**

29. 42 U.S.C. § 1396a, State plans for medical assistance, states in part:(e)(8):

> (8) If an individual is determined to be a qualified medicare beneficiary (as defined in section 1396d(p)(1) of this title), such determination shall apply to services furnished after the end of the month in which the determination first occurs.

30. Regarding retroactive Medicaid benefits, the Department's Program Policy Manual, CFOP 165-22, passage 0640.0509 states "(t)his policy does not apply to QMB. Medicaid is available for any one or more of the three calendar months preceding the application month..."

31. The above authority explains that an individual who is eligible for QMB benefits is not entitled to retroactive Medicaid benefits for the three months prior to the month of application.

32. As the petitioner's eligibility determination for QMB benefits was inititiated from a Medicaid/Medicare Buy-in Application dated in July 2015, the earliest month of eligibility for MSP benefits from that application would be July 2015 and there are no provisions for retroactive Medicaid benefits, the undersigned concludes that the Department's action to begin the QMB benefits in July 2015 was correct.

DECISION

Based upon the foregoing Findings of Facts and Principles of Laws and Analysis, the FAP appeal is dismissed as moot and the MSP appeal is denied.

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 2nd day of November, 2015,

in Tallahassee, Florida.

Raymond Muraida
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Email: Appeal_Hearings@dcf.state.fl.us

Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 66032

RESPONDENT.
_____/

APPEAL NO. 15F-07270

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on September 22, 2015 at 2:15 p.m.

APPEARANCES

For the petitioner: [redacted] pro se

For the respondent: Randy Bright, ACCESS Supervisor

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to terminate her Transitional Medicaid Program benefits effective July 31, 2015 and to enroll her in the Medically Needy (MN) Program with a share of cost (SOC) amount of $819.00 beginning August 2015. Petitioner is seeking full Medicaid for herself. The respondent carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

By notice dated June 26, 2015, the respondent notified the petitioner that her full Medicaid would end on July 31, 2015 and that she would be enrolled in the MN Program with an $819.00 SOC beginning August 2015.

Ilda Marrero, ACCESS Senior Specialist, translated the proceedings. Hearing Officer Raymond Muraida appeared as an observer.

Petitioner did not submit any exhibits. Respondent submitted three exhibits, entered as Respondent Exhibits "1" through "3". The record was held open until close of business on October 1, 2015 for submission of additional evidence from the respondent. On September 22, 2015, additional evidence was received and entered as Respondent Exhibit "4". The record closed on October 1, 2015.

FINDINGS OF FACT

1. Prior to the action under appeal, petitioner [redacted] was receiving Transitional (full) Medicaid Program benefits for herself and her child, age [redacted] Medicaid for the petitioner's child is not an issue.

2. Petitioner submitted an application on June 18, 2015 to recertify for Food Assistance and Medicaid Program benefits. As part of the eligibility process, the petitioner submitted her two most recent paystubs to verify her income. Petitioner submitted the following paystubs to the respondent: May 15, 2015, gross pay $684.25 and May 29, 2015, gross pay $763.94. Petitioner receives her paystubs bi-weekly. The petitioner's monthly income was $1,448.19 ($684.25 + $763.94). However, the respondent calculated her household income as $1,206.18 and used this amount in the Medicaid budget. It is unknown how the respondent arrived at $1,206.18.

3. The respondent compared the household income ($1,206.18) to the $241.00 income limit for a household size of two to determine if petitioner was eligible for full Medicaid. As the household income exceeded the income limit ($241.00) for full Medicaid, the respondent determined she was not eligible for full Medicaid and enrolled the petitioner in the MN Program with a SOC.

4. To determine the SOC amount, the respondent determined the Medically Needy Income Level (MNIL) for a household size of two was $387.00, this amount was subtracted from the gross monthly income of $1,206.18, resulting in a SOC amount of $819.00.

[redacted]

EARNED INCOME:+	1206.18	SFU SIZE:	2
UNEARNED INCOME:+	.00	INCOME STANDARD:	.00
TOTAL REPORTED INCOME:=	1206.18	MNIL:-	387.00
ALLOWABLE TAX DEDUCTIONS:-	.00	SHARE OF COST:=	819.00
MODIFIED ADJUSTED GROSS INC:=	1206.18	MED INSURANCE PREMIUM:-	.00
STANDARD DISREGARD:-	.00	RECURRING MED EXPENSE:-	.00
MAGI DISREGARD(5% OF FPL):-	.00	REMAINING SOC:=	819.00
COUNTABLE NET INCOME:=	1206.18	COUNT OF OOTHS:	0

AG HAS PASSED THE FAM RELATED MEDICAID/MED NEEDY BENEFIT DETERMINATION BUDGET

5. The petitioner did not dispute any of the facts presented by the respondent. She acknowledged her income. The petitioner did not understand why her full Medicaid was terminated when her income has not changed.

6. The respondent explained that the household had already received 12 months of Transitional Medicaid Program benefits from July 2014 through July 2015; therefore, the petitioner was no longer eligible for full Medicaid benefits.

7. On June 26, 2015, the respondent sent the petitioner a Notice of Case Action terminating the Transitional Medicaid Program benefits effective July 31, 2015.

CONCLUSIONS OF LAW

8. 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 Fla. Stat. § 409.285.

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

10. The Fla. Stat. § 445.029, Transitional medical benefits, sets forth,

"(1) A family that loses its temporary cash assistance due to earnings shall remain eligible for Medicaid without reapplication during the immediately succeeding 12-month period..."

11. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 2030.0203, Transitional Coverage (MFAM), states:

> Transitional coverage provides extended coverage for up to 12 months, beginning with the month of ineligibility. Changes during this period, other than the child turning 18 or loss of state residence, do not affect the transitional Medicaid period. An ex parte determination must be completed prior to cancellation and a notice sent when the parents and other caretaker relatives and/or children included in the assistance group becomes ineligible due to the following reasons:
> 1. initial receipt of earned income of the parent or caretaker relative, or
> 2. receipt of increased earned income of the parent or caretaker relative.
> Conditions that must be met:

1. The parents and other caretaker relatives assistance group must be ineligible for Medicaid as parents and other caretaker relatives based on initial receipt of earned income or receipt of increased earned income by the parent or caretaker relative. If more than one budget change is being acted on at the same time, a test budget(s) will be necessary to determine if the change in earned income is the sole cause of ineligibility.
2. At least one member of the assistance group was eligible for and received Medicaid in at least three of the preceding six months. The three months can include one month in which Medicaid was received in another state, or a retroactive month. All SFU members are eligible, even if they were not a part of the original assistance group.

12. Fla. Admin. Code R. 65A-1.716 Income and Resource Criteria states in part:

(2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows:

Family Size	Income Level
1	$180
2	$241

13. Fla. Admin. Code R. 65A-1.702, Special Provisions, states in relevant part:

(4) Ex Parte Process.
(a) When a recipient's eligibility for Medicaid ends under one or more coverage groups, the department must determine their eligibility for medical assistance under any other Medicaid coverage group(s) before terminating Medicaid coverage. Both family-related Medicaid and SSI-related Medicaid eligibility are determined based on available information. If additional information is required to make an ex parte determination, it can be requested from the recipient, or, for SSI-related Medicaid eligibility, from the recipient or from the Social Security Administration.
(b) All individuals who lose Medicaid eligibility under one or more coverage groups will continue to receive Medicaid until the ex parte redetermination process is completed. If the department determines that the individual is not eligible for Medicaid, the individual will be sent a notice to this effect which includes appeal rights. The individual may appeal the decision and, if requested by the individual within 10 days of the decision being appealed, Medicaid benefits will be continued pending resolution of the appeal.

14. Fla. Admin. Code R. 65A-1.707 Family-Related Medicaid Income and Resource Criteria., addresses Medically Needy and states in part:

> (1) Family-related Medicaid income is based on the definitions of income, resources (assets), verification and documentation requirements as follows.
> (a) Income. Income is earned or non-earned cash received at periodic intervals from any source such as wages, self-employment, benefits, contributions, rental property, etc. Cash is money or its equivalent, such as a check, money order or other negotiable instrument. Total gross income includes earned and non-earned income from all sources. To be financially eligible for family-related Medicaid, except for Medically Needy coverage, the coverage group's gross income...cannot exceed the consolidated need standard (CNS) (100% of the federal poverty level). For Medically Needy coverage groups, the amount by which the gross income exceeds the applicable payment standard income level is a share of cost as defined in Rule 65A-1.701, F.A.C. For the CNS criteria, refer to subsection 65A-1.716(1), F.A.C. For the payment standard income levels, refer to subsection 65A-1.716(2), F.A.C.

15. Petitioner's Transitional Medicaid Program benefits were authorized for twelve (12) months. The petitioner lost full Family-Related Medicaid coverage because her household's income exceeds program income limitations.

16. The above authority explains that when Medicaid ends under one or more coverage groups, the Department is to determine eligibility under any other possible coverage groups before terminating Medicaid benefits. The petitioner's child remained eligible for full Medicaid; therefore, the Department approved full Medicaid for the child. The respondent determined the petitioners' household income as $1,206.18 which exceeded the $241.00 full Medicaid income limit: therefore, petitioner was not eligible for full Medicaid. The next option, which was available to the petitioner, was to review her eligibility under the Medically Needy Program.

17. The above authority explains Medically Needy provides coverage for individuals who do not qualify for full Medicaid due to income.

18. The Policy Manual Appendix A-7, Family-Related Medicaid Income Limits chart sets forth a $387.00 MNIL for a household size of two.

19. The respondent subtracted the $387.00 MNIL from $1,206.18 to arrive at an $819.00 estimated SOC amount for the petitioner.

20. In careful review of the evidence and cited authorities, the undersigned concludes that the respondent's action to terminate the Transitional Medicaid Program benefits effective July 31, 2015 was within the rules and regulations of the Program. The undersigned also concludes that the Department correctly evaluated the petitioner for the Medically Needy Program effective August 2015 as her household income exceeded the income limit for full Medicaid.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the Department's action is 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 20 day of November, 2015,

in Tallahassee, Florida.

Cassandra Perez

Cassandra Perez
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

APPEAL NO. 15F-07322

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPT OF CHILDREN AND FAMILIES
CIRCUIT: 11 DADE
UNIT: 88601

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 26th, 2015 at 8:30 a.m.

APPEARANCES

For the Petitioner: [redacted] pro se.

For the Respondent: Olivia Milian Rodriguez, Economic Self-Sufficiency Supervisor

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to terminate her Medically Needy benefits. The respondent carries the burden of proving its position in this appeal by a preponderance of the evidence.

PRELIMINARY STATEMENT

Petitioner's Exhibits 1 and 2 were moved into evidence.

The respondent did not submit any documents into evidence.

By way of a Notice of Case Action dated June 30th, 2015, the respondent informed the petitioner that her Medically Needy benefits would end on July 31st, 2015. On August 26th, 2015, the petitioner filed a timely appeal to challenge this action.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner was enrolled in the Medically Needy program with an assigned share of cost.

2. The petitioner turned [redacted] years of age on [redacted] The petitioner is not disabled. These facts are undisputed.

3. The respondent contends that as the petitioner was now [redacted] years of age, the petitioner no longer met the age requirement as of June 1st, 2015.

4. The petitioner went to the hospital emergency room on July 2nd, 2015 and incurred two hospital bills for services totaling $1,151 (petitioner's exhibit 2, pages 6 and 7 of the exhibits.) The petitioner submitted these bills to the respondent in order to determine if her assigned share of cost had been met, and to determine if eligibility for July could therefore be established. The petitioner asserts that action should be taken on these bills, as the June 30th, 2015 Notice of Case Action indicates that her eligibility

will end on July 31st, 2015. The petitioner asserts that because she is an unemployed full-time college student, she cannot afford the expense of the bills on her own.

5. The respondent acknowledged its error in not terminating the petitioner's enrollment in the Medically Needy program timely; specifically, May 31st, 2015. The respondent explained that because the petitioner was no longer eligible for Medicaid as of June 1st, 2015, the respondent could not establish eligibility for July 2015.

PRINCIPLES OF LAW AND ANALYSIS

6. The Department of Children and Families Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to §120.80, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

7. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

8. The Family-Related Medicaid Coverage groups listed in Fla. Admin. Code R. 65A-1.703 addresses potential Medicaid eligibility from the presence of a child living in the home, or a pregnant woman. Paragraph (1) of this rule provides potential eligibility for Medicaid for "children under the age of 21" as follows:

> 65A-1.703 Family-Related Medicaid Coverage Groups.
>
> (1) The department provides mandatory Medicaid coverage for individuals, families and children described in Section 409.903, F.S., Section 1931 of the Social Security Act and other relevant provisions of Title XIX of the

> Social Security Act. The optional family-related Title XIX and Title XXI coverage groups served by the department are stated in each subsection of this rule.
>
> (a) Children under the age of 21 living with a specified relative who meet the eligibility criteria of Title XIX of the Social Security Act. Included in this coverage group are children who are under age 21 in intact families, provided that the children are living with both parents, unless a parent is temporarily absent from the home.

9. The above rule does provide potential Family-Related Medicaid coverage group for a child under age 21, but not age 21 and over. The Department's Public Assistance Program Policy manual passage1430.0500 echoes this age requirement as follows:

> Children in the assistance group must meet requirements for the factor of age in order for the assistance group to be eligible. A child must be under age 21 to be eligible for assistance.

10. Based on the above-cited authorities, the hearing officer concludes that the petitioner was no longer eligible for Medicaid effective June 2015, which was the first full month in which she was [redacted] years of age. The petitioner's arguments regarding the respondent's allowing Medically Needy benefits to continue for two months after she was no longer eligible were noted. The hearing officer recognizes that written notice was issued to the petitioner indicating that she remains eligible for these benefits through July 31st, 2015. However, the hearing officer does not have the authority to order the respondent to establish eligibility for any month in which eligibility cannot be established. Therefore, this appeal is hereby denied.

DECISION

Based on the foregoing Findings of Fact and Principles of Law, this appeal is denied. The respondent's action is 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 indigence to waive those fees. The Department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 24 day of November, 2015, in Tallahassee, Florida.

Justin Enfinger

Justin Enfinger
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

PETITIONER,

APPEAL NO. 15F-07361

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 10 Polk
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice and agreement, Hearing Officer Patricia C. Antonucci convened hearing in the above-captioned matter on November 2, 2015 at approximately 2:00 p.m. All parties and witnesses appeared via teleconference.

APPEARANCES

For the Petitioner: [redacted] Petitioner's mother

For the Respondent: Stephanie Lang, Registered Nurse Specialist,
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is a decision by Respondent, the Agency for Health Care Administration (AHCA), through its contracted peer review organization, eQHealth Solutions, Inc., to terminate Petitioner's Prescribed Pediatric Extended Care (PPEC) services. Respondent bears the burden of proving, by a preponderance of the evidence, that said termination is proper.

PRELIMINARY STATEMENT

Prior to hearing on the merits, a preliminary hearing convened via teleconference at approximately 2:00 p.m. on October 7, 2015 to determine whether Petitioner's benefits would continue pending outcome of Petitioner's appeal. After it was established that the benefit would, indeed, continue, the parties agreed to proceed to final hearing on November 2, 2015.

At hearing on November 2, 2015, the minor Petitioner was not present, but was represented by her mother, [redacted] Respondent was represented by Stephanie Lang, RN, on behalf of AHCA. Respondent presented one additional witnesses: Rakesh Mittal, M.D., Physician Reviewer with eQHealth Solutions (eQHealth).

Respondent's Exhibits 1 through 6, inclusive, were admitted into evidence. Administrative Notice was taken of Fla. Stat. § 409.905, Fla. Admin. Code R. 59G-1.001, Fla. Admin. Code R. 59G-1.010, Fla. Admin. Code R. 59G-4.260, and pertinent pages of the September 2013 Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook (PPEC Handbook).

FINDINGS OF FACT

1. The Petitioner is a 2-year old female, born August 28, 2013. She was born premature at 27-28 weeks gestation, and had a g-tube placed for feeding. The g-tube has since been removed, and Petitioner is on a regular diet. She is diagnosed with [redacted]

2. Petitioner is and has been eligible to receive Medicaid services at all times relevant to these proceedings.

3. On or about May 21, 2015, Petitioner's PPEC provider submitted a request on behalf of the Petitioner, to continue her previously authorized PPEC services (full day Monday through Friday, partial day some Saturdays) into her new certification period, spanning June 4, 2015 through November 30, 2015.

4. This prior service authorization request was submitted to AHCA's peer review organization (PRO), along with information and documentation required to make a determination of medical necessity. The PRO contracted by AHCA to review PPEC requests is eQHealth Solutions, Inc. (eQHealth).

5. On May 27, 2015, the PRO reviewed Petitioner's request for services and all supporting documentation. By letter dated May 28, 2015, the PRO notified Petitioner's provider of its decision to terminate PPEC, stating, in pertinent part:

> PR Principal Reason – Denial: Requested services are denied because the clinical information does not support the medical necessity.
>
> The patient is a 21 month old with a history of prematurity, asthma, and gastro esophageal reflux. The clinical information provided does not appear to supports [*sic*] skilled nursing interventions and does not meet the medical complexity requirement of PPEC services. The additional services are not approved: denied[.]

6. The May 28, 2015 denial letter sent to Petitioner did not include this explanation, noting only:

> The reason for the denial is that the services are not medically necessary as defined in 59G-1.010 (166), Florida Administrative Code (F.A.C.), specifically the services must be:
> Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.

> Reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.

7. On or about August 27, 2015, Petitioner requested a hearing to challenge this denial.

8. Per AHCA and eQHealth, Petitioner's services have continued pending the outcome of her appeal.

9. At hearing, Dr. Mittal testified based upon his review of Petitioner's request for services, in conjunction with her Plan of Care and some progress notes.

10. Petitioner's Plan of Care reflects that she is totally dependent on others for activities of daily living (ADL) care. While she requires precautions/monitoring, the only interventions indicated on the Plan are the administration of a nebulizer, as needed, and use of ambu-bag, in case of emergency. The "Current Medical Condition" portion of Petitioner's Plan states that she is monitored for respiration, reflux, and potential for aspiration due to [redacted] It also notes that she receives Speech Therapy (ST) while at PPEC and has recently been evaluated for Occupational Therapy (OT).

11. It is Dr. Mittal's opinion that at this time, Petitioner does not require skilled nursing interventions on a regular basis. Per Dr. Mittal, Petitioner's need for ADL care is consistent with her age, and ST and OT can be provided as distinct services, outside of the PPEC program.

12. Petitioner's mother confirmed that Petitioner's medications are provided on an as-needed basis, with the exception of her Pulmicort (twice per day), vitamins, and

Singulair. She is concerned because she has been unable to find a non-PPEC daycare that will administer medications to the Petitioner, or provide Albuterol, if needed.

13. The Agency noted that because Petitioner is enrolled with Children's Medical Services (CMS), she should have a CMS case manager who can assist Petitioner's mother in finding appropriate day care options.

CONCLUSIONS OF LAW

14. By agreement between AHCA and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction to conduct this hearing, pursuant to Florida Statutes Chapter 120.

15. Respondent, the Agency for Health Care Administration, administers the Medicaid Program. Legal authority governing the Florida Medicaid Program is found in Fla. Stat., Chapter 409, and in Chapter 59G of the Florida Administrative Code.

16. The September 2013 Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook (PPEC Handbook) has been promulgated into rule by Fla. Admin. Code R. 59G-4.260.

17. This is a Final Order, pursuant to § 120.569 and § 120.57, Fla. Stat.

18. This hearing was held as a *de novo* proceeding, in accordance with Fla. Admin. Code R. 65-2.056.

19. The burden of proof in the instant case is assigned to Respondent, who seeks to terminate Petitioner's PPEC services. The standard of proof in an administrative hearing is preponderance of the evidence. (See Fla. Admin. Code R. 65-2.060(1).)

20. Fla. Stat. § 409.905 addresses mandatory Medicaid services under the State Medicaid Plan:

> Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law....
> (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.—The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

21. Page 1-1 of the PPEC Handbook notes that, "[t]he purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) Services Program is to enable recipients under the age of 21 years with medically complex conditions to receive medical and therapeutic care at a non-residential pediatric center."

22. On page 2-1 – 2-2, the PPEC Handbook lists the requirements for PPEC services.

> To receive reimbursement for PPEC services, a recipient must meet all of the following criteria:
> - Be Medicaid eligible.
> - Diagnosed with a medically-complex or medically fragile condition as defined in Rule 59G-1.010, F.A.C.
> - Be under the age of 21 years.
> - Be medically stable and not present significant risk to other children or personnel at the center.
> - Require short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care due to a medically-complex condition.

23. Fla. Admin. Code R. 59G-1.010 defines "medically complex" and "medically fragile" as follows:

> (164) "Medically complex" means that a person has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention.
> (165) "Medically fragile" means an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, e.g., requires total parenteral nutrition (TPN), is ventilator dependant, or is dependent on a heightened level of medical supervision to sustain life, and without such services is likely to expire without warning.
> (emphasis added)

24. Consistent with the law, AHCA's agent, eQHealth, performs service authorization reviews under the Prior Authorization Program for Medicaid recipients in the state of Florida. Once eQHealth receives a PPEC service request, its medical personnel conduct file reviews to determine the medical necessity of requested services, pursuant to the authorization requirements and limitations of the Florida Medicaid Program.

25. Fla. Admin. Code Rule 59G-1.010(166) defines medical necessity, as follows:

> "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and

> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. ...
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

26. As the petitioner is under the age of 21, a broader definition of medically necessary applies, to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) requirements. Both EPSDT and Medical Necessity requirements (both cited, above) have been considered in the development of this Order.

27. EPSDT augments the Medical Necessity definition contained in the Florida Administrative Code via the additional requirement that all services determined by the agency to be medically necessary for the *treatment, correction, or amelioration* of problems be addressed by the appropriate services.

28. United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in Moore v. Reese, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, (which involved a dispute over private duty nursing):

> (1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.
> (2) A state Medicaid plan must include "reasonable standards ... for determining eligibility for and the extent of medical assistance" ... and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.
> (3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid

> services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."
> (4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."
> (5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to provide medically unnecessary, albeit desirable, EPSDT services. However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."
> (6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and my present its own evidence of medical necessity in disputes between the state and Medicaid patients (citations omitted).

29. In the instant case, PPEC is requested to treat and ameliorate the supervisory and monitoring needs which Petitioner's health conditions require. As such, in a general sense, PPEC is in keeping with Fla. Admin. Code R. 59G-1.010(166)(1). Because PPEC is a recognized Medicaid service, it is consistent with generally accepted medical standards, per Fla. Admin. Code R. 59G-1.010(166)(3).

30. More specifically, however, Fla. Admin. Code R. 59G-1.010(166) also requires that any authorized service not be in excess of a patient's needs, be furnished in a manner not intended for convenience, and be a service for which no equally effective and less-costly treatment is available. In order for PPEC to fulfill these criteria, the Petitioner must meet the requirements for PPEC, as provided in the PPEC Handbook.

31. There is little evidence to suggest that the Petitioner is dependent upon 24-hour per day medical or nursing care, or that she is dependent upon life-sustaining medical intervention or equipment, such that she would properly be deemed "Medically Complex" or "Medically Fragile." Her need for supervision, general monitoring, and precautions do not constitute a need for "intermittent continuous therapeutic interventions or skilled nursing care."

32. Tellingly, there is currently no skilled therapy or intervention provided to Petitioner at the PPEC site. While the PPEC program is "hosting" ST services, these services, as well as OT and any other needed therapy, can be authorized as distinct services, outside the PPEC environment. Petitioner is encouraged to pursue coordination of same.

34. When jointly considering the requirements of both ESPDT and Medical Necessity, along with a review of the totality of the evidence and legal authority, the undersigned concludes that Respondent has met its burden of proof to terminate PPEC.

36. Petitioner's mother is further encouraged to coordinate with AHCA and Petitioner's CMS case manager, to determine her options for day care, or any other service to meet Petitioner's needs. Should Petitioner request a service and receive a notice denying same, she will retain the right to appeal that/those, specific denial(s).

DECISION

Based upon the foregoing, 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 28 day of December, 2015,

in Tallahassee, Florida.

Patricia C. Antonucci
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Don Fuller, Area 6, AHCA Field Office Manager

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

[redacted]

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 20 Lee
UNIT: AHCA

RESPONDENT.
_____/

APPEAL NO. 15F-07364

CASE NO.

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter telephonically on October 22, 2015, at 3:20 p.m.

APPEARANCES

For the Petitioner: [redacted]
Petitioner's mother

For the Respondent: Patricia Brooks
Program Administrator
Agency for Health Care Administration

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the Agency for Health Care Administration incorrectly denied his request to remove his wisdom teeth?

PRELIMINARY STATEMENT

[redacted] the petitioner's mother, appeared on behalf of the petitioner, [redacted] ("petitioner"), who was not present. [redacted] appeared as a witness for the petitioner. [redacted] may sometimes hereinafter be referred to as the petitioner's "representative". [redacted] Interpreter [redacted] with Propio Language Services, provided Spanish-English translation for the hearing.

Patricia Brooks, Program Administrator with the Agency for Health Care Administration ("AHCA" or "Agency"), appeared on behalf of the Agency for Health Care Administration. The following individuals appeared as witnesses on behalf of the Agency: Alta Recio, Coordinator at Staywell; Alexandria Hicks, Senior Grievance Coordinator at Staywell; Stephanie Shupe, Senior Grievance Coordinator at Staywell; and John Singer, D.D.S., State of Florida Director for Liberty Dental Plan. Gregory Watson, a Hearing Officer with the Office of Appeal Hearings, was present solely for the purpose of observation.

The respondent introduced respondent's Exhibits "1" through "5", inclusive, at the hearing, all of which were accepted into evidence and marked accordingly. The hearing record in this matter was left open until the close of business on October 29, 2015 for the respondent to provide a copy of the prior authorization request from the petitioner's dentist. Once received, this information was accepted into evidence and marked as respondent's Exhibit "6". The hearing record was then closed.

At the respondent's request, the hearing officer took administrative notice of the Dental Services Coverage and Limitations Handbook.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. Petitioner is a minor male.

2. Petitioner was eligible to receive Medicaid services at all times relevant to this proceeding.

3. Petitioner is an enrolled member of Staywell. Staywell is a health maintenance organization ("HMO") contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in Florida.

4. Petitioner's effective date of enrollment with Staywell was June 1, 2014.

5. Staywell provides certain dental benefits to its members. With regard to its members under age 21, these benefits include the surgical extraction of wisdom teeth when such medical intervention is determined to be medically necessary.

6. Staywell has contracted Liberty Dental to be its dental vendor. Liberty Dental completes prior authorization reviews of requests for dental services submitted to it by Staywell members.

7. On or about June 30, 2015, the petitioner's dental provider submitted a prior authorization request to Liberty Dental for the following services:

1. Surgical removal of erupted tooth #17;
2. Removal of impacted tooth – partially bony #32;
3. Surgical removal of erupted tooth #1;
4. Surgical removal of erupted tooth #16;
5. Other drugs and/or medicaments, by report #Q3C;
6. Other drugs and/or medicaments, by report #Q4C;
7. Intravenous moderate (conscious) sedation/analgesia – first 30 minutes;
8. Inhalation of nitrous oxide/analgesia, anxiolysis.

8. In a Notice of Action dated July 2, 2015, Staywell informed the petitioner it was denying his request for the removal of his wisdom teeth. The Notice of Action provides the following explanation for the denial of each of the line items referenced in the preceding paragraph:

# 7	This service cannot be authorized because it is related to a denied procedure in the same treatment plan submitted by your dentist.
# 1, 2, 3, 4	Removal of asymptomatic (healthy) tooth/teeth is not a covered benefit.
# 8	This procedure is considered to be a part of an included in a more inclusive procedure. No additional payment or benefit is available.
# 5, 6	This procedure is not listed as covered by the plan. Please refer to the Evidence of Coverage (EOC) booklet or Schedule of Benefits for details or you may call us for additional information.

9. Teeth # 1, 16, 17, and 32 are an individual's wisdom teeth. They are the last teeth on both the left and right sides of both the top and bottom jaw.

10. The petitioner's dentist included a panoramic x-ray of the petitioner's mouth along with the prior authorization request for the removal of the petitioner's wisdom teeth.

11. The documentation submitted by the petitioner's dentist does not indicate pathology or disease associated with any of the petitioner's wisdom teeth.

12. The documentation submitted by the petitioner's dentist does not indicate any of the petitioner's wisdom have cavities.

13. The petitioner's dentist did not include a narrative along with the prior authorization request explaining the necessity for the removal of the wisdom teeth.

CONCLUSIONS OF LAW

14. By agreement between the Agency for Health Care Administration and the Department of Children and Families, the Agency for Health Care Administration has

conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80, Fla. Stat.

15. This is a final order pursuant to § 120.569 and § 120.57, Fla. Stat.

16. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

17. In the present case, the petitioner is requesting an additional service. Therefore, in accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof is assigned to the petitioner.

18. 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.).

19. The Florida Medicaid program is authorized by Chapter 409, Fla. Stat. and Chapter 59G, Fla. Admin. Code. The Medicaid program is administered by respondent.

20. Section 409.905, Fla. Stat. addresses mandatory Medicaid services under the State Medicaid Plan:

> Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law…

21. The definition of medically necessary is found in the Fla. Admin Code. R. 59G-1.010, which states:

> (166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:

> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider…
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

22. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Chapter 59G-4. The Handbook states the following on Page 1-27:

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.
>
> Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

23. Page 1-28 of the Florida Medicaid Provider General Handbook provides a list of HMO covered services. Page 1-30 of the Handbook explains "Other services that plans may provide include dental services, transportation, nursing facility and home and community-based services."

24. Page 1-30 of the Florida Medicaid Provider General Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

25. The Dental Services Coverage and Limitations Handbook – November 2011 is incorporated by reference in the Medicaid Service Rules by Fla. Admin. Code Rule 59G-4.060.

26. The Dental Services Coverage and Limitations Handbook addresses Covered Child Services (Ages under 21) on Page 2-3 and states as follows:

> The Medicaid children's dental services program may provide reimbursement for diagnostic services, preventive treatment, restorative, endodontic, periodontal, surgical procedures and extractions, orthodontic treatment, and full and partial dentures (fixed and removable) for recipients under age 21.

The removal of wisdom teeth falls under the category of surgical procedures and extractions.

27. The Dental Services Coverage and Limitations Handbook describes Oral Surgery Services on Page 2-13. It explains as follows:

> Oral surgery services include extractions as well as surgical and adjunctive treatment of diseases, injuries, deformities, and defects of the oral and maxillofacial regions.

28. The Staywell Member Handbook explains that Staywell will approve oral surgery for children under age 21. Staywell dental policy is not more restrictive than that of the Agency for Health Care Administration.

29. The petitioner did not provide information documenting the need for the removal of any of his four wisdom teeth. The information submitted by the petitioner's dentist does not indicate any of the four wisdom teeth have pathology or cavities which

would necessitate their removal. The petitioner's dentist also did not include a narrative explaining the medical necessity for the removal of the wisdom teeth.

30. The petitioner has not shown by a preponderance of the evidence that the respondent incorrectly denied his request for the removal of his wisdom teeth.

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 24 day of November, 2015,

in Tallahassee, Florida.

Peter J. Tsamis

Peter J. Tsamis
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Dietra Cole, Area 8, AHCA Field Office Manager

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

FILED
Nov 25, 2015
Office of Appeal Hearings
Dept. of Children and Families

[redacted]

APPEAL NO. 15F-07366

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 10 Polk
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 1, 2015, at 1:00 p.m.

APPEARANCES

For the Petitioner: [redacted] the petitioner's mother.

For the Respondent: Stephanie Lang, Registered Nurse Specialist, Agency for Health Care Administration (AHCA).

STATEMENT OF ISSUE

At issue is whether the Agency action of August 4, 2015 cancelling the petitioner's request for continued Prescribed Pediatric Extended Care Services (PPEC) is correct. The respondent has the burden of proof.

PRELIMINARY STATEMENT

Present as a witness for the respondent was Dr. Darlene Calhoun, Physician Reviewer, eQHealth Solutions.

The respondent submitted into evidence Respondent's Exhibits 1 through 3.

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, who is one-and-a half years of age, was born prematurely with a history of [redacted] and requires an evaluation for services as provided by the Agency for Health Care Administration (AHCA) under Florida's Medicaid State Plan. The petitioner's condition(s) is further outlined in Respondent Exhibit 1. AHCA will be further addressed as the "Agency."

2. eQHealth Solutions has been authorized to make Prior (service) Authorization decisions for the Agency. The Prior Authorization review is completed by board-certified pediatricians with eQHealth Solutions. On August 4, 2015, eQHealth Solutions denied the petitioner's request for continued Prescribed Pediatric Extended Care Services (PPEC) but approved a thirty (30) day extension in order for the petitioner to transition to alternative care. The petitioner timely requested this hearing and the PPEC services were continued.

3. According to the August 4, 2015 notice, the principal reason for the decision was the clinical information provided did not support the medical necessity of the requested services. The notice provided the following clinical rationale for the decision:

> The patient is a 1 year old with a history of prematurity (31 weeks), [redacted] The patient is ambulatory and on an age appropriate diet. The patient receives as needed nebulizer treatments but not has required any regular intermittent administration of these treatments. The clinical information provided does not support the medical necessity of the requested services. However, 30 days will be approved to transition the patient out of PPEC. The clinical information provided does not support the medical necessity of the additional services. The patient appears to no longer require skilled nursing services and does not meet the medical complexity requirements of PPEC services. The additional services are deemed excessive.

4. No reconsideration review was requested by the petitioner or the petitioner's provider.

5. The respondent physician witness reiterated the decision for this case is correct and agrees with the issued notice. She emphasized the petitioner's medical conditions do not require the constant nursing care being provided at PPEC.

6. The petitioner's representative argued the petitioner still has developmental issues. She argued the petitioner will benefit from continued PPEC services as he has speech/language problems.

7. The respondent witness countered that the need of speech therapy does not constitute an eligibility criteria for PPEC services. She indicated the petitioner can remain receiving speech therapy outside of PPEC. She also indicated that she reviewed this case under EPSDT guidelines and concluded petitioner does not meet the medical necessity definition to receive PPEC services.

PRINCIPLES OF LAW AND ANALYSIS

8. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to

§ 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

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

10. In accordance with Fla. Admin. Code R. 65-2.060 (1), the party having the burden shall establish his/her position by a preponderance of the evidence, to the satisfaction of the hearing officer.

11. Fla. Admin. Code R. 59G-1.010 states in part:

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
>
> (a) Meet the following conditions:
>
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
>
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
>
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
>
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;
>
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service…

12. The State Medicaid Manual in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services section states in part:

> *5010. Overview*
>
> *A. Early and Periodic Screening, Diagnostic and Treatment Benefit.-- Early and periodic screening, diagnostic and treatment services (EPSDT) is a required service under the Medicaid program for categorically needy individuals under age 21…*
>
> *5110. Basic Requirements*
>
> *OBRA 89 amended §§1902(a)(43) and 1905(a)(4)(B) and created §1905(r) of the Social Security Act (the Act) which set forth the basic requirements for the program. Under the EPSDT benefit, you[1] must provide for screening, vision, hearing and dental services at intervals which meet reasonable standards of medical and dental practice established after consultation with recognized medical and dental organizations involved in child health care. You must also provide for medically necessary screening, vision, hearing and dental services regardless of whether such services coincide with your established periodicity schedules for these services. Additionally, the Act requires that any service which you are permitted to cover under Medicaid that is necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be provided to EPSDT participants regardless of whether the service or item is otherwise included in your Medicaid plan.*

13. Fla. Stat. § 409.913 addresses "Oversight of the integrity of the Medicaid program," with (1)(d) describing "medical necessity or medically necessary" standards and saying in relevant part: "For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity." As stated above, this proceeding is a de novo proceeding for the purpose of the Agency reaching its final decision. The final decision making authority for this proceeding has been delegated to the hearing officer in Fla. Admin. Code R. 65-2.066.

---

[1] "You" in this manual context refers to the state Medicaid agency.

14. The Prescribed Pediatric Extended Care Services Coverage and Limitation Handbook has been promulgated into rule in the Florida Administrative Code at 59G-4.260 (2). The Prescribed Pediatric Extended Care Services Coverage and Limitation Handbook, September 2013, on page 1-1, states:

> The purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) services is to enable recipients under the age of 21 years with medically-complex conditions to receive medical and therapeutic care at a non-residential pediatric center.

15. The Prescribed Pediatric Extended Care Services Coverage and Limitation Handbook, September 2013, on page 2-1, provides standards for who can receive services and states recipients must meet all of the following criteria:

- Be Medicaid eligible.
- Diagnosed with a medically-complex or medically fragile condition as defined in Rule 59G-1.010, F.A.C.
- Be under the age of 21 years.
- Be medically stable and not present significant risk to other children or personnel at the center.
- Require short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care due to a medically complex condition.

16. Fla. Admin. Code R. 59G-1.010 defines the terms "medically complex" and "medically fragile" as follows:

> "Medically complex" means that a person has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour per day medical, nursing, or health supervision or intervention.

> "Medically fragile" means an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, i.e.,

> requiring total parenteral nutrition (TPN), is ventilator dependent, or is dependent on a heightened level of medical supervision to sustain life and without such services is likely to expire without warning.

17. As shown in the Findings of Fact, the Agency, through eQHealth Solutions denied the petitioner's request to receive continued PPEC services because the clinical information provided did not support the medical necessity of the requested services.

18. The petitioner's representative argued that the petitioner is in need of PPEC service mostly based on his speech problems.

19. The respondent's witness argued that the petitioner does not have any diagnoses or medical needs that would indicate the petitioner would meet the definition of either medically complex or medically fragile. Additionally, she argued the need of speech therapy would not be a medically necessary reason or eligibility criteria to be approved for PPEC service. She argued the petitioner does not meet the medical necessity requirements for the PPEC as found in the above noted authorities. The hearing officer agrees with the respondent's arguments.

20. There is no evidence to suggest that petitioner is dependent upon 24-hour per day medical or nursing care, or that he is dependent upon life-sustaining medical equipment, such that he would be deemed "Medically complex" or "Medically Fragile." As such, the petitioner's need for speech therapy would not warrant an authorization for PPEC services. Furthermore, the controlling legal authorities make clear that Medicaid services cannot be in excess of the patient's needs.

21. After considering the evidence and all of the appropriate authorities set forth above, the hearing officer concludes that the respondent has met its burden of proof and the Agency's action denying the petitioner's request for PPEC services is correct.

DECISION

This appeal is denied and the Agency action affirmed.

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 25 day of November, 2015,

in Tallahassee, Florida.

Robert Akel

Robert Akel
Hearing Officer
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1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Don Fuller, Area 6, AHCA Field Office Manager

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

FILED
Nov 24, 2015
Office of Appeal Hearings
Dept. of Children and Families

[redacted]

PETITIONER,

Vs.

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

RESPONDENT.
_____/

APPEAL NO. 15F-07369

CASE NO.

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on October 1, 2015, at 10:50 a.m.

APPEARANCES

For the petitioner: [redacted]
Petitioner

For the Respondent: Linda Latson, R.N.
Registered Nurse Specialist/Fair Hearing Coordinator
Agency for Health Care Administration

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the Agency for Health Care Administration incorrectly denied his request for a power wheelchair?

PRELIMINARY STATEMENT

[redacted] the petitioner ("petitioner"), appeared on his own behalf. Linda Latson, R.N., Registered Nurse Specialist and Fair Hearing Coordinator for the Agency for Health Care Administration ("AHCA" or "Agency"), appeared on behalf of the Agency for Health Care Administration. The following individuals appeared as witnesses on behalf of the Agency: Vincent Pantone, M.D., Chief Medical Officer of Better Health; and Diana Anda, Grievance and Appeals Supervisor for Better Health.

The respondent introduced respondent's Exhibits "1" through "6", inclusive, at the hearing, all of which were accepted into evidence and marked accordingly. The hearing officer took administrative notice of the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook.

FINDINGS OF FACT

1. Petitioner is a 54-year-old male. He resides in [redacted] Florida.

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

3. Petitioner is enrolled in the Better Health Managed Medical Assistance plan. Better Health is a health maintenance organization ("HMO") contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in [redacted].

4. Petitioner's effective date of enrollment with Better Health was July 1, 2015.

5. On or about August 6, 2015, the petitioner's physician submitted a prior authorization request to Better Health for a power wheelchair for the petitioner.

6. In a Notice of Action dated August 8, 2015, Better Health notified the petitioner it was denying his request for a power wheelchair.

7. The Notice of Action explains, in part:

> ■ We determined that your requested services are not medically necessary because the services do not meet the reasons(s) checked below: *(See Rule 59G-1.010)*
>
> - ■ Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury, and not be in excess of the patient's needs.
> - ■ Must be furnished in a manner not primarily intended for convenience of the recipient, caretaker, or provider.

8. The Notice of Action goes on to state: "The facts that we used to make our decision are: You requested a power wheelchair. This was denied because your doctor doesn't state that you are unable to use a regular wheelchair, no mention that you are unable to use your arms, and doesn't mention that you are unable to walk or perform daily activities otherwise."

9. On or about August 27, 2015, the petitioner submitted a written request for an internal reconsideration of the denial to Better Health.

10. Better Health formally dismissed the internal appeal after receiving notice that the petitioner requested a Medicaid Fair Hearing.

11. The petitioner is diagnosed with [redacted] He ambulates with the assistance of a wheelchair.

12. The petitioner has a prescription for a motorized wheelchair dated August 27, 2015 from his primary care physician. The prescription states the petitioner is "unable to walk due to tremors and unable to wheel himself due to a torn rotator cuff."

13. The petitioner has used a power wheelchair since December 2004.

14. Petitioner's physician did not provide a wheelchair evaluation completed by a registered physical or occupational therapist or a certified physiatrist to Better Health. As of the date of the hearing in this matter, a wheelchair evaluation had not yet been completed.

CONCLUSIONS OF LAW

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

16. The Florida Medicaid Program is authorized by Chapter 409, Fla. Stat., and Chapter 59G, Florida Administrative Code. The Program is administered by AHCA.

17. Goods and services requested under the Florida Medicaid Program must be shown to be medically necessary in order to be approved.

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

19. The petitioner in the present case is requesting a new service. Therefore, in accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof is assigned to the petitioner.

20. 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.).

21. Section 409.905, Fla. Stat. addresses mandatory Medicaid services under the State Medicaid Plan and explains as follows:

> Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law...
> (4) HOME HEALTH CARE SERVICES.–The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home...
> (a) The agency shall require prior authorization of home health services....
> (c) The agency may not pay for home health services unless the services are medically necessary ...

22. The Florida Medicaid Home Health Services Coverage and Limitations Handbook October 2014 is incorporated by reference and promulgated into Rule by 59G-4.130, Florida Administrative Code.

23. The Florida Medicaid Home Health Services Coverage and Limitations Handbook, on Page 2-27, states as follows:

> Home health agencies that provide DME must comply with the policies and procedures contained in this handbook and in the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook.

24. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Chapter 59G-4. The Handbook, on Page 1-27, states:

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.
>
> Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

25. Page 1-28 of the Florida Medicaid Provider General Handbook provides a list of HMO covered services. These services include durable medical equipment.

26. Page 1-30 of the Florida Medicaid Provider General Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

27. In order for durable medical equipment and supplies to be approved, the equipment and supplies must not only be medically necessary but must also meet all requirements set forth in the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook.

28. Although the terms medically necessary and medical necessity are often used interchangeably and may be used in a variety of contexts, their definition for Florida Medicaid purposes is contained in the Florida Administrative Code. Fla. Admin. Code R. 59G-1.010 states:

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods or services furnished or ordered must:
>
> (a) Meet the following conditions:
>
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods, or services medically necessary or a medical necessity or a covered service.

29. Section 409.913, Fla. Stat. governs the oversight of the integrity of the Florida Medicaid Program. Section (1)(d) sets forth the "medical necessity or medically necessary" standards, and states in pertinent part as follows

> "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice....
>
> Section (1)(d) goes on the further state:
>
> ...For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

30. Section (1)(d) highlights that the Agency makes the final decision regarding whether or not a requested service is medically necessary; however, the hearing officer is the final decision making authority for the Agency. See § 120.80, Fla. Stat.

31. The Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook (July 2010) ("DME Handbook") is promulgated into rule by Fla. Admin. Code R. 59G-4.070.

32. The DME Handbook describes the covered services, limitations, and exclusions associated with the acquisition and reimbursement of durable medical equipment and medical supplies obtained through the Medicaid program.

33. The DME Handbook sets forth the definition of durable medical equipment on Page 1-2. "Durable medical equipment (DME) is defined as medically-necessary equipment that can withstand repeated use, serves a medical purpose, and is appropriate for use in the recipient's home as determined by the Agency for Health Care Administration (AHCA)."

34. The DME Handbook provides the definition of a wheelchair on Page 2-91, where it states as follows: "A wheelchair is a seating device system mounted on wheels used to transport a non-ambulatory individual or an individual with severely limited mobility.

35. The DME Handbook, on Page 2-92, explains

> Prior authorization is required for all custom wheelchairs, power wheelchairs, power operated vehicles (POV), and modifications and custom upgrades. The following information must be submitted with the prior authorization request:

> Either the Medicaid Custom Wheelchair Evaluation form (Appendix A) or another document that contains the same information that is requested on the form; and
>
> Medical necessity documentation; and
>
> Written documentation describing the physical status of the recipient with regard to mobility, self-care status, strength, cognitive and physical abilities, coordination, and activity limitations; and
>
> ...
>
> What physical improvement(s) can be anticipated; and
>
> What physical deterioration may be prevented with the type of wheelchair and specific features requested; and
>
> ...
>
> Documentation of the recipient's home accessibility for the customized manual or motorized wheelchair requested...

36. The DME Handbook, on Page 2-96, states as follows

> All wheelchair evaluations for custom manual and power wheelchairs must be completed by a licensed physical therapist, occupational therapist, or physiatrist using either the Custom Wheelchair Evaluation, AHCA Med Serv Form 015, (Appendix A) or another document that contains the same information that is requested on the form.
>
> ...
>
> Documentation of home accessibility is required in a prior authorization request for an extra-wide wheelchair, custom or non-custom power wheelchair or POV.

37. In the present case, the petitioner's physician did not provide a wheelchair evaluation completed by a registered physical or occupational therapist or a certified physiatrist to Better Health. Furthermore, as of the date of the hearing in this matter, a wheelchair evaluation had not yet been completed. Without this wheelchair evaluation, Better Health cannot approve the petitioner's request for a power wheelchair.

38. Pursuant to the above, the petitioner has not met his burden of proof that Better Health incorrectly denied his request for a power wheelchair.

39. Once a wheelchair evaluation is completed, the petitioner may resubmit his request for a power wheelchair, along with the evaluation, to Better Health.

40. In rendering this decision, the undersigned hearing officer considered all of the testimony and documentary evidence presented during the hearing process and reviewed all conditions of "medical necessity" 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 24 day of November, 2015,

in Tallahassee, Florida.

Peter J. Tsamis

Peter J. Tsamis
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

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

[redacted]

APPEAL NO. 15F-07370

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 13 Hillsborough
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 4, 2015, at approximately 9:07 a.m.

APPEARANCES

For Petitioner: [redacted] Petitioner's Mother

For Respondent: Stephanie Lang, R.N. Specialist/Fair Hearing Coordinator
Agency for Healthcare Administration

STATEMENT OF ISSUE

Whether the Agency was correct in denying Petitioner's request for orthodontic treatment including braces and monthly treatment visits. Petitioner holds the burden of proof on this issue by a preponderance of the evidence.

PRELIMINARY STATEMENT

Appearing as witnesses for Respondent were Dr. John Nackashi (Medical Director, Ped-I-Care), Dr. Shelley Collins (Assistant Medical Director, Ped-I-Care), Holly Estep (Assistant Director of Utilization Review, Ped-I-Care), and Dr. Dolce (Orthodontic Consultant, Ped-I-Care).

Petitioner submitted one exhibit, marked and entered as Petitioner's Exhibit 1. Respondent submitted six exhibits into evidence, which were marked and entered as Respondent's Exhibits 1 through 6. Administrative notice was taken of Florida Statutes 409.910, 409.962 through 409.965, 409.973, Florida Administrative Code Rules 59G-1.001, 59G-1.010, 59G-4.060, as well as the Medicaid Dental Services Coverage and Limitations Handbook (November 2011).

FINDINGS OF FACT

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

1. Petitioner is a Medicaid recipient under 21 years of age. His orthodontist referred him for orthodontic treatment due to a crossbite of his right posterior side. The treatment goal is to avoid developing problems later.

2. On or about July 23, 2015, Petitioner's orthodontist submitted a prior authorization request to Petitioner's Medicaid plan, Ped-I-Care. Medicaid requires prior authorization for orthodontic treatment for children under 21.

3. Petitioner's orthodontist completed the Medicaid Orthodontic Initial Assessment form (IAF) and submitted it with the request. The IAF indicated Petitioner has an

overjet, an overbite, and a posterior unilateral crossbite. He indicated a total score of 13 on this assessment.

4. Ped-I-Care denied Petitioner's request for braces by notice dated July 30, 2015. The notice indicated the request was denied because Petitioner did not show medical necessity for the service.

5. The Ped-I-Care reviewer indicated that the models, x-rays, and photos do not meet Medicaid's requirements for orthodontic care.

6. Petitioner is concerned that he will develop problems without the treatment. He argues that since his dentist recommended this, there is a problem that needs to be addressed. Respondent contends that although Petitioner may benefit from orthodontic treatment, the request does not currently meet Medicaid's requirements for coverage. Respondent suggested the dentist monitor the teeth going forward and resubmit the request if there is a change.

CONCLUSIONS OF LAW

7. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80, Florida Statutes.

8. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.

9. This hearing was held as a de novo proceeding pursuant to Florida Administrative Code Rule 65-2.056.

10. In accordance with Florida Administrative Code Rule 65-2.060(1), the burden of proof was assigned to the Petitioner. The standard of proof needed to be met for an

administrative hearing is by a preponderance of the evidence, as provided by Florida Administrative Code Rule 65-2.060(1).

11. Section 409.912, Florida Statutes, notes that AHCA shall purchase goods and services for Medicaid recipients in the most cost-effective manner possible, consistent with the delivery of quality medical care.

12. All Medicaid services must be medically necessary, including dental. Florida Administrative Code, 59G-1.010(166), defines medical necessity, as follows:

> "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
>
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
> ...
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

13. The Medicaid Dental Services Coverage and Limitations Handbook, November 2011 (Dental Handbook) is promulgated into law by Rule 59G-4.060(2), Florida Administrative Code. Rule 59G-4.060(3), Florida Administrative Code specifically promulgates by incorporation the forms included in the Dental Handbook, including the

Medicaid Orthodontic Initial Assessment Form (IAF). Page 2-2 of the Dental Handbook states that all dental services must meet the definition of medical necessity as set forth above.

14. As the petitioner is under 21, a broader definition of medically necessary applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) requirements. Section 409.905, Fla. Stat., *Mandatory Medicaid services*, defines Medicaid services for children to include:

> (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems…

15. The Dental Handbook states on page 1-2: "The children's dental program provides full dental services for all Medicaid eligible children age 20 and below." Page 2-3 states that this includes medically necessary orthodontic treatment.

16. Orthodontic treatment is covered under the above authorities for a child under 21 if it is a medically necessary service. Page 2-15 of the Dental Handbook states as follows:

> Prior authorization is required for all orthodontic services. **Orthodontic services are limited to those recipients with the most handicapping malocclusion.** A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the patient by causing impaired mastication, dysfunction of the temporomandibular articulation, susceptibility to periodontal disease, susceptibility of dental caries, and impaired speech due to malpositions of the teeth.
>
> Treatment is routinely accomplished through fixed appliance therapy and monthly maintenance visits. Removable (D8210) or fixed (D8220)

> appliance therapy may be reimbursed, but is dependent upon individual case circumstances. If requesting a removable (D8210) or fixed (D8220) appliance for thumb sucking or other habit, clinical photos must be submitted with the prior authorization request for the determination of medical necessity. (emphasis added)

Page 2-16 explains further how this is determined:

> Criteria for approval is limited to one of the following conditions:
> - Correction of severe handicapping malocclusion as measured in the Medicaid Orthodontic Initial Assessment form (IAF) AHCA-Med Serv Form 013;
> - Syndromes involving the head and maxillary or mandible jaws such as cleft lip or cleft palate;
> - Cross-bite therapy, with the exception of one posterior tooth that is causing no occlusal interferences;
> - Head injury involving traumatic deviation; or
> - Orthognatic surgery, to include extractions, required or provided in conjunction with the application of braces.

17. Regarding scoring the IAF, the Dental Handbook explains on page 2-18 that a score of less than 26 "...does not say that [the case does] not represent some degree of malocclusion, but simply that the severity of the malocclusion does not qualify for coverage under the Florida Medicaid Orthodontic Program."

18. Petitioner alleges crossbite and future damage if left untreated. He does not allege any of the criteria for approval such as cleft lip or orthognatic surgery. Petitioner's orthodontist gave Petitioner a score of 13 on the assessment he completed.

19. Petitioner argues that greater weight should be given to his treating provider's recommendations. Petitioner's treating providers were not present at the hearing. The letter is considered hearsay, which can bolster other evidence but cannot be a finding of fact on its own. Regardless, based on the Agency's definition of medical necessity excerpted above, "[t]he fact that a provider has...recommended...services does not, in

itself, make such…services medically necessary or a medical necessity or a covered service."

20. Respondent agrees that Petitioner may need orthodontic care. However, his needs do not rise to the level necessary (determined by the assessment) for Medicaid to cover the service. Petitioner has not shown that he meets Medicaid's requirements for general orthodontic treatment at the present time.

21. After careful review of the relevant authorities, the testimony and the evidence in this matter, the hearing officer concludes that the Agency properly denied Petitioner's request for orthodontic treatment.

DECISION

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

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 30 day of December, 2015, in Tallahassee, Florida.

Danielle Murray

Danielle Murray
Hearing Officer
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1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Don Fuller, Area 6, AHCA Field Office Manager

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

[redacted]

PETITIONER,

Vs.

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

RESPONDENT.
_____/

APPEAL NO. 15F-07433

CASE NO.

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in this matter telephonically on October 20, 2015, at 3:15 p.m.

APPEARANCES

For the petitioner: [redacted]
Petitioner

For the respondent: Linda Latson, R.N.
Registered Nurse Specialist/Fair Hearing Coordinator
Agency for Health Care Administration

STATEMENT OF ISSUE

Did the respondent prove by a preponderance of the evidence that it correctly terminated the petitioner's respite services?

PRELIMINARY STATEMENT

[redacted]("petitioner"), the petitioner, appeared on her own behalf.

Linda Latson, R.N., Registered Nurse Specialist and Fair Hearing Coordinator at the Agency for Health Care Administration ("AHCA" or "Agency"), appeared on behalf of the Agency for Health Care Administration. The following individuals from Sunshine Health appeared as witnesses on behalf of the Agency: India Smith, Grievance and Appeals Coordinator; John M. Carter, M.D., Long-Term Care Medical Director; Mayra Infanzon, Executive Director of Service Area 4; Lisa Frischkorn, Long-Term Care Case Management Supervisor; and Merlyn Grant, Long-Term Care Case Manager.

The respondent introduced respondent's Exhibits "1" through "5", inclusive, at the hearing, which were accepted into evidence and marked accordingly. The petitioner did not introduce any exhibits.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. The petitioner is a 61-year-old female.

2. Petitioner was eligible to receive Medicaid services at all times relevant to this proceeding.

3. The petitioner is an enrolled member of Sunshine Health. Sunshine Health is a health maintenance organization ("HMO") contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in Florida.

4. The petitioner's effective date of enrollment with Sunshine Health was May 1, 2014.

5. The petitioner is a participant of the Long-Term Care Program.

6. The petitioner's medical history is remarkable for the following: [redacted]

7. The petitioner was previously approved to receive the following services: 14 hours per week of respite; 14 hours per week of personal care; and 7 hours per week of homemaker.

8. In a Notice of Action dated August 12, 2015 (*Resp. Exhibit 2*), Sunshine Health informed the petitioner it was terminating her respite services.

9. The Notice of Action (*Resp. Exhibit 2*) states, in part:

> Sunshine Health has reviewed your request for terminating (stopping) your Respite Care Service (The care given in your home to help give your caregiver a break) 2 hours x7 days per week, which we received on 07/28/2015. After our review, per your request, this service has been: TERMINATED (stopped) as of 08/21/2015.
>
> X We determined that your requested services are not medically necessary because the services do not meet the reasons(s) checked below: *(See Rule 59G-1.010)*
>
> X Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs.
>
> X Other authority: Based on member's request.
>
> You asked to terminate (stop) your Respite Care service (The care given in your home to help give your caregiver a break) because there is no live-in care giver in the home.

10. The petitioner did not request termination of her respite services.

11. The respondent's witnesses testified Sunshine Health's decision to end the petitioner's respite services was the result of information documented by the

petitioner's case manager in a face-to-face assessment with the petitioner on July 27, 2015.

12. Evidence introduced by the respondent pertaining to the July 27, 2015 face-to-face assessment (*Resp. Exhibit 1*) states the following:

> On 7/27/2015 [Case Manager] went to member's home to perform a face to face assessment. On this date, the member lives at home with her spouse whom is disabled with a "bad Hip" During the face to face it was established that the member required some assistance, but not total assistance, with her activities of daily living (ADL's) such as bathing, dressing, and using the bathroom. The member does not require assistance with eating and uses an assistive device for transferring and walking. However, during member's face to face visit member was observed walking to the bathroom without her walker as well as not using incontinent supplies. Individual Activities of Daily Living (IADL's) member needs total assistance with heavy chores and needs some assistance with housekeeping, preparing meals, shopping, managing medications, and using transportation. Member does not need assistance with using the phone or managing money.
>
> Member admitted to cooking sometimes and stated that the aide comes in and does a little of everything for both the member and the member's spouse. Member advised her spouse is not the caregiver, and does not want to take on the role of the caregiver and there is no other live-in caregiver at this time. Based on the given information the member's respite hours were set to be termed as of 7/31/2015. An NOA was sent to the member & agency Almost Family dated 8/12/2015 advising respite hours are to stop as of 8/21/2015.

13. Because of a 10-day notice of adverse action requirement, Sunshine Health was unable to terminate the petitioner's respite services on August 21, 2015. However, it did end these services effective August 31, 2015.

14. The respondent's witnesses testified at the hearing the petitioner's respite services were terminated based on the premise that there is no caregiver present in the petitioner's home.

15. The petitioner testified at the hearing that her husband is her caregiver.

16. Petitioner's husband is 64-years-old and suffers from a [redacted]

17. The petitioner's husband assists the petitioner with all of her activities of daily living including bathing and dressing. The petitioner is unable to lower herself into the bathtub independently and requires the assistance of her husband.

18. Although the petitioner's husband has a disability, it does not prevent him from being the petitioner's caregiver. The hearing officer finds the petitioner's husband is her caregiver.

19. The narrative provided by the respondent (*Resp. Exhibit 1*) states the petitioner was observed ambulating to the bathroom without an assistive device.

20. The petitioner ambulates short distances with the assistance of a walker. She uses a motorized wheelchair to ambulate longer distances. The petitioner is unable to walk independently.

21. The petitioner cannot walk up the stairs. She uses a chair lift to assist with this activity.

22. The petitioner's Long Term Care Plan of Care (*Resp. Exhibit 3*) introduced by the respondent at the hearing indicates that respite services are required to "prevent burnout of caregiver". Although the Plan of Care has a typewritten effective date of May 1, 2014 and reflects that respite services are requested from May 1, 2014 through July 31, 2014, there is a handwritten date of July 27, 2015 on the upper right hand corner of the first page of the Plan of Care. The respondent's witness testified at the hearing this Plan of Care was completed by the petitioner's Case Manager pursuant to information gathered at the July 27, 2015 face-to-face assessment.

23. The 701b Comprehensive Assessment (*Resp. Exhibit 4*) completed by the petitioner's Case Manager as a result of the face-to-face assessment completed on July 27, 2015 rates the petitioner's overall health as poor. It explains the petitioner is a fall risk and that the petitioner has visited the emergency room five times within the past year.

CONCLUSIONS OF LAW

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

25. This is a final order pursuant to § 120.569 and § 120.57, Fla. Stat.

26. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

27. In the present case, the respondent has terminated previously approved services. Therefore, in accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof is assigned to the respondent.

28. 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.).

29. The Florida Medicaid program is authorized by Chapter 409, Fla. Stat. and Chapter 59G, Fla. Admin. Code. The Medicaid program is administered by respondent.

30. Section 409.905, Fla. Stat. addresses mandatory Medicaid services under the State Medicaid Plan:

> Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law…

31. Under § 1915(c) of the Social Security Act (42 USC § 1396n(c)), a state may obtain a Medicaid waiver that allows the state to include in the state's Medicaid program the cost of home or community-based services (other than room and board) provided to individuals who otherwise would require care in a hospital, nursing facility, or intermediate care facility.

32. Home or community-based services include personal care services, habilitation services, and other services that are "cost effective and necessary to avoid institutionalization." See 42 CFR § 440.180.

33. Section 409.978, Florida Statutes, provides that the "Agency shall administer the long-term care managed care program," through the Department of Elder Affairs and through a managed care model. Fla. Stat. § 409.981(1), authorizes the Agency for Health Care Administration to bid for and utilize provider service networks to achieve this goal. In the instant case, the provider network/HMO is Sunshine Health.

34. The definition of medically necessary is found in the Fla. Admin. Code. R. 59G-1.010 which states:

> (166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider…
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

35. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Chapter 59G-4. In accordance with the above Statute, the Handbook states on page 1-27

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.
>
> Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

36. Page 1-30 of the Florida Medicaid Provider General Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

37. Respite services are not available through the Agency for Health Care Administration. Therefore, it cannot be said that the provision of these services by Sunshine Health is in any way more restrictive than the provision of these services by the Agency for Health Care Administration.

38. The LTC (Long Term Care) Ancillary Service Criteria (*Resp. Exhibit 5*), the Contract between the Agency for Health Care Administration and Sunshine Health governing the Long-Term Care Program, on Page 5, describe Respite Care as follows:

> Services provided to members unable to care for themselves furnished on a short-term basis due to the absence or need for relief of the persons normally providing the care. Respite services are only provided on the basis of need to relieve the primary caregiver. Respite cannot be approved if the member's caregiver must work and the member requires constant supervision and cannot be left alone in the absence of the caregiver. Other appropriate services must be considered, such as Adult Day Care or Adult Companion services when a caregiver works. Respite care does not substitute for the care usually provided by a registered nurse, a licensed practical nurse or a therapist. Respite care is provided in the home/place of residence, Medicaid licensed hospital, nursing facility or assisted living facility. Respite in-home services must be provided at the member's residence. Facility-based respite services must be provided in a Medicaid-certified nursing facility, a licensed adult day care facility or licensed assisted living facility.

39. The respondent's witnesses testified the petitioner's respite services were terminated due to the absence of a caregiver in the home. They proffered no argument that the other services in place could provide the care contemplated by these services.

40. Since it has been determined there is a caregiver in the home – the petitioner's husband, the respondent has not met its burden of proof to show that it correctly terminated the petitioner's respite services.

41. After careful consideration, the hearing officer concludes the respondent incorrectly terminated the petitioner's respite services.

DECISION

The petitioner's appeal is hereby GRANTED. The respondent is instructed to reinstate the petitioner's respite services.

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 30 day of November, 2015,

in Tallahassee, Florida.

Peter J. Tsamis

Peter J. Tsamis
Hearing Officer
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Tallahassee, FL 32399-0700
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Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

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

[redacted]

APPEAL NO. 15F-07496

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 10 Polk
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on November 5, 2015 at approximately 10:30 a.m.

APPEARANCES

For the Petitioner: [redacted]
Petitioner's mother

For the Respondent: Stephanie Lang
Registered Nurse Specialist, Fair Hearing Coordinator
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is Respondent's denial of Petitioner's request for extraction of four (4) wisdom teeth, as well as I.V. sedation. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

The following individuals were present as witnesses for Respondent:

- Carlene Brock – Quality Operations Nurse - Amerigroup
- Dr. Susan Hudson – Dental Consultant - DentaQuest

- Jackelyn Salcedo – Complaints & Grievances Specialist - DentaQuest

Petitioner's mother gave oral testimony, but did not move any exhibits into evidence. Respondent moved Exhibits 1 through 8 into evidence at the hearing. The record was held open until November 6, 2015 for Respondent to submit additional evidence. Respondent submitted additional evidence, entered as Exhibit 9.

The undersigned took administrative notice of the following:

- Florida Statutes §§ 409.910, 409.962, 409.963, 409.964, 409.965, and 409.973.
- Florida Administrative Code Rules 59G-1.001, 59G-1.010, and 59G-4.060

FINDINGS OF FACT

1. Petitioner is a 15-year-old female. At all times relevant to this proceeding, Petitioner was eligible to receive Medicaid services.
2. Petitioner is enrolled with Amerigroup as her Managed Medical Assistance (MMA) plan.
3. DentaQuest is Amerigroup's dental vendor for prior authorization determinations.
4. On August 11, 2015, Petitioner's dentist submitted to DentaQuest a prior authorization request for removal of all four (4) of her wisdom teeth.
5. The American Dental Association procedure code used for tooth # 1 and tooth # 16 was D7220. Procedure code D7220 is for "removal of impacted tooth – soft tissue: Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation." (Respondent's Exhibit 9).
6. The procedure code used for tooth # 17 and tooth # 32 was D7230. Procedure code D7230 is for "removal of impacted tooth – partially bony: Part of crown

covered by bone; requires mucoperiosteal flap elevation and bone removal." (Respondent's Exhibit 9).

7. The request also included procedure codes D9241, I.V. sedation for first 30 minutes, and D9242, I.V. sedation for each additional 15 minutes.
8. On August 13, 2015, DentaQuest issued an Authorization Determination that the extractions of all four (4) teeth should be denied, as well as the I.V. sedation. A copy was sent to Petitioner's dentist. Regarding the extractions, it stated: "Per Dental Director review the x-rays do not support the code requested. A less severe extraction code would be considered. Please review the ADA code you requested and resubmit with the appropriate extraction code." (Respondent's Exhibit 7). Regarding the I.V. sedation, it stated: "Anesthetic services are only covered when the associated services are approved."
9. Regarding the teeth, the Notice of Action, dated August 13, 2015, states: "Our dentist looked at the information your dentist sent. The information sent by your dentist, shows the tooth removal is not as bad as what your dentist says. Your dentist needs to resend the information to show where the tooth is located in the bone. We have also told your dentist. Please talk to your dentist." (Respondent's Composite Exhibit 8).
10. Regarding the I.V. sedation, the Notice of Action states: "Your dentist has asked for anesthesia (a medicine to make you sleep) for a service that has been denied. The request to make you sleep is also denied. We have also told your dentist. Please talk to your dentist." Dr. Hudson testified that the I.V. sedation is automatically denied if the extraction procedure is denied.

11. An appeal review was requested. On September 10, 2015, DentaQuest upheld the denial.

12. Petitioner's mother said she spoke to someone at the dentist's office after receiving the denial, although she did not speak directly with the dentist. She also said she tried to seek assistance from Amerigroup, but was unsuccessful in resolving the problem.

13. Petitioner's mother testified that some of the problems her daughter has are pain when she eats, swollen gums, pain with touching her gums, and has had pain so severe that she was unable to sleep. These problems persisted for about four (4) months prior to the extraction request.

14. There is no dispute that the teeth need to be extracted. The dispute regards the proper procedure codes that should be submitted for prior authorization.

15. Dr. Hudson testified that Petitioner's wisdom teeth appear to have already erupted and that removing them should be a simple extraction, although you can never be sure until the procedure is actually performed. She said Petitioner's dentist should resubmit the request with the appropriate procedure codes and it should be approved. The I.V. sedation would be considered for approval if the extractions were approved.

16. When asked what procedure code would be correct, Dr. Hudson stated D7140 would be used if it is just a simple extraction. She said she had not personally evaluated Petitioner, but if the procedure turned out to be an uncomplicated surgical extraction, it would be code D7210. The codes that were requested

would require a lot of surgery into the bone or soft tissue and that doesn't seem to be needed in Petitioner's case.

17. Ms. Salcedo said she would reach out to Petitioner's dentist in order to assist in getting the proper procedure codes submitted for authorization.

CONCLUSIONS OF LAW

18. By agreement between the Agency for Healthcare Administration ("AHCA" or "Agency") and the Department of Children and Families ("DCF"), the Office of Appeal Hearings has jurisdiction to conduct this hearing pursuant to Section 120.80, Fla. Stat.

19. The hearing was held as a *de novo* proceeding, in accordance with Florida Administrative Code Rule 65-2.056.

20. This is a Final Order, pursuant to Sections 120.569 and 120.57, Fla. Stat.

21. The standard of proof in an administrative hearing is a preponderance of the evidence. Fla. Admin. Code R.65-2.060(1). The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

22. Legal authority governing the Florida Medicaid Program is found in Fla. Stat. Chapter 409, and in Chapter 59G of the Florida Administrative Code. AHCA is the single state agency that administers the Medicaid Program.

23. The Florida Medicaid Dental Services Covered and Limitations Handbook, November 2011 ("Dental Handbook"), is promulgated into law by Chapter 59G of the Florida Administrative Code.

24. Page 2-14 of the Dental Handbook defines a "Simple Extraction" as:

> A simple extraction is the removal of a permanent or deciduous tooth by the closed method using the elevation and forceps removal technique in which a flap is not retracted.
>
> The incidental removal of cyst or lesions attached to the root(s) of an extraction is considered part of the extraction or surgical fee and should not be billed as a separate procedure.

25. Page 2-14 of the Dental Handbook defines a "Surgical Extraction" as:

> A surgical extraction is the removal of any erupted or unerupted tooth by the open method that includes the retraction of a mucoperiosteal flap and the removal of alveolar bone in order to extract or section a tooth.

26. Dr. Hudson stated either procedure code D7140 for a simple extraction or D7210 for an uncomplicated surgical extraction would be sufficient to address Petitioner's needs. D7140 is "extraction, erupted tooth or exposed root (elevation and/or forceps removal): Includes routine removal of tooth structure, minor smoothing of socket bone, and closure, as necessary." (Respondent's Exhibit 9). D7210 is "surgical removal of erupted tooth requiring removal of bone and/or suctioning of tooth, and including elevation of mucoperiosteal flap if indicated: Includes related cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure." Dr. Hudson stated the requested, more severe codes are not medically necessary.

27. The definition of medically necessary is found in Fla. Admin. Code R.59G-1.010, which states:

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
> . . . .
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods, or services medically necessary or a medical necessity or a covered service.

28. Since the Petitioner is under 21 years of age, a broader definition of medical necessity applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPDST) requirements. § 409.905, Fla. Stat., Mandatory Medicaid services, provides that Medicaid services for children include:

> (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

29. Under the above statute, the Agency offers dental services as an EPSDT service to Medicaid-eligible recipients less than 21 years of age.

30. The United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in *Moore v. Reese*, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the

following guiding principles in its opinion, which involved a dispute over private duty nursing:

> (1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.
> (2) A state Medicaid plan must include "reasonable standards ... for determining eligibility for and the extent of medical assistance" ... and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.
> (3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."
> (4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."
> (5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. **The state is not required to provide medically unnecessary, albeit desirable, EPSDT services.** However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."
> (6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and my present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)) (emphasis added).

31. Consistent with these requirements, the state is obligated to provide services to recipients under 21 years of age, but only to the extent such services are medically necessary. The definition of medical necessity for services provided under the EPSDT benefit is established by the state and the state is authorized to establish the amount, duration, and scope of such services.

32. Dr. Hudson gave credible testimony that Petitioner's wisdom teeth can be extracted under a less severe procedure code. The undersigned notes that she does not dispute the removal of the wisdom teeth, only the severity of the method used. Because a less severe procedure is appropriate in Petitioner's case, the requested procedure codes are in excess of her needs.

33. The undersigned has reviewed all pertinent rules and regulations, including EPSDT requirements. Petitioner has not met her burden to show, by the greater weight of the evidence, that the more severe extraction procedures are medically necessary

34. Petitioner and her mother are encouraged to work with Ms. Salcedo, DentaQuest, and Amerigroup, as well as her dentist, in order to ensure the proper request is submitted so that Petitioner can have her wisdom teeth removed.

DECISION

Based upon the foregoing, Petitioner's appeal is DENIED and the Agency's action is AFFIRMED.

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 16 day of December, 2015,

in Tallahassee, Florida.

Rick Zimmer

Rick Zimmer
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Don Fuller, Area 6, AHCA Field Office Manager

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

FILED
Nov 30, 2015
Office of Appeal Hearings
Dept. of Children and Families

[redacted]

PETITIONER,

Vs.

APPEAL NO. 15F-07498

CASE NO. [redacted]

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 05 Citrus
UNIT: 88004

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 2:20 p.m. on October 1, 2015.

APPEARANCES

For the Petitioner: [redacted] pro se

For the Respondent: Marilyn Ficke, ACCESS Supervisor

STATEMENT OF ISSUE

At issue is whether the respondent's action to terminate petitioner's Medicaid benefits is proper. The respondent carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

By notice dated September 1, 2015, respondent notified petitioner he was ineligible for Medicaid benefits. Petitioner timely requested a hearing to challenge the denial.

Petitioner did not submit exhibits. Respondent submitted four exhibits, entered as Respondent Exhibits "1" through "4". The record was closed on October 1, 2015.

FINDINGS OF FACT

1. Prior to the action under appeal, petitioner received Family-Related Medicaid benefits. On August 18, 2015, petitioner, [redacted], submitted a recertification application for Food Assistance and Medicaid benefits for himself and his son, [redacted] date of birth [redacted] Medicaid for petitioner is the only issue.

2. To be eligible for Family- Related Medicaid, a parent must have children under the age of 18 living at home.

3. Petitioner's son turned [redacted] Therefore, petitioner was no longer eligible under Family-Related Medicaid in November 2014. The Department erred by not terminating petitioner's Medicaid in November 2014.

4. To be eligible for Adult-Related (SSI-Related) Medicaid, an applicant must be age 65 or older, determined blind or disabled.

5. Petitioner is also not eligible for Adult-Related Medicaid because he is not age 65 or older and has not been determined blind or disabled.

6. On September 1, 2015, the respondent mailed petitioner a Notice of Case Action notifying he was not eligible for Medicaid benefits.

7. Petitioner believes since he is guardian and caretaker to his son and his son lives at home and attends high school; he should be eligible for Medicaid.

8. Petitioner also believes he should continue to receive Medicaid because the Department did not terminate his Medicaid in [redacted] when his son turned age [redacted]

9. Petitioner believes he should be given "a grace period of six months to one year" of Medicaid benefits.

10. Respondent explained Continuous Medicaid is applicable only to children.

CONCLUSIONS OF LAW

11. 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 Fla. Stat. § 409.285.

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

13. The Fla. Admin. Code R. 65A-1.705 Family-Related Medicaid General Eligibility Criteria in relevant part states:

> (7) A standard filing unit (SFU) is determined based on the individual for whom assistance is requested.
> (c) If assistance is requested for the parent of a deprived child, the parent and any deprived children…must be included in the SFU... For the parent to be eligible, there must be at least one child under age 18, with or without income, in the SFU, or who would be in the SFU if not receiving SSI…

14. The above authority explains for a parent to be eligible for Family-Related Medicaid there must be at least one child under age 18 in the home. Petitioner's son turned [redacted] on [redacted] therefore, he is no longer eligible for Family-Related Medicaid.

15. Florida Administrative Code R. 65A-1.711 SSI-Related Medicaid Non Financial Eligibility Criteria states:

> (1) For MEDS-AD Demonstration Waiver, the individual must be age 65 or older, or disabled as defined in 20 C.F.R. §416.905…

16. Title 20 Code of Federal Regulation § 416.903 address disability and blindness determinations and in part states:

> (b) Social Security Administration. The Social Security Administration will make disability and blindness determinations…

17. In accordance with the above authorities, to be eligible for Medicaid without minor children, an applicant must be age 65 or older, disabled or blind.

18. Petitioner is not age 65 or older and has not been considered blind or disabled. Therefore, he is not eligible for Adult-Related Medicaid.

19. The Department's Program Policy Manual, CFOP 165-22, passage 0830.0800 Continuous Medicaid Eligibility (MFAM), informs of the additional coverage for children and in part states:

> After Medicaid eligibility has been established, children who become ineligible for Medicaid for any reason may remain on Medicaid for up to twelve months from the last application, eligibility review or addition to Medicaid coverage. Children up to age 5 receive a minimum of twelve months continuous coverage. Children age five up to 19 receive a minimum of six months of continuous Medicaid coverage…

20. Petitioner argued that he should be given a "grace period" prior to having his Medicaid terminated. In accordance with the above Department policy, Continuous Medicaid is only for children.

21. The evidence establishes petitioner's son turned age [redacted] and petitioner is not age 65 or older and has not been determined blind or disabled.

22. In careful review of the cited authorities and evidence, the undersigned concludes respondent followed Rule in denying petitioner Medicaid.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the Respondent's action is 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 30 day of November, 2015, in Tallahassee, Florida.

Priscilla Peterson

Priscilla Peterson
Hearing Officer
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1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Email: Appeal.Hearings@myflfamiles.com

Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

APPEAL NO. 15F-07527

PETITIONER,

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 05 Citrus
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice and agreement, Hearing Officer Patricia Antonucci convened an administrative hearing in the above-referenced matter on three, separate occasions: October 20, 2015 at approximately 1:00 p.m., October 27, 2015 at approximately 9:00 a.m., and November 5, 2015 at approximately 9:00 a.m. All parties and witnesses appeared via teleconference.

APPEARANCES

For the Petitioner: [redacted] Petitioner's mother

For the Respondent: Selwyn Gossett, Medical/Health Care Program Analyst, Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is a May 4, 2015 decision by Respondent, the Agency for Health Care Administration (AHCA or "the Agency"), through its contracted health plan, United Healthcare Community Plan (United), to deny Petitioner's request for the prescription

medication [redacted]. Petitioner bears the burden of providing, by a preponderance of the evidence, that Respondent's denial was improper.

PRELIMINARY STATEMENT

The Agency for Health Care Administration is responsible for administering Florida's Medicaid Program. Following transition to a managed care system, AHCA now oversees provision of services through designated managed care organizations (MCOs)/Health Maintenance Organizations (HMOs). United is the MCO to which Petitioner belongs.

Prior to the action at issue, United authorized Petitioner to receive [redacted] for a one-year certification period, ending March 10, 2015. At hearing on November 5, 2015, United incorrectly testified to the end of this certification as March 6, 2015. Although testimony varied between hearing on October 20, 2015 and hearing on November 5, 2015, it appears that Petitioner's former prescribing physician (or a staff member from his practice) attempted to request re-authorization on or about March 6, 2015.

Per United, this request was denied, with notification sent to the physician and to Petitioner on or about March 7, 2015. This notice is not a part of the record, and Petitioner's mother does not recall receiving same. However, at hearing on October 20, 2015, Petitioner's mother clarified that Petitioner's former physician left his practice (All Children's Medical), and while Petitioner was transitioning between physicians, United encouraged her to contact another doctor at All Children's medical to file an updated request for [redacted] Petitioner was informed that this request to "bridge the gap" in coverage was received, but denied; however, because Petitioner had obtained an

appointment with a new treating physician, she decided to await that appointment and obtain a new [redacted] prescription from the new physician.

The record is unclear with regard to this alleged March denial, which is *not* the denial that forms the basis of Petitioner's instant appeal. As such, the undersigned makes no ruling with regard to any denial implemented on or about March 7, 2015. As a procedural matter, if Petitioner was not notified of his right to appeal a March denial, the undersigned notes that the time for her to do so may not have started to toll. Should Petitioner wish to pursue this matter, and/or to request review regarding potential/temporary reinstatement pending outcome of that appeal, Petitioner may do so by filing a separate request with the Office of Appeal Hearings. Said request would be reviewed under the same rules and regulations that govern the instant Final Order.

Multiple Hearings

This matter initially convened for hearing on October 20, 2015. Petitioner was represented by his mother, who presented two additional witnesses: [redacted], Petitioner's current prescribing physician, and [redacted] Case Manager with the Patient Advocate Foundation. Respondent was represented by Selwyn Gossett, AHCA Medical/Health Care Program Analyst, who presented the following witnesses from United: Susan Frishman, Senior Compliance Analyst; Holly Moreau, Pharmacy Account Manager; Charity Willis, Pharm.D, Clinical Pharmacist; and Miquel Fernandez, D.O., Chief Medical Officer.

Following substantial testimony, it was determined that after its initial denial, United also denied a request for a peer-to-peer conference between Petitioner's prescribing physician and a medical director with United. The parties agreed to

reschedule hearing/set a telephonic status conference for the following week to allow for facilitation of a peer-to-peer, in the event that same would resolve the issue.

When this matter reconvened, as scheduled, on October 29, 2015, [redacted] stated that she had completed a peer-to-peer with Dr. Fernandez, but that the parties did not reach a resolution. As the parties could not find a mutually agreeable date and time during which all witnesses could reconvene, it was agreed that [redacted] would provide testimony and be cross-examined by Respondent during the October 29, 2015 hearing, with the rest of the witnesses reconvening on November 5, 2015.

On November 5, 2015, all witnesses other than [redacted] appeared as scheduled, with the exception of Holly Moreau, who was not present on the conference line. Because Dr. Fernandez had to leave the proceeding early for a "heart stop," testimony was taken piece-meal to accommodate witness availability. Respondent's Exhibits 1 through 5, inclusive, and Petitioner's Exhibits 1 through 7, inclusive, were accepted into evidence.

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. Petitioner is an 11-year-old male, born [redacted] He has a confirmed diagnosis of [redacted] (history of [redacted] with [redacted]

2. Prior to the action at issue, Petitioner had been taking [redacted] on and off since approximately 2010. He was authorized to receive it in other states, and most recently, was authorized by United to receive [redacted] in Florida.

3. United explained that along with the request for [redacted] which was prior authorized for a one-year period, Petitioner's treating physician was required to submit updated prescriptions for the medication on a recurring basis.

4. At some point near the beginning of 2015, Petitioner's treating physician, Dr. Jeffrey Ewing, left his practice at All Children's Medical Hospital. While Petitioner attempted to find a new treating physician, Petitioner's prescription expired. As a result, while Petitioner twice attempted to refill the [redacted] (once around April 28, 2015 and once around May 1 of 2015), the last successful fill was dispensed on or about January 19, 2015. Petitioner has been off of [redacted] since finishing that bottle.

5. On April 21, 2015, Petitioner had his first appointment with his new/current treating physician, [redacted] Following that visit, on or about April 27, 2015, [redacted] submitted to United a request for [redacted]

6. Via Notice of Case Action (NOCA) dated May 4, 2015, United notified Petitioner's provider of its decision, noting, in pertinent part:

> UnitedHealthcare Community Plan has reviewed the request to approve the prescription for [redacted]. After a review: The request is denied based on the reason below:
>
> The requested medication is a drug used for people who are at least 16 years old. The facts given to us show the patient is less than 16 years old. The requested medicine is given for certain sleep disorders. The facts given to us do not show that you have any of these conditions. The facts given to us do not show that you have improved while taking this medication. This decision was made per the United Healthcare Florida Community Plan [redacted] medication guideline.
>
> The requested medication is provided for patients 6 years of age and older with a diagnosis of [redacted] excessive daytime sleepiness, and/or disrupted nocturnal sleep. The information reviewed does not show the patient is 6 years of age or

> older. The requested medication is provided for patients 16 years or age and older with a diagnosis of [redacted] excessive daytime sleepiness, and/or disrupted nocturnal sleep when prescribed by a sleep specialist or neurologist. The information reviewed does not show the patient is being treated for one of the above diagnosis with documentation Diagnosis must be confirmed by submission of supporting documentation to include the specialist's interpretation of the Polysomnography (PSG) and Multiple Sleep Latency Test (MSLT) results which was not submitted. The requested medication is continued if the patient has demonstrated a response to [redacted] as evidence by the EpworthSleepiness Scale (ESS) and/or the Maintenance of Wakefulness Test (MWT). The information reviewed does not show the patient has demonstrated a response to [redacted] as evidence by the EpworthSleepiness Scale (ESS) and/or the Maintenance Wakefulness Test (MWT). This decision was made per the United Healthcare Florida Community Plan [redacted] medication guideline.
>
> **The decision will take effect on: 05/04/2015.**
> (emphasis original)

The NOCA also noted that if the requesting physician wished to discuss denial with a medical director, he/she could do so within 7 working days, and if Petitioner wished to a file an appeal with United, said appeal must be filed within 30 calendar days.

7. Per [redacted] she attempted to contact United multiple times for a peer-to-peer review, but because she finally got through 10 days after the NOCA, United declined the peer-to-peer.

8. On June 19, 2015, the Patient Advocate Foundation (PAF), on behalf of Petitioner, filed with United a request to appeal the denial. PAF's cover letter points to the conflicting language of the NOCA, and requests United's review of documentation submitted along with the appeal, including Petitioner's sleep study reports, and copies of medical journal articles discussing the use of [redacted] in treatment of children.

9. United acknowledged receipt of this request via letter dated June 22, 2015, which stated they were reviewing the appeal. However, via letter dated June 29, 2015, United notified Petitioner:

> An initial letter was sent to you regarding your child on May 4, 2015. This letter said you need to file an appeal within thirty days from the date of the letter. We received this appeal June 19, 2015. This was longer than the time allowed. This is why we cannot review your child's appeal. Please contact your child's doctor if your child still needs this service. The doctor will need to send in a new request for the service.

10. After additional correspondence with United and attempts by [redacted] to submit additional prescriptions, United continued to uphold its denial.

11. On or about August 27, 2015, Petitioner filed an appeal with the Office of Appeal Hearings to challenge the denial of [redacted]

12. At hearing, [redacted] explained that although she has never treated Petitioner while he was taking [redacted] she has reviewed his clinical reports and medical history. Petitioner has tried multiple stimulant therapies, but when taking [redacted] in 2012, he was noted to be more functional, alert, energetic, and focused during the day. Per [redacted] review, the dosage of [redacted] had to be titrated but was eventually stabilized for about a year. When Petitioner stopped [redacted] and reverted back to high dose stimulates during the day, he began to experience side effects and to feel down, with increased hallucinations and vivid dreaming.

13. [redacted] has treated other pediatric patients with [redacted] when stimulants do not work, starting them at a low dose and titrating up to effect using the FDA adult dosing guidelines, and testing the patients on that dosage. She believes [redacted] would assist Petitioner by providing stage 3 sleep, helping to avoid seizure-type symptoms of

[redacted] during the day. It is [redacted] opinion that the stimulants are not optimizing Petitioner's treatment, and that [redacted] is currently the best medicine to treat him because of its good safety profile and past effectiveness when used by Petitioner. Without [redacted] she feels Petitioner's independence is limited as he must be closely monitored to avoid falls due to [redacted]

14. Under [redacted] Petitioner has been taking 36 mg of extended release [redacted] with booster doses of 5 mg (10mg pill cut in half) immediate release during the day, as needed. Petitioner's mother reports that she noticed some difference when Petitioner started this medication, but did not increase the booster dose to the full, 10 mg because she was expecting to restart [redacted] Petitioner also tried [redacted] to alleviate hallucinations, but did not respond well, so this was discontinued. [redacted] also prescribed [redacted] to treat nighttime symptoms; however, Petitioner's mother did not feel this worked, thought it might be increasing hallucinations, and did not refill the prescription after the first month's supply ran out. She now gives Petitioner [redacted] at night, and the [redacted] during the day.

15. Petitioner's mother is concerned that after years of testing, treatment changes, and finally finding something that works, Petitioner will now have to start over. She notes that Petitioner has started to hide knives under his bed to protect his family because he hallucinates that people are after them. He does not sleep during the night, is not doing well at school, and frequently naps during the day. His schedule and actions have upset the dynamic of the whole family. She does not understand why

[redacted] was approved before, but is now denied, and believes denial may be a cost-saving measure since [redacted] is an expensive medication.

16. United was unable to present a consistent timeline of events, and provided conflicting testimony regarding its denial decision. Dr. Fernandez clearly stated that, despite the generic language used in United's NOCA, he did not doubt either that Petitioner has an accurate diagnosis of [redacted] or that Petitioner did better while taking [redacted] however, it was Dr. Fernandez's opinion that United did not have sufficient information to approve [redacted] for an 11-year-old, in contravention to FDA protocol. United could not explain why it had authorized the medication in the past, but Dr. Fernandez did not want to "open a Pandora's Box" by making an exception and authorizing the medication, now. When asked how United determines whether to make an exception to FDA guidelines, Dr. Fernandez stated they review what they have, then go through the appeal process and leave the decision to the hearing officer. He also noted that [redacted] mentioned submitting copies of the international studies upon which she relies, but that he had not received same. Dr. Fernandez stated that if these studies and/or additional literature on the safety and efficacy of off-label use were submitted, he would review them to determine whether an exception is appropriate in Petitioner's case.[1]

17. Charity Willis, Pharm.D., testified that in her review, United's decision to deny was partly because Petitioner did not demonstrate an effective response to [redacted] While sleep studies from 2011 and 2013 were submitted, Dr. Willis felt that these were

[1] As Petitioner did not wish to further delay disposition of this appeal, United agreed to review any subsequently submitted literature as part of a new request, and issue a NOCA to Petitioner regarding its decisions related, thereto.

both too old to be reliable, and also noted that the dosages assessed during the studies might be different than what is currently requested.

18. Dr. Willis also testified that Petitioner is not taking the [redacted] at maximum dosages, may not be taking it at the proper time each day, and is only utilizing half of the 10mg booster dose. In conjunction with discontinuing the nighttime medication ([redacted] after one month, and not attempting higher dosages of [redacted] it was Dr. Willis' opinion that Petitioner has not attempted adjusting his current medications to maximum effectiveness. Dr. Willis feels that such adjustments should be attempted and ruled out before instituting a "very serious" medication, such as [redacted] which does not have FDA approval for children under 16 (Dr. Willis also noted that the reference to a minimum 6 years of age within the NOCA is a typo that has been brought to the author's attention).

CONCLUSIONS OF LAW

19. The Department of Children and Families Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 120.80, Florida Statutes. The Office of Appeal Hearings provided the parties with adequate notice of the administrative hearing.

20. Florida Medicaid State Plan is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The program is administered by the Agency.

21. This hearing was held as a *de novo* proceeding, pursuant to Florida Administrative Code R. 65-2.056.

22. As this matter involves a request for a prescription approval, the burden of proof

was assigned to the Petitioner, pursuant to Florida Administrative Code R. 65-2.060(1).

23. The standard of proof in an administrative hearing is preponderance of the evidence, as provided by Florida Administrative Code R. 65-2.060(1).

24. Section 409.912, Florida Statutes provides that AHCA shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care.

25. The Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook (July 2014) ("the Handbook") is promulgated into law by Florida Administrative Code R. 59G-4.250. Page 1-4 of the Handbook lists requirements for Health Maintenance Organizations (HMOs), as follows:

> Prescribed Drug Services
> HMO prescribed drug services are defined the same as for the Medicaid fee-for-service program and include all legend drug products covered by fee-for-service Medicaid as defined in Chapter 2 of this handbook, Legend Drugs. Medicaid's contract with HMOs states that Medicaid HMOs may use prior authorization and/or step therapy to encourage compliance with the preferred drug list.
>
> A Medicaid HMO is required to cover any product that is required to be covered under the fee-for-service Medicaid program as specified in section 1927 of Title XIX of the Social Security Act. If a product meets the definition of a covered service under that section there must be a provision to make it available through the HMO and through fee-for-service.

26. Page 2-2 of the Handbook notes:

> In order to be reimbursed by Medicaid, a drug must be medically necessary and either (a) prescribed for medically accepted indications and dosages found in the drug labeling or drug compendia in accordance with Section 1927(k)(6) of the Social Security Act, or (b) prior authorized by a qualified clinical specialist approved by the Agency. Notwithstanding this rule, the Agency may

> exclude or otherwise restrict coverage of a drug in accordance with Section 1927 of the Social Security Act.

27. At page 2-11, the Medicaid Handbook explains that:

> In order to be reimbursed by Medicaid, providers must obtain prior authorization before dispensing certain drugs.
>
> Prior authorization from Medicaid is required prior to reimbursement in the following situations:
> 1. The drug is not on the Preferred Drug List.
> 2. Clinical Prior Authorization is required for specific drugs a) For an indication not approved in labeling; b) To comply with certain clinical guidelines; or c) If the product has the potential for overuse, misuse, or abuse. The Agency may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug. A current list of drugs for which clinical prior authorization is required, and clinical prior authorization forms, may be found on the webpage at www.ahca.myflorida.com/Medicaid/Prescribed_Drug .[2]
> 3. If a prescriber hand writes "brand medically necessary" on the face of a prescription when a generic is available with a state or federal pricing limit.

28. As [redacted] is not on the preferred drug list, it requires prior authorization, and must also meet criteria listed on page 41 of AHCA's Summary of Drug Limitations (updated November 30, 2015, see link in footnote 2, below), which notes:

> [redacted] Solution Minimum age = 16

29. Because Petitioner is only 11-years of age, he does not meet this criteria. As such, the medication cannot be considered medically necessary, per Fla. Admin. Code R. 59G-1.010, which defines medical necessity, as follows:

> "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:

[2] As the cited link is not functional, for the parties' convenience, a better direct link for preferred drug list and prior authorization information is: http://ahca.myflorida.com/medicaid/Prescribed_Drug/preferred_drug.shtml (see "Preferred Drug List" and "Summary of Drug Limitations").

> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. ...
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

30. As the petitioner is under the age of 21, a broader definition of medically necessary applies, to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) requirements. Both EPSDT and Medical Necessity requirements (both cited, above) have been considered in the development of this Order.

31. EPSDT augments the Medical Necessity definition contained in the Florida Administrative Code via the additional requirement that all services determined by the agency to be medically necessary for the *treatment, correction, or amelioration* of problems be addressed by the appropriate services.

32. United States Court of Appeals for the Eleventh Circuit clarified the states'

obligation for the provision of EPSDT services to Medicaid-eligible children in Moore v. Reese, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, (which involved a dispute over private duty nursing):

> (1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.
> (2) A state Medicaid plan must include "reasonable standards ... for determining eligibility for and the extent of medical assistance" ... and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.
> (3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."
> (4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."
> (5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to provide medically unnecessary, albeit desirable, EPSDT services. However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."
> (6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and my present its own evidence of medical necessity in disputes between the state and Medicaid patients (citations omitted).

33. In the instant case, [redacted] is requested to treat and ameliorate

Petitioner's [redacted]. As such, in a general sense, [redacted] is in keeping with Fla. Admin. Code R. 59G-1.010(166)(1). However, because [redacted] is not indicated for children under the age of 16, it is not consistent with generally accepted medical standards for use in 11-year olds, and may be considered experimental, per Fla. Admin. Code R. 59G-1.010(166)(3). Additionally, Fla. Admin. Code R. 59G-1.010(166)(2) and (4) also require that any authorized service not be in excess of a patient's needs, and that there be no "equally effective and more conservative or less costly treatment is available; statewide."

34. Although United was not consistent it its approach to explaining its decision to deny [redacted] Dr. Fernandez correctly pointed to the age limitation set forth for dispensing of the drug, and Dr. Willis correctly noted that adjustments to Petitioner's stimulant therapy might be attempted prior to reinstituting [redacted]

35. It should be noted that the undersigned does not condone the manner in which United handled Petitioner's case. In refusing to speak with the treating physician until after hearing convened, United delayed potential resolution of an issue and failed to provide adequate customer service. Had United wanted additional literature to support a possible exception, they could have requested same when the decision was first appealed in June of 2015.

36. Petitioner's case is sympathetic, and the undersigned acknowledges the toll this has taken on Petitioner and his family. However, when jointly considering the requirements of both ESPDT and Medical Necessity, along with a review of the totality of the evidence and legal authority, the undersigned concludes that she does not have sufficient evidence to overturn United's denial.

37. Petitioner is encouraged to continue working with [redacted] in conjunction with United and Dr. Fernandez. Should Petitioner wish to file a new request for [redacted] including the literature requested by Dr. Fernandez, United is strongly encouraged to review same in light of Petitioner's individualized, specific needs, and his total medical history, to determine whether, consistent with EPDST, approval is appropriate in this, particular case.

DECISION

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

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 10 day of December, 2015,

in Tallahassee, Florida.

Patricia C. Antonucci
Hearing Officer
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1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: appeal.hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Debbie Stokes, Area 4, AHCA Field Office Manager

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

[redacted]

PETITIONER,

APPEAL NO. 15F-07553

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 the above-referenced matter telephonically on November 16, 2015, at 10:40 a.m.

APPEARANCES

For the Petitioner: [redacted]
Attorney-in-Fact

For the Respondent: Oscar Quintero
Program Operations Administrator
Agency for Health Care Administration

STATEMENT OF ISSUE

Did the respondent prove by a preponderance of the evidence that it correctly reduced the petitioner's monthly supply of 30' x 36' underpads from three cases (60 per case) to two cases (60 per case) and correctly terminated approval of the petitioner's dimethicone cream?

PRELIMINARY STATEMENT

[redacted] the petitioner's son and attorney-in-fact, appeared on behalf of the petitioner, [redacted] ("petitioner"). The petitioner was not present.

Oscar Quintero, Program Operations Administrator with the Agency for Health Care Administration ("AHCA" or "Agency"), appeared on behalf of the Agency for Health Care Administration. The following individuals appeared as witnesses on behalf of the Agency: Mary Colburn, M.D., Long-Term Care Medical Director for Amerigroup; and Carlene Brock, L.P.N., Quality Operations Nurse with Amerigroup.

The petitioner introduced Exhibits "1" through "9", inclusive, at the hearing, which were accepted into evidence and marked accordingly. The respondent introduced Exhibits "1" through "7", inclusive, at the hearing, which were accepted into evidence and marked accordingly. The hearing record in this matter was left open until the close of business on November 20, 2015 in order for the respondent to provide a copy of the Amerigroup Long-Term Care Member Handbook along with the relevant portions of the contract between the Agency for Health Care Administration and Amerigroup regarding the Long-Term Care program. Once received, this information was accepted into evidence and marked as respondent's Exhibit "8". The hearing record was then closed.

FINDINGS OF FACT

1. The petitioner is an 84-year-old female. She resides in [redacted] Florida.

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

3. Petitioner is enrolled in Amerigroup. Amerigroup is a health maintenance organization ("HMO") contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in Broward County.

4. The petitioner is diagnosed with the following: [redacted]

5. The petitioner is incontinent of both bowel and bladder.

6. The petitioner was previously approved to receive three cases (60 per case) of 30' x 36' underpads and one bottle (32 oz.) of dimethicone cream per month.

7. In a Notice of Action dated July 22, 2015, Amerigroup informed petitioner it was reducing her monthly supply of underpads from three cases to two cases, and that it was terminating her receipt of the remedy skin repair cream dimethicone. The Notice states these changes were to become effective August 1, 2015.

8. The Notice of Action states in part:

X We determined your requested services are **not medically necessary** because the services do not meet the reason(s) checked below: *(See Rule 59G-1.010)*

X Must be furnished in a manner not primarily intended for the convenience of the recipient, caretaker or provider....

9. At the petitioner's request, Amerigroup completed an internal review of its decision, called a Level 1 Appeal, to reduce the petitioner's underpads and terminate her receipt of the skin repair cream.

10. In a letter dated August 11, 2015, Amerigroup the informed petitioner it was upholding its original decision to reduce her monthly supply of underpads and terminate approval of the skin repair cream.

11. On or about September 9, 2015, Amerigroup received a request from the petitioner's son and attorney-in-fact asking for a continuation of benefits pending the resolution of a Medicaid Fair Hearing. Amerigroup approved continuation of benefits for the petitioner's incontinence supplies on September 24, 2015.

12. In September, 30' x 30' underpads were sent to the petitioner because the petitioner's durable medical equipment and supplies provider discontinued the 30' x 36' underpads. With the petitioner's approval, Amerigroup secured another durable medical equipment and supplies provider for the petitioner who was able to supply the petitioner with the 30' x 36' underpads from that point forward. However, Amerigroup maintained its position that it would reduce the supply of petitioner's underpads from three cases to two cases per month (60 per case) for a total of 120 underpads per month.

13. The petitioner is approved to receive briefs in addition to underpads. Briefs are adult diapers that have tape on the sides whereas underpads are designed to lay flat on the bed and absorb any waste not contained in the diaper.

14. The petitioner receives three cases of 72 high-absorbency briefs per month for a total of 216 briefs. Amerigroup has not proposed a reduction in the amount of briefs that the petitioner receives monthly.

15. Amerigroup has determined the petitioner requires between six to eight diaper changes daily. 216 briefs per month is equal to approximately seven briefs per day.

16. Briefs are considered the primary incontinence product for individuals who have incontinency issues.

17. The petitioner has a documented history of skin breakdown in the area between her lower back and upper thigh. The 30' x 36' underpad is the appropriate size to cover the area in which the petitioner has a history of skin breakdown. When she was receiving the 30' x 30' underpads, two underpads had to be used to cover the affected area.

18. Underpads help reduce the risk of skin breakdown.

19. It is the respondent's position that 120 underpads per month should be sufficient given the petitioner is also receiving 216 high-absorbency briefs per month. It is also the respondent's position that a moisturizer is not medically necessary for the petitioner.

20. The petitioner's representative testified that, because the petitioner is quadriplegic, she must be turned to one side and then the other in order to remove her soiled diaper. During this process, waste is left in her perineal area, lower back, and upper thigh. This waste consequently soils the underpad as the petitioner is being turned and necessitates the changing of the underpad each time petitioner is changed.

21. The petitioner's representative testified that, although the dimethicone is not a barrier cream, it helps to reduce the drying of the skin cause by the zinc oxide in the barrier cream and helps prevent skin breakdown and pressure sores. This testimony is consistent with the documentation provided by the petitioner's doctor and wound care nurse stating the dimethicone is medically necessary.

CONCLUSIONS OF LAW

22. 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.

23. The Florida Medicaid Program is authorized by Chapter 409, Fla. Stat., and Chapter 59G, Florida Administrative Code. The Program is administered by AHCA. All goods and services requested under the Florida Medicaid Program must be shown to be medically necessary in order to be approved.

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

25. The respondent in the present case is proposing to terminate, reduce, or change the petitioner's services. Therefore, in accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof is assigned to the respondent.

26. 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.).

27. The Florida Medicaid program is authorized by Fla. Stat. ch. 409 and Fla. Admin. Code R. 59G. The Medicaid program is administered by the respondent.

28. Under § 1915(c) of the Social Security Act (42 USC § 1396n(c)), a state may obtain a Medicaid waiver that allows the state to include in the state's Medicaid program the cost of home or community-based services (other than room and board) provided to individuals who otherwise would require care in a hospital, nursing facility, or intermediate care facility.

29. Home or community-based services include personal care services, habilitation services, and other services that are "cost effective and necessary to avoid institutionalization." See 42 CFR § 440.180.

30. Section 409.978, Florida Statutes, provides that the "Agency shall administer the long-term care managed care program," through the Department of Elder Affairs and through a managed care model. Fla. Stat. § 409.981(1), authorizes AHCA to bid for and utilize provider service networks to achieve this goal. In the instant case, the provider network/HMO is Amerigroup.

31. Section 409.905, Fla. Stat. addresses mandatory Medicaid services under the State Medicaid Plan:

> Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law…
> (4) HOME HEALTH CARE SERVICES.–The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home…
> (a) The agency shall require prior authorization of home health services….
> (c) The agency may not pay for home health services unless the services are medically necessary …

32. The Florida Medicaid Home Health Services Coverage and Limitations Handbook March 2013 is incorporated by reference and promulgated into Rule by Chapter 59G-4.130, Florida Administrative Code.

33. The Florida Medicaid Home Health Services Coverage and Limitations Handbook, on Page 2-30, states as follows

> Home health agencies that provide DME must comply with the policies and procedures contained in this handbook and in the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook.

34. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Chapter 59G-4. In accordance with the above Statute, the Handbook states on page 1-27

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.
>
> Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

35. Pages 1-28 of the Florida Medicaid Provider General Handbook provide a list of HMO covered services. These services include durable medical equipment.

36. Page 1-30 of the Florida Medicaid Provider General Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

37. In order for durable medical equipment and supplies to be approved, the equipment and supplies must not only be medically necessary but must also meet all requirements set forth in the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook.

38. Although the terms medically necessary and medical necessity are often used interchangeably and may be used in a variety of contexts, their definition for Florida Medicaid purposes is contained in the Florida Administrative Code. Fla. Admin. Code R. 59G-1.010 states:

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods or services furnished or ordered must:
>
> (a) Meet the following conditions:
>
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
>
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
>
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
>
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
>
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
>
> (b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods, or services medically necessary or a medical necessity or a covered service.

39. Section 409.913, Fla. Stat. governs the oversight of the integrity of the Florida Medicaid Program. Section (1)(d) sets forth the "medical necessity or medically necessary" standards, and states in pertinent part as follows

> "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice....
>
> Section (1)(d) goes on the further state:
>
> ...For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

40. Section (1)(d) highlights that the Agency makes the final decision regarding whether or not a requested service is medically necessary; however, the hearing officer is the final decision making authority for the Agency. See § 120.80, Fla. Stat.

41. The Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook (July 2010) ("DME Handbook") is promulgated into rule by Fla. Admin. Code R. 59G-4.070. The Handbook describes the covered services, limitations, and exclusions associated with the acquisition and reimbursement of durable medical equipment and medical supplies obtained through the Medicaid program.

42. The DME Handbook, on Pages 2-48 and 2-49, sets forth the medical necessity, age, and documentation requirements for receiving disposable incontinence

briefs, diapers, protective underwear, pull-ons, liners, shields, guards, pads, and undergarments, along with the associated limitations for receiving such supplies. These requirements include documentation from the recipient's physician regarding the need for incontinence products.

43. The Contract between the Agency for Health Care Administration and Amerigroup governing the provision of Long-Term Care Services, AHCA Contract No. FP021, in Attachment II, Exhibit II-B, Effective 07/15/15, Section V, Page 14 of 116 – Covered Services, explains as follows:

> (14) Medical Equipment and Supplies --- Medical equipment and supplies, specified in the plan of care, include: (a) devices, controls or appliances that enable the enrollee to increase the ability to perform activities of daily living; (b) devices, controls or appliances that enable the enrollee to perceive, control or communicate the environment in which he or she lives; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment that is necessary to address enrollee functional limitations; (e) necessary medical supplies not available under the State Plan including consumable medical supplies such as adult disposable diapers. This service includes the durable medical equipment benefits available under the state plan service as well as expanded medical equipment and supplies coverage under this waiver. All items shall meet applicable standards of manufacture, design and installation. This service also includes repair of such items as well as replacement parts.

44. The Amerigroup Member Handbook, on Page 14, explains that medical equipment and supplies is a covered service. This service includes "Disposable diapers, gloves and other consumable medical supplies".

45. In the present case, the petitioner's representative presented credible testimony and evidence refuting the Agency's claim that 120 underpads per month are sufficient and documenting the need for both the additional 60 underpads per month

and the skin repair cream. The respondent has not demonstrated by a preponderance of the evidence that it correctly reduced the petitioner's monthly supply of underpads or correctly terminated the approval of the skin repair cream.

46. In rendering this decision, the undersigned hearing officer considered all of the testimony and documentary evidence presented during the hearing process and reviewed all conditions of "medical necessity" set forth in the Florida Administrative Code and the rules governing the Florida Medicaid program.

DECISION

The petitioner's appeal is hereby GRANTED.

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 21 day of December, 2015, in Tallahassee, Florida.

Peter J. Tsamis

Peter J. Tsamis
Hearing Officer
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Tallahassee, FL 32399-0700
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Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

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

[redacted]

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 06 Pinellas
UNIT: AHCA

RESPONDENT.
_____/

APPEAL NO. 15F-07555

CASE NO.

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 22, 2015, at approximately 11:21 a.m.

APPEARANCES

For Petitioner: [redacted] Petitioner's Mother

For Respondent: Stephanie Lang, R.N. Specialist/Fair Hearing Coordinator
Agency for Healthcare Administration

STATEMENT OF ISSUE

Whether the Agency was correct in denying Petitioner's request for orthodontic treatment including braces, fixed appliance therapy, and monthly treatment visits. Petitioner holds the burden of proof on this issue by a preponderance of the evidence.

PRELIMINARY STATEMENT

Appearing as witnesses for Respondent were Carlene Brock (Quality Operations Nurse with Amerigroup), Jacqueline Salcedo (Complaints and Grievance Specialist with DentaQuest), and Dr. Susan Hudson (Dental Consultant with DentaQuest).

Respondent admitted twelve exhibits into evidence, which were marked and entered as Respondent's Exhibits 1 through 12. Petitioner submitted no exhibits into evidence. Administrative notice was taken of Florida Statutes 409.910, 409.962 through 409.965, 409.973, Florida Administrative Code Rules 59G-1.001, 59G-1.010, 59G-4.060, as well as the Medicaid Dental Services Coverage and Limitations Handbook (November 2011).

FINDINGS OF FACT

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

1. Petitioner is a Medicaid recipient under 21 years of age. Her orthodontist suggested treatment and explained to Petitioner's mother that Petitioner's spacing issues could cause problems, and her crossbite means her teeth will come in at an angle.

2. On or about August 24, 2015, Petitioner's orthodontist submitted a prior authorization request to Petitioner's Medicaid managed care plan, Amerigroup. DentaQuest handles the prior authorization reviews for Amerigroup members. Amerigroup requires prior authorization for orthodontic treatment for children under 21.

3. Petitioner's orthodontist noted that she had an anterior crossbite/traumatic occlusion, generalized spacing, and "bimax protrusion." He completed the Medicaid

Orthodontic Initial Assessment form (IAF) and submitted it with the request. The IAF indicated Petitioner has a crossbite of individual anterior teeth with destruction of soft tissue. He indicated a total score of 27 on this assessment.

4. DentaQuest received the prior authorization request on August 24, 2015. Amerigroup denied Petitioner's request for braces based on DentaQuest's recommendations by notice dated August 26, 2015. The notice indicated the request was denied because Petitioner did not show medical necessity by scoring 26 or more points on the IAF. The appliances were denied because Petitioner didn't show any bad habits which would require appliance therapy.

5. Petitioner scored a 12 on the initial assessment that DentaQuest's dental reviewer completed based on the submitted information. DentaQuest found that Petitioner has labio-lingual spread and an overjet, but not an anterior crossbite of individual teeth with tissue damage.

6. The difference in scoring on the initial assessment is the result of two different reviewers. The DentaQuest reviewer indicated that the models, x-rays, and photos do not meet Medicaid's requirements for anterior crossbite.

CONCLUSIONS OF LAW

7. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80, Florida Statutes.

8. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.

9. This hearing was held as a de novo proceeding pursuant to Florida Administrative Code Rule 65-2.056.

10. In accordance with Florida Administrative Code Rule 65-2.060(1), the burden of proof was assigned to the Petitioner. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Florida Administrative Code Rule 65-2.060(1).

11. Section 409.912, Florida Statutes, notes that AHCA shall purchase goods and services for Medicaid recipients in the most cost-effective manner possible, consistent with the delivery of quality medical care.

12. The Florida Medicaid Provider General Handbook (Provider Handbook) – July 2012 is incorporated by reference in Florida Administrative Code Rule 59G-5.020(1). In accordance with the Florida law, the Provider Handbook discusses managed care coverage, stating on page 1-27:

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.
>
> Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

13. Page 1-30 of the Provider Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

14. All Medicaid services must be medically necessary, including dental. Florida Administrative Code, 59G-1.010(166), defines medical necessity, as follows:

> "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
>
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
>
> ...
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

15. The Medicaid Dental Services Coverage and Limitations Handbook, November 2011 (Dental Handbook) is promulgated into law by Rule 59G-4.060(2), Florida Administrative Code. Rule 59G-4.060(3), Florida Administrative Code specifically promulgates by incorporation the forms included in the Dental Handbook, including the Medicaid Orthodontic Initial Assessment Form (IAF). Page 2-2 of the Dental Handbook states that all dental services must meet the definition of medical necessity as set forth above.

16. As the petitioner is under 21, a broader definition of medically necessary applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services

(EPSDT) requirements. Section 409.905, Fla. Stat., *Mandatory Medicaid services*, defines Medicaid services for children to include:

> (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems…

17. The Dental Handbook states on page 1-2: "The children's dental program provides full dental services for all Medicaid eligible children age 20 and below." Page 2-3 states that this includes medically necessary orthodontic treatment.

18. Orthodontic treatment is covered under the above authorities for a child under 21 if it is a medically necessary service. Page 2-15 of the Dental Handbook states as follows:

> Prior authorization is required for all orthodontic services. **Orthodontic services are limited to those recipients with the most handicapping malocclusion.** A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the patient by causing impaired mastication, dysfunction of the temporomandibular articulation, susceptibility to periodontal disease, susceptibility of dental caries, and impaired speech due to malpositions of the teeth.
>
> Treatment is routinely accomplished through fixed appliance therapy and monthly maintenance visits. Removable (D8210) or fixed (D8220) appliance therapy may be reimbursed, but is dependent upon individual case circumstances. If requesting a removable (D8210) or fixed (D8220) appliance for thumb sucking or other habit, clinical photos must be submitted with the prior authorization request for the determination of medical necessity. (emphasis added)

Page 2-16 explains further how this is determined:

> Criteria for approval is limited to one of the following conditions:

- Correction of severe handicapping malocclusion as measured in the Medicaid Orthodontic Initial Assessment form (IAF) AHCA-Med Serv Form 013;
- Syndromes involving the head and maxillary or mandible jaws such as cleft lip or cleft palate;
- Cross-bite therapy, with the exception of one posterior tooth that is causing no occlusal interferences;
- Head injury involving traumatic deviation; or
- Orthognatic surgery, to include extractions, required or provided in conjunction with the application of braces.

19. Regarding scoring the IAF, the Dental Handbook explains on page 2-18 that a score of less than 26 "...does not say that [the case does] not represent some degree of malocclusion, but simply that the severity of the malocclusion does not qualify for coverage under the Florida Medicaid Orthodontic Program."

20. Petitioner alleges handicapping malocclusion, which is measured by the IAF. She does not allege any of the criteria for approval such as cleft lip or orthognatic surgery. Petitioner's orthodontist noted she had an anterior crossbite, which the form instructed to mark an X and score no further. He gave Petitioner a score of 27 on the assessment he completed. There is no information as to how he obtained this specific number. To meet Medicaid's guidelines for an anterior crossbite as described on page A-4 of the Dental Handbook, "destruction of soft tissue must be clearly visible in the mouth and reproducible and visible on the study models. A minimum of 1.5mm of tissue recession must be evident to qualify as soft tissue destruction in anterior crossbite cases."

21. DentaQuest's dental consultant appeared at the hearing, and stated Petitioner's orthodontist did not score the IAF according to Medicaid rules. DentaQuest's multiple reviewers did not find evidence of the anterior crossbite with tissue damage that Petitioner's orthodontist indicated was present. In the absence of contrary testimony,

Petitioner was unable to meet her burden of proof. As Petitioner has not shown that she meets Medicaid's requirements for general orthodontic treatment, it is unnecessary to determine whether she requires fixed appliance therapies as part of that care.

22. Petitioner is going by her treating provider's recommendations. Petitioner's treating orthodontist was not present at the hearing. Based on the Agency's definition of medical necessity excerpted above, "[t]he fact that a provider has…recommended…services does not, in itself, make such…services medically necessary or a medical necessity or a covered service."

23. After careful review of the relevant authorities, the testimony and the evidence in this matter, the hearing officer concludes that the Agency properly denied Petitioner's request for orthodontic treatment.

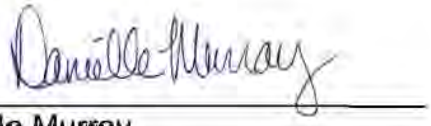
DECISION

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

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 17 day of December, 2015, in Tallahassee, Florida.



Danielle Murray
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Copies Furnished To: [redacted] Petitioner
Don Fuller, Area 5, AHCA Field Office Manager

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

[redacted]

APPEAL NO. 15F-07556

PETITIONER,

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 05 Marion
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice and agreement, Hearing Officer Patricia C. Antonucci convened hearing in the above-captioned matter on October 27, 2015 at approximately 11:30 a.m. All parties and witnesses appeared via teleconference.

APPEARANCES

For the Petitioner: [redacted] Petitioner's grandmother

For the Respondent: Selwyn Gossett, Medical/Health Care Program Analyst, Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is a decision by Respondent, the Agency for Health Care Administration (AHCA), through its contracted peer review organization, eQHealth Solutions, Inc., to terminate Petitioner's Prescribed Pediatric Extended Care (PPEC) services. Respondent bears the burden of proving, by a preponderance of the evidence, that said termination is proper.

PRELIMINARY STATEMENT

Prior to hearing on the merits, a preliminary hearing convened via teleconference at approximately 2:00 p.m. on September 30, 2015 to determine whether Petitioner's benefits should be reinstated and continue, pending outcome of Petitioner's appeal. After it was established that the benefit would be reinstated and continue until Final Order, the parties agreed to proceed to final hearing on October 27, 2015.

At hearing on October 27, 2015, the minor Petitioner was not present, but was represented by her grandmother, [redacted], who presented one additional witness: [redacted] Petitioner's great-grandmother. Respondent was represented by Selwyn Gossett, Medical/Health Care Program Analyst, on behalf of AHCA. Respondent presented one additional witnesses: Ellyn Theophilopoulos, M.D., Physician Reviewer with eQHealth Solutions (eQHealth).

Respondent's Exhibits 1 through 5, inclusive, were admitted into evidence. Administrative Notice was taken of Fla. Stat. § 409.905, Fla. Admin. Code R. 59G-1.001, Fla. Admin. Code R. 59G-1.010, Fla. Admin. Code R. 59G-4.260, and pertinent pages of the September 2013 Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook (PPEC Handbook).

At hearing, Petitioner's representative was not sure whether she had the most updated version of Respondent's evidence packet in front of her, but opted to proceed, using the paperwork she had available. Respondent was instructed to send an additional copy of the evidence to Petitioner, filing a Certificate of Service to confirm delivery of same. Petitioner did not wish the undersigned to hold the record open for a response to the new evidence.

Although the undersigned did not receive an updated Certificate of Service, since Petitioner did not opt to file a response, this Final Order is issued without confirmation that the evidence was furnished to her. To ensure that she has a copy for her records, the 60-page packet is attached, hereto.

FINDINGS OF FACT

1. The Petitioner is a 2-year old female, born [redacted] She was born premature at 27 weeks gestation, and was intubated while in the neonatal intensive care unit. Petitioner was diagnosed with [redacted] and given preventative medication for respiration. Her current, active diagnoses include [redacted] and [redacted]

2. While Petitioner was living with her mother, the Department of Children and Families (DCF) became involved as a result of the mother's failure to maintain Petitioner's medical appointments. Petitioner is now in the custody of her grandmother and great-grandmother, and DCF is no longer involved.

3. Petitioner is and has been eligible to receive Medicaid services at all times relevant to these proceedings.

4. On or about August 10, 2015, Petitioner's PPEC provider submitted a request on behalf of the Petitioner, to continue her previously authorized PPEC services into her new certification period, spanning August 18, 2015 through February 19, 2016.

5. This prior service authorization request was submitted to AHCA's peer review organization (PRO), along with information and documentation required to make a determination of medical necessity. The PRO contracted by AHCA to review PPEC requests is eQHealth Solutions, Inc. (eQHealth).

6. On August 13, 2015, the PRO reviewed Petitioner's request for services and all supporting documentation. By letter dated August 15, 2015, the PRO notified Petitioner's provider of its decision to terminate PPEC, stating, in pertinent part:

> PR Principal Reason – Denial: Requested services are denied because the clinical information does not support the medical necessity.
>
> The patient is a 2 year old with [redacted] and [redacted] The patient is on an age-appropriate diet. The patient is on as needed nebulizer treatments. The patient is currently receiving no other skilled nursing services. The patient appears to no longer require skilled nursing services and does not meet the medical complexity requirement of PPEC services. The clinical information provided does not support the medical necessity of the requested services; however, 30 days will be approved to provide the caregiver time to transition the patient out of PPEC. Partial approval PPEC: Mon thru Sat: 8/18/15 thru 9/15/15.

7. The August 15, 2015 denial letter sent to Petitioner did not include this explanation, noting only:

> The reason for the denial is that the services are not medically necessary as defined in 59G-1.010 (166), Florida Administrative Code (F.A.C.), specifically the services must be:
> Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.
> Reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.

8. On or about September 2, 2015, Petitioner requested a hearing to challenge this denial.

9. As Petitioner's request for hearing was received prior to the end of her certification period (September 15, 2015), Petitioner's services were reinstated as of preliminary hearing on September 30, 2015, and have continued pending the outcome of her appeal.

10. At hearing, Dr. Theophilopoulos testified based upon her review of Petitioner's request for services, in conjunction with her Plan of Care, PPEC Assessment, and progress notes.

11. Petitioner's Plan of Care reflects that she is totally dependent on others for activities of daily living (ADL) care. Petitioner is noted to have [redacted] While she requires precautions/monitoring, the only interventions indicated on the Plan are the administration of [redacted], as needed, and use of ambu-bag, in case of emergency. The Plan instructs that Petitioner be fed in an upright position, but notes that she takes an oral, whole milk diet, with increased foods as tolerated. The "Current Medical Condition" portion of Petitioner's Plan reflects her complicated medical history, notes that Petitioner may need PE tube placement, has trouble with balance, and may require a sleep study. The Plan indicates that receives speech therapy (ST) while at PPEC.

12. Per Dr. Theophilopoulos, Petitioner's PPEC Assessment appears normal, reflecting that Petitioner has some drainage from her nose, but shows good oxygen saturation, tolerates mouth feedings, and has good urine output. Petitioner is not dependent upon mechanical devices, and her ADLs are age-appropriate.

13. Petitioner's great-grandmother is concerned that Petitioner still requires services, and that while PPEC has helped, she still requires some form(s) of therapy to address [redacted] as well as [redacted] to address [redacted] and some [redacted]

14. Petitioner's grandmother is concerned that Petitioner has difficulty eating, in that she swallows her food whole, without chewing same. She is also concerned with

Petitioner's pulmonary issues, as well as her hearing, being that Petitioner failed four hearing tests and is awaiting tube placement.

15. It is Dr. Theophilopoulos's opinion that at this time, Petitioner does not require skilled nursing interventions on a regular basis. Per Dr. Theophilopoulos, Petitioner's needs were highest upon her admission to neonatal intensive care, but she has since stabilized and her [redacted] now appears dormant. Dr. Theophilopoulos opined that Petitioner's hearing and speech/swallowing deficits may be addressed through ST, which Petitioner can receive as a distinct service, outside of the PPEC setting.

16. The Agency noted that because Petitioner is enrolled with a medical managed care plan through Children's Medical Services (CMS), she should have a CMS case manager who can assist Petitioner's mother in finding appropriate services to address Petitioner's behavioral issues and any other outstanding needs.

CONCLUSIONS OF LAW

17. By agreement between AHCA and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction to conduct this hearing, pursuant to Florida Statutes Chapter 120.

18. Respondent, the Agency for Health Care Administration, administers the Medicaid Program. Legal authority governing the Florida Medicaid Program is found in Fla. Stat., Chapter 409, and in Chapter 59G of the Florida Administrative Code.

19. The September 2013 Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook (PPEC Handbook) has been promulgated into rule by Fla. Admin. Code R. 59G-4.260.

20. This is a Final Order, pursuant to § 120.569 and § 120.57, Fla. Stat.

21. This hearing was held as a *de novo* proceeding, in accordance with Fla. Admin. Code R. 65-2.056.

22. The burden of proof in the instant case is assigned to Respondent, who seeks to terminate Petitioner's PPEC services. The standard of proof in an administrative hearing is preponderance of the evidence. (See Fla. Admin. Code R. 65-2.060(1).)

23. Fla. Stat. § 409.905 addresses mandatory Medicaid services under the State Medicaid Plan:

> Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law....
> (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.—The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

24. Page 1-1 of the PPEC Handbook notes that, "[t]he purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) Services Program is to enable recipients under the age of 21 years with medically complex conditions to receive medical and therapeutic care at a non-residential pediatric center."

25. On page 2-1 – 2-2, the PPEC Handbook lists the requirements for PPEC services.

> To receive reimbursement for PPEC services, a recipient must meet all of the following criteria:

- Be Medicaid eligible.
- Diagnosed with a medically-complex or medically fragile condition as defined in Rule 59G-1.010, F.A.C.
- Be under the age of 21 years.
- Be medically stable and not present significant risk to other children or personnel at the center.
- Require short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care due to a medically-complex condition.

26. Fla. Admin. Code R. 59G-1.010 defines "medically complex" and "medically fragile" as follows:

> (164) "Medically complex" means that a person has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention.
> (165) "Medically fragile" means an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, e.g., requires total parenteral nutrition (TPN), is ventilator dependant, or is dependent on a heightened level of medical supervision to sustain life, and without such services is likely to expire without warning.
> (emphasis added)

27. Consistent with the law, AHCA's agent, eQHealth, performs service authorization reviews under the Prior Authorization Program for Medicaid recipients in the state of Florida. Once eQHealth receives a PPEC service request, its medical personnel conduct file reviews to determine the medical necessity of requested services, pursuant to the authorization requirements and limitations of the Florida Medicaid Program.

28. Fla. Admin. Code Rule 59G-1.010(166) defines medical necessity, as follows:

> "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. ...
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

29. As the petitioner is under the age of 21, a broader definition of medically necessary applies, to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) requirements. Both EPSDT and Medical Necessity requirements (both cited, above) have been considered in the development of this Order.

30. EPSDT augments the Medical Necessity definition contained in the Florida Administrative Code via the additional requirement that all services determined by the agency to be medically necessary for the *treatment, correction, or amelioration* of problems be addressed by the appropriate services.

31. United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in Moore v. Reese, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, (which involved a dispute over private duty nursing):

> (1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.
> (2) A state Medicaid plan must include "reasonable standards ... for determining eligibility for and the extent of medical assistance" ... and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.
> (3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."
> (4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."
> (5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to provide medically unnecessary, albeit desirable, EPSDT services. However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."
> (6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and my present its own evidence of medical necessity in disputes between the state and Medicaid patients (citations omitted).

32. In the instant case, PPEC is requested to treat and ameliorate the supervisory and monitoring needs which Petitioner's health conditions require. As such, in a general sense, PPEC is in keeping with Fla. Admin. Code R. 59G-1.010(166)(1).

Because PPEC is a recognized Medicaid service, it is consistent with generally accepted medical standards, per Fla. Admin. Code R. 59G-1.010(166)(3).

33. More specifically, however, Fla. Admin. Code R. 59G-1.010(166) also requires that any authorized service not be in excess of a patient's needs, be furnished in a manner not intended for convenience, and be a service for which no equally effective and less-costly treatment is available. In order for PPEC to fulfill these criteria, the Petitioner must meet the requirements for PPEC, as provided in the PPEC Handbook.

34. There is little evidence to suggest that the Petitioner is dependent upon 24-hour per day medical or nursing care, or that she is dependent upon life-sustaining medical intervention or equipment, such that she would properly be deemed "Medically Complex" or "Medically Fragile." Her need for supervision, general monitoring, and precautions do not constitute a need for "intermittent continuous therapeutic interventions or skilled nursing care."

35. Tellingly, there is currently no skilled therapy or intervention provided to Petitioner at the PPEC site. While the PPEC program is "hosting" ST services, these services, as well as any other needed therapy, can be authorized as a distinct service, outside the PPEC environment. Petitioner is encouraged to pursue coordination of same through CMS.

36. When jointly considering the requirements of both ESPDT and Medical Necessity, along with a review of the totality of the evidence and legal authority, the undersigned concludes that Respondent has met its burden of proof to terminate PPEC.

37. Petitioner's guardians are further encouraged to coordinate with AHCA and Petitioner's CMS case manager, to determine Petitioner's options for behavioral

services, and other services necessary to meet Petitioner's needs. Should Petitioner request a service and receive a notice denying same, she will retain the right to appeal that/those, specific denial(s).

DECISION

Based upon the foregoing, 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 29 day of December, 2015,

in Tallahassee, Florida.

Patricia C. Antonucci
Hearing Officer
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Tallahassee, FL 32399-0700
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Fax: 850-487-0662
Email: appeal.hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Debbie Stokes, Area 4, AHCA Field Office Manager

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

[redacted]

APPEAL NO. 15F-07557

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 13 Hillsborough
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on September 30, 2015, at approximately 11:06 a.m.

APPEARANCES

For Petitioner: [redacted] Petitioner

For Respondent: Stephanie Lang, RN Specialist
Agency for Healthcare Administration

STATEMENT OF ISSUE

Whether the Agency was correct in denying Petitioner's request for teeth extractions. Petitioner held the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

Appearing as witnesses for Respondent were India Smith (Grievance and Appeals Coordinator) and Donna Laber, R.N. (Manager of Grievance and Appeals) with

Sunshine Health Plan, and Dr. Kimberly Anderson (Dental Consultant) with Dental Health and Wellness. Tiffany Smith (Grievance and Appeals Coordinator) with Sunshine Health Plan, Karen Greyhack (Appeal Specialist) and Elias Vega (Appeals Specialist) both with Dental Health and Wellness, observed the hearing.

Respondent admitted five exhibits into evidence, which were marked and entered as Respondent's Exhibits 1 through 5. Petitioner submitted no documentary evidence. Administrative notice was taken of Florida Statutes Sections 409.910, 409.962 through 409.965, and 409.973. Administrative notice was also taken of Florida Administrative Code Rules 59G-1.001, 1.010, and 4.060.

FINDINGS OF FACT

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

1. Petitioner is a Medicaid recipient over 21 years of age who receives services through Sunshine Health Plan. She saw an oral surgeon in March who pulled some of her teeth in the hospital due to infection. She has a blood clot issue which her dentist could not handle in his office during a surgery, so surgical procedures need to be done in a hospital. The surgeon advised her to return if she had future need of him. She is back in the hospital with another infection.

2. Petitioner's primary dentist suggested the remaining teeth be pulled because of her degenerative bone disease, with the ultimate goal to be dentures. Petitioner returned to the oral surgeon she saw in March. He submitted a request for prior authorization for the extractions, bone adjustment to Sunshine Health. Dental

authorization requests are reviewed by Sunshine's Dental vendor, Dental Health and Wellness. Sunshine received Petitioner's authorization request on August 18, 2015.

3. Sunshine denied the request by notice dated September 14, 2015. The notice stated the service was denied because the provider is out of network.

4. Petitioner was able to see the oral surgeon in March because at the time, Sunshine was transitioning to using Dental Health and Wellness. Providers had a "grace period" to accept Sunshine patients and receive payment for services through Sunshine. However, the providers could not be paid by Sunshine if they did not become credentialed (in network) by a set date. In this case, the oral surgeon did not agree to become an in-network provider with Sunshine, and was considered out of network as of April 1, 2015.

5. Sunshine's case manager has been working with Petitioner to refer her to an in network surgeon. Petitioner has not yet found a surgeon willing to perform the surgery in a hospital. The authorization request from Petitioner's oral surgeon included "hospital call" but included no other indication that this would be done in a hospital or why it was necessary to be done there. Petitioner's testimony is the only evidence that the surgery needs to be done in the hospital.

6. Sunshine agreed that the services as requested could be approved but only if Petitioner uses an in network provider. Petitioner can work with her primary dentist to find an in network provider that will meet her needs.

7. Once Petitioner finds an in network surgeon, that surgeon can evaluate her and submit a prior authorization request for the services he/she feels are appropriate for Petitioner's care. However, as far as the request to do the surgery in a hospital,

Sunshine cautioned that all requests must be medically necessary and accompanied by any information showing that.

CONCLUSIONS OF LAW

8. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80, Florida Statutes.

9. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.

10. This hearing was held as a de novo proceeding pursuant to Florida Administrative Code Rule 65-2.056.

11. Section 409.912, Florida Statutes, notes that AHCA shall purchase goods and services for Medicaid recipients in the most cost-effective manner possible, consistent with the delivery of quality medical care.

12. The Florida Medicaid Provider General Handbook (Provider Handbook) – July 2012 is incorporated by reference in Florida Administrative Code Rule 59G-5.020(1). Regarding providers, the Provider Handbook states on page 1-2:

> Only health care providers that meet the conditions of participation and eligibility requirements and are enrolled in Medicaid may provide and be reimbursed for rendering Medicaid-covered services.

13. The Provider Handbook also discusses freedom to choose a Medicaid provider, stating on page 1-3:

> Per Title 42 of the Federal Code of Regulations Part 431.51, recipients may obtain services from any qualified Medicaid provider that undertakes to provide the services to them.

The exceptions to a recipient's freedom of choice of providers are as follows:

- The allowable restrictions that are specified in section 1915(a) of the Social Security Act.
- If the recipient is enrolled in a Medicaid managed care program. An exception is freedom of choice of providers for family planning services, which may not be restricted. Managed care plans are responsible for paying for family planning for their members regardless of whether the family planning provider is a plan subcontractor.

14. These authorities explain that a Medicaid recipient (even through a managed care plan) must see a participating Medicaid provider in order for Medicaid to cover the service. If a recipient obtains services from a non-Medicaid provider, the recipient may be responsible for payment for the services. Page 1-7 of the Provider General Handbook explains when a Medicaid recipient may have to pay a provider for care.

15. Page 1-30 of the Provider Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

16. Regardless of Petitioner's medical need for the service, the authorities are clear that Medicaid will only reimburse providers who accept and bill Medicaid for services. Sunshine is not required to pay for services provided by a surgeon that is not in its network because the surgeon does not accept Sunshine/Medicaid.

17. Sunshine has shown that there are sufficient oral surgeons in its network in Petitioner's area that she could receive services from. Petitioner would need to show by a preponderance of the evidence that none of those surgeons would be appropriate to treat her. She did not provide any evidence that the available surgeons were unwilling or unable to treat her. Her testimony that she has made phone calls and was told no (because they won't operate in the hospital) is not sufficient to overcome Sunshine's

evidence that the surgeons are available. Whether or not the surgery needs to take place in a hospital is up to the treating surgeon to determine.

18. After careful review of the relevant authorities, the testimony and the evidence in this matter, the hearing officer concludes that Petitioner's request for services by an out of network provider was properly denied. Petitioner may resubmit her request for services through an in network provider, and will have appeal rights if denied.

DECISION

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

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 01 day of December, 2015, in Tallahassee, Florida.

Danielle Murray
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Don Fuller, Area 6, AHCA Field Office Manager

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

[redacted]

PETITIONER,

Vs.

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

RESPONDENT.
_____/

APPEAL NO. 15F-07559

CASE NO.

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in this matter telephonically on October 27, 2015, at 1:10 p.m.

APPEARANCES

For the petitioner: [redacted]
Petitioner's daughter

For the Respondent: Linda Latson, R.N.
Registered Nurse Specialist/Fair Hearing Coordinator
Agency for Health Care Administration

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the respondent incorrectly denied her request for an additional 10 hours of long-term care services comprising of any combination of companion services and respite services?

PRELIMINARY STATEMENT

[redacted] the petitioner's daughter, appeared on behalf of the petitioner, [redacted] ("petitioner"), who was not present. [redacted] may sometimes hereinafter be referred to as the petitioner's "representative".

Linda Latson, R.N., Registered Nurse Specialist and Fair Hearing Coordinator with the Agency for Health Care Administration ("AHCA" or "Agency"), appeared on behalf of the Agency for Health Care Administration. The following individuals from Amerigroup appeared as witnesses on behalf of the Agency: Mary Colburn, M.D., Long-Term Care Medical Director; and Carlene Brock, L.P.N., Quality Operations Nurse.

The petitioner introduced Exhibits "1" and "2", inclusive, at the hearing, which were accepted into evidence and marked accordingly. The respondent introduced Exhibits "1" through "5", inclusive, at the hearing, which were accepted into evidence and marked accordingly. The hearing record in this matter was left open until the close of business on November 3, 2015 in order for the respondent to submit the relevant portion of the contract between the Agency for Health Care Administration and Amerigroup and the Amerigroup Long-Term Care Member Handbook. Once received, this information was accepted into evidence and marked as respondent's Exhibit "6". The hearing record was then closed.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. Petitioner is an 86-year-old female residing in [redacted] Florida.

2. Petitioner was eligible to receive Medicaid services at all times relevant to this proceeding.

3. The petitioner is an enrolled member of Amerigroup. Amerigroup is a health maintenance organization ("HMO") contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in Florida.

4. The petitioner's effective date of enrollment with Amerigroup was November 1, 2013.

5. The petitioner is a bilateral lower extremity amputee. She is diagnosed with the following: [redacted]

6. The petitioner requires assistance with all of her activities of daily living. She can no longer be placed in the shower and must be given bed baths.

7. The petitioner uses a bed pan to evacuate her bladder and bowels.

8. The petitioner was hospitalized due to dehydration and renal failure from August 23, 2015 through August 29, 2015. She was re-hospitalized from September 4, 2015 through September 12, 2015.

9. The petitioner has been very weak since returning home from the hospital. Although the petitioner requires hydration, she is too weak to hold a glass of water and drink independently. She requires the assistance of another individual to drink. She also requires the assistance of another person to take her medication.

10. The petitioner presently requires a two-person assist for transfers.

11. The petitioner lives in the family home with her representative, another adult daughter, and her adult son.

12. The petitioner's representative is her primary caregiver.

13. The petitioner's primary caregiver works from 10:00 p.m. to 10:00 a.m., three nights per week. On the days on which the petitioner's primary caregiver works, she must sleep during the day.

14. Petitioner's representative recently underwent a cardiac catheterization due to a heart condition.

15. Due to her heart condition and other medical limitations, the petitioner's representative can no longer assist the petitioner as extensively as she did previously. She is no longer able to assist the petitioner with transfers.

16. The petitioner's other adult daughter and her adult son are able to assist the petitioner in the evenings when they return home from work.

17. The petitioner is presently approved to receive 26 hours per week of long-term care services. The specific services approved are as follows: 14 hours per week of Personal Care services; four hours per week of Homemaker services; four hours per week of Companion services; and four hours per week of Respite services. These services total 26 hours per week.

18. The petitioner normally allocates the 26 hours per week as follows: six hours per day, three days per week; and two hours per day the remaining four days of the week.

19. On August 11, 2015, the petitioner requested an additional 10 hours per week of long-term care services. The services formally requested were companion services or respite services.

20. The petitioner's representative explained at the hearing she is not familiar with the individual types of services available under the long-term care program, nor does she care what type of services are approved, as long as her mother receives the additional care she requires.

21. In a Notice of Action dated August 18, 2015, Amerigroup notified petitioner that her request for additional services was denied. Although the Notice only addresses respite services, the parties testified the petitioner requested 10 hours of either respite care or companion services.

22. The Notice of Action states, in part:

> ■ We determined that your requested services are not medically necessary because the services do not meet the reasons(s) checked below: *(See Rule 59G-1.010)*
>
> > ■ Must be furnished in a manner not primarily intended for convenience of the recipient, caretaker, or provider. …

23. The petitioner normally goes to bed around 10:00 p.m. and gets out of bed at 9:30 a.m. or 10:00 a.m.

24. The petitioner has difficulty sleeping at night due to phantom limb pain. That is why she gets out of bed so late in the morning.

25. The petitioner was attending [redacted] on multiple days of the week prior to her hospitalization. [redacted] is an exercise class at a local hospital. The petitioner was attending the class to help build and maintain her upper body strength.

26. The petitioner's condition has deteriorated to the point where she can no longer attend [redacted]

27. The petitioner's Plan of Care and 701b Comprehensive Assessment were completed prior to her two most recent hospitalizations. These evaluations reflect the petitioner's condition and service needs at that time.

28. The petitioner's service needs have intensified since the time her Plan of Care and 701b Comprehensive Assessment were completed. The Plan of Care and 701b no longer accurately reflect the petitioner's needs.

29. It is the position of the petitioner's representative that both the petitioner's health and her health have deteriorated and additional services are necessary to ensure the petitioner's health and safety.

30. It is the respondent's position that the presently approved services are sufficient to assist the petitioner with her basic needs if they are allocated differently.

CONCLUSIONS OF LAW

31. 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 Chapter 120.80, Fla. Stat.

32. This is a final order pursuant to § 120.569 and § 120.57, Fla. Stat.

33. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

34. In the present case, the petitioner is requesting additional services. Therefore, in accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof is assigned to the petitioner.

35. 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.).

36. The Florida Medicaid program is authorized by Chapter 409, Fla. Stat. and Chapter 59G, Fla. Admin. Code. The Medicaid program is administered by respondent.

37. Section 409.905, Fla. Stat. addresses mandatory Medicaid services under the State Medicaid Plan:

> Mandatory Medicaid services.—The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law…

38. Under § 1915(c) of the Social Security Act (42 USC § 1396n(c)), a state may obtain a Medicaid waiver that allows the state to include in the state's Medicaid program the cost of home or community-based services (other than room and board) provided to individuals who otherwise would require care in a hospital, nursing facility, or intermediate care facility.

39. Home or community-based services include personal care services, habilitation services, and other services that are "cost effective and necessary to avoid institutionalization." See 42 CFR § 440.180.

40. Section 409.978, Florida Statutes, provides that the "Agency shall administer the long-term care managed care program," through the Department of Elder Affairs and through a managed care model. Fla. Stat. § 409.981(1), authorizes AHCA to bid for and utilize provider service networks to achieve this goal. In the instant case,

the provider network/HMO is Amerigroup.

41. The definition of medically necessary is found in the Fla. Admin Code. R. 59G-1.010 which states:

> (166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider…
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

42. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Chapter 59G-4. In accordance with the above Statute, the Handbook states on page 1-27

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.

> Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

43. Page 1-28 of the Florida Medicaid Provider General Handbook provides a list of HMO covered services. Page 1-30 of the Handbook explains "Other services that plans may provide include dental services, transportation, nursing facility and home and community-based services."

44. Page 1-30 of the Florida Medicaid Provider General Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

45. In the present case, the services contemplated are available under the long-term care program but not under Medicaid. Therefore, it cannot be said that the provision of these services by Amerigroup is more restrictive than the provision of these services by the Agency for Health Care Administration.

46. AHCA Contract No. FP021, Attachment II, Exhibit II-B, Effective 07/15/15, Page 11 of 91 (the Long-Term Care Program Contract between the Agency for Health Care Administration and Amerigroup) defines Adult Companion Care as follows:

> Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discreet services. The provision of companion services does not entail hands-on nursing care. This service includes light housekeeping tasks incidental to the care and supervision of the enrollee.

47. AHCA Contract No. FP021, Attachment II, Exhibit II-B, Effective 07/15/15, Pages 13 and 14 of 91 (the Long-Term Care Program Contract between the Agency for Health Care Administration and Amerigroup) defines Homemaker Services as follows:

> General household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control may be included in this service.

48. AHCA Contract No. FP021, Attachment II, Exhibit II-B, Effective 07/15/15, Page 15 of 91 (the Long-Term Care Program Contract between the Agency for Health Care Administration and Amerigroup) defines Personal Care as follows:

> A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

49. AHCA Contract No. FP021, Attachment II, Exhibit II-B, Effective 07/15/15, Page 15 of 91 (the Long-Term Care Program Contract between the Agency for Health Care Administration and Amerigroup) defines Respite Care as follows:

> Services provided to enrollees unable to care for themselves furnished on a short-term basis due to the absence or need for relief of persons normally providing the care. Respite care does not substitute for the care usually provided by a registered nurse, a licensed practical nurse or a therapist. Respite care is provided in the home/place of residence, Medicaid licensed hospital, nursing facility or assisted living facility.

50. In the present case, the petitioner's condition has deteriorated since her two most recent hospitalizations resulting in an increase in her service needs. In addition, the petitioner's primary caregiver has physical limitations which limit her ability to provide care to the petitioner and, furthermore, the primary caregiver works overnight and needs to sleep during the day while the petitioner is awake. The services presently

approved for the petitioner are not adequate to provide her with the care necessary to ensure her health and safety and prevent institutionalization.

51. Pursuant to the above, the petitioner has met her burden of proof to show the respondent incorrectly denied her request for additional long-term care services.

DECISION

The petitioner's appeal is hereby GRANTED. The respondent is hereby ordered to provide an additional 10 hours of respite services per week.

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 01 day of December, 2015, in Tallahassee, Florida.

Peter J. Tsamis

Peter J. Tsamis
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

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

[redacted]

APPEAL NO. 15F-07583

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 15 Palm Beach
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on December 10, 2015 at 2:32 p.m.

APPEARANCES

For the Petitioner: [redacted]
Petitioner's Daughter

For the Respondent: Doretha Rouse
Registered Nurse Specialist

ISSUE

Whether respondent's action to reduce petitioner's personal care services from 56 hours per week to 49 hours per week was proper. The burden of proof is assigned to the respondent.

PRELIMINARY STATEMENT

A hearing was first scheduled for October 6, 2015. Due to the unavailability of the hearing officer, the matter was continued to October 29, 2015.

On October 29, 2015 respondent's witness from Humana failed to appear. Respondent's request for a continuance was granted. The matter was rescheduled for December 10, 2015.

Petitioner was not present for the December 10, 2015 hearing. Petitioner's exhibit "1" was entered into evidence.

Ms. Rouse appeared as both a representative and witness for the respondent. Present from Humana were: Dr. Axel Juan, Medical Director; Dr. Teresita Hernandez, Medical Director; and Stacey Larson, Clinical Guidance Analyst.

Respondent's exhibit "1" and "2" were entered into evidence.

Administrative notice was taken of the Florida Medicaid Provider General Handbook.

Present as an English to Spanish interpreter from Propio Language Services was interpreter [redacted]

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. Petitioner is 78 years of age. She resides in her daughter's home. Also in the household is petitioner's husband, her son-in-law; and grandchildren. Petitioner's daughter and son-in-law are employed outside the household.

2. Petitioner's diagnoses include [redacted]

3. Petitioner is enrolled in respondent's Long Term Managed Care Program (LTMC Program).

4. Respondent does not have a promulgated Coverage and Limitations Handbook for the LTMC Program. LTMC services are defined by contract.

5. All services in the LTMC Program must be medically necessary.

6. Respondent contracts with Health Maintenance Organizations (HMOs) to provide comprehensive, cost-effective medical services to Medicaid recipients in the LTMC Program.

7. Petitioner's LTMC services are provided by Humana/American Eldercare.

8. Petitioner requires total assistance with bathing; dressing; toileting; and transferring[1].

9. Petitioner was approved to receive 43 hours per week of personal care services. On or about May 21, 2015 the hours were increased to 56 hours per week on a temporary basis. The rationale for the increase was, in part, to facilitate the caregivers search for a skilled nursing facility.

10. Humana/American Eldercare suggested the Sunday through Saturday schedule be:

- 7:00 a.m. to 9:00 a.m.
- 11:00 a.m. to 1:00 p.m.
- 3:00 p.m. to 5:00 p.m.
- 7:00 p.m. to 9:00 p.m.

11. The schedule implemented by petitioner's representative was:

- 8:30 a.m. to 1:30 p.m.: Sunday through Saturday
- 5:30 p.m. to 8:30 p.m.: Sunday through Saturday

[1] See 701B Comprehensive Assessment: Respondent's exhibit "2".

12. Petitioner also receives Hospice services from a source other than the LTMC Program. Services include:

- One hour of personal care; three times per week
- A weekly home visit by a nurse
- Massage/Physical therapy

13. On August 17, 2015 Humana/American Eldercare issued to petitioner a Notice of Action. The notice reduced the weekly personal care hours from 56 to 42 hours. The rationale was that 56 hours was in excess of the petitioner's need.

14. On September 3, 2015 petitioner's representative contacted the Office of Appeal Hearings and requested a Fair Hearing.

15. A request for an internal appeal was thereafter received by Humana/American Eldercare.

16. On September 9, 2015 Humana/American Eldercare issued an appeal resolution letter. The correspondence stated, in part:

> The Appeal Committee has decided to partially uphold the decision to reduce your personal care services – instead of 42 hours you will receive 49 hours of personal care services weekly. Based on our assessment of your current capabilities and family support, this amount of personal care hours is enough to provide you with the needed help with dressing, bathing, personal hygiene, and other activities of daily living.

17. Humana/American Eldercare states the 49 hours should be divided into the following daily seven hour segments:

- 3 hours each morning
- 2 hours each afternoon
- 2 hours each evening

18. Respondent has continued 56 hours per week of personal care services pending the outcome of this proceeding.

19. Petitioner's representative argues her mother is in the last stages of [redacted] As such, around the clock assistance/supervision is required. Petitioner's husband has been injured while attempting to provide assistance. Petitioner's representative states a new schedule would be confusing for her mother.

20. Respondent argues petitioner's personal care needs can be met within 7 properly scheduled hours each day.

CONCLUSIONS OF LAW

21. By agreement between the Agency for Health Care Administration (AHCA) 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.

22. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

23. The standard of proof in an administrative hearing is by 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.).

24. Regarding the LTMC Program, Humana/American Eldercare and the respondent entered into a contractual relationship. The contract enumerates and defines requires services. The contractual definition relevant to this proceeding is:

> Personal Care – A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

25. Florida Medicaid, which includes the LTMC Program, only covers those services determined to be medically necessary. See § 409.905 (4) (c), Fla. Stat.

26. The definition of medical necessity is found in Fla. Admin Code. R. 59G-1.010 and states:

> (166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider...
> . . .
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

27. The Findings of Fact establish petitioner requires total assistance with most activities of daily living. In response to an assessment completed by Humana/American Eldercare, the number of personal care hours was determined.

28. The contractual definition for personal care does not include supervision. The purpose of the service is to address personal care needs and limited housekeeping duties.

29. A service need should match the service definition. In this appeal, the need for 56 hours per week also includes supervision.

30. Compelling evidence was not presented that personal care needs cannot be addressed by seven properly scheduled service hours each day.

31. It is noted petitioner also receives three hours each week of personal care through Hospice.

32. The role of a Hearing Officer is not to determine the number of medically necessary personal care hours. Rather, the undersigned must determine whether the party vested with the burden of proof has established its position in a preponderant manner.

33. After considering the documentary evidence and testimony, respondent has established, by the greater weight of evidence, that a reduction of personal care to 49 hours per week was proper.

34. If desired, petitioner's representative can review the definitions of the LTMC Program (see page 114 of respondent's evidentiary package) to determine if a service in addition to personal care meets medical necessity criteria.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, petitioner's appeal is 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 15 day of December, 2015,

in Tallahassee, Florida.

Frank Houston

Frank Houston
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Judy Jacobs, Area 7, AHCA Field Office

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

[redacted]

APPEAL NO. 15F-07623
APPEAL NO. 15F-09629

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 15 Palm Beach
UNIT: 88701

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 13, 2015 at 8:34 a.m.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Jamekia Howard, ACCESS supervisor

ISSUE

The petitioner is appealing the denial of his Medicare/Medicare Buy-in application for himself and his wife. Also at issue is the termination of the petitioner's eligibility in the Extra Help Program (Medicare Part D). The petitioner carries the burden of proof by a preponderance of evidence.

PRELIMINARY STATEMENT

The respondent presented one exhibit which was accepted into evidence and marked as Respondent's Composite Exhibit 1. The petitioner presented one exhibit which was accepted into evidence and marked as Petitioner's Composite Exhibit 1.

An order To Reopen Record And Request For Supplemental Information was mailed on October 21, 2015, to both parties. The respondent submitted one additional exhibit which was accepted into evidence and marked as Respondent's Exhibit 2. One additional exhibit was received from the petitioner which was accepted into evidence and marked as Petitioner's Exhibit 2. The record was closed on October 31, 2015.

FINDINGS OF FACT

1. On August 25, 2015, the petitioner submitted a Medicare/Medicare Buy-in application for himself and his wife.

2. An applicant may be eligible to receive MSP for payment of Medicare Part B premiums through the Medicaid Program under one of three categories: Qualifying Medicare Beneficiary (QMB), Special Low Income Medicare Beneficiary (SLMB), or Qualifying Individual 1 (QI1) benefits, if all criteria are met. To be eligible the applicant must be enrolled in Medicare Part A and meet all technical criteria, including having income within the established limits. The category of QI1 benefits has the highest income eligibility limit.

3. The petitioner's application was reviewed and the Department determined the petitioner's household gross income for October 2015, as $2,271.70. A $20 standard disregard was subtracted to get the household countable income of $2,251.70. This was compared to the income limit of $1,793 for a couple for QI1 benefits. It was

determined the petitioner's countable income of $2,251.70 exceeded the income limit of $1,793 for the petitioner to be eligible for QI1 benefits.

4. On August 28, 2015, a Notice of Case Action was sent to the petitioner informing him that his application dated August 24, 2015 for QI1 benefit was denied. The reason given for the denial was that his household's income was too high to qualify for this program.

5. On September 4, 2015, the petitioner requested a hearing to challenge the Department's decision.

6. At the hearing, the petitioner asserted him and his wife's retirement and pension were issued in [redacted] dollars and is deposited in his bank in US dollars. He receives $393.54 [redacted] dollars monthly from his Pension Plan (CPP) and $310.06 [redacted] dollars monthly from his Old Age Security (OAS). His wife's CPP is $41.04 [redacted] dollars monthly and her OAS is $310.06 [redacted] dollars monthly. He also receives Social Security Administration (SSA) income of $639 US dollars (USD) monthly and his wife receives SSA of $580 USD monthly. The petitioner's CPP and OAP converted to US dollars are $296.41 and $234 respectively. His monthly income in US dollars when added to his SS income is $1,169.41. His wife's CPP is $30.91 and OAP is $234. Her monthly income in US dollars when added to SS income is $844.91. The monthly household's income totals $2,014.32.

7. The petitioner asserts that he received a letter informing him that his eligibility in the Extra Help Program will end. The Department asserts Social Security Administration determines eligibility in the Extra Help Program, not the Department.

CONCLUSIONS OF LAW

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

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

JURISDICTION REGARDING THE EXTRA HELP PROGRAM

10. The petitioner was also seeking a ruling by the undersigned regarding the correctness of the termination for the Extra Help Program (Medicare Part D). The action was not taken by the Department of Children and Families, it was taken by the Social Security Administration. Section 409.285, Fla. Stat., defines the hearing officer's jurisdiction as action taken by the Department of Children and Families. This action under appeal was not taken by the respondent. Therefore, the undersigned does not have authority over action taken by the Social Security Administration and cannot determine if that action was correct.

THE MEDICARE SAVINGS PROGRAM/MEDICARE BUY IN PROGRAM WILL NOW BE ADDRESSED

11. Income limits for Medicare savings plan benefits are set forth in the Fla. Admin. Code R. 65A-1.713:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:

> (b) For QMB, income must be less than or equal to the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C...
> (g) For SLMB, income must be greater than 100 percent of the federal poverty level but less than 120 percent of the federal poverty level....
> (j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. QI1 is eligible only for payment of the Part B Medicare premium through Medicaid.
> (2) Included and Excluded Income. For all SSI-related coverage groups the department follows the SSI policy specified in 20 C.F.R. 416.1100, et seq...
> (4) Income Budgeting Methodologies. To determine eligibility SSI budgeting methodologies are applied except where expressly prohibited by 42 U.S.C. §1396, or another less restrictive option is elected by the state under 42 U.S.C. §1396a(r) (2)...

12. Fla. Admin. Code R. 65A-1.702 addresses Medicaid "Special Provisions" and informs:

> (12) Limits of Coverage.
> ...
> (d) Part B Medicare Only Beneficiary (QI1). Under QI1 coverage, individuals are only entitled to payment of their Medicare Part B premium. (This is coverage for individuals who would be eligible for QMB or SLMB coverage except their income exceeds limits for those programs.

13. The above authority explains that an individual must have income that is within the limits established by federal and state law as well as the Medicaid State plan.

14. Federal regulation at 20 C.F.R. § 416.1124(c) (12) establishes a $20 disregard for "the first $20 of any unearned income in a month" and income is reduced by that amount. There is no other disregard.

15. The Department's Program Policy Manual, CFOP 122-65 at Appendix A-9, shows the Income Limit for a QMB Couple as $1,328, SLMB Couple as $1,593, and QI1 Couple as $1,793. The petitioner's household's monthly income of $2,014.32 minus $20 disregard, equals income of $1,994.32.

16. The state must follow all financial and technical standards. There is no state rule or federal regulation that permits QI1 Buy-In eligibility when income exceeds the income standard. The petitioner's income of $1,994.32 (after disregard) exceeds the QI1 income standard of $1,793.

17. After careful review of facts and regulations, it is concluded the respondent's decision to deny the petitioner's application for Medicare Saving Program/Buy-In Program is upheld.

DECISION

Based upon the foregoing Findings of Fact and Principles of Law and Analysis, appeal regarding Medicare cost savings benefit is denied.

The appeal regarding the Extra Help Program is dismissed as non-jurisdictional.

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 25 day of November, 2015,

in Tallahassee, Florida.

Christiana Gopaul-Narine

Christiana Gopaul-Narine
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

PETITIONER,

APPEAL NO. 15F-07638

Vs.

CASE NO. [redacted]

FLORIDA DEPT OF CHILDREN AND FAMILIES
CIRCUIT: 17 Broward
UNIT: 88140

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 13, 2015, at 9:05 a.m.

APPEARANCES

For the Petitioner: [redacted] pro se.

For the Respondent: Janice Johnson, Operations Management Consultant one, Department of Children and Families (DCF).

STATEMENT OF ISSUE

At issue is the Department's action in denying the petitioner's application for SSI-Related Medicaid benefits on the basis that he did not meet the disability requirements of the program. The petitioner carries the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The respondent submitted into evidence Respondent's Exhibits 1 and 2.

The record was left open for seven days in order for the petitioner to submit additional information. Additional information was submitted by the petitioner. The information submitted by petitioner was accepted into evidence as Petitioner Exhibit 1 and 2.

The respondent submitted into evidence Respondent Exhibit 1 and 2.

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 filed an application for SSI-Related Medicaid benefits with the Department on August 13, 2015. To be eligible for SSI- Related Medicaid, an individual must be disabled, blind, or aged (65 years or older). As petitioner had not yet turned sixty-five years of age and is [redacted] years of age, her application was forwarded by the Department to DDD (Division of Disability Determinations) for disability consideration.

2. The petitioner applied for disability benefits through the Social Security Administration (SSA) on or about December 11, 2013. This application was denied by Social Security on or about April 30, 2014 with an N-35 code. N-35 means "Lack of Duration." The petitioner filed an appeal for that determination with SSA on November 10, 2014. This appeal remains pending.

3. DDD adopted the SSA decision for the petitioner's DCF application on August 24, 2015, also with an N-35 code. The Department denied the petitioner's application for Medicaid benefits on August 25, 2015.

4. The petitioner indicated that she has worsening conditions. She submitted medical information as part of petitioner Exhibit 1 and 2, which does not show a condition not reviewed by SSA.

CONCLUSIONS OF LAW

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

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

7. In accordance with Fla. Admin. Code R. 65-2.060 (1), the party having the burden shall establish his/her position by a preponderance of the evidence, to the satisfaction of the hearing officer.

8. Federal Regulations at 42 C.F.R. § 435.541 states in part:

> (a) *Determinations made by SSA.* The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issue presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility...(b)(i) An SSA disability determination is binding on an agency until the determination is changed by SSA... (2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination,... (c) *Determination made by the Medicaid agency.* The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist...(4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA, and...(i) Alleges a disability condition

different from, or in addition to, that considered by SSA in making its determination...

9. As shown in the Findings of Fact, the Department denied the petitioner's application for SSI-Related Medicaid benefit on the basis she did not meet the disability requirements of the program. DDD adopted the SSA decision. The petitioner did not allege a new condition not previously considered by SSA. She did allege her conditions were getting worse.

10. The petitioner was denied by the SSA and appealed that decision. As noted in the above cited Regulation, "[a]n SSA disability determination is binding on an agency until the determination is changed by SSA....The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations." Thus, the petitioner must continue with her appeal with SSA as its decision is binding on the Department and cannot be overturned by this hearing officer.

DECISION

This appeal is denied and the Department action 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 08 day of December, 2015,

in Tallahassee, Florida.

Robert Akel

Robert Akel
Hearing Officer
Building 5, Room 255
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Tallahassee, FL 32399-0700
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Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

FILED
Dec 16, 2015
Office of Appeal Hearings
Dept. of Children and Families

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 17 Broward
UNIT: 88249

RESPONDENT.
_____/

APPEAL NO. 15F-07639

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 5, 2015, at 11:30 a.m.

APPEARANCES

For the Petitioner: [redacted] pro se.

For the Respondent: Rosa Alvarez Casado, Economic Self Sufficiency Specialist Supervisor, Department of Children and Families (DCF).

STATEMENT OF ISSUE

At issue is the Department's action in denying the petitioner's application for SSI-Related Medicaid benefits on the basis that she did not meet the disability requirements of the program. The petitioner carries the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The record was left open for fourteen days in order for the petitioner to submit additional information. Additional information was submitted within the timeframe allotted, accepted as Petitioner Exhibit 2 and 3.

The respondent submitted into evidence Respondent Exhibit 1 through 3.

The petitioner submitted into evidence Petitioner Exhibit 1 through 3.

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 filed an application for Medicaid with the Department on August 24, 2015. To be eligible for SSI- Related Medicaid, an individual must be disabled, blind, or aged (65 years or older). As the petitioner has not turned sixty-five years of age and is [redacted] her application was forwarded to DDD (Division of Disability Determinations) for disability consideration.

2. The petitioner applied for disability benefits through the Social Security Administration (SSA) on or about January 29, 2014. This application was denied by Social Security on or about March 6, 2014 with an N-32 code. N-32 means "Capacity for other work." The petitioner filed an appeal with SSA in July 2014. The petitioner has an ALJ hearing scheduled with SSA on December 8, 2015.

3. DDD adopted the SSA decision for the petitioner's DCF application on August 28, 2015, also with an N-32 code. The Department denied the petitioner's application for Medicaid benefits on August 28, 2015.

4. The petitioner alleged new and worsening conditions since the SSA decision was initially made. However, the information provided in Petitioner Exhibit 1 shows these alleged new conditions were already reported by the petitioner to the SSA reconsideration adjudicator.

CONCLUSIONS OF LAW

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

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

7. In accordance with Fla. Admin. Code R. 65-2.060 (1), the party having the burden shall establish his/her position by a preponderance of the evidence, to the satisfaction of the hearing officer.

8. Federal Regulations at 42 C.F.R. § 435.541 states in part:

> Determinations of disability.
> (a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.
> ....
>
> (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under §435.909.
>
> (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.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.

(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:

....
(4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and—

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, ***and has not applied to SSA for a determination with respect to these allegations*** [emphasis added].

9. As shown in the Findings of Fact, the Department denied the petitioner's application for SSI-Related Medicaid on the basis that she did not meet the disability requirements of the program. DDD adopted the SSA decision. The petitioner alleged new conditions not previously considered by SSA, but the evidence presented shows the alleged new conditions have been provided to SSA for that appeal process.

10. The petitioner was denied by the SSA and she appealed that decision. As noted in the above cited Regulation, "[a]n SSA disability determination is binding on an agency until the determination is changed by SSA....The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA

determinations." Thus, the petitioner must continue the appeal with SSA as its decision is binding on the Department and cannot be overturned by this hearing officer.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is denied and the Department action 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 16 day of December, 2015, in Tallahassee, Florida.

Robert Akel

Robert Akel
Hearing Officer
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Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

FILED
Nov 25, 2015
Office of Appeal Hearings
Dept. of Children and Families

[redacted]

APPEAL NO. 15F-07667

PETITIONER,

VS.

CASE NO. [redacted]

FLORIDA DEPT OF CHILDREN AND FAMILIES
CIRCUIT: 11 DADE
UNIT: 88653

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 30th, 2015 at 10:50 a.m.

APPEARANCES

For the Petitioner: [redacted] pro se

For the Respondent: Osmin Bejerano, Operations Management Consultant for the Economic Self-Sufficiency (ESS) program.

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny his application for Medicaid. The petitioner carries the burden of proving his position in this appeal by a preponderance of the evidence.

PRELIMINARY STATEMENT

Serving as a translator was [redacted] of ESS.

The petitioner did not submit any documents into evidence.

Respondent's Exhibits 1 and 2 were moved into evidence.

No Notice of Case Action describing the action under appeal was issued to the petitioner or submitted into evidence. On September 1st, 2015, the petitioner filed an appeal to challenge the respondent's denial of his application. Absent evidence to the contrary, the appeal is considered to be timely filed.

FINDINGS OF FACT

1. The petitioner applied for Medicaid for himself on May 18th, 2015. As part of the application process, the respondent is required to explore and verify all factors of eligibility.

2. The petitioner is a single-person household, [redacted] years of age.

3. The respondent's position is that because the petitioner has no minor children in his custody, and he is not at least 65 years of age, eligibility for Medicaid can only be established if the petitioner is found to be disabled.

4. On the record, the petitioner claimed not to be disabled. Additionally, the petitioner reported that he was not disabled on his application; therefore, a determination of disability was not explored.

CONCLUSIONS OF LAW

5. The Department of Children and Families Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to §120.80, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

6. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

7. Florida Administrative Code 65A-1.711 et seq. sets forth the rules of eligibility for elderly and disabled individuals. For an individual under 65 years of age to receive benefits, he or she must meet the disability criteria of Title XVI of the Social Security Act (SSA) appearing in 20 C.F.R. §416.905. The regulations state, in part:

> (a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see §416.960(b)) or any other substantial gainful work that exists in the national economy.

8. As established in the Findings of Fact, the petitioner is not elderly, and claimed not to be disabled when he applied for benefits on May 18th, 2015.

9. Based on the above-cited authorities, the hearing officer concludes that the petitioner is not eligible for Medicaid based on the technical factor of being under the age of 65, and not meeting the criteria for SSA-Related Medicaid coverage. Therefore, the hearing officer affirms the respondent's action to deny Medicaid benefits.

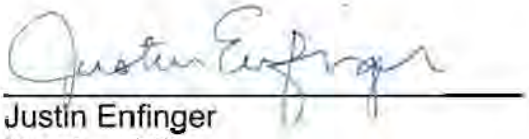
DECISION

Based on the foregoing Findings of Conclusions of Law, this appeal is denied, and the respondent's action is 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 indigence to waive those fees. The Department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 25 day of November, 2015, in Tallahassee, Florida.



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Copies Furnished To: [redacted] - [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

APPEAL NO. 15F-07668

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 5, 2015 at 10:00 a.m.

APPEARANCES

For Petitioner: [redacted]
Pro Se

For Respondent: Linda Latson
Registered Nurse Specialist

STATEMENT OF ISSUE

At issue is whether Respondent's denial of the prescription drug [redacted] was proper. The burden of proof is assigned to the Petitioner.

PRELIMINARY STATEMENT

The Petitioner did not submit any documents as evidence for the hearing other than the hearing request which was already part of the record.

Appearing as witnesses for the Respondent were Mindy Aikman, Grievance and Appeals Specialist, and Dr. Ian Nathanson, Medical Director, from Humana, which is Petitioner's managed care plan.

Respondent submitted the following documents into evidence for the hearing: Exhibit 1 – Member Information and Prior Authorization Request; Exhibit 2 – Denial Notice; Exhibit 3 – Grievance/Appeal Documents; Exhibit 4 – Medical Director Review; and Exhibit 5 – Determination Letter.

FINDINGS OF FACT

1. The Petitioner is a fifty-one year old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. She receives services under the plan from Humana.

2. On or about June 15, 2015, Petitioner's treating physician submitted a prior authorization request to Humana for the prescription drug [redacted] The prior authorization request also contained medical records describing Petitioner's need for this medication.

3. On June 18, 2015, Humana sent a notice to Petitioner stating her request for [redacted] had been denied. The notice stated the following:

> [redacted] is one of the drugs that are not covered by Medicaid. You should work with your doctor or other prescriber to determine if a drug on our list of covered drugs is medically appropriate for treating your condition.

4. Petitioner testified she needs the medication due to inflammation in her left knee. She stated she received this medication previously for her right knee through Medicaid in 2013 and 2014 when she was covered by a different plan (Molina Healthcare). She also stated she has been denied an alternate medication call [redacted]

5. Respondent's witness, Dr. Nathanson, stated that Medicaid MMA plans must follow Medicaid guidelines and [redacted] is not on the Medicaid Preferred Drug List (PDL).

CONCLUSIONS OF LAW

6. 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.

7. This is a final order pursuant to § 120.569 and § 120.57, Fla. Stat.

8. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

9. The standard of proof in an administrative hearing is by a preponderance of the evidence. (See Fla. Admin. Code R. 65-2060(1).) The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

10. The Florida Medicaid program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid program is administered by the Respondent.

11. The Florida Medicaid Provider Handbook (Provider Handbook) is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Chapter 59G-4. In accordance with the above Statute, the Handbook states on page 1-27:

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.

12. In this proceeding, Humana is the health maintenance organization which provides Petitioner's Medicaid services.

13. Page 1-28 of the Provider Handbook lists HMO covered services. The service list includes prescribed drug services.

14. Page 1-30 of the Provider Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

15. The Prescribed Drug Services Handbook has been promulgated into rule by reference in Fla. Admin. Code R. 59G-4.250. Relevant to this proceeding:

> Page 1-4:
>
> HMO prescribed drug services are defined the same as for the Medicaid fee-for-service program and include all legend drug products covered by fee-for-service Medicaid as defined in Chapter 2 of this handbook, Legend Drugs. Medicaid's contract with HMOs states that Medicaid HMOs may use prior authorization and/or step therapy to encourage compliance with the preferred drug list.
>
> Page 2-2:
>
> To be reimbursed by Medicaid, a drug must be medically necessary and either (a) prescribed for medically accepted indications and dosages found

> in the drug labeling or drug compendia ..., or (b) prior authorized by a qualified clinical specialists approved by the Agency. Notwithstanding this rule, the Agency may exclude or otherwise restrict coverage of a drug in accordance with Section 1927 of the Social Security Act.

16. The definition of "medically necessary" is found in the Fla. Admin. Code R. 59G-1.010, which states, in part:

> (166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
>
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider...
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

17. Pertaining to the PDL, the Drug Handbook continues by providing the following additional information:

> Page 2-4:
>
> The Preferred Drug List (PDL) is a listing of prescription products recommended by the Pharmaceutical and Therapeutics (P&T) Committee for consideration by AHCA as efficacious, safe, and cost effective choices when prescribing for Medicaid patients.
> ...

> Products included on the PDL must be prescribed first unless the patient has previously used these products unsuccessfully or the prescriber submits documentation justifying the use of a none-PDL product.
> ...
>
> Non- PDL drugs may be approved for reimbursement upon prior authorization.
>
> Page 2-5:
>
> Approval of reimbursement for alternative medications that are not listed on the preferred drug list shall be considered if listed products have been tried without success within the previous twelve months. The step-therapy prior authorization may require the prescriber to use medications in a similar drug class or that are indicated for a similar medical indication unless contraindicated in the Food and Drug Administration labeling. The trial period between the specified steps may vary according to the medical indication. A drug product may be approved without meeting the step-therapy prior authorization criteria if the prescribing physician provides the agency with additional written medical or clinical documentation that the product is medically necessary because:
>
> - There is not a drug on the preferred drug list which is an acceptable clinical alternative to treat the disease or medical condition; or
> - The alternatives have been ineffective in the treatment of the beneficiary's disease; or
> - Based on historic evidence and known characteristics of the patient and the drug, the drug is likely to be ineffective; or
> - The number of doses has been ineffective.

18. The Findings of Fact establish [redacted] is not included on Respondent's PDL.

19. Clinical evidence was not presented demonstrating PDL medications were attempted in the last year and found to be ineffective. As such, it was not demonstrated that the above step therapy process was addressed.

20. Petitioner has not established that the following conditions of medical necessity have been satisfied:

> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

3. Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational;

21. The greater weight of evidence in this matter does not establish Respondent's denial of [redacted] was improper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner's appeal is 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 03 day of December, 2015, in Tallahassee, Florida.

Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal_Hearings@dcf.state.fl.us

Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

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

FILED
Dec 03, 2015
Office of Appeal Hearings
Dept. of Children and Families

[redacted]

APPEAL NO. 15F-07669
15F-08233

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 5, 2015 at 11:30 a.m. and on October 23, 2015 at 1:30 p.m.

APPEARANCES

For the Petitioner: [redacted] Petitioner

For the Respondent: Linda Latson, Registered Nurse Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the Respondent's denial of the Petitioner's requests for dental services was correct. The Petitioner has the burden of proving his case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The Petitioner had two separate hearing requests, which were combined for purposes of conducting the hearing. The Petitioner did not submit any documents as evidence for the hearing, other than his original hearing request which was already part of the record.

Appearing as witnesses for the Respondent were Dr. Frank Mantega, Dental Consultant; Dr. Daniel Dorrego, Dental Consultant; and Jackeline Salcedo, Grievance Specialist, from DentaQuest, which is the Petitioner's dental services organization. Also present as a witness for the Respondent was Mindy Aikman, Grievance and Appeals Specialist from Humana, which is Petitioner's managed health care organization.

Respondent submitted several documents as evidence for the hearing, which were marked as follows: For Appeal 15F-7669: Exhibit 1 – Member Information and Claim Form; Exhibit 2 – x-rays; Exhibit 3 – Denial Notices; Exhibit 4 – Criteria; Exhibit 5 – Dental Director Review Form; Exhibit 6 – Updated Determination Letter; For Appeal 15F-8233: Exhibit 1 – Member Information and Claim Form; Exhibit 2 – Authorization determination; Exhibit 3 – Notice of Action; Exhibit 4 – Updated Authorization determination; Exhibit 5 – DentaQuest reference manual; Exhibit 6 – Fee Schedule.

FINDINGS OF FACT

1. The Petitioner is a fifty-eight year old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA)

plan. He receives services under the plan from Humana, which utilizes DentaQuest for review and approval of dental services.

2. On or about August 12, 2015 and September 9, 2015, the Petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from DentaQuest to perform various dental procedures, including dental crowns, core buildup, crown lengthening, and retreatment of previous root canal. DentaQuest denied these requests on August 13, 2015 and September 10, 2015. On September 24, 2015, DentaQuest modified its prior decision and approved dental crowns on five teeth (Tooth 3, Tooth 12, Tooth 13, Tooth 14, and Tooth 19).

3. Petitioner testified that his main concern is Tooth 12. He states he has a fistula under Tooth 13 which was caused by an infection and he cannot get a crown on Tooth 12 until the infection on Tooth 13 is resolved. Petitioner stated he needs gum surgery because this is affecting his heart condition and the gum surgery is medically necessary.

4. The Respondent's expert witness, Dr. Dorrego, testified that some of the services requested by the Petitioner are non-covered services. The crown-lengthening procedure (Code D4249) is used to expose more of the tooth surface to allow placement of a crown on the tooth, but this is a non-covered service. Dr. Dorrego also stated that retreatment of a prior root canal, which is another of the services requested by Petitioner, would treat the fistula under Tooth 13 but this is also a non-covered service.

5. Ms. Salcedo from DentaQuest testified there may have been some prior confusion regarding what services had been approved and what had been denied

because two different providers submitted similar service requests and one was denied because it did not contain sufficient clinical information and one was approved since it contained more detailed information.

6. Services under the Medicaid State Plan in Florida are provided in accordance with the Respondent's Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012 and the Dental Services Coverage and Limitations Handbook ("Dental Handbook"), effective November 2011.

.

CONCLUSIONS OF LAW

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

8. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

9. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

10. The standard of proof in an administrative hearing is a preponderance of the evidence, in accordance with Rule 65-2.060 (1), Fla. Admin. Code. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

11. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the Respondent. The Medicaid Handbook and the Dental Handbook are incorporated by reference in Chapter 59G-4, Florida Administrative Code.

12. The Medicaid Handbook and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

> "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide;
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
> . . .
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

13. The Florida Medicaid Program provides limited dental services for adults. The Dental Handbook describes the covered services for adults as follows on page 2-3:

> The adult dental program provides for the reimbursement of full and removable partial dentures. Extractions and other surgical procedures essential to the preparation of the mouth for dentures are reimbursable if the patient is to receive dentures. Procedures relating to dentures such as repairs, relines and adjustments are reimbursable.
>
> Medicaid will reimburse for medically-necessary emergency dental procedures to alleviate pain and or infection for eligible adult Medicaid recipients 21 years of age or older. Emergency dental care shall be limited to emergency problem-focused evaluations, necessary radiographs to make a diagnosis, extraction, and incision and drainage of abscess.

14. Managed care plans, such as Humana, may provide more generous benefits but cannot be more restrictive than the Medicaid guidelines contained in the Dental

Handbook. Petitioner's managed care plan has approved several dental crowns for the Petitioner but denied the remaining requested services as being non-covered services.

15. Petitioner stated his requested services are medically necessary and he needs gum surgery because of his heart condition.

16. Respondent's witnesses did not admit or deny that the services requested by Petitioner are medically necessary, but stated that the requested services are non-covered services.

17. After considering the evidence and testimony presented, the undersigned concludes that the Petitioner has not demonstrated that the requested services should have been approved by DentaQuest or Humana. Although the services may be medically necessary, the services requested (core buildup, crown lengthening, and retreatment of prior root canal) are non-covered services for adults under the Medicaid guidelines referenced above and under the Humana Medicaid dental plan. Therefore, the hearing officer cannot make a determination that these services must be covered by the Petitioner's plan.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is 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 agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 03 day of December, 2015,

in Tallahassee, Florida.

Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662

Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

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

[redacted]

PETITIONER,

APPEAL NO. 15F-07674

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 04 Duval
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 6, 2015 at 1:23 p.m.

APPEARANCES

For the Petitioner: [redacted] mother

For the Respondent: Sheila Broderick, registered nurse specialist

STATEMENT OF ISSUE

Whether dental services the petitioner requested through Medicaid are medically necessary. The burden of proof was assigned to the petitioner.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (Agency or AHCA or respondent) administers the Florida Medicaid Program. Medicaid rules require that most recipients receive their Medicaid services through the Managed Care Plan. The Agency contracts

with numerous health care organizations to provide medical services to its program participants. Molina Healthcare (Molina) is the contracted health care organization in the instant case. Molina subcontracts with DentaQuest of Florida (DentaQuest) to provide dental services. DentaQuest took the action currently under appeal.

By notice dated August 18, 2015, DentaQuest informed the petitioner that her request for root canal therapy and a porcelain crown for tooth #14 was denied in part. The noticed explains that the porcelain crown was denied because "you have a cap on your teeth. Your dentist asked to put a new cap on the same tooth. The x-rays of your tooth do not show that you have a cavity under the old cap. It is not medically necessary to replace the cap on your tooth. ..." The notice continued to inform the petitioner that prior authorization was not required for root canal therapy.

The petitioner timely requested a hearing to challenge the denial decision on September 9, 2015.

There were no additional witnesses for the petitioner. The petitioner did not submit exhibits.

Present as witnesses for the respondent were Carlos Galvez, government contract specialist with Molina; Jackelyn Salcedo, grievance and compliance officer with DentaQuest; and Dr. Susan Hudson, dental consultant with DentaQuest. Respondent's Composite Exhibit 1 was admitted into evidence.

The record was held open until close of business on November 13, 2015 for the submission of additional evidence. Evidence was received from the respondent and

admitted as Respondent's Composite Exhibit 2. No additional evidence was received from the petitioner.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. The petitioner (age 15) is a Florida Medicaid recipient. The petitioner is enrolled with Molina HMO. DentaQuest is the contracted dental provider for Molina enrollees.

2. The petitioner underwent root canal therapy on tooth #14 approximately two years ago. The tooth was capped with a stainless steel crown. The petitioner has experienced chronic pain and sensitivity to heat/cold since the procedure was performed.

3. The petitioner is no longer a patient of the dentist who performed the original root canal. The petitioner's current dentist, [redacted] submitted a prior service authorization to DentaQuest on August 14, 2015 to perform another root canal on tooth #14 and to replace the stainless steel crown with a porcelain crown.

4. DentaQuest's written response explained that root canal therapy does not require prior service authorization. DentaQuest determined that the porcelain crown was not medically necessary because the tooth showed no signs of decay.

5. Jackelyn Salcedo, grievance and compliance officer with DentaQuest and Dr. Susan Hudson, dental consultant with DentaQuest, testified as witnesses for the Agency. The testimony of the DentaQuest witnesses, regarding the reason the

porcelain crown was denied, was not consistent with the denial reason cited in the notice. The witnesses testified that the porcelain crown was denied because original root canal was not performed properly; the tooth was not correctly filled. The petitioner's dentist must properly fill the tooth and then submit another prior service authorization request for the porcelain crown. The new request should include updated x-rays which prove the required dental work has been performed.

6. DentaQuest could not explain the discrepancy between the denial reason cited on the notice and the verbal explanation of the denial.

7. The petitioner's mother asserted that the petitioner's pain is so severe at times she cannot attend school. The frequency and the severity of the pain have increased over time. The petitioner's dental issues have greatly impacted her day to day life. The petitioner's mother argued that the opinion of the treating dentist who has examined the petitioner and concluded that she requires a porcelain crown should carry great weight.

8. Dr. Hudson, DentaQuest dental consultant, testified that the industry standard of care specifies use of stainless steel crowns for small children only. Industry standard of care specifies use of porcelain crowns for teenagers like the petitioner.

CONCLUSIONS OF LAW

9. By agreement between the AHCA 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.

10. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

11. In accordance with Fla. Admin. Code § 65-2.060 (1), the burden of proof was assigned to the petitioner. The standard of proof in an administrative hearing is by 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.). In the instant case, such means the petitioner must establish that orthodontic services were incorrectly denied by the respondent.

12. All Medicaid services must be medically necessary. The definition of medical necessity is found in the Fla. Admin Code. R. 59G-1.010 and states:

> (166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider…
> . . .
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

13. Fla. Admin. Code R. 59G-4.060 addresses dental services and states, in part:

> (2) All dental services providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Dental Services Coverage and Limitations Handbook, November 2011, ... and the Florida Medicaid Provider Reimbursement Handbook, ADA Dental Claim Form, July 2008, which are incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which is incorporated by reference in Rule 59G-4.001, F.A.C. ...

14. The petitioner is under 21, a broader definition of medically necessary applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) requirements. Section 409.905, Fla. Stat., *Mandatory Medicaid services*, defines Medicaid services for children to include:

> (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.—The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems,

15. The Florida Medicaid Dental Handbook states on page 1-2: The children's dental program provides full dental services for all Medicaid eligible children age 20 and below.

16. The petitioner's treating dentist requested prior service authorization to repeat root canal therapy on tooth #14 and to replace her current stainless steel crown with a porcelain crown.

17. DentaQuest witnesses acknowledged that the original root canal was not done properly and corrective action is required. DentaQuest also acknowledged that

the industry standard of care specifies that stainless steel crowns should only be used for small children. Industry standard specifies use of porcelain crowns for teenagers like the petitioner. DentaQuest argued that the petitioner's dentist must correct the root canal, a procedure that does not require prior service authorization, and then file a prior service authorization for the porcelain crown.

18. DentaQuest's position is not supported by the controlling legal authorities. EPSDT provides a broader definition of medical necessity for children under age 21. EPSDT requires provision of all services determined to be medically necessary to treat, correct or ameliorate the condition.

19. The undisputed evidence proves that it is medically necessary to repeat the root canal on tooth #14. The undisputed evidence also proves that the petitioner's current stainless steel crown does not meet the industry standard for someone her age. Medicaid rule requires that services be consistent with generally accepted professional medical standards.

20. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the petitioner met her burden of proof in this matter. The petitioner proved that it is medically necessary for her to receive a porcelain crown for tooth #14. The Agency's denial decision was incorrect.

21. No ruling is required for the root canal therapy because, as previously noted, root canal therapy does not require prior service authorization.

DECISION

The appeal is GRANTED.

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 10 day of December, 2015,

in Tallahassee, Florida.

Leslie Green

Leslie Green
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: [redacted] Petitioner
Debbie Stokes, Area 4, AHCA Field Office Manager

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

[redacted]

APPEAL NO. 15F-07728

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 (Dade)
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on October 9, 2015 at 10:00 a.m. in Doral, Florida.

APPEARANCES

For the Petitioner: [redacted] Petitioner's mother

For the Respondent: Monica Otalora, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the Respondent's action to partially deny Petitioner's request for Speech Therapy (ST) service hours for the certification period July 22, 2015 through January 16, 2016, was correct. Respondent bears the burden of proof in this matter.

PRELIMINARY STATEMENT

Appearing as a witness for the Petitioner was [redacted] from [redacted] the Petitioner's speech therapy provider. The Petitioner did not submit any documents as evidence for the hearing.

Appearing as a witness for the Respondent was Rakesh Mittal, M.D., physician-consultant with eQHealth Solutions, Inc. Respondent submitted the following as evidence for the hearing, which were marked Respondent Exhibits 1 through 4: Exhibit 1 – Statement of Matter; Exhibit 2 – Outpatient Review History; Exhibit 3 – Denial Notices; and Exhibit 4 – Speech Therapy reports.

FINDINGS OF FACT

1. The Petitioner's ST service provider, [redacted] (hereafter referred to as "the provider"), requested the following ST service hours for the certification period at issue: 14 units (3.5 hours) weekly. Each unit is the equivalent of fifteen (15) minutes.

2. eQHealth Solutions, Inc. is the Quality Improvement organization (QIO) contracted by the Respondent to perform prior authorization reviews for therapy services. The provider submitted the service request through an internet based system. The submission included, in part, information about the petitioner's medical conditions; his functional limitations; and other pertinent information related to the household.

3. eQHealth Solutions' personnel had no direct contact with the Petitioner, his family, or his physicians. All pertinent information was submitted by the provider directly to eQHealth Solutions.

4. The medical information submitted by the provider contained, in part, the following information in regard to the petitioner:

- 17 years old
- Diagnosis includes [redacted] and [redacted]

5. The petitioner has been receiving speech therapy services since 2008, and he also receives occupational therapy and physical therapy through the Medicaid Program. He received 13 units weekly of speech therapy in the prior certification period. He attends a private school but receives no speech therapy services at school.

6. A Plan of Care was also submitted by the provider. The document was signed by a physician and outlined the type of assistance to be provided by the ST provider. The long-term goals include the following:

- Improving receptive language skills
- Improving literacy skills
- Improving verbal expressive language skills
- Improving social/behavioral communication

7. A physician at eQHealth Solutions, who is board-certified in pediatrics, reviewed the submitted information and partially denied the requested ST services, approving 8 units (2 hours) weekly rather than the requested 14 units (3.5 hours) weekly. The rationale for the decision was: "The patient is a 16 year old with [redacted] and [redacted] Based on the severity of delay and rate of modest progress partial approval for speech therapy … ." A notice of this determination was sent to all parties on July 28, 2015.

8. The above notice stated that a reconsideration review of this determination by eQHealth could be requested, and additional information could be provided with the request for reconsideration. A reconsideration review was requested on August 6, 2015 by the Petitioner's provider.

9. A second physician at eQHealth Solutions reviewed the submitted information and upheld the initial decision to approve 2 hours weekly of ST services. A notice of this reconsideration decision was mailed to all parties on August 17, 2015.

10. The petitioner thereafter requested a fair hearing and this proceeding followed.

11. The respondent's witness, Dr. Mittal, testified that the reduction of the Petitioner's speech therapy service to 2 hours weekly was appropriate because he has been receiving therapy since 2008 and has made steady progress on his goals and services should be reduced as progress is made. Dr. Mittal stated the Petitioner has mastered some goals with 100% success and is progressing on other goals. He also stated a home therapy program can supplement the therapy sessions with the provider.

12. The Petitioner's mother testified her son's ST services should not be reduced because she believes he will benefit from continuing therapy at the current level. She believes her son has the potential to be able to perform a job if he continues improving his skills.

13. The Petitioner's therapy provider testified that she believed a reduction in service would cause him to regress in his skill level because he requires repetition. She stated he has not yet mastered all his therapy goals. She also stated the Petitioner struggles with his expressive language skills and needs prompting.

14. ST services for children is a covered service under the Medicaid State Plan in Florida. These services are provided in accordance with the respondent's Therapy Services Coverage and Limitations Handbook ("Therapy Handbook"), effective August, 2013.

CONCLUSIONS OF LAW

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

16. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

17. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

18. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the respondent since the Petitioner had been previously approved for 13 units weekly of speech therapy service and the Respondent is seeking to reduce this service to 8 units weekly. 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.).

19. The Florida Medicaid Program is authorized by Chapter 409, Fla. Stat. and Chapter 59G, Fla. Admin. Code. The Medicaid Program is administered by the respondent.

20. The petitioner has requested ST services. As the petitioner is under 21 years of age, the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements apply to the evaluation of the petitioner's eligibility for or amount of this service.

21. The Centers for Medicare and Medicaid Services, State Medicaid Manual makes available to all State Medicaid agencies informational and procedural material needed by the States to administer the Medicaid program. It is the method by which the Health Care Financing Administration (HCFA) issues mandatory, advisory, and optional Medicaid policies and procedures to the Medicaid State agencies.

22. The State Medicaid Manual in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services section states in part:

> 5010. Overview
> A. Early and Periodic Screening, Diagnostic and Treatment Benefit.-- Early and periodic screening, diagnostic and treatment services (EPSDT) is a required service under the Medicaid program for categorically needy individuals under age 21...
>
> 5110. Basic Requirements
>
> OBRA 89 amended §§1902(a)(43) and 1905(a)(4)(B) and created §1905(r) of the Social Security Act (the Act) which set forth the basic requirements for the program. Under the EPSDT benefit, you[1] must provide for screening, vision, hearing and dental services at intervals which meet reasonable standards of medical and dental practice established after consultation with recognized medical and dental organizations involved in child health care. You must also provide for medically necessary screening, vision, hearing and dental services regardless of whether such services coincide with your established periodicity schedules for these services. Additionally, the Act requires that any service which you are permitted to cover under Medicaid that is necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be provided to EPSDT participants regardless of whether the service or item is otherwise included in your Medicaid plan.

23. The service the petitioner has requested (ST services) is one of the services provided by the state to treat or ameliorate an individual's conditions under the State plan. Chapter 409.905, Fla. Stat., states, in part:

---

[1] "You" in this manual context refers to the state Medicaid agency.

> Any service under this section shall be provided only when medically necessary …

24. The issue to be decided is the medical necessity of the service or amount of service. The State Medicaid Manual provides for limitations on services as follows:

> 5110. Basic Requirements…
> …Services under EPSDT must be sufficient in amount, duration, or scope to reasonably achieve their purpose. The amount, duration, or scope of EPSDT services to recipients may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. Appropriate limits may be placed on EPSDT services based on medical necessity.
>
> 5122. EPSDT Service Requirements
> F. Limitation of Services.--The services available in subsection E are not limited to those included in your State plan.
> Under subsection E, the services must be "necessary . . . to correct or ameliorate defects and physical or mental illnesses or conditions . . ." and the defects, illnesses and conditions must have been discovered or shown to have increased in severity by the screening services. You make the determination as to whether the service is necessary. You are not required to provide any items or services which you determine are not safe and effective or which are considered experimental.
>
> 5124. Diagnosis and Treatment
> B. Treatment.--
> 1. General. - You must make available health care, treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services. Treatment services may be limited as described in §5122 F.

25. Once a service has been identified as requested under EPSDT, the Medicaid program determines the amount or necessity for that service based on the State of Florida's published definition of medical necessity. The Fla. Admin. Code R. 59G-1.010 defines medical necessity:

> (166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:

> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider…
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services do not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

26. Based upon the information submitted by the Petitioner's provider, eQHealth Solutions completed a prior authorization review to determine medical necessity for the requested ST services.

27. In the Petitioner's case, the Respondent has determined that 8 units (2 hours) weekly of ST service is medically necessary, rather than the 14 units (3.5 hours) weekly requested by the Petitioner. The Petitioner was previously approved for 13 units of speech therapy weekly.

28. Fla. Stat. § 409.913 governs the oversight of the integrity of the Florida Medicaid Program. Section (1)(d) sets forth the "medical necessity or medically necessary" standards, and states in pertinent part as follows:

> "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice….

Section (1)(d) goes on to further state:

> ...For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

29. Section (1)(d) highlights that the Agency makes the final decision regarding whether or not a requested service is medically necessary. As stated above, this proceeding is a de novo proceeding for the purpose of the Agency reaching its final decision. The final decision making authority for this proceeding has been delegated to the hearing officer in Fla. Admin. Code R. 65-2.066.

30. ST services, also referred to as speech-language pathology services, are described on page 1-4 of the Therapy Handbook as follows:

> Speech-language pathology services involve the evaluation and treatment of speech-language disorders.
>
> Services include the evaluation and treatment of disorders of verbal and written language, articulation, voice, fluency, phonology, mastication, deglutition, cognition, communication (including the pragmatics of verbal communication), auditory processing, visual processing, memory, comprehension and interactive communication as well as the use of instrumentation, techniques, and strategies to remediate, maintain communication functioning, acquire a skill set, restore a skill set, and enhance the recipient's communication needs, when appropriate. Services also include the evaluation and treatment of oral pharyngeal and laryngeal sensorimotor compete*ncies.*

31. The Therapy Handbook on page 2-2 sets forth the requirements for ST services, as follows:

> Medicaid reimburses for services that are determined medically necessary and do not duplicate another provider's service.

32. The Petitioner's physician ordered a ST service frequency greater than that approved by eQHealth Solutions. Rule 59G-1.010(166) (c), however, specifically states a prescription does not automatically mean the requirements of medical necessity have been satisfied.

33. The respondent's witness, Dr. Mittal, stated he believed Petitioner's therapy should be reduced since he has been making steady progress on his therapy goals and a home therapy program can be used to supplement the therapy sessions.

34. The Petitioner's speech therapist stated the Petitioner still struggles with his expressive language and has not mastered all his therapy goals. She believes the Petitioner will regress if services are reduced since he requires repetition.

35. After considering all the documentary evidence and witness testimony presented, the undersigned concludes the Respondent has not met its burden of proof in demonstrating it was correct in reducing the requested speech therapy services for the certification period at issue. The petitioner's speech therapist provided testimony that supports continuing the therapy at the current level. In addition, eQHealth Solutions provided inconsistent rationale to justify the reduction in services – the denial notice state the services should be reduced because Petitioner has made only "modest progress", but Dr. Mittal stated the services should be reduced because the Petitioner has mastered many of his goals and has made "steady progress" in his therapy.

36. The undersigned notes that Petitioner's request was for 14 units of speech therapy weekly, although he had previously been receiving 13 units weekly. The undersigned has concluded that the therapy should continue at the current level of 13 units weekly and that an increase in services is not warranted at this time.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is GRANTED, and the petitioner shall continue receiving 13 units of speech therapy services weekly for the current certification period.

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 agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 08 day of December, 2015, in Tallahassee, Florida.

Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662

Copies Furnished To: [redacted] Petitioner
Rhea Gray, AHCA Area 11, Field Office Manager

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

FILED
Dec 03, 2015
Office of Appeal Hearings
Dept. of Children and Families

[redacted]

APPEAL NO. 15F-7745
15F-7746

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPT OF CHILDREN AND FAMILIES
CIRCUIT: 11 DADE
UNIT: 88652

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter October 30th, 2015 at 1:15 p.m.

APPEARANCES

For the Petitioner: [redacted], pro se.

For the Respondent: Laura Gomez, Economic Self-Sufficiency Specialist

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to impose a Child Support Enforcement sanction on her Food Assistance and Medicaid benefits (appeals 15F-7745 and 15F-7746 respectively). The respondent carries the burden of proving its position by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing was originally scheduled for October 5th, 2015. On that date, the respondent requested a continuance. The petitioner had no objection. The hearing was rescheduled and convened as described above.

Appearing as a witness for the respondent was Jose Lopez, Administrator for the Child Support Program, Miami-Dade State Attorney's Office.

The petitioner did not submit any documents for consideration.

Respondent's Exhibits 1 through 5 were moved into evidence.

By way of a Notice of Case Action dated June 26th, 2015, the respondent informed the petitioner that her FA benefits would be reduced from $318 to $95 effective August 2015 through November 2015. The same notice informs the petitioner that her Medicaid benefits would end on July 31st, 2015. The reason for both actions, as stated on the notice, is "You or a member(s) of your household is not eligible due to failure to cooperate with child support enforcement." On September 10th, 2015, the petitioner filed a timely appeal to challenge the respondent's action.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner had been receiving FA for herself and her minor child, and Medicaid for herself. (The petitioner's child receives SSI-related Medicaid through the Social Security Administration.)

2. On May 27th, 2015, CSE received a request for services for the petitioner from the respondent. Pursuant to such, on May 29th, 2015, CSE issued to the petitioner a

notice allowing the petitioner until June 9th, 2015 to go to the Child Support office for the purposes of establishing cooperation (a technical requirement required of FA and Medicaid recipients who have minor children). The notice was issued to the petitioner at [redacted] A copy of the notice was not submitted into evidence.

3. As of June 16th, 2015, CSE had not heard from the petitioner, and the application for services mentioned above was closed. As a result, on June 17th, 2015, the respondent received an alert via its Data Exchange system (the system that collects from various sources data to be used in determining an individual's eligibility for benefits) a request from Child Support Enforcement (CSE) to impose a sanction on the petitioner due to non-compliance.

4. On June 25th, 2015, the respondent took action to impose the sanction under appeal, and the sanction became effective August 2015.

5. The petitioner asserts that she did not receive the May 29th, 2015 notice from CSE regarding the need for an office visit. The petitioner moved from the address to which the notice was issued in April 2015. The petitioner reported her new (current) address to the respondent in May 2015.

6. The respondent's witness concurred that CSE did receive the petitioner's new address from the respondent through an interface system, but that the address was only reflecting for residential purposes, but not postal.

CONCLUSIONS OF LAW

7. The Department of Children and Families Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to §120.80, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

8. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

9. Florida Statute addresses public assistance and the requirement for Child Support Enforcement compliance, in general, as follows:

> 409.2551 Legislative intent.—... It is declared to be the public policy of this state that this act be construed and administered to the end that children shall be maintained from the resources of their parents, thereby relieving, at least in part, the burden presently borne by the general citizenry through public assistance programs.
>
> 414.0252 Definitions–(10) "Public assistance" means benefits paid on the basis of the temporary cash assistance, food stamp, Medicaid, or optional state supplementation program.

10. Florida Statute establishes the general requirement to pursue parental support as related to authorizing public assistance, including assistance or Medicaid. Pursuit of parental support is required. Florida Statute addresses the need to comply with the CSE requirements as follows:

> 409.2572 Cooperation--(1) An applicant for, or recipient of, public assistance for a dependent child shall cooperate in good faith with the department or a program attorney in: ...(c) Assisting in obtaining support payments from the obligor.
>
> (2) Noncooperation, or failure to cooperate in good faith, is defined to include, but is not limited to, the following conduct:... (d) All actions of the

> obligee which interfere with the state's efforts to proceed to establish paternity, the obligation of support, or to enforce or collect support. ...
>
> (3) The Title IV-D staff of the department shall be responsible for determining and reporting to the staff of the Department of Children and Family Services acts of noncooperation by applicants or recipients of public assistance. Any person who applies for or is receiving public assistance for, or who has the care, custody, or control of, a dependent child and who without good cause fails or refuses to cooperate with the department, a program attorney, or a prosecuting attorney in the course of administering this chapter shall be sanctioned by the Department of Children and Family Services pursuant to chapter 414 and is ineligible to receive public assistance until such time as the department determines cooperation has been satisfactory.
>
> (5) As used in this section only, the term "applicant for or recipient of public assistance for a dependent child" refers to such applicants and recipients of public assistance as defined in s. 409.2554(8).

11. According to the above regulations, cooperation with Child Support Enforcement is a condition of eligibility for public assistance. The requirements indicate that if an individual is not cooperating with CSE, the respondent may deny benefits for that individual. Ineligibility for the individual would continue until the individual is deemed by CSE to be cooperating.

12. The Fla. Admin. Code R. 65-2.060 addresses burden of proof, and states as follows:

> (1) The burden of proof, except where otherwise required by statutes, is on the party asserting the affirmative of an issue. **The burden is upon the Department when the Department takes action which would reduce or terminate the benefits or payments being received by the recipient**. *[Emphasis added.]* The burden is upon the petitioner if an application for benefits or payments is denied. The party having the burden shall establish his/her position, by a preponderance of evidence, to the satisfaction of the hearing officer.

13. Authorities cited above set forth the rules for assigning the burden of proof in

an administrative hearing. In the instant appeal, the respondent held the burden of proof (by a preponderance of the evidence) as it terminated the petitioner's benefits. The respondent asserts its action of termination of the petitioner's FA and Medicaid benefits is due to non-compliance with CSE.

14. However, the findings show that although CSE may have issued a notice on May 29th, 2015, the notice was issued to an address at which the petitioner no longer resided. The findings show, in fact, that the petitioner did not receive the notice.

15. The findings show that the petitioner moved from the address in question in April 2015, and reported her new address upon recertification in May 2015. The findings show that the petitioner's newly-reported address was transmitted to CSE in May 2015, but only for residential purposes not postal purposes. Upon review of these facts, the hearing officer concludes that the petitioner cannot be faulted for this. Therefore, the hearing officer concludes that the respondent's action to impose a sanction for non-compliance with CSE is incorrect. Accordingly, the respondent will, within ten days of this order, remove the sanction requested by CSE and reinstate the petitioner's FA and Medicaid benefits retroactively, not to precede August 1st, 2015, which is the date the sanction became effective.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, both appeals are granted. The respondent's action is reversed.

ANY FOOD ASSISTANCE BENEFITS DUE APPELLANT PURSUANT TO THIS ORDER MUST BE AVAILABLE WITHIN (10) TEN DAYS OF THIS DECISION OR WITHIN (60) SIXTY DAYS OF THE REQUEST FOR THE HEARING. ANY BENEFITS DUE WILL BE OFFSET BY PRIOR UNPAID OVERISSUANCES.

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 indigence to waive those fees. The Department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 03 day of December, 2015,

in Tallahassee, Florida.

Justin Enfinger
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.hearings@myFLfamilies.com

Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

PETITIONER,

Vs.

APPEAL NO. 15F-07787

CASE NO. [redacted]

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 20 LEE
UNIT: 88287

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 5, 2015 at 2:07 p.m.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Signe Jacobson, Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

The petitioner is appealing the Department's action to deny Medicaid benefits. The petitioner is asserting the affirmative and bears the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any exhibits into evidence for consideration.

The respondent submitted thirteen (13) exhibits which were accepted into evidence and marked as Respondent's Exhibits "1" through "13" respectively. The record was held open until the close of business on October 7, 2015 for the respondent to supplement the record. The respondent timely provided the additional documentation, which were accepted into evidence and marked as Respondent's Exhibits "14" through "19". The record closed on October 7, 2015.

The record was reopened for additional evidence; whereas on October 21, 2015, the undersigned issued an Order for Department's Response and requested a Memorandum of Law. The Department provided a response on October 26, 2015, which was accepted into evidence and marked as Respondent's Exhibit "20". The record was closed on October 26, 2015.

FINDINGS OF FACT

1. The petitioner, a one-person household, age [redacted] applied for Medicaid benefits on August 10, 2015 via a paper application. She is currently receiving Medicare Parts A and B benefits.

2. The respondent stated that the Department did not know the petitioner was married at the time of the application. She did not include him on her application. She recently moved to Florida from [redacted] in August 2015. She separated from her husband, [redacted] when she moved without him. She informed that she does not have the money to divorce him at this time.

3. As part of the application and eligibility process, the respondent explored and verified all factors of eligibility which included, but not limited to, meeting the asset limits for the Medicaid programs. During the process, the respondent reviewed electronic notifications from its Data Exchange Inquiry/Asset Verification (DEAV) system. DEAV notified the respondent that the petitioner has four bank accounts – two accounts with [redacted] (checking and savings) in her name only and two accounts with [redacted] (checking and savings) which has a co-owner on the account, her husband. As of August 21, 2015, the [redacted] Checking account showed a balance of $134.83, the Bank of America Savings account showed a balance of $201.14, the [redacted] Checking account showed a balance of $782.35, and the JP Morgan/Chase Savings account showed a balance of $13,226.06. Asset information provided through the Data Exchange system is considered to be verified upon receipt.

4. The balances of the four bank accounts exceeded the asset limit for the Medically Needy Program of $5000.

5. Via Notice of Case Action dated August 24, 2015, the Department notified the petitioner that she was denied Medically Needy benefits as "the value of [her] assets is too high for this program."

6. The petitioner provided a Customer Summary printout to the Department dated September 21, 2015, that noted the petitioner has no bank accounts available with [redacted] The petitioner provided the Department a letter, dated September 21, 2015, from her husband, who states that he removed the petitioner from accessing the [redacted] accounts.

7. The Department alleges that the bank balances held by the petitioner's spouse should count when determining the petitioner's eligibility as they continue to be legally married and that the petitioner owns the liquid assets as a whole, until such time the petitioner and her husband are legally separated or divorce.

8. From the submitted Memorandum of Law, the respondent noted that the petitioner did not furnish the address and approximate date of the separation from her husband. As such, the Department held its position that petitioner was still not eligible for Medicaid benefits.

9. The petitioner states that she had a liver transplant in 2002 and needs to take medicine related to the transplant for the rest of her life and that the medicine is very expensive.

CONCLUSIONS OF LAW

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

11. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056, which states:

> (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.

12. The Fla. Admin. Code R. 65A-1.701 sets forth:

> (20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services.

13. There is no evidence to reflect that the petitioner is enrolled in Medicaid covered institutional care services, hospice services, or home and community based services. According to the above controlling authority, the petitioner is ineligible to receive full Medicaid as she is a Medicare recipient and does not fit one of the exclusions of a Medicare recipient. The undersigned concludes that the Department was correct in its action to deny full Medicaid for the petitioner.

14. The Fla. Admin. Code R. 65.A-1710, SSI-Related Medicaid Coverage Groups, states, "(5) Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. §§ 1396a and 1396d, for aged, blind or disabled individuals ... who do not qualify for categorical assistance."

15. The Fla. Admin. Code R. 65A-1.712, SSI-Related Medicaid Resource Eligibility Criteria, sets forth:

> (1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C., with the following exceptions:
>
> (e) For Medically Needy, an individual or couple cannot have resources exceeding the applicable Medically Needy resource limit set forth in subsection 65A-1.716(3), F.A.C.

16. The Fla. Admin. Code R. 65A-1.716(3) sets forth that the asset limit for a household size of one is $5000.

17. Federal regulation 20 C.F.R. § 416.432, Change in status involving a couple; eligibility continues, sets forth:

> When there is a change in status which involves the formation or dissolution of an eligible couple (for example, marriage, divorce), a redetermination... shall be made for the months subsequent to the month of such formation or dissolution of the couple in accordance with the following rules:
>
> (a) When there is a dissolution of an eligible couple and each member of the couple becomes an eligible individual, ...each person shall be determined individually for each month beginning with the first month after the month in which the dissolution occurs.

18. The Department's Program Policy Manual, CFOP 165-22, passage 2240.0604.08, Married but Not Living with Spouse, states that the following applies to the Medically Needy program:

> An applicant who is married, but not living with the spouse will be asked to furnish the spouse's name and address and the date (or approximate date) of the separation.
>
> They will be considered a couple during the month of separation but treated as individuals beginning the month following separation.

19. Using the de novo concept, the undersigned can consider additional evidence not available to the respondent at the time of the application. As such, after careful review of the evidence and controlling legal authorities, the undersigned concludes that, since the petitioner stated on the record that she separated from her husband in August 2015, and that he remains in the State of [redacted] the respondent correctly denied the petitioner's Medicaid application for the month of August due to her countable assets exceeding the eligibility limits; however, for the subsequent months of

September 2015 and ongoing, the respondent incorrectly denied the Medicaid application as the petitioner was separated from her husband and can be considered a household of one. Due to the fact that the petitioner is a Medicare recipient, the Department cannot determine Medicaid eligibility, but the Department can determine whether or not the petitioner is eligible to be enrolled in the Medically Needy Program. Therefore, the undersigned hereby remands the matter to the Department to complete the eligibility determination process for her Medicaid application through the Medically Needy Program for the months of September 2015 and ongoing. Once an eligibility determination is made, the respondent is to issue a new Notice of Case Action to the petitioner including her appeal rights.

DECISION

Based upon the foregoing Findings of Facts and Conclusions of Law, the appeal is partially granted and remanded back to the Department to take action as specified in the Conclusions of Law.

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 23 day of November, 2015,

in Tallahassee, Florida.

Raymond Muraida
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

PETITIONER,

Vs.

APPEAL NO. 15F-07798

CASE NO. [redacted]

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 17 Broward
UNIT: 88139

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 8, 2015 at 10:13 a.m.

APPEARANCES

For the Petitioner: [redacted] authorized representative

For the Respondent: Yolanda Smith, eligibility specialist

STATEMENT OF ISSUE

Whether the petitioner is eligible for Institutional Care Program (ICP) Medicaid coverage for October 2014 and November 2014.

PRELIMINARY STATEMENT

The Florida Department of Children and Families (Department or DCF or respondent) determines eligibility for Family-Related and SSI-Related Medicaid programs.

By notice dated August 17, 2015, the Department informed the petitioner that his request for retroactive ICP Medicaid for the months of October 2014 and November 2014 was denied.

The petitioner timely filed a request for hearing on September 11, 2015.

There were no additional witnesses for the petitioner. Petitioner's Composite Exhibit 1 was admitted into evidence.

Suzanne Wong, program administrator with Department of Elder Affairs (DOEA), was present as a witness for the Department. Respondent's Composite Exhibits 1 and 2 were admitted into evidence.

The record was held open until close of business on October 9, 2015 for the submission of additional evidence. Evidence was received from the Department and admitted as Respondent's Exhibit 3.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. The petitioner (age [redacted]) was admitted to [redacted] a skilled nursing facility, on October 23, 2014, after a hospitalization at [redacted] Hospital. The petitioner suffers from multiple [redacted]

2. The nursing facility filed applications for ICP Medicaid with the Department on December 16, 2014; February 6, 2015; April 2, 2015; and August 12, 2015 to cover the cost of the petitioner's care.

3. Applicants for ICP Medicaid must require skilled nursing care. Via interagency agreement, DOEA's CARES unit determines if ICP Medicaid applicants

meet the nursing home level of care requirement (commonly known as level of care). DOEA/CARES must determine that an applicant meets the level of care before the Department can approve ICP Medicaid benefits.

4. The Department denied all but the last of the petitioner's ICP applications because it had not received a level of care determination from DOEA/CARES. The Department approved the August 2015 application, retroactively to December 2014, after receiving, in June 2015, confirmation from DOEA/CARES that the petitioner met the ICP level of care.

5. The petitioner also requested ICP Medicaid coverage for the months of October 2014 and November 2014. Medicaid rule includes three months of retroactive coverage prior to the month of application if the applicant meets all of the eligibility requirements. The Department determined that the petitioner was ineligible for retroactive ICP coverage for October 2014 and November 2014 because the ICP level of care was not effective until December 2014.

6. The petitioner disagreed with the Department's decision. The petitioner asserted that he met nursing home level of care October 2014 and seeks to have the Department's decision overturned.

7. DOEA/CARES uses the Pre-Admission Screen and Resident Review (PASRR) form to complete the level of care assessment. This is a Florida Medicaid form designed to collect and screen potential nursing home patients for appropriate placement.

8. The PASRR review process should be initiated before the patient is discharged from the hospital or, at the latest, as soon as the patient is admitted into the

nursing home. The review is initiated by the hospital or nursing home by completing the appropriate section of the PASRR form and submitting the form to DOEA/CARES.

9. The petitioner's medical records show [redacted] submitted a PASRR form to DOEA/CARES on October 15, 2014.

10. Department witness, Suzanne Wong, administrator with DOES/CARES, testified that DOEA/CARES never received the October 2014 PASRR form. DOEA/CARES received a PASRR review request on December 16, 2014, when the nursing home filed the first ICP Medicaid application.

11. DOEA/CARES visited the petitioner at the nursing home December 18, 2014 to conduct the PASRR screening interview. During the interview, DOEA/CARES determined that the petitioner's primary diagnosis was [redacted] Patients with a serious [redacted] as the primary diagnosis require a separate screening assessment, commonly known as a PASRR II review. The review completed by DOEA/CARES for [redacted] is commonly known as PASRR I review. DOEA/CARES contracts with APS Healthcare (APS) to complete PASRR II reviews.

12. DOEA/CARES referred the petitioner's case to APS for the PASRR II review at the end of December 2014. APS completed the PASRR II review on January 8, 2015. APS concluded that the petitioner met the ICP level of care due to [redacted] DOEA/CARES completed the PASRR I review on January 26, 2015. CARES concluded that the petitioner also met the ICP level of care due to [redacted]

13. DOEA/CARES communicates the level of care decision to the Department via the PASRR form. The level of care decision is required before the Department can approve an application for ICP Medicaid.

14. For reasons that the DOEA/CARES could not explain, it did not submit the petitioner's PASRR form to the Department until June 24, 2015, five months after the decision was made that the petitioner met ICP level of care. This delay caused the Department to deny three applications, filed by the petitioner in December 2014, February 2015, and April 2015, for ICP Medicaid due to lack of verification that he met the required level of care.

15. The petitioner filed a fourth application in August 2015. The Department approved ICP Medicaid in August 2015, retroactive to December 1, 2014. Retroactive coverage was denied for October 2014 and November 2014 because DOEA/CARES concluded that the PASRR process was initiated by the nursing home in December 2014. The nursing home argued that the PASRR process was initiated by the hospital in October 2014, as evidenced by the PASRR form included in the petitioner's medical records. The PASRR review process does not include a retroactive component that allows DOES/CARES to approve level of care for a month prior to the month the PASRR review was requested.

16. Taking into consideration the fact that DOEA/CARES delayed many months before completing the petitioner's December 2014 PASRR form, and the fact that the petitioner's medical records contain a October 2014 PASRR request, the undersigned finds that the PASRR review process was initiated in October 2014 by the hospital.

CONCLUSIONS OF LAW

17. 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.

18. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code § 65-2.056.

19. In accordance with Fla. Admin. Code § 65-2.060 (1), the burden of proof was assigned to the petitioner.

20. The Fla. Admin. Code R. 65A-1.203(9) defines representative: "Authorized/Designated Representative: An individual who has knowledge of the assistance group's circumstances and is authorized to act responsibly on their behalf."

21. [redacted] is the petitioner's authorized represented and acted on his behalf in this case.

22. Fla. Stat. §409.912 addresses the role of DOEA/CARES in the ICP Medicaid Program:

> (14)(a)The agency shall operate the Comprehensive Assessment and Review for Long-Term Care Services (CARES) nursing facility preadmission screening program **to ensure that Medicaid payment for nursing facility care is made only for individuals whose conditions require such care and to ensure that long-term care services are provided in the setting most appropriate to the needs of the person** and in the most economical manner possible. The CARES program shall also ensure that individuals participating in Medicaid home and community-based waiver programs meet criteria for those programs, consistent with approved federal waivers.
>
> (b) The agency shall operate the CARES program through an interagency agreement with the Department of Elderly Affairs. The agency, in consultation with the Department of Elderly Affairs, may contract for any function or activity of the CARES program, including any function or activity required by 42 C.F.R. s. 483.20, relating to preadmission screening and resident review.

23. The PASRR screening is set forth in Fla. Admin. Code R. 59G-1.040, which states, in part:

> (1) Purpose.
>
> (a) The Pre-Admission Screening and Resident Review (PASRR) is a federal requirement mandated by the Social Security Act, Title 42, Subpart C, Sections 483.100 through 483.138, Code of Federal Regulations. **It is intended to ensure that Medicaid-certified nursing facility applicants and residents with a diagnosis of or suspicion of serious mental illness or intellectual disabilities, or related conditions, are identified and admitted or allowed to remain in the nursing facility only if there is a verified need for such services.** (emphasis added)
>
> (b) PASRR is required for all applicants to Medicaid-certified nursing facilities, regardless of payor.
>
> (2) Definitions.
>
> (a) Adult(s) – Individuals who are age 21 and older.
>
> …
>
> (c) CARES – The Florida Department of Elder Affairs' Comprehensive Assessment and Review for Long-Term Care Services program.
>
> …
>
> (i) Level I PASRR Screener… The CARES program or the entity to which CARES delegates this responsibility shall perform the Level I PASRR screening for all adults. AHCA and CARES will collectively be referred to as the Level I PASRR Screener….
>
> (k) Nursing Facility (NF) – A Medicaid-certified nursing facility.

24. The intent of the cited authorities is to ensure that individuals placed into nursing facilities receive the appropriate level of care, based upon each patient's individual needs. To this end, prior to establishing ICP Medicaid eligibility and payment for nursing facility services, DOEA/CARES staff must complete PASRR preadmission screening and ensure that the prescreening properly confirms a patient's need for nursing home care.

25. The record clearly demonstrates that the petitioner's nursing home placement was appropriate and he is eligible for ICP Medicaid. The remaining issue is the onset date of his eligibility. The petitioner argued the onset date should be October 1, 2014, the month the hospital initiated the PASRR review. The respondent argued that the onset date should be December 1, 2014, the month the nursing home initiated the PASRR review.

26. The Department's Integrated Public Assistance Policy Manual Passage 0640.0509, retroactive Medicaid (MSSI), Application Processing, explains:

> This policy does not apply to QMB.
> 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 [Standard Filing Unit] 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.

27. Department policy states that retroactive Medicaid is available for up to three months preceding the application if all eligibility requirements are met.

28. The petitioner filed his first ICP Medicaid application in December 2014 and seeks retroactive coverage for October 2014 and November 2014. After carefully considering the arguments of both parties, the undersigned found the petitioner's argument to be the most persuasive and concludes that a PASRR review request was initiated in October 2014 while the petitioner was still in the hospital. The petitioner meets the ICP level of care requirement for October 2014 and November 2014.

29. Fla. Admin. Code 65-2.066, Final Orders, explains: "(6) In the Final Order the Hearings Officer shall authorize corrective action retroactively to the date the incorrect

action was taken." Therefore, the Department is ordered to approve ICP Medicaid benefits for the months of October 2014 and November 2014.

DECISION

The appeal is granted. The Department is ordered to take corrective action within 10 days from the date of this order.

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 10 day of December, 2015, in Tallahassee, Florida.

Leslie Green

Leslie Green
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

PETITIONER,

VS.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 06 PINELLAS
UNIT: AHCA

RESPONDENT.
_____/

APPEAL NO. 15F-07802

CASE NO.

FINAL ORDER

Pursuant to notice, a hearing in the above-styled matter convened on November 4, 2015 at 10:41 a.m. All parties appeared telephonically from separate locations.

APPEARANCES

For Petitioner: [redacted] Petitioner's Mother

For Respondent: Stephanie Lang, RN Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

Whether Respondent properly denied Petitioner's request for durable medical equipment (DME), specifically a bariatric hospital bed and air mattress. Petitioner held the burden of proof on this issue.

PRELIMINARY STATEMENT

Petitioner was not present. Petitioner's daughter, [redacted] served as a witness for Petitioner. Respondent's witnesses included India Smith (Grievance and Appeals Coordinator), Dr. John M. Carter (Long Term Care Medical Director), Sylvia Jordan (Long Term Care Case Manager) and Stacia Hammond (Supervisor for Region 5), all with Sunshine Health Plan.

Respondent's Exhibits 1 through 8 were entered into evidence. Petitioner did not submit any documentary evidence. The undersigned took administrative notice of Florida Statutes Sections 409.910, 409.962 through 409.965, and 409.973, Florida Administrative Code Rules 59G-1.001, 59G-1.010, and 59G-4.070, and the Florida Medicaid Durable Medical Equipment and Medical Supply Services Fee Schedule.

FINDINGS OF FACT

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

1. Petitioner is an adult female diagnosed with [redacted] She is bed bound and suffers with bed sores. She requires total assistance with all activities of daily living. She receives services through Sunshine Health's Long Term Care plan.

2. Petitioner was in a nursing facility prior to home placement. Her physician wrote a script for a bariatric bed and an air flow (pressure reducing) mattress. The air flow mattress is intended to help the bed sores and the bariatric bed is to replace a current non-working, unsafe bed.

3. The requests were received on or about July 30, 2015. Sunshine Health denied the requests by notice dated August 6, 2015. The items were denied as not medically necessary. The relevant explanation from the letter stated:

> ...Sunshine Health did not get any documentation (letter or note from your doctor) indicating you require rapid change in position, you have a condition to which (sic) requires you to be maintained at a 30 degree angle, or the Medical need for an Air Mattress (A special mattress that helps relieve pressure). Your case manager will continue to assess your needs.

4. Petitioner's physician provided a script, but Sunshine Health never received any supporting medical records or clinical information to indicate why the items were necessary. Without any supporting documentation to determine medical need, the requests were denied as not medically necessary.

5. Petitioner's prior case manager and current case manager attempted to get records from the physician. The physician's office claimed the records were sent, but Sunshine Health never received them. Sunshine Health did not otherwise get a copy from the physician or case manager as of the hearing date.

CONCLUSIONS OF LAW

6. By agreement between AHCA and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction to conduct this hearing pursuant to Florida Statutes Chapter 120.

7. Legal authority governing the Florida Medicaid Program is found in Florida Statutes Chapter 409, and in Chapter 59G of the Florida Administrative Code. Respondent, AHCA, administers the Medicaid Program.

8. The DME and Medical Supply Services Coverage and Limitations Handbook ("DME Handbook") has been incorporated, by reference, into Florida Administrative Code Rule 59G-4.070(2).

9. This is a Final Order, pursuant to Sections 120.569 and 120.57, Florida Statutes.

10. This hearing was held as a *de novo* proceeding, in accordance with Florida Administrative Code Rule 65-2.056.

11. The burden of proof was assigned to the Petitioner in accordance with Florida Administrative Code Rule 65-2.060(1). The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Florida Administrative Code Rule 65-2.060(1).

12. Section 409.905 of the Florida Statutes addresses mandatory Medicaid services under the State Medicaid Plan:

> Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law....

13. With regard to the need for DME, Section 409.906(10), Florida Statutes, states in relevant part, "[t]he agency may authorize and pay for certain durable medical equipment and supplies provided to a Medicaid recipient as medically necessary."

14. Similarly, the Handbook defines the guidelines for DME on page 1-2, as follows:

> Durable medical equipment (DME) is defined as medically-necessary equipment that can withstand repeated use, serves a medical purpose, and is appropriate for use in the recipient's home as determined by the Agency for Health Care Administration (AHCA).

15. Florida Administrative Code Rule 59G-1.010(166) defines medical necessity, as follows:

> 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. ...
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

16. In order for any service to be paid for by Medicaid, it must meet the above definition. Whether it meets the definition is determined by medical records and clinical documentation. Although a doctor provided the prescription, that does not automatically make the item medically necessary or covered per the above rules.

17. Sunshine Health has guidelines it uses for different requests to determine medical necessity. For the bariatric bed, Petitioner will need to show that her medical condition requires positioning that cannot be met with a standard bed and needs more than a 30 degree angle elevation; that a standard bed does not allow proper positioning to alleviate pain, promote proper body alignment, prevent contractures, or avoid

pulmonary complications; that heart failure, chronic pulmonary disease, or aspiration risk requires head of bed elevation over 30 degrees; and/or that a hospital bed is required for attachment of traction equipment. See Respondent's Exhibit 8. Sunshine Health's submitted records indicate the air flow mattress was denied as a non-covered item, but testimony indicated it was denied due to lack of information.

18. Petitioner agreed to work with her doctor to get the needed documentation for the bed and mattress. She should ensure the documentation explains how the equipment will meet her needs over lesser cost alternatives. She can also work with her doctor to verify whether her medical needs meet Sunshine Health's criteria for the bed, and locate a suitable alternative if necessary.

19. After reviewing the totality of the evidence and legal authority, the undersigned finds that the Agency's action was correct and consistent with the governing rules and laws.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Petitioner's appeal is denied and the Agency's action is affirmed.

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 28 day of December, 2015,

in Tallahassee, Florida.

Danielle Murray
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Don Fuller, Area 5, AHCA Field Office Manager

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

[redacted]

PETITIONER,

APPEAL NO. 15F-07806

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 04 Duval
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 9, 2015 at 1:11 p.m.

APPEARANCES

For the Petitioner: [redacted] daughter

For the Respondent: Sheila Broderick, registered nurse specialist

STATEMENT OF ISSUE

Whether respondent's action reducing the home health care hours the petitioner receives through Medicaid was correct. The respondent holds the burden of proof in this matter.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (AHCA or Agency or respondent) administers the Florida Medicaid Program. The respondent contracts with healthcare maintenance organizations (HMOs) to provide medical services to its program participants. Sunshine Health (Sunshine) is the contracted HMO in the instant case.

By notice dated August 28, 2015, Sunshine informed the petitioner that the home health care hours he receives through Medicaid were being reduced from 32 hours of Personal Care weekly to 8 hours of Personal Care, 4 hours of Respite Care, and 3 hours of Homemaker Services weekly (15 hours).

The petitioner requested reconsideration.

By notice dated September 30, 2015, Sunshine informed the petitioner that the decision had been partially overturned. The home health care hours were being reduced from 32 hours of Personal Care weekly to 15 hours of Personal Care, 4 hours of Respite Care, and 7 hours of Homemaker care weekly (26 hours total).

The petitioner timely requested a hearing to challenge the reduction decision. The home health care hours have been continued at the previous level pending the outcome of the hearing.

There were no additional witnesses for the petitioner. His home health aide, [redacted] called in for the hearing, but had to leave due to a scheduling conflict before she was called to testify. Petitioner's Composite Exhibits 1 and 2 were admitted into the record.

Representing Sunshine were Dr. John Carter, long term care medical director; Paula Daley, appeals and grievance coordinator; Natalie Grissett, long term care supervisor; Felicia Young, long term care case manager; and Tammi Swan, long term care director. Respondent's Composite Exhibit 1 was admitted into evidence.

The record was held open until close of business on November 12, 2015 for the submission of additional evidence. Evidence was received from the petitioner and admitted as Petitioner's Composite Exhibit 3.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. The petitioner (age 63) is a Florida Medicaid recipient. He is enrolled with Sunshine HMO.

2. The petitioner's suffers from [redacted] and a history of [redacted] The petitioner is technically verbal, he can express when he in hungry, but lacks the cognitive ability to engage in a conversation or respond to questions. The petitioner can walk short distances only, he usually transports by wheelchair. The petitioner feeds and takes medications by mouth. The petitioner is incontinent of bowel and bladder. The petitioner requires total assistance with all activities of daily living (ADLs).

3. The petitioner lives in the family home with his daughter, the daughter's husband and their two minor children (ages 16 and 12). The daughter was the petitioner's primary caregiver. She does not work outside the home. She underwent

back surgery recently. She is no longer able to assist with the petitioner's care, except light ADLs. Both children suffer from developmental delay and require a lot of care. The husband is a long distance truck driver. He works six days a week, 14 hours a day. He does not assist with the petitioner's care.

4. Prior to the action under appeal, the petitioner was enrolled in Sunshine's Managed Care Plan. He received 28 hours of Personal Care weekly under the Managed Care Plan. His daughter provided the remainder of his care.

5. The daughter reached out to the Eldercare Resource Center to inquire about receiving additional Personal Care hours. Caring for the petitioner and her family was depleting her personal and financial resources. She was advised to enroll in a program which specializes in long term care home health services. She was advised that the petitioner could receive additional support services in a specialized program

6. The daughter applied for participation in Sunshine's Long Term Care Program (LTCP) in late 2014. LTCP provides home health services to individuals who would otherwise require nursing home placement. The level of service provided by Medicaid is based on recipient's medical condition, support needs, and natural supports. Enrollment slots in the LTCP are limited. The petitioner was wait listed for approximately a year. During this time, he continued to participate in Sunshine's Managed Care Plan and receive 28 hours of Personal Care weekly.

7. In August 2015, the petitioner was approved for participation in Sunshine's LTCP. LTCP staff reached out to the petitioner to determine the level of home health service he needed. The daughter was scheduled for back surgery during this time

which would prevent her from being able to assist with the petitioner's care, particularly heavy ADLs (changing incontinence pads, bathing, dressing, etc.). The two parties settled on 39 hours of home health services weekly: 32 hours of Personal Care, 4 hours of Respite, and 3 hours of Homemaker Care. Because of his age (63), the petitioner was allowed to remain enrolled in the Managed Care Program as well. He receives all non-LTCP services through the Managed Care Program.

8. Sunshine LTCP approved the 39 hours of care weekly for approximately 30 days and then reduced the weekly home health hours to 8 hours of Personal Care, 4 hours of Respite Care, and 3 hours of Homemaker Services,15 total hours weekly of home health services. The petitioner's daughter requested reconsideration. Sunshine partially reversed its decision; it authorized 15 hours of Personal Care, 4 hours of Respite Care, and 7 hours of Homemaker Care weekly, 26 total hours weekly of home health services.

9. Sunshine based its decision on a review of the petitioner's status assessment, called a 701B assessment, Plan of Care, and available clinical records.

10. The 701B assessment is a snapshot of the petitioner's functional, behavioral, and physical status. The 701B assessment is completed quarterly by the member's case manager. The manager interviews the member (when possible), family, and caregivers. The petitioner's 701B assessment was completed on August 4, 2015. The assessment concluded that the petitioner required moderate to maximum assistance with all ADLs.

11. The Plan of Care is a narrative developed with the assistance of the member's support team. It outlines the needed services, service goals, and service providers for the upcoming certification period. The petitioner's Plan of Care was completed on August 1, 2015. The Plan of Care concluded that the petitioner's goal was to remain safely in the family home with consumable medical supplies and home health care services.

12. The clinical data reviewed by Sunshine included a prescription from the petitioner's treating physician which generically prescribes continuation of home health care services.

13. The 701B assessment, the Plan of Care, and clinical records were submitted to a Sunshine utilization review team, comprised of nurses and clinicians. The team reviewed the data and determined that the petitioner's service needs could be met with 8 hours of Personal Care, 4 hours of Respite Care, and 3 hours of Homemaker Services,15 total hours weekly of home health services.

14. The utilization team submitted its recommendation to the LTCP medical director, Dr. John Carter. Dr. Carter made the final decision. He concurred with the recommendation of the utilization review team.

15. The petitioner's daughter requested reconsideration. The reconsideration review was completed by another Sunshine physician, not Dr. Carter. The reviewing physician determined that the petitioner's incontinence needs warranted additional service hours; 15 hours of Personal Care, 4 hours of Respite Care, and 7 hours of Homemaker Care weekly, 26 total hours weekly of home health services.

16. Dr. Carter is board certified in home health care. Dr. Carter appeared as a witness during the hearing. Dr. Carter concurred with the reconsideration decision. Dr. Carter opined that, based on the available data, the petitioner's needs can be met with 26 hours of home health services weekly. Dr. Carter opined that the available date does not support the necessity of additional hours of care.

17. The petitioner's daughter questioned how it was possible for Sunshine's Managed Care Plan, a generic plan, to conclude that more home health hours were necessary, 28 hours weekly versus 26 hours weekly determined by its LTCP, the home health care specialty plan. Sunshine witnesses could not answer the question. The Managed Care Plan and the LTCP are staffed by a different team of people. Each teams works independently. The teams do not consult or communicate when making service decisions.

18. The petitioner's daughter disputed the accuracy of the 701B assessment which concluded that the petitioner requires moderate to maximum assistance with ADLs. The petitioner requires total assistance with all ADLs. Caring for the petitioner is complicated by his mental illness and behaviors. Caregivers must be patient and wait for him to comply with care needs. It takes approximately an hour to bathe and dress the petitioner twice daily. It takes approximately 45 minutes to change the petitioner's diapers two to three times daily between baths. It takes 30 to 45 minutes to feed the petitioner three times daily. He also has multiple snacks daily. He is an aspiration risk and cannot be left alone. The petitioner must be supervised at all times due to his

behaviors. The petitioner cannot attend day programs because he engages in sexually inappropriate behaviors.

19. The daughter had back in surgery in September 2015. She had a rod placed in her back. She will never be able to life more than 20 pounds. The petitioner weighs 130 pounds. The daughter can no longer assist with his ADLs (changing diapers, bathing, dressing, etc.), except light duties, like feeding or grooming.

20. The daughter attends physical therapy three times weekly for an hour. The household circumstances are further complicated by the fact that the daughter's two children suffer from developmental delay. They attend therapy and other activities, which require the daughter to be away from home several hours per week. The petitioner cannot be left home alone.

21. The family currently pays out of pocket for approximately five hours of Personal Care weekly; this is above and beyond the 39 hours of home health services the petitioner receives from LTCP weekly. (The higher service level of 39 hours approved during the daughter's surgery has been continued pending the hearing decision.)

22. The petitioner has lived with the daughter's family since 2012. The family took him in because he failed to thrive in an institutional setting. The family feared for his life.

CONCLUSIONS OF LAW

23. By agreement between the Agency for Health Care Administration (AHCA) 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.

24. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

25. At issue is a reduction in Medicaid services. In accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof was assigned to the respondent.

26. The standard of proof in an administrative hearing is by a preponderance of the evidence (See Fla. Admin. Code R. 65-2.060(1)). The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

27. The Florida Medicaid Program is authorized by Fla. Stat. Chapter 409 and Fla. Admin. Code Chapter 59G. The Medicaid Program is administered by the respondent. Section 409.905, Fla. Stat. addresses mandatory Medicaid services under the State Medicaid Plan:

> Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law…
>
> (4) HOME HEALTH CARE SERVICES.--The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home…
> (b) The agency shall implement a comprehensive utilization management program that requires prior authorization of all private duty nursing

services, an individualized treatment plan that includes information about medication and treatment orders, treatment goals, methods of care to be used, and plans for care coordination by nurses and other health professionals. The utilization management program shall also include a process for periodically reviewing the ongoing use of private duty nursing services. The assessment of need shall be based on a child's condition, family support and care supplements, a family's ability to provide care, and a family's and child's schedule regarding work, school, sleep, and care for other family dependents; and a determination of the medical necessity for private duty nursing instead of other more cost-effective in-home services. (c) The agency may not pay for home health services unless the services are medically necessary …

28. The definition of medically necessary is found in the Fla. Admin Code. R 59G-1.010 which states:

(166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
(a) Meet the following conditions:
1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider…
. . .

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

29. The cited authorities explain that home health services must be medically necessary. The level of service provided by Medicaid is based on numerous factors, including recipient's medical condition, support needs and natural supports. The authorities explain further that Medicaid services cannot be provided in excess of a recipient's needs.

30. The respondent approved 39 hours weekly of home health services for the petitioner because his primary caretaker, his daughter, was undergoing back surgery and would not be able to participate in his care. The respondent approved the higher level of care for 30 days only, expecting that the daughter would recover completely be able to resume her previous level of care. The respondent later reduced the petitioner's home health services to 26 hours weekly.

31. The evidence proves that there has been a permanent change in the daughter's medical condition. She has a 20 pound lifting restriction. The petitioner weighs 130 pounds and requires total assistance with all ADLS. The daughter will never be able to resume her role as the petitioner's primary caretaker.

32. The respondent was not aware of the permanent change in the petitioner's level of natural supports when it made the decision under challenge. This hearing is a de novo proceeding which means relevant information not previously known to one or both parties can be taken into consideration.

33. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that respondent did not meet its burden of proof in this matter. The respondent did not prove by a preponderance of the evidence that the petitioner's

home health service needs can be met with 26 hours of care weekly. The evidence proves that the petitioner's current level of home health services, 39 hours weekly, is medically necessary due to loss of natural supports.

DECISION

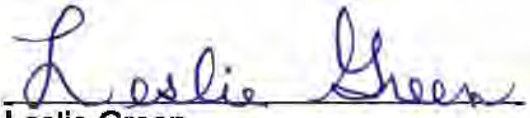
The appeal is GRANTED.

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 09 day of December, 2015,

in Tallahassee, Florida.



Leslie Green
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Debbie Stokes, Area 4, AHCA Field Office Manager

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

[redacted]

APPEAL NO. 15F-07811

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 Dade
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in this matter on October 21, 2015 at 8:39 a.m. and reconvened on November 17, 2015 at 8:30 a.m.

APPEARANCES

For the Petitioner: [redacted] Mother

For the Respondent: Dianna Chirino,
Senior Human Services Program Specialist,
Agency for Health Care Administration

STATEMENT OF ISSUE

The Petitioner is appealing the Agency for Health Care Administration's (AHCA's) decision to deny the Petitioner's request for dental procedure D8660, pre-orthodontic treatment examination to monitor growth and development (braces).

Because the issue under appeal involves a request for service, the Petitioner carries the burden of proof.

PRELIMINARY STATEMENT

Appearing as Respondent's witness from the Petitioner's managed care plan Humana Healthcare was Wendy Aikman, Grievance and Appeals Coordinator. Appearing as Respondent's witnesses from DentaQuest were Jackelyn Salcedo, Grievance and Compliance Specialist and Dr. Frank Mantega, Dental Consultant.

Respondent entered a 29-page exhibit into evidence, which was marked Respondent Exhibit 1.

The record was held open to November 2, 2015 to allow the agency representative time to provide a copy of page 155 of DentaQuest's explanation of dental benefits related to procedure code D8660, as well as clarification from the contract manager on the appropriateness of the prior authorization request for this procedure. Respondent provided this information by the deadline.

Respondent's contract/policy memo was marked Respondent Exhibit 2; Page 155 of the plan's benefits covered for Children's Medicaid was marked as Respondent Exhibit 3; and Respondent's EPSDT memo of August 5, 2014 was marked as Respondent Exhibit 4. Petitioner also submitted additional information that was sent to the Respondent and forwarded to the undersigned by the November 2, 2015 deadline. Petitioner's documents related to medical necessity for the procedure.

At the November 17, 2015 proceeding, Petitioner's documents were entered into evidence and marked Petitioner Exhibit 1. Respondent also submitted a 3-page document that was entered as Respondent Exhibit 5.

FINDINGS OF FACTS

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

1. The Petitioner is a ten year-old Medicaid recipient enrolled with Humana Healthcare, a Florida Health Managed Care provider.

2. Humana Healthcare requires prior authorization for services related to dental care. The plan's dental vendor, DentaQuest, is responsible for making dental prior authorizations decisions.

3. The Petitioner's dentist submitted a request for prior authorization for procedure code D8660: pre-orthodontic treatment examination to monitor growth and development (braces). This request was received by DentaQuest on August 11, 2015.

4. A Notice of Action was sent to the Petitioner on August 12, 2015 stating the pretreatment visit for braces was denied. The reason provided in relevant part was:

> Your dentist has asked for services that are part of a request for braces. We have not received a request for braces from your dentist for you. We have asked your dentist to tell us if this request should be part of a request for braces for you. Please talk to your dentist.

5. Petitioner's mother explained that her daughter is in pain and is having difficulty eating due to the sensitivity her mouth has to hot and cold foods. She asserted her daughter needs this procedure and will work with the dentist to provide the information requested by DentaQuest.

6. It was noted that the dental fee schedule issued in January 2015 does not require a prior authorization for procedure D8660. However, DentaQuest understands it has the right to require prior authorization per its contract.

7. The agency representative understood that a managed care plan could not have more restrictive services than Medicaid fee for service. The agency representative stated she would seek clarification from the contract manager. DentaQuest also referenced page155 of its members explanation of benefits form, which outlines the requirements for procedure code D8660. The record was held open to November 2, 2015 to allow time for the agency representative to provide a copy of DentaQuest's page 155 as well as a clarification from the contract manager of the prior authorization requirements for procedure code D8660 with attention to any appropriate EPSDT requirements.

8. Respondent Exhibit 5 provides general billing information for Orthodontics and states in relevant part:

> 1.) A Pre-orthodontic visit (code D8660) which includes diagnostic casts, photographs, radiographs (panoramic and cephalometric), an IAF form, a ADA claim form, and a narrative including the diagnosis and treatment plan. These services are not reimbursed separately.
>
> 2.) Comprehensive orthodontic treatment which is the coordinated diagnosis and treatment leading to the improvement of a patient's craniofacial dysfunction or dentofacial deformity including anatomical and functional relationships. Comprehensive orthodontic treatment utilizes fixed orthodontic appliances through procedure codes D8070, D8080 or D8090 in conjunction with the appropriate state of dentition development.

CONCLUSIONS OF LAW

9. By agreement between the Agency for Health Care Administration and the Department of Children and Families, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80 Florida Statutes.

10. The hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R.65-2.056.

11. Florida Statutes 409.971 – 409.973 establishes the requirement for Medicaid recipients to be enrolled in the statewide managed medical assistance program and the minimum benefits the managed care plans shall cover. Dental services are one of the mandatory services that must be provided.

12. § 409.912, Fla. Stat. also provides that the Agency may mandate prior authorization for Medicaid services.

13. Fla. Admin. Code R. 59G-1.010 defines "prior authorization" as:

> (226) "Prior authorization" means the approval by the Medicaid office for a Medicaid provider, or by a prepaid health plan for its affiliated providers, to deliver Medicaid covered medical or allied care, goods, or services in advance of the delivery of the care, goods, or services.

14. Fla. Admin. Code R. 59G-1.010 (166) also provides…

> "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
>
> (a) Meet the following conditions:
>
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

> (b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

15. The Florida Medicaid Coverage and Limitations Handbooks are incorporated by reference in the Medicaid Services Rules in Chapter 59G-4, 59G-8, and 59G-13, Florida Administrative Code. The Florida Medicaid Provider General Handbook, promulgated July 2012, states on page 1-30 in regard to HMO limitations: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service." On the same page, it also explains exemptions from HMO authorizations:

> All services **may** be prior authorized by the HMO plan except for the following [emphasis added]:
> □ Emergency services;
> □ Family planning services regardless of whether the provider is a plan provider;
> □ The diagnosis and treatment of sexually transmitted diseases and other communicable diseases such as tuberculosis and human immunodeficiency rendered by county health departments;
> □ OB/GYN services for one annual visit and the medically-necessary follow up care for a condition(s) detected at that visit (the recipient must use a plan provider for these services);
> □ Chiropractic, podiatry, and some dermatology services (the recipient must use a plan provider for these services); and
> □ Immunizations by county health departments.

16. The Florida Medicaid Provider General Handbook, promulgated July 2012, page 1-42 is also applicable because the Petitioner is under 21 years of age. It states:

> Florida Medicaid provides all medically necessary services to eligible children under 21 years of age, to correct or ameliorate a defect, a condition, or a physical or mental illness, even if the services are not

> covered for adults. Included are diagnostic services, treatment, equipment, supplies, and other measures described in Section 1905(a) of the Social Security Act, codified at 42 USC 1396d(a).
> Prior authorization is required in order to receive reimbursement for special services that meet one or more of the following conditions:
>
> □ The service is not listed in the service-specific Medicaid Coverage and Limitations Handbook as a covered service;
> □ The service is not included in the applicable fee schedule;
> □ The service is described in the service-specific handbook as an □ "excluded service";
> □ The amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or the fee schedule.
>
> Providers seeking prior authorization for special services should first refer to the service-specific handbook for a description of the prior-authorization process. For example, if the provider is seeking additional units of occupational therapy which exceed the service limits, the provider should refer to the Medicaid Therapy Services Coverage and Limitations Handbook for instructions on prior authorization.
> If the service is not listed in the service-specific handbook, or if there are not any instructions for requesting additional services, the provider can submit a request for prior authorization to their local Medicaid area office. An optional form for requesting prior authorization for special services is available online at ahca.myflorida.com/CHCUP.

17. The general Dental Fee Schedule published by the Agency for Health Care Administration with an effective date of January 1, 2015 indicates no prior authorization is required for procedure D8660.

18. The Florida Medicaid Dental Services Coverage and Limitations Handbook-November 2011 (Handbook), incorporated by reference into Chapter 59G-4, Fla. Admin. Code, sets standards for dental services and states on page 1-1:

> The purpose of the dental program is to provide dental care to recipients under the age of 21 years, emergency dental services to recipients age 21 and older, and denture and denture-related services and oral and maxillofacial surgery services to all Medicaid-eligible recipients.

19. Because the Petitioner is under 21, the federal regulations regarding Early and Periodic Screening, Diagnosis, and Treatment, also called Child Health Check-Up by Florida Medicaid, apply. This is a comprehensive, preventive child-health screening to identify and correct medical conditions before the conditions become serious or disabling. Fla. Stat. 409.905 Mandatory Medicaid services defines Medicaid services for children to include:

> (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

20. The Florida Medicaid Child Health Check-Up handbook has been promulgated by reference in the Florida Administrative Code at 59G-4.080 (2). Section 2-3 of the Child Health Check-Up manual states under the paragraph titled "Diagnosis, Treatment, Referral, and Follow-Up", that...

> Once the child has had a Child Health Check-Up, **any further diagnoses and treatments, referrals and follow-up are provided through the applicable Medicaid program, such as physician services** [emphasis added].

21. Based on the above citations, medical necessity needs to be established prior to a service being provided. Page 1-30 of the general handbook indicates the HMO may require prior authorizations except in limited exceptions as listed on the page. (See paragraph 14 above.) DentaQuest testified that it requires prior authorization for this procedure. The HMO asserts Petitioner failed to provide a plan of treatment and an

Initial Assessment Form (IAF) which are necessary for it to determine medical necessity.

22. The Agency for Health Care Administration has contracted with managed care plans, such as Humana, to provide comprehensive medical care and authorizes them to establish procedures to determine medical necessity.

23. While the Petitioner's mother testified that her daughter is in pain and needs the service, Respondent has provided proof that the provider has failed to provide the necessary information for them to determine medical necessity. The Petitioner's mother is encouraged to work with her provider, Humana, and AHCA in order to ensure the proper documentation is submitted for dental procedure code D8660.

DECISION

Based on the evidence presented at the final hearing and on the entire record of this proceeding, the Agency for Health Care Administration acted correctly when it denied procedure code D8660, pre-orthodontic treatment examination to monitor growth and development (braces). Therefore, 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 agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 22 day of December, 2015,

in Tallahassee, Florida.

Warren Hunter
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal_Hearings@dcf.state.fl.us

Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Mana

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

[redacted]

PETITIONER,

VS.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 06 PASCO
UNIT: AHCA

RESPONDENT.
_____/

APPEAL NO. 15F-07812

CASE NO.

FINAL ORDER

The undersigned convened a telephonic administrative hearing on October 14, 2015 at 3:15 p.m. All parties appeared from separate locations.

STATEMENT OF ISSUE

At issue is whether Respondent's denial of Petitioner's request for home modification by a particular contractor was proper. Petitioner holds the burden of proof on this issue by a preponderance of the evidence.

PRELIMINARY STATEMENT

Respondent's Exhibits 1 through 6 were marked and entered into evidence. Petitioner did not submit any documentary evidence. Dr. Marc Kaprow (Medical Director of the Long Term Care Program) and Christian Laos (Senior Compliance Analyst) with United Health Care were present as Respondent's witnesses.

FINDINGS OF FACT

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

1. Petitioner is an adult male over the age of 21 enrolled in United Health Care's long term care managed care plan. He is bed bound and unable to perform any activities of daily living (ADLs) independently. He requires total assistance for hygiene, and has a hoyer lift to assist with transferring.

2. Petitioner has a makeshift ramp that has been used since Petitioner returned home from a hospital visit. He requested a more permanent ramp to allow him access in and out of the home. United does not dispute that Petitioner requires a ramp to access his home.

3. As part of the request, United asked two contractors to evaluate Petitioner's home and submit a quote for building an appropriate ramp.

4. The lower bid contractor took pictures of the home and evaluated the need based on the pictures. His suggestion is to modify the existing ramp, add a turnaround, and add railings. The railings would block the access to the outside yard and outdoor shower, which Petitioner's caregiver uses to bathe him.

5. The higher bid contractor went to Petitioner's home to evaluate the need. His suggestion is to move the door to a new position, add a 5x5 pad outside the door, make a new ramp, and leave the outside yard access.

6. United's position is that both contractors will provide in and out access that Petitioner needs. The service must comply with applicable building and fire codes. The

services are provided for the member's needs only. United asserts the member does not need access to an outdoor shower as he should be receiving bed baths.

7. Petitioner argues that he does require access to the outside yard and shower because that is where he receives showers. Additionally, he argues the current ramp is unstable, too steep, and is cracked, and a new ramp must be built for safety.

CONCLUSIONS OF LAW

8. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80, Florida Statutes.

9. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.

10. This hearing was held as a de novo proceeding pursuant to Florida Administrative Code Rule 65-2.056.

11. Florida Administrative Code Rule 59G-1.010(166), defines medical necessity, as follows:

> "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and

> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider....
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

12. Petitioner's main concern is safety and the access to the backyard. Respondent asserted that the contractors must be in compliance with all building and fire codes, therefore any ramp built or modified will be safe. The contractors were not present to discuss their qualifications or opinions on the best ramp. None of the parties at the hearing were construction experts. Therefore, the undersigned assumes that any work completed by a licensed contractor will be safe and effective for its intended use.

13. The service must meet the definition of medical necessity as set forth above. The parts of the definition at issue are subsections 4 and 5. First, the service provided must be an equally effective least cost alternative. There are two ramps, and assuming both are safe and provide access in and out of the home, these are considered equal. They would provide the exact same service. Therefore, the lower bid is the least cost alternative.

14. The next subsection relates to convenience for the caregiver. The caregiver does not want a ramp which blocks Petitioner's outside yard access because that is where he has showers. Petitioner is unable to stand or shower. He is bed bound and can receive bed baths. Respondent's medical director testified that a bed bath is safer because it does not require a hoyer lift transfer, and as effective as a shower. Therefore, an outside shower would be for the caregiver's convenience and not

medically necessary for Petitioner's care as he could have bed baths. Petitioner does not require access to the outside yard for showers.

15. After reviewing the totality of the evidence and legal authority, the undersigned finds that the Petitioner did not meet his burden of proof, and Agency's action was correct.

DECISION

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

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 11 day of December, 2015, in Tallahassee, Florida.

Danielle Murray
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal_Hearings@dcf.state.fl.us

Copies Furnished To: [redacted] Petitioner
Don Fuller, Area 5, AHCA Field Office Manager

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

[redacted]

APPEAL NO. 15F-07821
15F-07822

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on November 17, 2015, at 10:10 a.m., in Ft. Lauderdale, Florida.

APPEARANCES

For the Petitioner: [redacted] pro se.

For the Respondent: Linda Latson, Registered Nurse Specialist, Agency for Health Care Administration (AHCA).

STATEMENT OF ISSUE

At issue is the Agency's action, through Amerigroup, in denying the petitioner's request for name brand incontinent supplies based on the request not meeting the medically necessary requirements. The respondent carries the burden of proving its case by a preponderance of the evidence.

PRELIMINARY STATEMENT

Present as witnesses for the respondent were Dr. Mary Colburn, Medical Director, Carlene Brock, Quality Operations Nurse and Melinda Combast, Director of Long Term Care, all with Amerigroup.

The respondent submitted into evidence Respondent Exhibit 1 through 6. The petitioner submitted in to evidence Petitioner Exhibit 1.

Regarding appeal 15F-07822, a medical alert device, the Agency was unprepared and submitted no evidence for hearing. The Agency then requested the hearing be continued; however, the petitioner expressed she no longer wished to move forward with this matter. In light of this; 15F-07822 is treated as withdrawn on the record.

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 is a Long Term Care Medicaid recipient receiving services through Amerigroup. Amerigroup is a Managed Care Organization authorized by AHCA to make prior service authorizations for individuals enrolled in the Long Term Care Program. The petitioner was recently enrolled and started receiving Medicaid services through Amerigroup.

2. The petitioner requested to continue receiving Tena pads and Depends incontinent supplies through Amerigroup.

3. On September 10, 2015, Amerigroup mailed the petitioner a Notice of Action stating:

> Amerigroup has reviewed your request for continuation of your Depends Silhouette Pull up/Adult Diaper size XL and Tena Ultimate/Overnight Pad/Liners, which we received 9/2/15. After our review, this service has been: TERMINATED as of 9/20/15
>
> We determined your requested services are not medically necessary because the services do not meet the reason checked below.
>
> Must be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
>
> Amerigroup offered to provide generic brand pull-ups and pads and you declined to receive this product.

4. The petitioner requested this hearing and the terminated incontinent supplies were reinstated based on a timely hearing request.

5. The information as found in Petitioner Exhibit 1 was sent to the respondent witnesses during this hearing. Part of this exhibit included a copy of a letter from the petitioner's treating physician, Dr. Davilla. This letter states in part:

> She has tried multiple adult protective garments and reports to me that the only one that is working for her is the Depend Silhouette underwear...brand only and Tena pads. She states the others do not provide her sufficient protection and therefore she requires the use of this for medical indications.

6. The respondent's physician witness indicated that the above doctor statement was reviewed along with the rest of the Petitioner Exhibit. She indicate this statement appears to be a letter of self-report from the petitioner. She indicated the petitioner's doctor cited no medical explanation about any medical problems. Thus, she indicated the decision remains the correct medically necessary decision. She indicated that the

generic incontinent supplies are equivalent to the name brand incontinent supplies. She indicated Amerigroup is offering incontinent supplies for the petitioner which should be sufficient for her needs.

7. The petitioner argued she has tried at least twenty different incontinent products on her own, though she agreed that she may not have tried the supplies as offered by Amerigroup. She argued that only the Depends and Tena products are the only products that actually work for her.

CONCLUSIONS OF LAW

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

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

10. In accordance with Fla. Admin. Code R. 65-2.060 (1), the party having the burden shall establish his/her position by a preponderance of the evidence, to the satisfaction of the hearing officer.

11. Fla. Admin. Code R. 59G-1.010 states in part:

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
>
> (a) Meet the following conditions:
>
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
>
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
>
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;
>
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service…

12. As shown in the Findings of Fact, the Agency through Amerigroup, terminated the Tena pads and Depends incontinent supplies and offered the petitioner generic incontinent supplies as a replacement, based on medically necessary criteria.

13. For the case at hand, it is the respondent's position that that the generic equivalent incontinent supplies are equivalent to the name brand incontinent supplies and that the incontinent supplies offered to the petitioner should be sufficient for her needs. Additionally, the respondent's position is that the incontinent supplies as requested do not meet the medically necessary requirements that they be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. The hearing officer agrees with the respondent's position and arguments.

14. After considering the evidence and all of the appropriate authorities set forth above, the hearing officer concludes that the respondent has met its burden of proof

and the Agency's action to terminate the petitioner's request for continued Tena pads and Depends incontinent supplies is correct.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is denied and the Agency action affirmed

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 31 day of December, 2015, in Tallahassee, Florida.

Robert Akel

Robert Akel
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

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

[redacted]

APPEAL NO. 15F-07844

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 (Dade)
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 16, 2015 at 11:30 a.m.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Monica Otalora, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the Respondent's denial of the Petitioner's request for an electrical nerve stimulator (TENS unit) was correct. Petitioners bear the burden of proof in this matter.

PRELIMINARY STATEMENT

The hearing in this matter was originally scheduled for October 9, 2015, but was heard on October 16, 2015 in conjunction with another hearing request filed by the Petitioner.

The Petitioner did not submit any documents as evidence for the hearing.

Appearing as witnesses for the Respondent were Susan Frischman, Senior Compliance Analyst, and Dr. Miguel Fernandez, Chief Medical Officer, for United Healthcare, which is the Petitioners' managed health care organization. Respondent submitted the following documents into evidence: Exhibit 1 – Statement of Matters; Exhibit 2: Service/Equipment Request; Exhibit 3 – Denial Notice; and Exhibit 4: Grievance and Appeals documents, including medical records.

FINDINGS OF FACT

1. The Petitioner is a thirty-nine (39) year old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. He receives services under the plan from United Healthcare.

2. Petitioner's coverage with United Healthcare began on January 1, 2015. He was previously covered by Humana.

3. On or about March 24, 2015, Petitioners' treating physician (through a durable medical equipment provider) submitted an authorization request to United Healthcare for approval of an electrical nerve stimulator (a/k/a TENS unit).

4. On or about March 25, 2015, United Healthcare denied the pre-authorization request for the TENS unit. Petitioner filed an internal appeal/grievance with United

Healthcare and United Healthcare denied his appeal/grievance on or about April 15, 2015. The denial notice stated the following:

> Based on our review of your appeal, we have determined that the service you requested cannot be approved. We made the decision because this does not meet the 2015 Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook. It says for this to be approved, the item must be on the list of approved items. The item you asked for is not on the list. This is why we cannot approve this request.

5. The Petitioner testified he believes the TENS unit should be approved because he used a TENS unit previously when he was covered by Humana and he uses this item as a painkiller because he does not take any narcotic medications.

6. The Respondent's witness, Dr. Fernandez, stated the request for the TENS unit was not denied because of any medical necessity considerations, but because the item is not covered under Florida Medicaid guidelines.

7. Services under the Medicaid State Plan in Florida are provided in accordance with the Respondent's Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July, 2012, and the Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook ("DME Handbook"), effective July, 2010.

CONCLUSIONS OF LAW

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

9. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

10. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

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

12. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the Respondent. The Medicaid Handbook and the DME Handbook are incorporated by reference in Chapter 59G-4, Florida Administrative Code.

13. The DME Handbook lists various types of medical equipment which are covered by the Florida Medicaid Program. The DME Handbook also states the following on page 2-3:

> Many durable medical equipment (DME) items and services are limited to recipients under 21 years of age.
>
> To determine whether a service is available to all recipients or limited to recipients under age 21 years of age, refer to the DME and Medical Supply Services Provider Fee Schedules and the service specific requirements described in this handbook.

14. The electrical nerve stimulator, or TENS unit, requested by the Petitioner is not listed as a covered benefit or service in either the DME Handbook or the accompanying fee schedules.

15. Managed care plans, such as United Healthcare, are required to comply with the various Medicaid Handbooks and regulations.

16. After considering all the documentary evidence and witness testimony presented, the undersigned concludes United Healthcare correctly denied Petitioner's request for the electrical nerve stimulator.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is 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 agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 14 day of December, 2015, in Tallahassee, Florida.

Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Rhea Gray, AHCA Area 11, Field Office Manager

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

[redacted]

APPEAL NO. 15F-07847

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 Dade
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 16, 2015 at 10:00 a.m.

APPEARANCES

For the Petitioner: [redacted] Petitioner

For the Respondent: Monica Otalora, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the Respondent's denial of the Petitioner's request for bariatric surgery was correct. The Petitioner bears the burden of proof in this matter.

PRELIMINARY STATEMENT

The Petitioner did not submit any documents as evidence for the hearing.

Appearing as witnesses for the Respondent were Dr. Vincent Pantone, Chief Medical Officer, and Lourdes Gayo, Grievance and Appeals Manager, from Simply Healthcare, which is the Petitioner's managed health care organization. Respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Exhibits: Exhibit 1 – Statement of Matters; Exhibit 2 – Authorization Request; Exhibit 3 – Denial Notice; Exhibit 4 – Plan Appeal Request; Exhibit 5 – Medical Criteria.

Also present for the hearing was a Spanish language interpreter – [redacted] Interpreter Number [redacted] from Propio Language Services.

FINDINGS OF FACT

1. The Petitioner is a thirty-eight (38) year-old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. She receives services under the plan from Simply Healthcare.

2. On or about September 3, 2015, the Petitioner's treating physician (hereafter referred to as "the provider"), requested prior authorization from Simply Healthcare to perform a bariatric surgery procedure on the Petitioner. Simply Healthcare denied this request on September 11, 2015 based on medical necessity criteria. The denial notice also stated the following: "There is no documentation that you have been following a consistent medically supervised weight loss diet plan prior to the decision to operate."

3. The Petitioner has been diagnosed with [redacted] and [redacted] She is seeking the bariatric surgery procedure as a means of achieving weight loss.

4. Simply Healthcare's notice to the Petitioner advised her that her request for bariatric surgery was denied based on medical necessity guidelines. The Respondent's expert witness, Dr. Pantone, testified that the applicable medical necessity criteria for this type of surgery require there be documentation that the patient has tried and failed a medically supervised weight loss program for at least six months prior to approval of the surgery. Dr. Pantone also stated he reviewed medical records submitted by Petitioner's primary care physician and surgeon and there is no listing of a specific diet plan. In addition, the submitted medical records only covered an approximately three month period from June to mid-August, 2015. Dr. Pantone also mentioned that the records submitted by Petitioner's psychologist stated she had been eating rice, beans, ice cream and bread because she could not follow her diet.

5. The Petitioner believes her request for the bariatric surgery should be approved because she has not been able to lose weight by any other means. She stated she has tried to follow a diet and perform exercise. She also stated she suffers from depression and anxiety which has made it difficult to follow a diet because she overeats when she feels the effects of anxiety. With regard to her psychologist's reference to her eating rice, beans, bread, and ice cream, she stated she does not eat those things every day, only when she feels her anxiety.

6. Services under the Medicaid State Plan in Florida are provided in accordance with the Respondent's Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July, 2012.

CONCLUSIONS OF LAW

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

8. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

9. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

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

11. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the Respondent. The Medicaid Handbook referred to above is incorporated by reference in Fla. Admin. Code R. 59G-5.020.

12. Florida Statute § 409.912 requires that Respondent "purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care."

13. The Medicaid Handbook and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

> "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide;
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
> . . .
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

14. Although Petitioner testified she has done all she can to try to lose weight, she must also satisfy each of the remaining components of the rule's requirements concerning medical necessity. Respondent's medical expert testified that medical necessity guidelines require a documented trial and failure of a medically supervised six month weight loss program and this was not established in the Petitioner's case. Although the Petitioner's treating physician has requested the bariatric surgery, this does not in itself establish that this service is medically necessary according to the rule provisions outlined above.

15. After considering the evidence and testimony presented, the undersigned concludes that the Petitioner has not met her burden of proof in establishing that the Respondent's action was incorrect. The medical records submitted only cover a three-month period and do not include a specific diet plan. In addition, the psychological

records submitted and the Petitioner's testimony establish she has not been consistently complying with any diet guidelines due to her anxiety issues.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is 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 agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 11 day of December, 2015, in Tallahassee, Florida.

Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

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

[redacted]

PETITIONER,

APPEAL NO. 15F-07861

Vs.

CASE NO.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 20, 2015, at 1:00 p.m.

APPEARANCES

For the Petitioner: [redacted] pro se.

For the Respondent: Linda Latson, Registered Nurse Specialist, Agency for Health Care Administration (AHCA).

STATEMENT OF ISSUE

At issue is whether the Agency's denial of a dental procedure was correct. The petitioner carries the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

Present as witnesses for the respondent were Dr. Vincent Pantone, Chief Medical Officer, and Lourdes Gayo, Director of Member Services, both with Simply Health Care. Also present as witnesses for the respondent were Heidi Penaranda,

Complaints and Grievances Specialist, and Dr. Susan Hudson, Dental Consultant, both with DentaQuest.

The respondent submitted into evidence Respondent Exhibit 1 and 2.

The petitioner submitted into evidence Petitioner Exhibit 1.

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 is over 21 years of age and is a Medicaid recipient living in [redacted] Florida. She is enrolled in the Medicaid MMA (Managed Medical Assistance) Program with Better Health/Simply Health Care. Simply is a Managed Care Organization that has been authorized by AHCA to make certain prior service authorization decisions for individuals enrolled in Medicaid MMA Programs. DentaQuest is contracted by Simply Health Care to provide dental services and perform prior authorization reviews.

2. On July 18, 2015, the petitioner's dental provider provided a prior service authorization request to DentaQuest. This request was for procedural code D4341 which is periodontal scaling and root planning for upper right and left quadrant and lower right and left quadrant (or deep cleaning).

3. On July 18, 2015, the Agency, through DentaQuest, denied the above request and sent the petitioner a Notice of Action stating:

> DentaQuest, on behalf of Better Health, has reviewed your request for the services below, which we received on July 18, 2015. ...This service has been denied.
>
> ...This requested service is not a covered service.

4. The respondent's witness, DentaQuest Dental Consultant, pointed out per the Agency's Dental Services Coverage and Limitation Handbook, the requested dental procedure is not a covered service. She also indicated based on this decision, no medical necessity review or decision was made for this request.

5. Petitioner Exhibit 1, a letter from the petitioner's dental office but signed by the office manager, was reviewed by the respondent's witnesses during the hearing. The letter indicated the petitioner has "generalized periodontitis."

6. The petitioner argued that she has bleeding gums and that her general health will deteriorate if she does not get the requested dental procedure approved.

7. The Dental Consultant indicated the decision remains the same even after review of the information from the petitioner.

CONCLUSIONS OF LAW

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

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

10. In accordance with Fla. Admin. Code R. 65-2.060 (1), the party having the burden shall establish his/her position by a preponderance of the evidence, to the satisfaction of the hearing officer.

11. The Dental Services Coverage and Limitation Handbook (November 2011), which has been incorporated by reference into Chapter 59G-4, Fla. Admin. Code, states on page 2-3:

> Medicaid will reimburse for medically-necessary emergency dental procedures to alleviate pain and or infection for eligible adult Medicaid recipients 21 years of age or older. Emergency dental care shall be limited to emergency problem-focused evaluations, necessary radiographs to make a diagnosis, extraction, and incision and drainage of abscess.

12. As shown in the Findings of Fact, DentaQuest denied the petitioner's request for dental procedure code D4341, which is periodontal scaling and root planning for upper right and left quadrant and lower right and left quadrant (or deep cleaning).

13. For the case at hand, the respondent's denial of the service request was in accordance with the Dental Services Coverage and Limitation Handbook which indicates that Medicaid reimbursement of a dental procedure for individuals over 21 years of age can be provided to alleviate pain and or infection, and for emergency dental care limited to emergency problem-focused evaluations, necessary radiographs to make a diagnosis, extraction, and incision and drainage of abscess. Thus, the requested service does not fit this definition and the service requested is not a covered service.

14. After considering the evidence and all of the appropriate authorities set forth in the findings above, the hearing officer concludes that the petitioner has not met her burden of proof and the Agency's action denying the petitioner's request for the dental procedures is correct.

DECISION

The appeal is denied and the Agency action affirmed.

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 14 day of December, 2015,

in Tallahassee, Florida.

Robert Akel

Robert Akel
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 17 Broward
UNIT: 88249

RESPONDENT.
_____/

APPEAL NO. 15F-07865

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on November 4, 2015, at 10:03 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Mary Triplett, DCF supervisor.

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of denying him full Medicaid benefit and enrolling him in the Medically Needy Program with a high estimated share of cost (SOC). The petitioner is seeking full Medicaid coverage. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

On September 10, 2015, the petitioner requested an appeal challenging his enrollment in the Medically Needy (MN) Program.

During the hearing, the petitioner did not submit any exhibits for the undersigned to consider. The Department submitted four (4) exhibits which were accepted into evidence and marked as Respondent's Exhibits 1 through 4.

FINDINGS OF FACT

1. The petitioner, DOB [redacted] is [redacted] years old with [redacted] and [redacted] problems. He has had multiple [redacted] and has been determined disabled by Social Security Administration (SSA).

2. Petitioner's monthly gross Social Security Disability (SSD) benefit is $2,098, of which about $300 is being garnished by the Internal Revenue Service (IRS). The SSD income amount is not in dispute, *see* Respondent's Exhibit 3. Petitioner is not yet eligible for Medicare benefits.

3. Petitioner recently moved from to Florida from Pennsylvania, where he was receiving full Medicaid benefits. Petitioner has not received any major medical services since moving to Florida.

4. On July 27, 2015, the petitioner applied for benefits and did not report any recurring medically related expenses, *see* Respondent's Exhibit 1.

5. The Department's representative explained its action to enroll the petitioner in the Medically Needy Program with a share of cost. The share of cost amount is directly dependent on the petitioner's income.

6. To begin the budgeting process for the petitioner's Medically Needy Program, the Department counted monthly income of $2,098, minus a $20 standard income disregard followed by a $180 Medically Needy Income Level (MNIL) deduction for one person, from his resulting income. After these deductions, the share of cost was determined to be $1,898, *see* Respondent's Exhibit 4.

7. On August 7, 2015, the Department sent a notice to the petitioner informing him he was approved for the Medically Needy Medicaid with a $1,898 share of cost effective July 2015, *see* Respondent's Exhibit 2.

8. The petitioner did not dispute the income amount used by the Department in the eligibility process, but asserted as follows: That he has serious health issues that require constant monitoring, resulting in recurring medical expenses, but less than his SOC. That his SOC is too high and that he cannot afford that much monthly expense on a fixed income. That the Medically Needy Program is only good for hospitalization. That he is being monitored for a [redacted] and is reluctant to get a much needed [redacted], because he has to pay upfront. Petitioner argued after paying for his household expenses, he has no money left and cannot afford any deductibles. He explained that he has a $295 bill for an ultrasound and is not sure what to do with it. Petitioner explained he had had access to [redacted] and [redacted] when he was in [redacted] and that all his medical expenses were paid for and does not understand why things are so different in Florida.

9. The Department's representative explained that petitioner does not have to spend out of pocket if he has recurring medical expenses that exceed his SOC, and explained how the share of cost was determined and how it could be met. Petitioner

was advised to submit all outstanding medical bills to the Department so that it can be determined when the share of cost is met and when Medicaid coverage could begin. The Department's representative explained that all unpaid medical bills not previously used can be used during any future months for which eligibility is needed.

CONCLUSIONS OF LAW

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

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

12. The Department determines Medicaid eligibility based on the household circumstances. When the household consists of parents and children, Medicaid eligibility is determined under Family-Related Medicaid policy. When the household consists of an elderly or disabled individual or couple, Medicaid eligibility is determined under Adult-Related Medicaid policy (also referred to as SSI-Related Medicaid or Medically Needy). Medicaid eligibility is based on federal regulations. Petitioner was evaluated under the SSI-Related Medicaid coverage group.

13. Federal Regulations at 45 C.F.R. §435.500 sets forth the regulations for requirements for determining the eligibility of both categorically and medically needy individuals.

14. In this case, petitioner has been determined disabled by the SSA. For the SSI-Related Medicaid Programs, an individual must either be aged 65 or older or

determined disabled by the SSA or the Department. Based on this regulation, the Department determined Medicaid eligibility for petitioner and approved him for SSI-Related Medically Needy Program benefits.

15. Federal Regulations at 20 C.F.R. §416.1123 defines how unearned income is counted and states in relevant part:

> (b) Amount considered as income. We may include more or less of your unearned income than you actually receive.
> (1) We include more than you actually receive where another benefit payment (such as a social security insurance benefit) (see Sec. 416.1121) has been reduced to recover a previous overpayment. You are repaying a legal obligation through the withholding of portions of your benefit amount, and the amount of the debt reduction is also part of your unearned income. Exception: We do not include more than you actually receive if you received both SSI benefits and the other benefit at the time the overpayment of the other benefit occurred and the overpaid amount was included in figuring your SSI benefit at that time.

16. In this instant case, the respondent considers more income than petitioner actually receives, because part of his Social Security benefits being recouped by the IRS was not excluded in the respondent's budget.

17. Fla. Admin. Code R. 65A-1.701, Definitions, states:

> (20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services...

18. The above authority explains that the MEDS-AD (full Medicaid for an aged or disabled person) has an income limit of 88% of the federal poverty level.

19. The Eligibility Standards for SSI-Related Programs appear in the Department's Program Policy Manual CFOP 165-22 (the Policy Manual), Appendix A-9. Effective July

2015, 88% of FPL for a one member household is $864. The petitioner's countable income after the $20 deduction is $2,078, which exceeds the standard for full Medicaid benefits. Petitioner is not receiving Medicare but his income is in excess of the Program limit to receive full Medicaid benefits. The respondent explored petitioner's eligibility for the Medically Needy Program.

20. The Medically Needy Program provides coverage for individuals who meet the technical requirements for Medicaid but whose income or assets exceed the income limits.

21. Fla. Admin. Code R. 65A-1.710, SSI-Related Medicaid Coverage Groups, states in part:

> The department covers all mandatory coverage groups and the following optional coverage groups:
> (1) MEDS-AD Demonstration Waiver. A coverage group for aged and disabled individuals (or couples), as provided in 42 U.S.C. § 1396a(m)...(5) Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. §§ 1396a and 1396d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance due to their level of income or resources. The program does not cover nursing facility care, intermediate care for the developmentally disabled services, or other long-term care services...
> (30) Share of Cost (SOC): SOC represents the amount of recognized medical expenses that a Medically Needy enrolled individual or family must incur each month before becoming eligible to receive Medicaid benefits for medical expenses incurred during the remainder of the month.

22. The above authorities also define Medically Needy and Share of Cost (SOC). SOC represents the amount of recognized medical expenses that a Medically Needy enrolled individual or family must incur each month before becoming eligible to receive Medicaid benefits. This program is available for aged or disabled individuals or eligible couples who do not qualify for the MEDS-AD Program.

23. Federal regulations at 20 C.F.R. § 416.1124, Unearned income we do not count, "(c) (12). The first $20 of any unearned income in a month..."

24. Fla. Admin. Code R. 65A-1.716 (2), Income and Resource Criteria, sets forth the MNIL for an individual at $180.

25. The above cited rules explain the budgeting procedure to determine the share of cost. The gross income is reduced by a standard deduction ($20) and the MNIL for the assistance group size of one at $180. The Department followed this procedure and determined the share of cost at $1,898 effective July 2015.

26. Based on the evidence, testimony, and the controlling authorities, the undersigned concludes that the Department correctly determined that the petitioner is not eligible for full Medicaid benefits and should be enrolled in the Medically Needy Program. No errors were found in the calculation of the amount of the share of cost.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal is denied. The Department's action is upheld.

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 25 day of November, 2015,

in Tallahassee, Florida.

Roosevelt Reveil

Roosevelt Reveil
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

APPEAL NO. 15F-07897

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 Dade
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, a telephonic administrative hearing was convened in this matter before the undersigned hearing officer on November 9, 2015 at 3:03 p.m.

APPEARANCES

For the Petitioner: [redacted] Pro Se

For the Respondent: Dianna Chirino,
Senior Human Services Program Specialist,
Agency for Health Care Administration

STATEMENT OF ISSUE

The Petitioner is appealing the Agency for Health Care Administration's (AHCA's) decision, through DentaQuest, in denying requests for the following dental procedures:

- D2950-a filing for a crown with posts, Tooth 3 and 19;
- D2751-white glass with metal crown, Tooth 3 and 19;
- D7210-surgical extraction, Tooth 6, 8 and 9;
- D3330-nerve treatment on molar tooth, Tooth 19;
- D5213-partial upper denture; and
- D5214-partial lower denture

Because the issue under appeal involves requests for services, the burden of proof was assigned to the Petitioner.

PRELIMINARY STATEMENT

Mindy Aikman, Grievance and Appeals Specialist, appeared as Respondent's witness from Petitioner's managed care plan Humana. Sara Miller, Grievance and Appeals Specialist from Humana also appeared as an observer. Appearing as Respondent witnesses from DentaQuest were Dr. Susan Holden, Dental Consultant and Jackelyn Salcedo, Complaints and Grievance Specialist.

Respondent submitted a 46-page document, which was entered into evidence and marked Respondent Exhibit 1.

On October 22, 2015, DentaQuest sent Petitioner an appeal determination letter in which she was notified that the following procedures have been approved:

- D2751-crown-porcelain fused to predominantly base metal, Tooth 3;
- D7210-surgical extraction of Tooth 6, 8, and 9;
- D5213-partial denture, upper arch;
- D5214-partial denture, lower arch; and
- D4341-periodontal scaling, upper left quadrant.

The following procedures remain denied and are the remaining issues for Petitioner's appeal:

- D2950-core buildup, including any pins when required, Tooth 3 and 19;
- D3330-endodontic therapy, molar, Tooth 19;
- D2751-crown, porcelain fused to predominant base metal, Tooth 19; and
- D4341-periondontal scaling and root planting-four or more teeth per quadrant, upper left quadrant

FINDINGS OF FACTS

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

1. Petitioner is a 61 year-old Medicaid recipient enrolled with Humana Medical Plan (Humana), a Florida Health Managed Care provider.

2. Human requires prior authorization for services related to dental care and has subcontracted with DentaQuest to perform the prior authorization requests.

3. Petitioner asserts she has [redacted] as a result of using fosomax for two years. She asserts she needs the dental procedures requested.

4. DentaQuest's dentist explained for procedure D4341, Petitioner's upper left quadrant has less than four teeth which is the minimum number of teeth required for this procedure to be approved. For procedure D2751 for tooth 19, there is significant bone loss around the roots of the tooth. The likelihood of losing tooth 19 is high and is the reason for the denial of this procedure. Procedure code D2950 (core buildup, including any pins when required, Tooth 3 and 19) and D3330 (endodontic therapy, molar, Tooth 19) were denied because they are not covered services.

5. Petitioner wanted to know what other options she had. Respondent suggested she discuss that with her dentist but noted that extraction of tooth 19 would result in including it in her partial denture.

CONCLUSIONS OF LAW

6. By agreement between the Agency for Health Care Administration and the Department of Children and Families, the Agency for Health Care Administration has

conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80 Florida Statutes.

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

8. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Florida Administrative Code Rule 65-2.060(1).

9. Florida Statutes 409.971 – 409.973 establishes the requirement for Medicaid recipients to be enrolled in the statewide managed medical assistance program and the minimum benefits the managed care plans shall cover. Dental services are one of the mandatory services that must be provided.

10. § 409.912, Fla. Stat. also provides that the Agency may mandate prior authorization for Medicaid services.

11. Fla. Admin. Code R. 59G-1.010 defines "prior authorization" as:

> (226) "Prior authorization" means the approval by the Medicaid office for a Medicaid provider, or by a prepaid health plan for its affiliated providers, to deliver Medicaid covered medical or allied care, goods, or services in advance of the delivery of the care, goods, or services.

12. Fla. Admin. Code R. 59G-1.010 (166) provides…

> "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
>
> (a) Meet the following conditions:
>
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

13. Page 33, paragraph 5 of the Attachment II to the AHCA Standard Contract No. FP026 for managed care states in relevant part:

> The Agency shall be responsible for promulgating coverage requirements applicable to Managed Care Plan through the Florida Medicaid Coverage and Limitations Handbooks…

14. The Florida Medicaid Dental Services Coverage and Limitations Handbook-November 2011 (Handbook), incorporated by reference into Chapter 59G-4, Fla. Admin. Code, sets standards for dental services and describes on pages 1-2 and 2-3 the covered services for adults (21 years old and over):

> The purpose of the dental program is to provide dental care to recipients under the age of 21 years, emergency dental services to recipients age 21 and older, and denture and denture-related services and oral and maxillofacial surgery services to all Medicaid-eligible recipients.
> ….
>
> The adult dental program provides for the reimbursement of full and removable partial dentures. Extractions and other surgical procedures essential to the preparation of the mouth for dentures are reimbursable if the patient is to receive dentures. Procedures relating to dentures such as repairs, relines and adjustments are reimbursable.
>
> Medicaid will reimburse for medically-necessary emergency dental procedures to alleviate pain and or infection for eligible adult Medicaid recipients 21 years of age or older. Emergency dental care shall be limited

to emergency problem-focused evaluations, necessary radiographs to make a diagnosis, extraction, and incision and drainage of abscess.

15. In addition to the Handbook, the Dental General Fee Schedule published by the Agency for Health Care Administration indicates what dental procedure codes are covered by Medicaid. Procedure codes D2950, D3330, are not covered for adults by Medicaid.

16. While the Petitioner asserted she needs the requested dental procedures, Respondent has provided credible testimony and justification why the remaining dental procedures requested (D4341, D2751, D2950 and D3330) are denied. The Petitioner has failed to meet her burden.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Agency for Health Care Administration acted correctly in denying service procedure codes D4341, D2751, D2950 and D3330 for the Petitioner. Therefore Petitioner's appeal is 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 28 day of December, 2015,

in Tallahassee, Florida.

Warren Hunter
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal_Hearings@dcf.state.fl.us

Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

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

[redacted]

APPEAL NO. 15F-07898

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 Dade
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 16, 2015 at 11:30 a.m.

APPEARANCES

For Petitioner: [redacted]

For Respondent: Monica Otalora
Senior Program Specialist

STATEMENT OF ISSUE

At issue is whether Respondent's denial of the prescription drug [redacted] was proper. The Petitioner bears the burden of proof in this matter.

PRELIMINARY STATEMENT

The Petitioner did not submit any documents as evidence for the hearing.

Appearing as witnesses for the Respondent were Susan Frischman, Senior Compliance Analyst, and Shauna Bush, Pharmacy Director, from United Healthcare, which is Petitioner's managed care plan.

Respondent submitted the following documents into evidence for the hearing: Exhibit 1 – Statement of Matters; Exhibit 2 – Prior Authorization Request; Exhibit 3 – Denial Notice; and Exhibit 4 – Grievance/Appeal Documents, including medical records.

FINDINGS OF FACT

1. The Petitioner is a thirty-nine (39) year-old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. He receives services under the plan from United Healthcare.

2. On or about August 28, 2015, Petitioner's treating physician submitted a prior authorization request to United Healthcare for the prescription drug [redacted]

3. On August 30, 2015, United Healthcare denied the request for [redacted] The denial notice stated the following:

> The request does not meet the health plan's reason(s) for an exception to the Medicaid Preferred Drug List (PDL), also sometimes known as the formulary. Other medications are available on the Preferred Drug List that may work for you.

4. Petitioner testified he needs this medication to help him lose weight, and he cannot take any other weight loss medications according to his doctor. He stated he is

overweight and suffers from [redacted] and [redacted] He also stated he cannot exercise due to hip and back problems.

5. Respondent's witness, Ms. Buch, stated that the United Healthcare plan only covers prescription drugs authorized by the Florida Medicaid Handbooks and that Medicaid does not cover this weight loss medication.

CONCLUSIONS OF LAW

6. 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.

7. This is a final order pursuant to § 120.569 and § 120.57, Fla. Stat.

8. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

9. The standard of proof in an administrative hearing is by a preponderance of the evidence. (See Fla. Admin. Code R. 65-2060(1).) The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

10. The Florida Medicaid program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid program is administered by the Respondent.

11. The Florida Medicaid Provider Handbook (Provider Handbook) is incorporated by reference in Fla. Admin. Code Chapter 59G-5.020. The Handbook states on page 1-27:

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.

12. In this proceeding, United Healthcare is the health maintenance organization which provides Petitioner's Medicaid services.

13. Page 1-28 of the Provider Handbook lists HMO covered services. The service list includes prescribed drug services.

14. Page 1-30 of the Provider Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

15. The Prescribed Drug Services Handbook has been promulgated into rule by reference in Fla. Admin. Code R. 59G-4.250. Relevant to this proceeding:

> Page 1-4:
>
> HMO prescribed drug services are defined the same as for the Medicaid fee-for-service program and include all legend drug products covered by fee-for-service Medicaid as defined in Chapter 2 of this handbook, Legend Drugs. Medicaid's contract with HMOs states that Medicaid HMOs may use prior authorization and/or step therapy to encourage compliance with the preferred drug list.
>
> Page 2-2:
>
> To be reimbursed by Medicaid, a drug must be medically necessary and either (a) prescribed for medically accepted indications and dosages found in the drug labeling or drug compendia ..., or (b) prior authorized by a qualified clinical specialists approved by the Agency. Notwithstanding this rule, the Agency may exclude or otherwise restrict coverage of a drug in accordance with Section 1927 of the Social Security Act.

16. The definition of "medically necessary" is found in the Fla. Admin. Code R. 59G-

1.010, which states, in part:

> (166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
>
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider...
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

17. Pertaining to the PDL, the Drug Handbook continues by providing the following additional information:

> Page 2-4:
>
> The Preferred Drug List (PDL) is a listing of prescription products recommended by the Pharmaceutical and Therapeutics (P&T) Committee for consideration by AHCA as efficacious, safe, and cost effective choices when prescribing for Medicaid patients.
> ...
>
> Products included on the PDL must be prescribed first unless the patient has previously used these products unsuccessfully or the prescriber submits documentation justifying the use of a non-PDL product.
> ...
>
> Non- PDL drugs may be approved for reimbursement upon prior authorization.

Page 2-5:

Approval of reimbursement for alternative medications that are not listed on the preferred drug list shall be considered if listed products have been tried without success within the previous twelve months. The step-therapy prior authorization may require the prescriber to use medications in a similar drug class or that are indicated for a similar medical indication unless contraindicated in the Food and Drug Administration labeling. The trial period between the specified steps may vary according to the medical indication. A drug product may be approved without meeting the step-therapy prior authorization criteria if the prescribing physician provides the agency with additional written medical or clinical documentation that the product is medically necessary because:

- There is not a drug on the preferred drug list which is an acceptable clinical alternative to treat the disease or medical condition; or
- The alternatives have been ineffective in the treatment of the beneficiary's disease; or
- Based on historic evidence and known characteristics of the patient and the drug, the drug is likely to be ineffective; or
- The number of doses has been ineffective.

18. The Findings of Fact establish [redacted] is not included on Respondent's PDL.

19. Clinical evidence was not presented demonstrating PDL medications were attempted in the last year and found to be ineffective. As such, it was not demonstrated the above step therapy process was addressed.

20. Petitioner has not established the following conditions of medical necessity have been satisfied:

2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational;

21. The greater weight of evidence in this matter does not establish Respondent's denial of [redacted] was improper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner's appeal is 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 15 day of December, 2015, in Tallahassee, Florida.

Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pinellas
UNIT: 88694

RESPONDENT.
_____/

APPEAL NO. 15F-07904

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, a telephonic administrative hearing in the above referenced matter was convened on November 3, 2015 at 8:36 a.m.

APPEARANCES

For the Petitioner: [redacted]
Authorized Representative

For the Respondent: Signe Jacobson
Economic Self Sufficiency Specialist II

ISSUE

Whether petitioner's monthly Institutional Care Program (ICP) responsibility of $3758.11 was correctly determined. Petitioner seeks a hardship allocation to offset the living expenses of his son, [redacted] The burden of proof is assigned to the respondent[1].

[1] Prior to the issuance of a Notice of Case Action on August 7, 2015 petitioner's monthly patient responsibility was $2141.34.

PRELIMINARY STATEMENT

Petitioner was represented by his father-in-law. Also present was his mother-in-law, [redacted] Petitioner's exhibit "1" was entered into evidence.

Ms. Jacobson appears as both the representative and witness for the respondent. Respondent' exhibit "1" was entered into evidence.

The record was held open through November 10, 2015 for respondent to provide:

- Clarification of how the amount of petitioner's uncovered medical expenses was calculated.
- Relevant running record comments.

Information was received and entered as respondent's exhibit "2".

The record was held open through November 13, 2015 to allow the petitioner to respond to post hearing submissions. Information received from the petitioner was entered as petitioner's exhibit "2".

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. During a surgical procedure in July 2014, petitioner experienced a [redacted] He was thereafter admitted to [redacted] [redacted] is a skilled nursing facility.

2. Petitioner was subsequently determined eligible for Institutional Care Program (ICP) Medicaid.

3. At time of ICP eligibility, petitioner had a community spouse and a disabled son. Part of petitioner's monthly income was diverted to his spouse, [redacted]

4. In July 2015 petitioner's representative reported [redacted] died on [redacted]

[redacted]

5. Petitioner's son, [redacted] relocated to an assisted living facility.

6. Based on the reported change, respondent re-calculated petitioner's monthly ICP patient responsibility. A Notice of Case Action was issued on August 7, 2015[2] that, effective September 1, 2015, the month patient responsibility would be $3758.11.

7. The monthly responsibility was based on petitioner's income less deductions for a personal needs allowance and uncovered medical expenses. The initial calculations were:

$2509.20	Pension
$1563.00	Social Security
$4072.20	Total Gross Income

8. Petitioner does not refute respondent's calculation of income.

9. Deductions from petitioner's income were:

$ 105.00	Personal Needs Allowance
$ 209.08	Uncovered Medical Expenses
$ 314.08	Total Deductions

10. The final calculation of petitioner's monthly patient responsibility was:

$4072.20	Total Gross Income
-$ 314.08	Total Deductions
$3758.12	Petitioner's Monthly Responsibility

11. Respondent's exhibit "1" shows the following medical expenses deducted from petitioner's pension:

- $50.82: Health Insurance
- $ 5.93: Dental/Vision Premium

[2] In response to this notice, petitioner's representative contacted the Office of Appeal Hearings on September 11, 2015 and requested a fair hearing.

$56.75: Total monthly medical expenses

12. Respondent was unable to explain how $209.08 in monthly uncovered medical expense was calculated. The record was held open for further clarification.

13. Post hearing respondent replied stating, in part:

> ... it was discovered that an error had occurred within the system that miscalculated the uncovered medical expenses. The system was corrected and now shows correct UMED amounts in the budget effective 8/2015 – ongoing. A notice of case action was mailed on 11/6/2015 showing the corrected patient responsibility. Patient responsibility was calculated as follows: $4072.20 Total Gross Unearned Income - $105 Personal Need Allowance - $56.75 Uncovered Medical Expenses = $3910.45 Patient Responsibility.

14. Petitioner's son, [redacted] was born [redacted] In 2011 petitioner and his wife were appointed guardian for their son. The son was determined to have a [redacted]

15. The cost of [redacted] assisted living facility is $1500 per month. He also attends a job training program. The cost is $250.00 per month. Each amount is self-paid.

16. The monthly unearned income of [redacted] consists of Social Security Disability and Social Security. The combined amount is $1036.60 per month.

17. The amount of [redacted] monthly unearned income is not disputed.

18. Petitioner's representative argues that prior to the death of [redacted] sufficient income was diverted from [redacted] to help pay [redacted] expenses. The representative requests a hardship allocation from petitioner's income for the purpose of covering the monthly deficit of [redacted] living and vocational expenses.

19. Respondent considered whether [redacted] qualified for a dependent allowance. As petitioner no longer had a community spouse, the calculation was based on the following:

$981.00:	Consolidated Need Standard (CNS) for 1 dependent
- $1036.00:	[redacted] monthly income
$ 0.00	Dependent's Allowance

CONCLUSIONS OF LAW

20. 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 Fla. Stat. § 409.285.

21 This proceeding is a de novo proceeding pursuant to Fla. Admin. Code § 65-2.056.

22. The standard of proof in an administrative hearing is by 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.).

23. Petitioner's representative requests a hardship allocation be granted so that additional income can be directed toward the care of the disabled son. As such, analysis is directed toward the calculation of petitioner's monthly patient responsibility.

24. Fla. Admin Code R. 65A-1.7141 states, in part:

> After an individual is determined eligible for ... Institutional Care Program (ICP), the Department determines the individual's patient responsibility. "Patient responsibility" is the amount the Agency for Health Care Administration (AHCA) must reduce its payments to a medical institution and intermediate care facility or payments for home and community based services provided to an individual towards their cost of care. Patient

responsibility is based on the amount of income remaining after the following deductions are applied pursuant to 42 CFR § 435.725 and 42 CFR § 435.726. This process is called "post eligibility treatment of income".

(1) For institutional care services and Hospice, the following deductions are applied to the individual's income to determine patient responsibility in the following order:

(a) A Personal Needs Allowance (PNA) of $105. Individuals residing in medical institutions and intermediate care facilities shall have $105 of their monthly income protected for their personal need allowance.

...

(c) An additional PNA for therapeutic wages. If the institutionalized individual earns therapeutic wages, an additional deduction from income equal to one-half of the monthly therapeutic wages, up to a maximum of $111, shall be applied and treated as an additional PNA protected for personal need.

(d) An additional PNA for court ordered child support. If the institutionalized individual is court ordered to pay child support an additional PNA is deducted in an amount equal to the court ordered support paid by the individual to meet their court ordered obligation. The additional PNA is applied only if a court ordered deduction was not made under another provision under the post eligibility process.

(e) The community spouse income allowance. The Department applies the formula and policies under § 1924 of the Social-Security Act, and Rule 65A-1.716, F.A.C., to compute the community spouse income allowance after the institutionalized spouse is determined eligible for institutional care benefits.

(f) The community spouse's excess shelter and utility expenses. The amount by which the sum of the spouse's expenses for rent or mortgage payment (including principal and interest), taxes and insurance and, in the case of a homeowner's association, condominium or cooperative, required maintenance charge, for the community spouse's principal residence and utility expense exceeds thirty percent of the amount of the Minimum Monthly Maintenance Needs Allowance (MMMNA) is allowed. The utility expense is based on the current Food Assistance Program's standard utility allowance as referenced in subsection 65A-1.603(2) F.A.C.

...

(i) Uncovered medical expense deduction. The following policy will be applied in considering medical deductions for institutionalized individuals and individuals receiving HCBS services to calculate the amount allowed for the uncovered medical expense deduction:

1. For institutionalized persons or residents of medical institutions and

intermediate care facilities, the deduction includes:

a. Any premium, deductible, or coinsurance charges or payments for health insurance coverage.

b. For other incurred medical expenses, the expense must be for a medical or remedial care service and be medically necessary as specified in subsection 59G-1.010(166), F.A.C., and be recognized in state law. For medically necessary care, services and items not paid for under the Medicaid State Plan, the actual billed amount will be the amount of the deduction, not to exceed the maximum payment or fee recognized by Medicare, commercial payors, or any other third party payor, for the same or similar item, care, or service.

2. The expense must have been incurred no earlier than the three month period preceding the month of application providing eligibility.

3. The expense must not have been paid for under the Medicaid State Plan.

4. Other health insurance policies, including long term care insurance, are considered to be the first payor for medical items, care, or services covered by such policies and the remaining items can be used as an uncovered medical expense deduction. Therefore, to be deducted from the individual's income, the individual must demonstrate that other insurance does not cover such medical items, care, or services.

5. The medical and remedial care expenses that were incurred as the result of imposition of a transfer of asset penalty is limited to zero.

25. The greater weight of evidence establishes the above deductions applicable to the petitioner are the personal needs allowance and uncovered medical expenses. Neither evidence nor testimony establish petitioner has therapeutic wages or court ordered child support. Additionally, the Findings of Fact establish petitioner no longer has a community spouse.

26. Respondent correctly allocated a personal needs allowance of $105.00 as a deduction from petitioner's income.

27. The only evidence presented regarding uncovered medical expenses was $50.82 for health insurance and $5.93 for a dental/vision premium. The combined total for these expenditures is $56.75. It is noted this information is found in respondent's exhibit "1" and petitioner's exhibit "2".

28. Regarding a hardship allocation, Fla. Admin. Code R. 65A-1.712(4)(f) addresses exceptional circumstances. The circumstances, however, are only applicable to a community spouse. The Findings of Fact establish petitioner's community spouse died in June 2015.

29. It is noted that 42 C.F.R. §435.725 addresses the maintenance need of a family member in the home.

30. The authority addressing a dependent allowance is found in the Department's Program Policy Manual, CFOP 165-22, which states:

> **2640.0121 Dependent Allowance (MSSI)**
>
> For ICP, MEDS-ICP, institutional Hospice, Long Term Care Diversion, PACE, and the Assisted Living Waiver Programs when the eligible individual does not have a community spouse but does have a dependent unmarried child under the age of 21 or a disabled adult child living at home, the dependent is entitled to a portion of the individual's income equal to the TCA Consolidated Needs Standard minus the dependent's income. (Refer to Appendix A-5 for the CNS.)

31. The Department's Program Policy Manual, 165-22, Appendix A-5 identifies the Consolidated Needs Standard (CNS) for one individual is $981.00.

32. The Findings of Fact establish the petitioner's son lives in assisted living. Regardless of his place of residence, his monthly income of $1036.60 exceeds the CNS of $981.00. As such, the controlling authority does not support a dependent allowance.

33. It is noted that respondent's position changed in regard to the monthly patient responsibility. At time of hearing, the patient responsibility was $3758.11. Due to an error related to calculating uncovered medical expenses, the amount changed to $3910.45. A new Notice of Case Action was issued on November 6, 2015.

34. Based on the Notice of Case Action dated August 7, 2015, the greater weight of evidence establishes the following:

- An applicable authority allowing for a hardship allocation was not presented.
- Petitioner was correctly allocated a personal needs allowance of $105.00.
- Petitioner's monthly uncovered medical expenses are $56.75.
- After issuance of the notice, petitioner's monthly patient responsibility was corrected to $3910.45

35. Respondent has met its required evidentiary burden in this matter. Income and deductions were correctly considered.

36. If the petitioner disputes the income or uncovered medical expenses associated with the Notice of Case Action issued on November 6, 2015, hearing rights can once again be exercised.

37. If the amount of petitioner's uncovered medical expenses should increase, a new calculation of the monthly patient responsibility can be requested from the Department.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is denied.

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 20 day of November, 2015,

in Tallahassee, Florida.

Frank Houston
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

APPEAL NO. 15F-07920
APPEAL NO. 15F-08780

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 15 Palm Beach
UNIT: 88701

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on October 19, 2015 at 11:30 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Corrie Driscoll, supervisor

STATEMENT OF ISSUE

At issue is the amount of Food Assistance Program (FAP) benefits the petitioner was approved to receive as his benefits were reduced. The Department carries the burden of proof in the FAP appeal.

The petitioner is also appealing the denial of full Medicaid and enrollment in the Medically Needy Program with an estimated share of cost (SOC). He is seeking full Medicaid. The petitioner caries the burden of proof in the Medicaid appeal.

PRELIMINARY STATEMENT

The Department presented five exhibits at the hearing which were entered into evidence and marked as Respondent's Exhibits 1 through 5. The petitioner presented one exhibit which was entered into evidence and marked as Petitioner's Composite Exhibit 1. The record was held open until October 24, 2015, for the respondent to provide the Medicaid budget and the Notice of Case Action for the Medicaid benefits.

The respondent submitted a Medicaid budget and a Notice of Case Action for Medicaid benefits which were accepted, entered evidence and marked as Respondent's Exhibit 6. The record was closed on October 24, 2015.

FINDINGS OF FACT

1. The petitioner was receiving $194 in FAP benefits in a prior certification. There was no income budgeted in the petitioner's FAP budget in that certification period.

2. On June 1, 2015, the petitioner submitted an application for SSI Related Medicaid benefits.

3. On June 1, 2015, the petitioner began receiving Supplemental Security Income (SSI) of $733 and effective June 30, 2015, the SSI ended and he started receiving Social Security Disability Income (SSDI) of $926 effective July 1, 2015. The Department updated the petitioner's case record with his SSDI and reauthorized FAP and Medicaid benefits. The petitioner's FAP benefits decreased. The reason given for the decrease was his unearned income increased.

4. To determine the FAP benefits for July 2015, the respondent counted the petitioner's gross monthly income of $926. It subtracted $155 resulting in a total adjusted income of $771. The shelter cost of $600 was added to the utility standard of $36 to get the total shelter/utility cost of $636. Fifty percent of the adjusted net income ($385.50) is the standard shelter. This was subtracted from the total shelter/utility, resulting in $250.50. This was subtracted from the adjusted income ($771) resulting in $520.50 as the Food Assistance adjusted income. The maximum net income limit for a household size of one is $973. As the petitioner's net income was lower than the maximum net income limit, the respondent proceeded to calculate the benefit reduction. The Food Assistance adjusted income of $520.50 was multiplied by 30%, to get the benefit reduction of $157 (rounded up). This was subtracted from the maximum FAP amount of $194 resulting in $37.

5. On June 29, 2015, the Department determined Medicaid eligibility for the petitioner's June 1, 2015 application.

6. On June 11, 2015, the respondent sent the petitioner a Notice of Case Action informing him that his Food Assistance benefits will decrease from $194 to $37 effective July 1, 2015.

7. To determine the petitioner's SSI- Related Medicaid benefits, the respondent determined the petitioner's gross income of $926. The respondent compared it to the income limit for one person which is $864 and found the petitioner exceeded the income limit for full Medicaid benefits. The petitioner does not have Medicare Part A or Medicare Part B. The respondent proceed to enroll him in the Medically Needy Program with a share of cost (SOC) based on his income.

8. The respondent performed the following budget calculations when it determined the petitioner's estimated SOC. It determined the petitioner's monthly gross income was $926. A $20 unearned income disregard was subtracted resulting to $906 as the petitioner's countable income. The Medically Needy Income Limit of $180 for household size of one was subtracted resulting to $726 as the petitioner's SOC.

9. By notice dated June 30, 2015, the respondent notified the petitioner his estimated share of cost was $726 effective July 2015 and ongoing.

10. On September 16, 2015, the petitioner requested a hearing to have his FAP benefits reviewed and to challenge his enrolment in the Medically Needy Program with an estimated SOC.

11. At the hearing, the petitioner reported his household expenses as follows: rent expense of $600, telephone and internet of $150, medications of $37.87, bus pass $20, and toiletries of $20. The petitioner confirmed that his water and electricity were included in his rent.

12. The respondent updated the petitioner's case with his medical expenses. Upon updating, the petitioner's medical expenses his FAP benefits increased by $2 effect November 2015. The respondent did not provide a Notice of Case Action to confirm the $2 increase in FAP benefits.

13. The petitioner did not dispute that he receives $926 in SSDI. He argues that he cannot purchase medication and buy food with that little amount of money.

CONCLUSION OF LAW

14. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to

§ 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

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

The FAP benefits issue will be addressed first.

16. Federal regulation C.F.R. § 273.9 addresses income/allowable deductions budgeting in the FAP in part and states:

> (a) Income eligibility standards. Participation in the Program shall be limited to those households whose incomes are determined to be a substantial limiting factor in permitting them to obtain a more nutritious diet.
> (b) Definition of income...
> (2) Unearned income shall include, but not be limited to: ...
> (ii) Annuities; pensions; retirement, veteran's, or disability benefits; worker's or unemployment compensation including any amounts deducted to repay claims for intentional program violations as provided in §272.12; old-age, survivors, or social security benefits...

17. Federal regulation 7 C.F.R. § 273.9(d) sets forth the specific deductions allowable in the calculation of the final Food Assistance Program benefit allotment. These **potential allowable deductions** are limited to include only: (1) standard deduction, (2) earned income deduction, (3) excess medical deduction, (4) dependent care deduction, (5) child support deduction, (6) standard utility allowance, and shelter expenses.

18. The respondent must follow these federal budgeting guidelines when determining eligibility. It also directs the Department to consider Social Security Disability Income, as unearned income that must be included in the eligibility determination.

19. The federal regulation 7 C.F.R. § 273.10 (e) addresses "Calculating net income and benefit levels" as follows:

> (1) Net monthly income (i)...
> (A) Add the gross monthly income earned by all household members and the total monthly unearned income of all household members, minus income exclusions, to determine the household's total gross income...
> (C) Subtract the standard deduction.
> (D) If the household is entitled to an excess medical deduction as provided in §273.9(d)(3), determine if total medical expenses exceed $35. If so, subtract that portion which exceeds $35.
> (H) Total the allowable shelter expenses to determine shelter costs, unless a deduction has been subtracted in accordance with paragraph (e)(1)(i)(G) of this section. Subtract from total shelter costs 50 percent of the household's monthly income after all the above deductions have been subtracted. The remaining amount, if any, is the excess shelter cost, compute the shelter deduction according to paragraph (e)(1)(i)(I) of this section.
> (I) Subtract the excess shelter cost up to the maximum amount allowed for the area (unless the household is entitled to the full amount of its excess shelter expenses) from the household's monthly income after all other applicable deductions. Households not subject to a capped shelter expense shall have the full amount exceeding 50 percent of their net income subtracted. The household's net monthly income has been determined.
> (2) Eligibility and benefits...
> (ii)(A)...the household's monthly allotment shall be equal to the maximum food stamp allotment for the household's size reduced by 30% of the household's net monthly income...

20. The Department's Program Policy Manual (Policy Manual) CFOP 165-22, section 2410.0346 states, "The telephone standard (refer to Appendix A-1) is available to assistance groups who have only a telephone expense."

21. The above-cited regulation describes the eligibility process and defines deductions. The telephone standard and the petitioner's rent expense make up the petitioner's total shelter cost. The petitioner was credited with a standard deduction and

an excess shelter deduction (which included the telephone standard). There is no indication the petitioner was eligible for any other deductions.

22. In accordance with the federal regulations, the Food Assistance standards for income and deductions appear in the Policy Manual, at Appendix A-1. The 200% Federal Poverty level (FPL) for a household size of one prior to October 2015 was $1,605. A one-person assistance group's net income limit was $973, the standard deduction was $155 and the standard utility allowance was $337. Effective October 2015, the 200% Federal Poverty level (FPL) for a household size of one is $1,619. A one-person assistance group's net income limit is $981, the standard deduction is $155 and the phone standard is $36. The same reference shows the maximum FAP benefits for one person as $194 effective October 2014.

23. The undersigned determined the petitioner's FAP for November 2015 and ongoing to include his medical expenses. To determine the FAP benefits for November 2015 and ongoing, the undersigned used the petitioner's SSDI income of $926 and subtracted a standard deduction of $155 and an excess medical expense of $2, which resulted in a total adjusted income of $768. The excess medical deduction was determined by subtracting the medical standard of $35 from the petitioner total medical expenses of $37.87. The shelter cost of $600 was added to the phone standard of $36 to get the total shelter/utility cost of $636. Fifty percent of the adjusted net income ($384.07) is the standard shelter. This was subtracted from the total shelter/utility, resulting in $251.94. It was then subtracted from the adjusted income ($768.13) resulting in $516.20 as the Food Assistance adjusted income. It was compared to the maximum net income limit for household size of one. As the petitioner's Food

Assistance adjusted net income was lower than maximum net income standard, the undersigned proceeded to calculate the benefit reduction. The Food Assistance adjusted income of $516.20 was multiplied by 30%, to get the benefit reduction of $155 (rounded up). This was subtracted from the maximum FAP amount of $194 resulting in $39 as the petitioner's monthly FAP benefits. The FAP amount increased by $2 at stated by the respondent at the hearing.

24. After considering the evidence, the testimony, and the appropriate authorities cited above, the hearing officer determined the petitioner's FAP for July 2015 through October 2015 of $37 is correct. The undersigned also determined the petitioner's FAP benefits for November 2015 of $39 is correct. The hearing officer concludes the petitioner is not eligible for any additional FAP benefits based on the income and expenses presented and the controlling authorities.

Medicaid Benefits will now be addressed

25. The Department determined the petitioner's Medicaid benefits under the SSI Related Program.

26. Fla. Admin. Code R. 65A-1.701, Definitions, states in part:

> (20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services.

27. The above authority explains that the MEDS-AD (full Medicaid for an aged or disabled person) has an income limit of 88% of the federal poverty level and in addition to meeting that limit the person must not have Medicare.

28. The Department's Program Policy Manual (Policy Manual), CFOP 165-22 at Appendix A-9, lists the MEDS-AD income limit as $864 for an individual effective July 2015.

29. The above controlling authorities explain the full Medicaid coverage group (MEDS-AD Demonstration Waiver) in the SSI-Related Program is for individuals whose income is below the federal poverty level and are not receiving Medicare. The MEDS-AD income limit for an individual is $864. The petitioner does not have Medicare benefits but his income of $926 exceeds the income limit for full Medicaid benefits therefore, eligibility is not found for full Medicaid benefits. The undersigned further concludes Medically Needy eligibility must be explored for the petitioner.

The Medically Needy share of cost will now be addressed

30. Fla. Admin. Code R. 65A-1.701 (30) defines Share of Cost (SOC) as:

> Share of Cost (SOC): SOC represents the amount of recognized medical expenses that a Medically Needy enrolled individual or family must incur each month before becoming eligible to receive Medicaid benefits for medical expenses incurred during the remainder of the month.

31. Fla. Admin. Code R. 65A-1.710, SSI-Related Medicaid coverage Groups, states in part:

> (5) Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. §§ 1396a and 1396d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance due to their level of income or resources.

32. The above authority explains the Medically Needy Program is a coverage group for aged, blind or disabled individuals who do not qualify for full Medicaid due to the level of income.

33. Fla. Admin. Code R. 65A-1.702 (13) Determining Share of Cost (SOC). The SOC is determined by deducting the Medically Needy Income Level from the individual's or family's income.

34. Federal Regulations at 20 C.F.R. § 416.1124 (c) (12), Unearned Income we do not count, states in part, "The first $20 of any unearned income in a month..."

35. Income budgeting is set forth in Fla. Admin. Code R. 65A-1.713. It states:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
> (h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses...
> (4) (c) Medically Needy. The amount by which the individual's countable income exceeds the Medically Needy income level, called the "share of cost", shall be considered available for payment of medical care and services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical costs. If countable income exceeds the Medically Needy income level the department shall deduct allowable medical expenses in chronological order, by day of service. Countable income is determined in accordance with subsection 65A-1.713(2), F.A.C. To be deducted the expenses must be unpaid, or if paid, must have been paid in the month for which eligibility is being determined or incurred and paid during the three previous calendar months to the month for which eligibility is being determined but no earlier than the three retroactive application months. The paid expense may not have been previously deducted from countable income during a period of eligibility. Medical expenses reimbursed by a state or local government not funded in full by federal funds, excluding Medicaid program payments, are allowable deductions. Any other expenses reimbursable by a third party are not allowable deductions. Examples of recognized medical expenses include:
> 1. Allowable health insurance costs such as medical premiums, other health insurance premiums, deductibles and co-insurance charges; and,
> 2. Allowable medical services such as the cost of public transportation to obtain allowable medical services; medical services provided or prescribed by a recognized member of the medical community; and personal care services in the home prescribed by a recognized member of the medical community.

36. Fla. Admin. Code R. 65A-1.716 (2), Income and Resource Criteria, sets forth the Medically Needy Income Level for one person at $180.

37. The above rule states the SOC is determined by subtracting the Medically Needy Income Level from the family's income. For the petitioner, the determination of the SOC is the monthly income of $926 less a $20 disregard, less the MNIL of $180, which resulted in a share of cost of $726 effective July 2013 and ongoing. Eligibility for a lower SOC is not found.

38. The Policy Manual at passage 2440.0102, Medically Needy Income Limits (MSSI) states:

> When the assistance group has met the technical eligibility criteria and the asset limits, it is enrolled. There is no income limit for enrollment. The assistance group is income eligible (entitled to Medicaid) once income is less than or equal to the Medically Needy Income Level (MNIL) or medical bills equal the amount by which his income exceeds the MNIL. Once medical bills are equal to this surplus income, referred to as share of cost, the assistance group is eligible.
> The eligibility specialist must determine eligibility for Medically Needy any time the assistance group's income exceeds the income limits for another full Medicaid Program.

39. A review of the rules did not find any exceptions to the income limits. The undersigned concludes the Department correctly followed its policy in determining the SOC. The undersigned concludes the respondent's actions to deny full-coverage Medicaid and enroll the petitioner in the Medically Needy Program with a monthly share of cost in the amount of $726 was a correct action.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal for FAP benefit is denied as the Department had already determined

the petitioner was eligible for $39 effective November 2015 and the benefit amount prior was correct.

The appeal is denied for full Medicaid benefits and the respondent's action is upheld.

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 16th day of November, 2015,

in Tallahassee, Florida.

Christiana Gopaul-Narine

Christiana Gopaul-Narine
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 66292

RESPONDENT.
_____/

APPEAL NO. 15F-07928

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on October 27, 2015 at 1:00 p.m.

APPEARANCES

For the petitioner: [redacted] pro se

For the respondent: Clara Ford. ACCESS Supervisor

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to enroll her in the Medically Needy (MN) Program with a share of cost (SOC). Petitioner is seeking full Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

By notice dated September 1, 2015, the respondent notified the petitioner that she was enrolled in the MN Program with a $741.00 SOC beginning July 2015.

Petitioner submitted one exhibit, entered as Petitioner Exhibit "1". Respondent submitted five exhibits, entered as Respondent Exhibits "1" through "5". The record was held open until close of business on November 6, 2015 for submission of additional evidence from the respondent. On November 6, 2015, additional evidence was received and entered as Respondent Exhibit "6". The record closed on November 6, 2015.

FINDINGS OF FACT

1. On July 31, 2015, petitioner submitted an application for Adult Medicaid Assistance. Petitioner listed herself ([redacted] and her husband ([redacted]. On the application, petitioner reported she was disabled and the only source of income was her Social Security Disability (SSDI) benefits of $941.00 that would begin on August 2015. The petitioner's husband is not aged (65 or older), blind or disabled.

2. To be eligible for full Medicaid benefits, an individual must meet specific technical, income and resource requirements. The petitioner met the technical factors; the next step is to review the household income.

3. The respondent calculated the petitioner's total countable income as $921.00, after a $20.00 unearned income disregard was subtracted from her $941.00 SSDI benefits. The income limit for an aged/disabled individual to receive full Medicaid is $864.00. Therefore, petitioner's countable income ($921.00) exceeded the income limit.

4. The respondent enrolled the petitioner in the MN Program with a SOC. To determine the SOC amount, the respondent determined the Medically Needy Income Level (MNIL) for a household size of one was $180.00, this amount was subtracted from

the countable monthly income of $921.00, resulting in a SOC amount of $741.00. The respondent calculated the petitioner's SOC amount as follows:

[redacted]

TOTAL UNEARNED INCOME:		941.00	COUNTABLE EARNED INCOME:		.00
PARENT"S DEEMED INCOME:	+	.00	COUNTABLE UNEARNED INCOME:	+	921.00
MISC. INCOME DISREGARDS:	-	.00	MEDICALLY NEEDY DISREGARD:	-	.00
UNEARNED INCOME DISREGARD:	-	20.00	TOTAL COUNTABLE INCOME:	=	921.00
COUNTABLE UNEARNED INCOME:	=	921.00			
			INCOME STANDARD:		.00
SELF-EMP. ADJ. GROSS EARN.:		.00			
ADDITIONAL EARNED INCOME:	+	.00			
MISC. INCOME DISREGARDS:	-	.00	TOTAL COUNTABLE INCOME:		921.00
REM. UNEARNED INC. DISREGARD:	-	.00	MNIL:	-	180.00
EARNED INCOME DISREGARD:	-	.00	SHARE OF COST:	=	741.00
1/2 REMAINING DISREGARD:	-	.00			
BLIND WORK EXPENSES:	-	.00	MED. INSURANCE PREMIUM:	-	.00
COUNTABLE EARNED INCOME:	=	.00	RECURRING MED. EXPENSES:	-	.00
			REMAINING SOC:	=	741.00

AG HAS PASSED THE SSI-RELATED MEDICAID ELIGIBILITY DETERMINATION BUDGET

5. On September 1, 2015, the respondent sent the petitioner a Notice of Case Action notifying her enrollment in the MN Program with a SOC beginning July 2015 based on her household income. However, evidence presented by the respondent shows petitioner was scheduled to receive her first SSDI payment for July 2015 around August 2015. The award letter from Social Security Administration (SSA) explained the following:

We are writing to let you know that you are entitled to monthly disability benefits from Social Security beginning June 2015.

Your Benefits

The following chart shows your benefit amount(s) before any deductions or rounding. The amount you actually receive may differ from your full benefit amount. When we figure how much to pay you, we must deduct certain amounts, such as Medicare premiums and worker's compensation offset. We must also round down to the nearest dollar.

Beginning Date	Benefit Amount	Reason
June 2015	$941.70	Entitlement began

What We Will Pay

- The day of the month you receive your payments depends on your date of birth.

We are paying you beginning August 2015.

- You will receive $941.00, which is the money you are due for July 2015.
- After that, you will receive $941.00 each month.

[redacted]

We are writing to you about your Social Security benefits.

What You Should Know

As you requested on or about July 31, 2015 we changed your direct deposit information. We will send your Social Security payments to the new financial institution or account you selected.

You should keep the old account open until we send a payment to the new account. It usually takes us 1 to 2 months to change where we send payments.

Please let us know right away if your address changes so we can send any future letters to your new address. Also let us know if you change the bank account where we send your payments.

What We Will Pay And When

- You will receive $941.00 for August 2015 around September 9, 2015.

6. Respondent included the petitioner's SSDI benefits in the Medicaid budget beginning July 2015.

7. Petitioner presented unpaid medical bills for date of services from March 16, 2014, through May 15, 2015. Overall unpaid amount owed was $5,474.34. During the

hearing, petitioner reported that she has recurring out of pocket medical expenses that average to $120.00 per month.

8. Respondent explained the medical bills are allowable medical expenses to meet the SOC. Recurring medical expenses when verified can be used to reduce the SOC.

CONCLUSIONS OF LAW

9. 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.

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

11. Fla. Admin. Code R. 65A-1.710, SSI-Related Medicaid Coverage Groups, states in part:

> The Department covers all mandatory coverage groups and the following optional coverage groups:
> (1) MEDS-AD Demonstration Waiver. A coverage group for aged and disabled individuals (or couples), as provided in 42 U.S.C. § 1396a(m).
> ...
> (5) Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. §§ 1396a and 1396d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance due to their level of income or resources. The program does not cover nursing facility care, intermediate care for the developmentally disabled services, or other long-term care services.

12. Fla. Admin. Code R. 65A-1.713 defines the income limits for SSI-Related Medicaid programs:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:

> (a) For MEDS-AD Demonstration Waiver, income cannot exceed 88 percent of the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.
> ...
> (h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses.

13. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 2640.0500, Share of Cost (MSSI) sets forth:

> The eligibility specialist must determine eligibility for Medically Needy any time the assistance group's assets and/or income exceeds the appropriate categorical asset/income limits. The eligibility specialist determines whether the assistance group's assets are within the Medically Needy asset limits and whether the assistance group members meet the technical factors. If the Medically Needy asset limit is met and the assistance group meets all technical factors, the eligibility specialist determines the amount of countable income and computes a budget using the MNIL which is the same for both family and SSI-Related Medicaid coverage groups (refer to Appendix A-7).
> If income is equal to or less than the MNIL, there is no share of cost and the individual is eligible. Medicaid is authorized for individuals who are eligible without a share of cost.
> If income is greater than the MNIL, share of cost is determined for appropriate members. Appropriate members are enrolled but cannot be eligible until the share of cost is met.

14. The Code of Federal Regulations 20 C.F.R. § 416.1124 defines unearned Income that is not counted in SSI – Related Medicaid programs:

> (C)(12) The first $20 of any unearned income in a month other than income in the form of in-kind support and maintenance received in the household of another (see §416.1131) and income based on need. Income based on need is a benefit that uses financial need as measured by your income as a factor to determine your eligibility.

15. The Policy Manual, CFOP 165-22, passage 2640.0508, Proof of Medical Expenses - MN (MSSI):

> The following are verification requirements for allowable medical expenses to be counted toward share of cost.

For Medicare premiums the individual's statement may be accepted (including coinsurance charges).
For other health insurance premiums proof is needed of the amount and frequency of the premium. Acceptable evidence is the insurance policy, canceled check, receipt, pay stub or verbal verification from the agent.
For paid medical services bills (includes coinsurance payments) proof is needed of the date of the payment, amount of payment and an estimate of third party liability/TPP, if applicable. Acceptable evidence is the paid bill, receipt, canceled check, written statement from doctor or verbal verification from the provider. (For TPP, verbal verification is not acceptable.)
Exception: The individual's statement for bus charges may be accepted. The individual's statement of a TPL/TPP estimate may be accepted if no other verification is available.
For unpaid medical expenses less than one year old from a hospital, nursing home or provider other than pharmacy ($100 or more), proof is needed of the date of service, total bill and the TPL estimate. Acceptable evidence is a provider's statement and bill or statement of account.
For other unpaid medical services less than one year old proof is needed of the amount due and the date of service. Acceptable evidence is a bill, statement of account, insurance statement showing uncovered services or verbal verification from the provider.
For unpaid medical services one year old or older proof is needed that the individual continues to have the responsibility for payment, the amount due and date of service. Acceptable evidence is a statement of account that is not more than 30 days old and shows the date of service and amount due.

16. The Policy Manual, CFOP 165-22, passage 2640.0509, Proof That an Unpaid Bill is Still Owed (MSSI):

For an unpaid bill to be counted as an allowable medical expense and used to reduce the assistance group's share of cost, the assistance group must be held responsible for payment by the provider. The older an unpaid bill, the more likely that the provider will have "written off" the amount as a bad debt, and therefore no longer expects to be paid. When an individual has an unpaid bill, the eligibility specialist must determine if the individual still owes the unpaid bill, as follows:
1. When the unpaid bill is under one year old, the eligibility specialist will accept the individual's statement that the bill is/is not still owed.
2. When the unpaid bill is one year old or older, the eligibility specialist will require the individual to provide proof that the unpaid bill is still owed.
Only the unpaid portion not previously used to meet share of cost can be counted.

17. The Policy Manual, CFOP 165-22, passage 2240.0611, Couple/Both Request Medicaid (MSSI):

> The following policy is applicable only to MEDS-AD, QMB, SLMB, QI-1, EMA, Protected Medicaid, Medically Needy and Working Disabled Programs.
> If an eligible individual is living with an eligible spouse, the income standard for two must be used. Eligibility as a couple must be determined using both spouses' income and assets.
> Income is not allocated to family members or dependents.
> If an eligible individual is living with their ineligible spouse, the income and assets must be deemed from the spouse who is not eligible for or requesting assistance. If there is not enough income to be deemed, the income standard for one must be used. If there is enough income to deem, the individual must first pass the individual test for one. If they pass the individual income test, they must also pass the couple standard using deemed income from the spouse. Regardless of the income standard used, the asset standard for a couple must be used.

18. Fla. Admin. Code R. 65A-1.716 (2), Income and Resource Criteria, sets forth the MNIL for one person at $180.00. The petitioner's spouse would not be eligible for Medicaid because he is not aged or disabled. Therefore, the eligibility was based on a household size of one, the petitioner.

19. The above authority explains that to be eligible for full Medicaid, income cannot exceed 88 percent of the federal poverty level. The Medically Needy Program provides coverage for individuals who do not qualify for full Medicaid due to income.

20. The SOC is determined by subtracting the MNIL from the individual's total countable income. For the petitioner, the determination of the SOC is her monthly SSDI ($941.00) less a $20.00 unearned income disregard, less the MNIL of $180.00, which resulted in her share of cost of $741.00 effective July 1, 2015 and ongoing. However, petitioner's first SSDI payment did not begin until August 2015. The petitioner did not receive any SSDI income in July 2015.

21. After careful review of the cited authorities and evidence, the undersigned hereby remands the matter back to the Department to reduce the petitioner's SOC to $0.00 for July 2015, due to no income received in the month of the application. Once a determination is complete, the respondent is to notify the petitioner of the outcome with a new notice that includes appeal rights.

22. The undersigned also concludes that the Department correctly enrolled the petitioner in the MN Program and calculated her SOC as $741.00 effective August 2015.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is in partially granted and partially denied. It is denied in that petitioner is not eligible for full Medicaid and partially granted in that petitioner's SOC for July 2015 is reduced from $741.00 to $0.00. The appeal is remanded back to the respondent to take corrective action as specified in the Conclusions of Law.

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 15 day of December, 2015,

in Tallahassee, Florida.

Cassandra Perez

Cassandra Perez
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 06 Pinellas
UNIT: AHCA

RESPONDENT.
_____/

APPEAL NO. 15F-07969

CASE NO.

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 21, 2015, at approximately 9:06 a.m.

APPEARANCES

For Petitioner: [redacted] Petitioner's Aunt/Guardian

For Respondent: Stephanie Lang, R.N. Specialist/Fair Hearing Coordinator
Agency for Healthcare Administration

STATEMENT OF ISSUE

Whether the Agency was correct in denying Petitioner's request for orthodontic treatment including non-removable appliances, braces, and monthly treatment visits. Petitioner holds the burden of proof on this issue by a preponderance of the evidence.

PRELIMINARY STATEMENT

Petitioner's guardian ad litem, [redacted] appeared as a witness for Petitioner. Appearing as witnesses for Respondent were Carlene Brock (Quality Operations Nurse with Amerigroup), Heidi Penaranda (Complaints and Grievance Specialist with Dentaquest), and Dr. Frank Manteiga (Dental Consultant with Dentaquest).

Respondent admitted eleven exhibits into evidence, which were marked and entered as Respondent's Exhibits 1 through 11. Petitioner submitted no exhibits into evidence. Administrative notice was taken of Florida Statutes Sections 409.910, 409.962 through 409.965, 409.973, Florida Administrative Code Rules 59G-1.001, 59G-1.010, 59G-4.060, as well as the Medicaid Dental Services Coverage and Limitations Handbook (November 2011).

FINDINGS OF FACT

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

1. Petitioner is a Medicaid recipient under 21 years of age. She was placed in her aunt's care by the state due to parental neglect. She has teeth growing in her mouth where they should not be. This is causing some pain as well as interference with eating, talking, and her self-esteem. Petitioner does not want any of her teeth pulled as part of the orthodontic treatment.

2. On or about August 24, 2015, Petitioner's orthodontist submitted a prior authorization request to Petitioner's Medicaid managed care plan, Amerigroup. DentaQuest handles the prior authorization reviews for Amerigroup members. Amerigroup requires prior authorization for orthodontic treatment for children under 21.

3. Petitioner's orthodontist completed the Medicaid Orthodontic Initial Assessment Form (IAF), indicating Petitioner has a crossbite of individual anterior teeth with destruction of soft tissue. Petitioner received a total score of 27 on this assessment.

4. DentaQuest received the prior authorization request on August 24, 2015. Amerigroup denied Petitioner's request for braces based on DentaQuest's recommendations by notice dated August 25, 2015. The notice indicated the request was denied because Petitioner did not show medical necessity by scoring 26 or more points on the IAF. The appliances were denied because Petitioner didn't show any bad habits which would require appliance therapy.

5. Petitioner scored a 15 on the initial assessment that DentaQuest's dental reviewer completed based on the submitted information. DentaQuest found that Petitioner has ectopic eruptions and edge to edge anterior teeth, but not an anterior crossbite of individual teeth with tissue damage.

6. The difference in scoring on the initial assessment is the result of two different reviewers. The DentaQuest reviewer indicated that the models, x-rays, and photos do not meet Medicaid's requirements for anterior crossbite.

CONCLUSIONS OF LAW

7. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80, Florida Statutes.

8. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.

9. This hearing was held as a de novo proceeding pursuant to Florida Administrative Code Rule 65-2.056.

10. In accordance with Florida Administrative Code Rule 65-2.060(1), the burden of proof was assigned to the Petitioner. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Florida Administrative Code Rule 65-2.060(1).

11. Section 409.912, Florida Statutes, notes that AHCA shall purchase goods and services for Medicaid recipients in the most cost-effective manner possible, consistent with the delivery of quality medical care.

12. The Florida Medicaid Provider General Handbook (Provider Handbook) – July 2012 is incorporated by reference in Florida Administrative Code Rule 59G-5.020(1). In accordance with the Florida law, the Provider Handbook discusses managed care coverage, stating on page 1-27:

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.
>
> Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

13. Page 1-30 of the Provider Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

14. All Medicaid services must be medically necessary, including dental. Florida Administrative Code, 59G-1.010(166), defines medical necessity, as follows:

> "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
>
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
>
> ...
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

15. The Medicaid Dental Services Coverage and Limitations Handbook, November 2011 (Dental Handbook) is promulgated into law by Rule 59G-4.060(2), Florida Administrative Code. Rule 59G-4.060(3), Florida Administrative Code, specifically promulgates by incorporation the forms included in the Dental Handbook, including the Medicaid Orthodontic Initial Assessment Form (IAF). Page 2-2 of the Dental Handbook states that all dental services must meet the definition of medical necessity as set forth above.

16. As the petitioner is under 21, a broader definition of medically necessary applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services

(EPSDT) requirements. Section 409.905, Fla. Stat., *Mandatory Medicaid services*, defines Medicaid services for children to include:

> (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems…

17. The Dental Handbook states on page 1-2: "The children's dental program provides full dental services for all Medicaid eligible children age 20 and below." Page 2-3 states that this includes medically necessary orthodontic treatment.

18. Orthodontic treatment is covered under the above authorities for a child under 21 if it is a medically necessary service. Page 2-15 of the Dental Handbook states as follows:

> Prior authorization is required for all orthodontic services. **Orthodontic services are limited to those recipients with the most handicapping malocclusion.** A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the patient by causing impaired mastication, dysfunction of the temporomandibular articulation, susceptibility to periodontal disease, susceptibility of dental caries, and impaired speech due to malpositions of the teeth.
>
> Treatment is routinely accomplished through fixed appliance therapy and monthly maintenance visits. Removable (D8210) or fixed (D8220) appliance therapy may be reimbursed, but is dependent upon individual case circumstances. If requesting a removable (D8210) or fixed (D8220) appliance for thumb sucking or other habit, clinical photos must be submitted with the prior authorization request for the determination of medical necessity. (emphasis added)

Page 2-16 explains further how this is determined:

> Criteria for approval is limited to one of the following conditions:

- Correction of severe handicapping malocclusion as measured in the Medicaid Orthodontic Initial Assessment form (IAF) AHCA-Med Serv Form 013;
- Syndromes involving the head and maxillary or mandible jaws such as cleft lip or cleft palate;
- Cross-bite therapy, with the exception of one posterior tooth that is causing no occlusal interferences;
- Head injury involving traumatic deviation; or
- Orthognatic surgery, to include extractions, required or provided in conjunction with the application of braces.

19. Regarding scoring the IAF, the Dental Handbook explains on page 2-18 that a score of less than 26 "...does not say that [the case does] not represent some degree of malocclusion, but simply that the severity of the malocclusion does not qualify for coverage under the Florida Medicaid Orthodontic Program."

20. Petitioner alleges handicapping malocclusion, which is measured by the IAF. She does not allege any of the criteria for approval such as cleft lip or orthognatic surgery. Petitioner's orthodontist noted she had an anterior crossbite, which the form instructed to mark an X and score no further. He gave Petitioner a score of 27 on the assessment he completed. There is no information as to how he obtained this specific number. To meet Medicaid's guidelines for an anterior crossbite as described on page A-4 of the Dental Handbook, "destruction of soft tissue must be clearly visible in the mouth and reproducible and visible on the study models. A minimum of 1.5mm of tissue recession must be evident to qualify as soft tissue destruction in anterior crossbite cases."

21. DentaQuest's dental consultant appeared at the hearing, and suggested Petitioner's orthodontist did not score the IAF according to Medicaid rules. DentaQuest's multiple reviewers did not find evidence of the anterior crossbite with tissue damage that Petitioner's orthodontist indicated was present. The DentaQuest

reviewer found ectopic eruptions, which are the upper teeth growing in the wrong place. In the absence of contrary testimony, Petitioner was unable to meet her burden of proof.

22. Petitioner argues that greater weight should be given to her treating providers' recommendations. Petitioner's treating providers were not present at the hearing. Their letters are considered hearsay, which can bolster other evidence but cannot be a finding of fact on their own. Regardless, based on the Agency's definition of medical necessity excerpted above, "[t]he fact that a provider has…recommended…services does not, in itself, make such…services medically necessary or a medical necessity or a covered service."

23. The dental consultant agrees with Petitioner that she likely needs orthodontic care. However, her needs do not rise to the level necessary (determined by the assessment) for Medicaid to cover the service. As Petitioner has not shown that she meets Medicaid's requirements for general orthodontic treatment, it is unnecessary to determine whether she requires fixed appliance therapies as part of that care.

24. After careful review of the relevant authorities, the testimony and the evidence in this matter, the hearing officer concludes that the Agency properly denied Petitioner's request for orthodontic treatment.

DECISION

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

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 16 day of December, 2015, in Tallahassee, Florida.

Danielle Murray

Danielle Murray
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Don Fuller, Area 5, AHCA Field Office Manager

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

[redacted]

PETITIONER,

Vs.

APPEAL NO. 15F-07992

CASE NO. [redacted]

FLORIDA DEPT OF CHILDREN AND FAMILIES
CIRCUIT: 17 Broward
UNIT: 88249

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 3, 2015, at 1:30 p.m.

APPEARANCES

For the Petitioner: [redacted] pro se.

For the Respondent: Mary Triplett, Economic Self Sufficiency Specialist Supervisor, Department of Children and Families (DCF).

STATEMENT OF ISSUE

At issue is the Department's action in cancelling the petitioner's SSI-Related Medicaid benefits on the basis that he did not meet the disability requirements of the program. The respondent carries the burden of proving its case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The respondent submitted into evidence Respondent's Exhibits 1 and 2.

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 filed an application for Medicaid with the Department on August 25, 2015. To be eligible for SSI- Related Medicaid, an individual must be disabled, blind, or aged (65 years or older). The petitioner is [redacted] years of age. His application was forwarded to DDD (Division of Disability Determinations) for disability consideration.

2. The petitioner was approved for Medicaid benefits after a favorable DDD disability decision in March 2014. He was due for a redetermination of these benefits in July 2015. The petitioner also applied for Social Security Disability benefits in July 2014. SSA denied this application for benefits in September 2014 with an N-32 code. N-32 means "Capacity for other work." The petitioner appealed this SSA decision in March 2015 and is awaiting an appeal date.

3. On September 11, 2015, DDD adopted the SSA decision also with an N-32 code. The Department cancelled the petitioner's Medicaid benefits on September 14, 2015. The Notice mailed to the petitioner on September 14, 2015 indicated: "Your Medicaid benefits for the person listed below will end on September 30, 2015." The person "listed below" is the petitioner.

4. The petitioner filed this appeal on September 24, 2015, but indicated he was not aware that he could request continued Medicaid benefits until a hearing decision

was made. He requested on record that his Medicaid benefits continue. The respondent indicted his Medicaid benefits will be reinstated the day after this hearing and will continue until the hearing decision is made.

5. The petitioner indicated he filed for SSA and Medicaid benefits based on a condition of [redacted] He indicated that within the last year he has developed a [redacted] condition. He indicated based on his lack of health insurance, he has not been able to see a psychiatrist or psychologist, therefore he has no actual medical diagnosis of a [redacted] disorder. There was no medical information submitted to indicate that the petitioner has a [redacted] disorder or condition.

CONCLUSIONS OF LAW

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

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

8. In accordance with Fla. Admin. Code R. 65-2.060 (1), the party having the burden shall establish his/her position by a preponderance of the evidence, to the satisfaction of the hearing officer.

9. Federal Regulations at 42 C.F.R. § 435.541 states in part:

> Determinations of disability.
> (a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.
> ....

> (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under §435.909.
>
> (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** [emphasis added].
>
> (ii) If the SSA determination is changed, the new determination is also binding on the agency.

10. As shown in the Findings of Fact, the Department cancelled the petitioner's application for SSI-Related Medicaid benefit on the basis that he did not meet the disability requirements of the program. The petitioner applied for Social Security Disability benefits in July 2014 and was denied by SSA. The petitioner did not allege a new medically diagnosed condition not previously considered by SSA. Therefore, DDD adopted the SSA decision.

11. The petitioner was denied by SSA and appealed that decision. As noted in the above cited Regulation, "[a]n SSA disability determination is binding on an agency until the determination is changed by SSA....The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations." Thus, the petitioner must continue his appeal with SSA as its decision is binding on the Department and cannot be overturned by this hearing officer.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is denied and the Department action 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 17 day of December, 2015, in Tallahassee, Florida.

Robert Akel

Robert Akel
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

FILED
Dec 18, 2015
Office of Appeal Hearings
Dept. of Children and Families

[redacted]

APPEAL NO. 15F-08026

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPT OF CHILDREN AND FAMILIES
CIRCUIT: 19 Martin
UNIT: 88500

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 24, 2015, at 9:00 a.m.

APPEARANCES

For the Petitioner: [redacted] pro se.

For the Respondent: Nardalisa Figueroa, Economic Self Sufficiency Specialist II, Department of Children and Families (DCF).

STATEMENT OF ISSUE

At issue is the Department's action in denying the petitioner's application for SSI-Related Medicaid benefits on the basis he did not meet the disability requirements of the program. The petitioner carries the burden of proving his case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The respondent submitted into evidence Respondent Exhibit 1 and 2.

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 filed an application for Medicaid with the Department on July 29, 2015. To be eligible for SSI- Related Medicaid, an individual must be disabled, blind, or aged (65 years or older). As the petitioner has not turned sixty-five years of age and is [redacted] years of age, his application was forwarded to DDD (Division of Disability Determinations) for disability consideration.

2. The petitioner applied for disability benefits through the Social Security Administration (SSA) on or about July 29, 2015. This application was denied by Social Security on or about September 1, 2015 with an N-35 code. N-35 means "Lack of Duration." The petitioner filed an appeal with SSA on November 4, 2015 and has recently received correspondence indicating a hearing notice will be mailed to him in twenty days.

3. DDD adopted the SSA decision, N-35 code, for the petitioner's DCF application, and the Department denied the petitioner's application for Medicaid benefits on September 1, 2015.

4. The petitioner indicated he is receiving [redacted] for his [redacted] but that he does not have a new condition.

CONCLUSIONS OF LAW

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

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

7. In accordance with Fla. Admin. Code R. 65-2.060 (1), the party having the burden shall establish his/her position by a preponderance of the evidence, to the satisfaction of the hearing officer.

8. Federal Regulations at 42 C.F.R. § 435.541 states in part:

> (a) *Determinations made by SSA.* The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issue presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility...(b)(i) An SSA disability determination is binding on an agency until the determination is changed by SSA... (2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination (c) *Determination made by the Medicaid agency.* The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist...(4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA, and...(i) Alleges a disability condition different from, or in addition to, that considered by SSA in making its determination...

9. As shown in the Findings of Fact, the Department denied the petitioner's application for SSI-Related Medicaid on the basis that he did not meet the disability requirements of the program. DDD adopted the SSA decision. The petitioner did not allege a new condition not previously considered by SSA.

10. The petitioner was denied by the SSA and he has appealed that decision. As noted in the above cited Regulation, "[a]n SSA disability determination is binding on an agency until the determination is changed by SSA....The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA

determinations." Thus, the petitioner must continue his appeal with SSA as its decision is binding on the Department and cannot be overturned by this hearing officer.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is denied and the Department action 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 18 day of December, 2015, in Tallahassee, Florida.

Robert Akel

Robert Akel
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

APPEAL NO. 15F-8032

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPT OF CHILDREN AND FAMILIES
CIRCUIT: 14 BAY
UNIT: 88113

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 19th, 2015 at 2:00 p.m.

APPEARANCES

For the Petitioner: [redacted] owner of [redacted]

For the Respondent: Julie Mount, Supervisor for the Institutionalize Care Program with Economic Self-Sufficiency.

STATEMENT OF ISSUE

The petitioner is appealing the respondent's denial to consider uncovered medical expense deductions (UMEDs) in the months of January 2015 and February 2015 in determining her financial responsibility to the nursing home in which she

resides. The petitioner carries the burden of proving its position by a preponderance of the evidence in this appeal.

PRELIMINARY STATEMENT

The petitioner was not present at the hearing, but was represented as indicated above. Appearing as a witness for the petitioner was [redacted]

Appearing as an observer was Gregory Watson, Hearing Officer with the Office of Appeal Hearings.

At the hearing, Respondent's Exhibit 1 was submitted into evidence.

The record was held open until the close of business October 26th, 2015 to allow the parties to submit additional documents. During this period of time, the petitioner submitted documents which were marked into evidence as Petitioner's Exhibit 1. The respondent submitted a Department Policy Transmittal, of which administrative note was made.

During the month of June 2015, the petitioner submitted an application for ICP benefits, which was approved with retroactive benefits authorized from March 2015 through May 2015. The petitioner filed an appeal on September 21st, 2015 to seek consideration of UMEDs for January 2015 and February 2015. The appeal is considered to have been filed timely.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner was a recipient of ICP benefits until October 31st, 2014. The petitioner's benefits were closed upon discovery that assets were in excess of the limit allowed for ICP benefits. This fact is undisputed.

2. On June 17th, 2015, the petitioner submitted an application for ICP benefits. A copy of the application was not submitted into evidence; however, this fact is undisputed.

3. The petitioner is a nursing home resident. ICP Medicaid, if approved, covers the cost of nursing home residence.

4. After proper exploration and verification of all eligibility factors (including assets), the respondent determined the petitioner to be eligible for ICP benefits effective June 2015. The respondent also established eligibility retroactively for March 2015 through May 2015 (three months prior to the month of the application, once the application was approved).

5. The petitioner does not dispute lack of eligibility for ICP benefits for January and February 2015. As the petitioner was a resident of a nursing home during these months, the petitioner was responsible for any financial obligations to the nursing home.

6. In determining patient responsibility, policy allows for a deduction of uncovered medical expenses from the petitioner's monthly income. The petitioner's exhibit reflects

uncovered room and board expenses incurred at the nursing facility for January and February 2015.

7. The respondent contends that the petitioner is not eligible for consideration of these two months, as they are not within the three-month retroactive period from the month of application.

CONCLUSIONS OF LAW

8. The Department of Children and Families Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to §120.80, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

9. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

10. The Florida Administrative Code 65A-1.7141(1), pertaining to SSI-Related Medicaid Post Eligibility Treatment of Income, states in pertinent relative part:

> (i) Uncovered medical expense deduction. The following policy will be applied in considering medical deductions for institutionalized individuals and individuals receiving HCBS services to calculate the amount allowed for the uncovered medical expense deduction:
> 1. For institutionalized persons or residents of medical institutions and intermediate care facilities, the deduction includes:
> a. Any premium, deductible, or coinsurance charges or payments for health insurance coverage.
> b. For other incurred medical expenses, the expense must be for a medical or remedial care service and be medically necessary as specified in subsection 59G-1.010(166), F.A.C., and be recognized in state law. For

> medically necessary care, services and items not paid for under the Medicaid State Plan, the actual billed amount will be the amount of the deduction, not to exceed the maximum payment or fee recognized by Medicare, commercial payors, or any other third party payor, for the same or similar item, care, or service.
> 2. **The expense must have been incurred no earlier than the three month period preceding the month of application providing eligibility.** *[Emphasis added.]*
> 3. The expense must not have been paid for under the Medicaid State Plan.

11. The findings show that the petitioner applied for ICP Medicaid benefits on June 17th, 2015. The findings show that eligibility for these benefits was established effective June 2015. The findings also show that retroactive eligibility for these benefits was established for the three months prior to the month of application, which were March, April, and May 2015. The above regulations state that uncovered medical expenses cannot be considered if the expenses were incurred prior to the three-month period preceding the month of application. The petitioner is seeking reimbursement for uncovered medical expenses for January and February 2015, which are beyond the three-month period prior to the month of application. Therefore, the hearing officer affirms the respondent's position that the petitioner is not eligible for consideration of expenses incurred during these two months.

DECISION

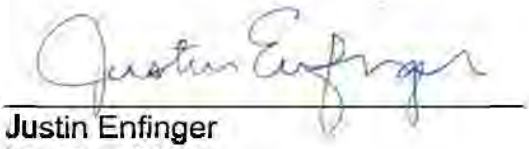
Based on the foregoing Findings of Fact and Conclusions of Law, this appeal is denied. The respondent's action is affirmed.

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 indigence to waive those fees. The Department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 23 day of December, 2015,

in Tallahassee, Florida.



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Office of Economic Self Sufficiency
[redacted]

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

[redacted]

APPEAL NO. 15F-08045

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 Dade
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened a telephonic administrative hearing in this matter on November 4, 2015 at 10:08 a.m.

APPEARANCES

For the Petitioner: [redacted] Daughter

For the Respondent: Monica Otalora,
Senior Human Services Program Specialist,
Agency for Health Care Administration

STATEMENT OF ISSUE

The Petitioner is appealing the Agency for Health Care Administration's (AHCA's) decision to deny the Petitioner's request for an additional three packages of pull-ups (adult diapers) per month and reducing her boxes of underpads from two to one per month.

Because the issue under appeal involves a request for a change in monthly medical supplies, Petitioner carries the burden of proof.

PRELIMINARY STATEMENT

Witnesses for the Respondent from Sunshine Health were: India Smith, Grievance and Appeals Coordinator; Linda Albe, Long-Term Care Director; and Lenon Juan, Case Manager.

Respondent submitted a 47-page document, which was entered into evidence and marked as Respondent Exhibit 1.

Petitioner submitted a 5-page document, which was entered into evidence and marked as Petitioner Exhibit 1.

FINDINGS OF FACTS

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

1. Petitioner is a 92 year-old Medicaid recipient enrolled with Sunshine Health, a Florida Health Managed Care provider.

2. Petitioner has Medicare which is her primary medical insurance provider.

3. On September 17, 2015, Sunshine received a request from the Petitioner for three (3) additional packages of pull-ups. Notice of Action dated September 18, 2015 advised Petitioner her request was denied because it was determined her request was not medically necessary.

4. At the hearing, and reflected in Petitioner's exhibit, Petitioner clarified she was requesting an additional three (3) packages of pull-ups not three (3) boxes.

5. Respondent explained that Sunshine has tried to accommodate Petitioner's needs including Companion and Homemaker services, but noted that Medicare is her primary medical insurance. Medicare should be providing the medical supplies and Medicaid would cover any co-pays.

6. Petitioner is a member of Humana HMO through the Medicare Advantage plan, as well as a member of the Sunshine Health managed care plan through the Medicaid program.

7. Respondent admitted difficulty in coordinating member services with Medicare.

CONCLUSIONS OF LAW

8. By agreement between the Agency for Health Care Administration and the Department of Children and Families, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80 Florida Statutes.

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

10. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Florida Administrative Code Rule 65-2.060(1).

11. Florida Statutes 409.971 – 409.973 establishes the requirement for Medicaid recipients to be enrolled in the statewide managed medical assistance program and the minimum benefits the managed care plans shall cover.

12. § 409.912, Fla. Stat. also provides that the Agency may mandate prior authorization for Medicaid services.

13. Fla. Admin. Code R. 59G-1.010 defines "prior authorization" as:

(226) "Prior authorization" means the approval by the Medicaid office for a Medicaid provider, or by a prepaid health plan for its affiliated providers, to deliver Medicaid covered medical or allied care, goods, or services in advance of the delivery of the care, goods, or services.

14. Fla. Admin. Code R. 59G-1.010 (166) also provides…

"Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

15. The Florida Medicaid Provider General Handbook, July 2012, incorporated in Fla. Admin. Code R. 59G, provides an explanation of Medicaid limits for Medicare Cross Over claims and provides on pages 1-2 and 4-3 in relevant parts:

> Responsibility For Exhausting TPL Sources
> Medicaid is the payer of last resort. If a recipient has other insurance coverage through a third party source, such as Medicare, TRICARE, insurance plans, AARP plans, or automobile coverage, the provider must bill the primary insurer prior to billing Medicaid.
> ....
> Medicaid Program Limits
> Medicaid will not pay a crossover claim if:
> Both Medicare and Medicaid cover the service, and Medicare has determined that the service is not medically necessary. **If Medicare determines that a service that Medicaid also covers is not medically necessary, it is also considered to be not medically necessary by Medicaid** [emphasis added].

16. No testimony or documentation was provided that Medicare has reviewed or approved the medical supplies as well as the monthly amount.

17. The Respondent, by a preponderance of the evidence and testimony, supported its decisions in denying Petitioner's request for the additional pull-ups as not medically necessary. However, both Petitioner and Respondent should work closely with the Medicare provider to ensure that Medicaid appropriately covers its costs after Medicare has determined medical necessity and met its coverage limits. The Petitioner has failed to meet her burden of proof

DECISION

Based on the evidence presented at the final hearing and on the entire record of this proceeding, the Petitioner's appeal is denied and the Respondent's action is affirmed.

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 18 day of December, 2015,

in Tallahassee, Florida.

Warren Hunter
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal_Hearings@dcf.state.fl.us

Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

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

[redacted]

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 06 Pasco
UNIT: AHCA

RESPONDENT.
_____/

APPEAL NO. 15F-08047

CASE NO.

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on November 17, 2015 at 10:40 a.m.

APPEARANCES

For the Petitioner: [redacted]
Petitioner

For the Respondent: Stephanie Lang, R.N.
Registered Nurse Specialist/Fair Hearing Coordinator
Agency for Health Care Administration

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the respondent incorrectly denied her request for a thoracic radiofrequency neurolysis?

PRELIMINARY STATEMENT

[redacted] ("petitioner"), the petitioner, appeared on her own behalf.

Stephanie Lang, R.N., Registered Nurse Specialist and Fair Hearing Coordinator for the Agency for Health Care Administration ("AHCA" or "Agency"), appeared on behalf of the Agency for Health Care Administration. The following individuals appeared as witnesses on behalf of the Agency: Elizabeth Schneider, M.D., Medical Director of Amerigroup Florida; and Tracy Parks, Clinical Manager for Quality at Amerigroup Florida.

The petitioner introduced petitioner's Exhibit "1", inclusive, at the hearing, which was accepted into evidence and marked accordingly. The respondent introduced respondent's Exhibits "1" through "6", inclusive, at the hearing, which were accepted into evidence and marked accordingly. The hearing record in this matter was left open until the close of business on November 20, 2015 for the respondent to provide a copy of the Amerigroup Member Handbook. Once received on November 19, 2015, the information was accepted into evidence and marked as respondent's Exhibit "7". The hearing record was then closed.

FINDINGS OF FACT

1. The petitioner is a 38-year-old female.

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

3. Petitioner is enrolled in Amerigroup. Amerigroup is a health maintenance organization ("HMO") that is contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in Florida.

4. On August 6, 2015, the petitioner's pain management doctor submitted a request to Amerigroup for a thoracic radiofrequency neurolysis.

5. Thoracic Radiofrequency Neurolysis is a procedure that involves using radio waves to selectively destroy both large and small nerve fibers in the thoracic spine in an attempt to break the pain communication cycle from the nerve fibers to the portion of the brain that registers pain.

6. The prior authorization request from the petitioner's pain management doctor asks for bilateral T4-5, T5-6 and T6-7 thoracic radio-frequency rhizotomy, two weeks apart. The request explains as follows:

> The patient has experienced pain that has limited their activities for at least 6 months or more. The patient has tried treatments such as correction of posture abnormalities, pharmacotherapy, and back support. Pain is moderate to severe. The patient has undergone a diagnostic facet injection with significant initial relief of their pain of 90% or more. To improve QOL and FC, I feel that the patient would benefit from a radio-frequency rhizotomy procedure to reduce the pain mainly due their facet joint anthropathy syndrome.

7. Under History of Present Illness, the prior authorization request states the petitioner "has tried physical therapy and chiropractic treatment, which worsened her pain. She has also tried anti-inflammatory medications." The request does not go into detail regarding the duration of the physical therapy and chiropractic treatment.

8. In a Notice of Action dated August 17, 2015, Amerigroup notified the petitioner it was denying her request for a thoracic radiofrequency neurolysis.

9. The Notice of Action states, in part:

We determined your requested services are **not medically necessary** because the services do not meet the reason(s) checked below: *(See Rule 59G-1.010)*

> Must be individualized, specific and consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs.
> Must meet accepted medical standards and not be experimental or investigational.
> Must be able to be the level of service that can be safely furnished and for which no equally effective and more conservative or less costly treatment is available statewide.

10. The Notice of Action goes on to explain:

> The facts that we used to make our decision are: we cannot cover the pain shots your doctor is asking for (thoracic level radiofrequency neurolysis). You have back pain. The pain is in the middle of your back (thoracic spine). Your doctor wants to give you pain shots in the middle part of your spine (thoracic). We have not seen that a pain shot in the middle of the spine will help you. It needs to be looked at more (investigational). We used your health plan medical policy Amerigroup, Medical Policies, SURG.00066: Percutaneous Neurolysis for Chronic Neck and Back Pain to decide this....

11. On or about August 25, 2015, Amerigroup's Medical Director completed a peer-to-peer consultation with the petitioner's provider who requested the thoracic level radiofrequency neurolysis. The Medical Director explained Amerigroup's position to the provider that it will not approve the procedure because it is considered investigational.

12. On or about September 2, 2015, Amerigroup completed an internal review of its decision to deny the petitioner's request. The decision to deny the procedure was upheld on reconsideration.

13. The thoracic spine is the part of the spine that spans from approximately the shoulders to the hip bone.

14. The petitioner has [redacted] as well as [redacted] in her thoracic spine.

15. The results of the petitioner's MRI completed on July 22, 2014 contain the following impressions:

1. Right foraminal protrusions T5-T6, T6-T7 and T7-T8 with right foraminal narrowing. The T6-T7 and T7-T8 disc protrusions are larger than the T5-T6 protrusion, but again unchanged from the prior study.
2. Blocked vertebra T3-T4.
3. Bulging disc T2-T3.

16. The petitioner experiences substantial pain as a result of the problems in her thoracic spine.

17. The petitioner underwent thoracic facet joint injections on July 21, 2015. These injections are designed to anesthetize the nerves in the affected area in order to provide temporary pain relief.

18. The thoracic facet joint injections the petitioner received on July 21, 2015 were successful in providing the petitioner with temporary pain relief.

19. The thoracic facet joint injections the petitioner received are different than the requested procedure. Thoracic facet joint injections involve administering a numbing agent whereas thoracic radiofrequency neurolysis involves physically burning the nerve and destroying the tissue.

20. Successful results from thoracic facet joint injections do not necessarily indicate thoracic radiofrequency neurolysis will be successful.

21. Successful results from thoracic facet joint injections do not necessarily indicate thoracic radiofrequency neurolysis will be successful.

22. It is the respondent's position that thoracic radiofrequency neurolysis is an investigational procedure – that the safety and efficacy of the procedure have not been demonstrated.

23. The Amerigroup Medical Director testified there is no evidence based medicine to support burning the nerves in the thoracic spine. She explained you only want to pursue an invasive treatment if the potential benefit is greater than the risk of harm.

24. Thoracic radiofrequency neurolysis has a risk of complications including infection and potentially worse pain. Studies indicate there is usually a recurrence of pain. Most patients experience a 50 percent reduction of pain for anywhere between three to six months.

25. The Amerigroup Medical Director suggested a number of alternatives to thoracic radiofrequency neurolysis including cognitive behavioral therapy, certain types of exercises, and physical therapy.

CONCLUSIONS OF LAW

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

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

28. All goods and services requested under the Florida Medicaid Program must be shown to be medically necessary in order to be approved.

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

30. The petitioner in the present case is requesting a new service. Therefore, in accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof is assigned to the petitioner.

31. 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.).

32. The Florida Medicaid program is authorized by Fla. Stat. ch 409 and Fla. Admin. Code R. 59G. The Medicaid program is administered by the respondent.

33. Section 409.905, Fla. Stat. addresses mandatory Medicaid services under the State Medicaid Plan:

> Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law…
> (9) PHYSICIAN SERVICES.—The agency shall pay for covered services and procedures rendered to a recipient by, or under the personal supervision of, a person licensed under state law to practice medicine or osteopathic medicine. These services may be furnished in the physician's office, the Medicaid recipient's home, a hospital, a nursing facility, or elsewhere, but shall be medically necessary for the treatment of an injury, illness, or disease within the scope of the practice of medicine or osteopathic medicine as defined by state law. The agency shall not pay for services that are clinically unproven, experimental, or for purely cosmetic purposes.

34. Section 409.912, Fla. Stat. states, in relevant parts:

> **Cost effective purchasing of health care.** - The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program.

35. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Chapter 59G-4. In accordance with the above Statute, the Handbook states on page 1-27

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.
>
> Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

36. Pages 1-28 of the Florida Medicaid Provider General Handbook provide a list of HMO covered services. These services include physician services.

37. Page 1-30 of the Florida Medicaid Provider General Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

38. Although the terms medically necessary and medical necessity are often used interchangeably and may be used in a variety of contexts, their definition for

Florida Medicaid purposes is contained in the Florida Administrative Code. Fla. Admin. Code R. 59G-1.010 states:

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
> (b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods, or services medically necessary or a medical necessity or a covered service.

39. Section 409.913, Fla. Stat. governs the oversight of the integrity of the Florida Medicaid Program. Section (1)(d) sets forth the "medical necessity or medically necessary" standards, and states in pertinent part as follows

> "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice....

Section (1)(d) goes on the further state:

> ...For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

40. Section (1)(d) highlights that the Agency makes the final decision regarding whether or not a requested service is medically necessary; however, the hearing officer is the final decision making authority for the Agency. See § 120.80, Fla. Stat.

41. Amerigroup follows Anthem policy on percutaneous neurolysis for chronic neck and back pain. The policy states as follows:

> Initial radiofrequency (RF) neurolysis for chronic cervical facet pain (C2-C3 thru C7-T1 vertebrae) or chronic lumbosacral facet pain (T12-L1 thru L5-S1 vertebrae) is considered **medically necessary** when **all** of the following criteria are met:
>
> 1. No prior spinal fusion surgery in the vertebral level being treated; **AND**
> 2. Pain that is *not* radicular; **AND**
> 3. Low back (lumbosacral) or neck (cervical) pain, suggesting facet joint origin when evidenced by the absence of nerve root compression is documented in the medical record on history, physical and radiographic evaluations;
> 4. Pain that has failed to respond to 3 months of conservative therapy* **AND**
> 5. A diagnostic, temporary block with local anesthetic of the facet nerve (medial branch block) or injection under fluoroscopic guidance into the facet joint has resulted in at least a 50% reduction in pain for the duration of the specific local anesthetic effect used [e.g., generally 3-4 hours for bupivacaine (Marcaine, Sensorcaine) and 30 minutes to 1 hour for lidocaine (Xylocaine)]. **Note:** a diagnostic, temporary block is not required for repeat RF at a previously treated site, if it has been less than one year since the last RF.
>
> ...

***Note:** Conservative therapy consists of an appropriate combination of medication (e.g., NSAIDs, analgesics), physical therapy, spinal manipulation therapy, epidural steroid injections, or other interventions based on the individual's specific presentation, physical findings and imaging results.

Investigational and Not Medically Necessary:

1. Radiofrequency neurolysis is considered **investigational and not medically necessary** for the treatment of chronic back pain for all uses that do not meet the criteria identified as medically necessary listed above, including but not limited to treatment of cervicogenic headache or thoracic facet pain.

...

42. The petitioner has not demonstrated by a preponderance of the evidence that she meets all the criteria in the previous paragraph for thoracic radiofrequency neurolysis to be determined medically necessary. A careful review of the evidence indicates only paragraph 5 of the initial requirements – A diagnostic, temporary block with local anesthetic of the facet nerve (medial branch block) or injection under fluoroscopic guidance into the facet joint has resulted in at least a 50% reduction in pain for the duration of the specific local anesthetic effect used – has been fulfilled. Therefore, the petitioner has not met her burden of proof to demonstrate the Agency for Health Care Administration incorrectly denied her request for thoracic radiofrequency neurolysis.

43. If the petitioner continues to experience pain in the area of her thoracic spine, her pain management doctor may submit another request to Amerigroup for thoracic radiofrequency neurolysis, providing concrete information to support each of the requirements set forth above. Should the respondent deny any such request, the petitioner will have the right to request another fair hearing associated with that denial. The petitioner may have her doctor testify at any future hearing.

44. In rendering this decision, the undersigned hearing officer considered all of the testimony and documentary evidence presented during the hearing process and reviewed all conditions of "medical necessity" 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 21 day of December, 2015,

in Tallahassee, Florida.

Peter J. Tsamis
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Don Fuller, Area 5, AHCA Field Office Manager

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pasco
UNIT: 88265

RESPONDENT.
_____/

APPEAL NO. 15F-08068

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on October 21, 2015 at 9:32 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the petitioner: [redacted] petitioner's authorized representative and owner of [redacted]

For the respondent: Signe Jacobson, Economic Self Sufficiency Specialist II.

STATEMENT OF ISSUE

Petitioner is appealing the Department's action to deny her application for Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

On June 10, 2015, the Department sent the petitioner a Notice of Case Action (NOCA) denying her application for Medicaid because "you or a member(s) of your household do not meet the disability requirement." A subsequent NOCA was mailed on August 3, 2015 denying her application for Medicaid because "you or a member(s) of your household do not meet the disability requirement." The petitioner requested a hearing on September 21, 2015.

The petitioner presented a total of 26 pages of evidence for the undersigned to consider, which were entered into the record as Petitioner's Exhibit 1. The Department presented a total of 132 pages of evidence for the undersigned to consider, which were entered into the record as Respondent's Exhibits 1 through 14. The record was closed on October 21, 2015.

FINDINGS OF FACT

1. The petitioner had applied for Medicaid on April 18, 2014 claiming she was disabled. The respondent forwarded that application and medical records to the Division of Disability Determination (DDD) on May 2, 2014. On May 30, 2014, DDD denied the application with a code N36, which is non-pay-insufficient or no medical data furnished. The primary diagnosis was 12-Affective Disorder from the Social Security Administration (SSA) Blue Book.

2. The petitioner filed a disability application with SSA on May 8, 2014. On June 25, 2014, the SSA denied her application. The petitioner appealed the SSA denial on June 25, 2014 and that appeal is currently pending.

3. On June 4, 2015, the petitioner's representative applied for Medicaid on her behalf. The petitioner is [redacted] years old and claimed to be disabled. She has no children, is not pregnant and is not aged (65 or older). A new and worsening condition was reported on this application. On June 10, 2015, the Department sent a NOCA denying her application for Medicaid because "you or a member(s) of your household do not meet the disability requirement." The petitioner requested an appeal for this issue on September 21, 2015.

4. On July 27, 2015, the petitioner's representative submitted another application on her behalf for Medicaid claiming she was disabled. The Department sent her a NOCA on July 28, 2015 requesting for her to complete an interview on or before August 3, 2015, complete and sign the Authorization to Disclose Information Form, and to complete and sign the Affidavit for Designated Representative Form. Her representative, [redacted] sent the requested information and the same medical records that were submitted in April 2014. The interview was not completed. During the hearing, the Department initially stated that the interview was required.

5. The petitioner was not present to describe her disabling conditions. Her representative described that she has [redacted] The medical records provided show that she was diagnosed with [redacted] This condition is under [redacted] in the SSA Blue Book. Testimony was given by the petitioner's representative indicating that no new medical records were sent to verify the alleged new and worsening condition as the petitioner has been unable to receive recent medical care without insurance.

6. The Department's final position is that it must adopt the determination made by SSA as no additional evidence was provided to reflect that she has a new or worsening condition. The lack of interview completed had no effect on the Department's action to adopt the SSA denial decision.

CONCLUSIONS OF LAW

7. 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 Fla. Stat. § 409.285.

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

IN REGARDS TO THE JUNE 10, 2015 MEDICAID DENIAL:

9. Fla. Admin. Code R. 65-2.046 "Time Limits in Which to Request a Hearing" states in relevant part:

> (1) The appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs. Additionally, in the Food Stamp Program, a household may request a fair hearing at any time within a certification period to dispute its current level of benefits. 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.

10. On June 10, 2015, the Department sent a NOCA to the petitioner denying her application for Medicaid. This NOCA gave the petitioner the right to appeal within

90 days. The petitioner would have had to request an appeal by September 8, 2015. The appeal was requested on September 21, 2015. The undersigned concludes the petitioner did not request this appeal timely; therefore, the issue regarding the June 10, 2015 Medicaid denial, is dismissed as non-jurisdictional.

IN REGARDS TO THE AUGUST 3, 2015 MEDICAID DENIAL:

11. On August 3, 2015, the Department sent the petitioner a NOCA denying her application for Medicaid. The petitioner timely appealed this action on September 21, 2015. The undersigned concludes that she does have jurisdiction to decide on this issue.

12. Florida Administrative Code, Section 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. For an individual to receive Medicaid who are less than 65 years of age, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. The regulation states, in part:

> (a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work or any other substantial gainful work that exists in the national economy...

13. The Code of Federal Regulations at 42 C.F.R. § 435.541 Determination of Disability states:

> (a) *Determinations made by SSA.* The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.
> (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in

> § 435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under § 435.909.
> (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.** [emphasis added]
> (ii) If the SSA determination is changed, the new determination is also binding on the agency.
> (2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.
> (c) *Determinations made by the Medicaid agency.* The agency must make a determination of disability in accordance with the requirements of this section if any of following circumstances exist…
> (4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and-
> (i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or
> (ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.
> (iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—
> (A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or
> (B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

14. The above federal regulation explains that the respondent may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.912 on the same issues presented in the Medicaid application. The respondent is bound by the federal agency's decision unless there is evidence of a new disabling condition not reviewed by SSA. The

petitioner's representative confirmed all of her medical conditions have been reported to SSA. SSA denied the petitioner's disability claim on June 25, 2014, because it determined she was not disabled under their rules. The petitioner disagreed with SSA's disability denial and has filed an appeal with SSA, which is still pending. The respondent adopted SSA's decision and denied the petitioner's Medicaid application.

15. In careful review of the evidence and controlling legal authorities, the undersigned concludes that the respondent followed rule in adopting the SSA disability denial from June 25, 2014, and denying the petitioner's Medicaid disability application.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal concerning the June 10, 2015 Medicaid denial is dismissed as non-jurisdictional and the appeal concerning the August 3, 2015 Medicaid denial is denied and the Department's action is 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 18 day of December, 2015,

in Tallahassee, Florida.

Brandy Ricklefs

Brandy Ricklefs
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

PETITIONER,

Vs.

APPEAL NO. 15F-08078

CASE NO. [redacted]

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 05 Hernando
UNIT: 88083

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 8:20 a.m. on October 16, 2015.

APPEARANCES

For the Petitioner: [redacted] pro se

For the Respondent: Marilyn Ficke, ACCESS Supervisor

STATEMENT OF ISSUE

At issue is whether respondent's action to deny petitioner Medicaid benefits is proper. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

By notice dated September 14, 2015, the respondent notified petitioner he was denied Medicaid; due to not meeting the disability requirement. Petitioner timely requested a hearing to challenge the denial.

Petitioner did not submit exhibits. Respondent submitted four exhibits, entered as Respondent Exhibits "1" through "4". The record was held open until October 20, 2015 for the respondent to submit an additional exhibit. The exhibit was received timely and entered as Respondent Exhibit "5". The record was closed on October 20, 2015.

FINDINGS OF FACT

1. Petitioner previously received Medicaid through the Social Security Administration (SSA). In January 2015, the SSA terminated petitioner's Supplemental Security Income (SSI). As a result, his Medicaid was also terminated.

2. Petitioner asserts the SSA wrongfully terminated his SSI.

3. Petitioner has reapplied several times for disability through the SSA since the January 2015 termination. The last application was on May 1, 2015. The SSA denied petitioner's May 1, 2015 application on July 2, 2015.

4. On September 1, 2015 petitioner appealed the SSA denial. An appeal date has not been set.

5. On September 8, 2015, petitioner (age 24) submitted a SSI-Related Medicaid application for himself. Petitioner does not have children.

6. The Department is required to adopt the SSA denial decision when the SSA denial is made within 12 months of the applicant's Medicaid application. Unless the applicant claims the medical condition has changed or deteriorated.

7. There is no indication that the petitioner's medical condition has changed or deteriorated since the SSA terminated his SSI.

8. On September 14, 2015, the Department mailed petitioner a Notice of Case Action notifying Medicaid was denied due to not meeting the disability requirement.

CONCLUSIONS OF LAW

9. 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 Fla. Stat. § 409.285.

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

11. The Code of Federal Regulations at 42 C.F.R. § 435.541 "Determination of Disability" in part states:

> (a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...
> (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under 435.909.
> (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.
> (2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except In cases specified in paragraph (c) (4) of this section.
> (c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist...
> (4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA. and-
> (i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

> (ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.
> (iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act. and-
> (A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or
> (B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

12. In accordance with the above authority, respondent denied petitioner's September 8, 2015 SSI-Related Medicaid application due to adopting the SSA July 2 2015 denial decision.

13. The above authority states the Department must make a determination of disability if the individual "alleges a disabling condition different from, or in addition to, that considered by the SSA in making its determination".

14. Petitioner did not indicate that he has a different or new medical condition the SSA is unaware of.

15. The evidence establishes that the SSA denied petitioner disability on July 2, 2015 and petitioner appealed the SSA denial decision on September 1, 2015.

16. In careful review of the cited authority and evidence, the undersigned concludes respondent followed Rule in denying petitioner Medicaid; due to adopting the July 2, 2015 SSA denial decision.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the respondent's action is 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 17 day of December, 2015,

in Tallahassee, Florida.

Priscilla Peterson

Priscilla Peterson
Hearing Officer
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Tallahassee, FL 32399-0700
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

APPEAL NO. 15F-08094
15F-08254

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 09 Osceola
UNIT: 88999

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter at 1:30 p.m. on October 28, 2015; at the Department of Children and Families in Kissimmee, Florida.

APPEARANCES

For the Petitioner: [redacted] pro se

For the Respondent: Nydia Galarza, ACCESS Supervisor

STATEMENT OF ISSUE

At issue is whether respondent's action to deny petitioner Food Assistance (FA) and Medicaid benefits is proper. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

By notice dated September 18, 2015, the respondent notified the petitioner FA and Medicaid application dated September 8, 2015 was denied; due to not meeting the citizenship requirements. Petitioner timely requested a hearing to challenge the denial. [redacted] petitioner's wife, was present and did not testify. [redacted] petitioner's minor daughter, was also present. Pamela Vance, Hearing Officer, was present as an observer. Petitioner submitted one exhibit, entered as Petitioner Exhibit "1". Respondent submitted six exhibits, entered as Respondent Exhibits "1" through "6". The record was closed on October 28, 2015.

FINDINGS OF FACT

1. Petitioner's family moved to the United States (U.S.) from Pakistan in February 2014, on visitor visas. About two months ago (petitioner was unsure of the date) petitioner's family moved from Kentucky to Florida. Petitioner's family received FA and Medicaid benefits in Kentucky.

2. In June 2014 the family applied for asylum. The application is pending.

3. In October 2014 petitioner applied for employment authorization. Petitioner's application was approved; he is authorized employment in the U.S. from March 27, 2015 through March 26, 2016.

4. On September 8, 2015, petitioner submitted a FA and Medicaid application for his household. Household members include petitioner, his wife and minor child.

5. Petitioner's family has not been approved a qualified alien status. Therefore, the family is not eligible for FA or Medicaid benefits.

6. On September 18, 2015, the respondent mailed petitioner a Notice of Case Action notifying application dated September 8, 2015 was denied; due to not meeting the citizenship requirement.

7. Petitioner believes his family should be eligible for FA and Medicaid benefits because they applied for asylum and the family received benefits in Kentucky.

CONCLUSIONS OF LAW

8. 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 Fla. Stat. § 409.285.

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

10. The Code of Federal Regulations at 42 C.F.R. § 435.406, explains Medicaid Citizenship and alienage requirements and in part states:

> (a) The agency must provide Medicaid to otherwise eligible residents of the United States who are—
> (1) Citizens: (i) Under a declaration required by section 1137(d) of the Act that the individual is a citizen or national of the United States; and
> (ii) The individual has provided satisfactory documentary evidence of citizenship or national status, as described in § 435.407.
> (iii) An individual for purposes of the declaration and citizenship documentation requirements discussed in paragraphs (a)(1)(i) and (a)(1)(ii) of this section includes both applicants and beneficiaries under a section 1115 demonstration (including a family planning demonstration project) for which a State receives Federal financial participation in their expenditures, as though the expenditures were for medical assistance.
> (iv) Individuals must declare their citizenship and the State must document the individual's citizenship in the individual's eligibility file on initial applications and initial redeterminations effective July 1, 2006.
> (v) The following groups of individuals are exempt from the requirements in paragraph (a)(1)(ii) of this section:
> (A) Individuals receiving SSI benefits under title XVI of the Act.
> (B) Individuals entitled to or enrolled in any part of Medicare.

(C) Individuals receiving disability insurance benefits under section 223 of the Act or monthly benefits under section 202 of the Act, based on the individual's disability (as defined in section 223(d) of the Act).
(D) Individuals who are in foster care and who are assisted under Title IV-B of the Act, and individuals who are beneficiaries of foster care maintenance or adoption assistance payments under Title IV-E of the Act.
(2)(i) Except as specified in 8 U.S.C. 1612(b)(1) (permitting States an option with respect to coverage of certain qualified aliens), qualified aliens as described in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641) (including qualified aliens subject to the 5-year bar) who have provided satisfactory documentary evidence of Qualified Alien status, which status has been verified with the Department of Homeland Security (DHS) under a declaration required by section 1137(d) of the Act that the applicant or beneficiary is an alien in a satisfactory immigration status.
(ii) The eligibility of qualified aliens who are subject to the 5-year bar in 8 U.S.C. 1613 is limited to the benefits described in paragraph (b) of this section.
(b) The agency must provide payment for the services described in § 440.255(c) of this chapter to residents of the State who otherwise meet the eligibility requirements of the State plan (except for receipt of AFDC, SSI, or State Supplementary payments) who are qualified aliens subject to the 5-year bar or who are non-qualified aliens who meet all Medicaid eligibility criteria, except non-qualified aliens need not present a social security number or document immigration status.

11. Federal Regulations at 7 C.F. R. § 273.4, explains FA Citizenship and alien status requirements and in part states:

(a) Household members meeting citizenship or alien status requirements. No person is eligible to participate in the Program unless that person is...
(6) An individual who is both a qualified alien as defined in paragraph (a)(6)(i) of this section and an eligible alien as defined in paragraph (a)(6)(ii) or (a)(6)(iii) of this section.
(i) A qualified alien is:
(A) An alien who is lawfully admitted for permanent residence under the INA;
(B) An alien who is granted asylum under section 208 of the INA;
(C) A refugee who is admitted to the United States under section 207 of the INA;
(D) An alien who is paroled into the U.S. under section 212(d)(5) of the INA for a period of at least 1 year;

(E) An alien whose deportation is being withheld under section 243(h) of the INA as in effect prior to April 1, 1997, or whose removal is withheld under section 241(b)(3) of the INA;
(F) An alien who is granted conditional entry pursuant to section 203(a)(7) of the INA as in effect prior to April 1, 1980;
(G) An alien who has been battered or subjected to extreme cruelty...
(H) An alien who is a Cuban or Haitian entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980.
(ii) A qualified alien, as defined in paragraph (a)(6)(i) of this section, is eligible to receive food stamps and is not subject to the requirement to be in qualified status for 5 years as set forth in paragraph (a)(6)(iii) of this section, if such individual meets at least one of the criteria of this paragraph (a)(6)(ii):
(A) An alien age 18 or older lawfully admitted for permanent residence under the INA who has 40 qualifying quarters as determined under Title II of the SSA...
(B) An alien admitted as a refugee under section 207 of the INA;
(C) An alien granted asylum under section 208 of the INA;
(D) An alien whose deportation is withheld under section 243(h) of the INA as in effect prior to April 1, 1997, or whose removal is withheld under section 241(b)(3) or the INA;
(E) An alien granted status as a Cuban or Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980);
(F) An Amerasian admitted pursuant to section 584 of Public Law 100-202, as amended by Public Law 100-461;
(G) An alien with one of the following military connections...
(H) An individual who is receiving benefits or assistance for blindness or disability (as specified in § 271.2 of this chapter).
(I) An individual who on August 22, 1996, was lawfully residing in the U.S., and was born on or before August 22, 1931...
(iii) The following qualified aliens, as defined in paragraph (a)(6)(i) of this section, must be in a qualified status for 5 years before being eligible to receive food stamps. The 5 years in qualified status may be either consecutive or nonconsecutive. Temporary absences of less than 6 months from the United States with no intention of abandoning U.S. residency do not terminate or interrupt the individual's period of U.S. residency. If the resident is absent for more than 6 months, the agency shall presume that U.S. residency was interrupted unless the alien presents evidence of his or her intent to resume U.S. residency. In determining whether an alien with an interrupted period of U.S. residency has resided in the United States for 5 years, the

12. In accordance with the above authorities non U.S. citizens must have a qualified alien status to be eligible for FA and Medicaid benefits.

13. Petitioner argued that his household should be eligible for FA and Medicaid benefits because they received the benefits in Kentucky and have applied for asylum.

14. The evidence establishes that petitioner's household entered the U.S. in 2014 on visitor visas and are waiting asylum status approval. And petitioner's household currently does not have a qualified alien status.

15. In careful review of the cited authorities and evidence, the undersigned concluded the respondent followed Rule in denying petitioner FA and Medicaid benefits.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the respondent's action is 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 19 day of November, 2015,

in Tallahassee, Florida.

Priscilla Peterson

Priscilla Peterson
Hearing Officer
Building 5, Room 255
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

APPEAL NO. 15F-08114

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 19 St. Lucie
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 3, 2015 at 1:36 p.m.

APPEARANCES

For the Petitioner: [redacted]
Pro Se

For the Respondent: Doretha Rouse
Registered Nurse Specialist

ISSUE

Whether respondent's denial of a partial upper denture (Procedure D5213) was proper. The burden of proof was assigned to the petitioner.

PRELIMINARY STATEMENT

Petitioner entered no exhibits into evidence.

Ms. Rouse appeared as both a representative and witness for the respondent. Present for respondent from Humana was Mindy Aikman, Grievance and Appeals

Specialist. Present from DentaQuest were Dr. Frank Manteiga, Dental Consultant and Haydee Penaranda, Appeals and Grievance Specialist. Respondent's exhibit "1" and "2" were entered into evidence.

Administrative notice was taken the Dental Services Coverage and Limitations Handbook; and the Florida Medicaid Provider General Handbook.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. Petitioner's date of birth is [redacted] At all times relevant to this proceeding, petitioner was Medicaid eligible.

2. Petitioner receives Medicaid services through respondent's Statewide Medicaid Managed Care Program. Humana is petitioner's managed care provider.

3. DentaQuest is Humana's dental vendor. All requests for dental services are reviewed by DentaQuest. DentaQuest determines whether the requested procedure is medically necessary and in compliance with pertinent rules and regulations.

4. Both Humana and DentaQuest must be in compliance with the Florida Medicaid Dental Services Coverage and Limitations Handbook (Dental Handbook).

5. On or about September 2, 2015 DentaQuest received from petitioner's dentist an x-ray and prior authorization request for a partial upper denture. The request was then review by a DentaQuest licensed dentist.

6. On September 3, 2015 DentaQuest issued a Notice of Action to the petitioner which denied the partial upper denture. The notice stated the partial denture was not

medically necessary and "You still have enough teeth to properly chew your food, therefore, you do not qualify for a partial denture."

7. On September 23, 2015 petitioner contacted the Office of Appeal Hearings and timely requested a fair hearing.

8. Upon receipt of the hearing request, a second DentaQuest dentist reviewed submitted information and upheld the original denial. It was noted the petitioner has more than eight posterior contacts in occlusion.

9. Petitioner has 15 posterior teeth in occlusion.

10. Posterior teeth are those necessary for adequate chewing.

11. Occlusion is the contact between the upper and lower teeth when they approach each other for chewing.

12. Petitioner argues she contacted Humana and was told a partial denture is a covered service. The partial is needed as food gets trapped in her gums. She is forced to chew on one side of her mouth, only. The side of her mouth in which she chews is also missing a tooth.

13. Respondent argues a partial denture could be approved if medical necessary and the requirements enumerated in the Dental Handbook satisfied.

CONCLUSIONS OF LAW

14. 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.

15. This is a final order pursuant to § 120.569 and § 120.57, Fla. Stat.

16. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

17. The standard of proof in an administrative hearing is by a preponderance of the evidence. (See Fla. Admin. Code R. 65-2060(1).) The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

18. The Florida Medicaid Provider General Handbook (Provider Handbook) – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code R. 59G-4. The Provider Handbook states on page 1-27:

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee. Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

19. Page 1-30 of the Provider Handbook continues by stating: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

20. Respondent's Dental Handbook – November 2011 is also incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code R. 59G-4.

21. The Dental Handbook states "Medicaid reimburses for services that are determined medically necessary ..."

22. The definition of "medically necessary" is found in the Fla. Admin. Code R. 59G-

1.010, which states, in part:

> (166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
>
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider...
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

23. The Dental Handbook states on page 2-3:

> Covered Adult Services (Ages 21 and over):
>
> The adult dental program provides for the reimbursement of full and removable partial dentures. Extractions and other surgical procedures essential to the preparation of the mouth for dentures are reimbursable if the patient is to receive dentures. Procedures relating to dentures such as repairs, relines and adjustments are reimbursable.
>
> Medicaid will reimburse for medically-necessary emergency dental procedures to alleviate pain and or infection for eligible adult Medicaid recipients 21 years of age or older. Emergency dental care shall be limited to emergency problem-focused evaluations, necessary radiographs to make a diagnosis, extraction, and incision and drainage of abscess.

24. The above authorities establish, if medical necessary, a partial denture is a covered Medicaid service.

25. In regard to partial dentures, pages 2-30 through 2-33 the Dental Handbook states, in part:

> For all eligible Medicaid recipients, Medicaid may reimburse for the fabrication of full and removable partial dentures ...
>
> The standard for all dentures, whether seated immediately after extractions or following alveolar healing, is that the denture be fully functional.
> ...
>
> Partial dentures refer to the prosthetic appliance that replaces missing teeth and is on a framework that is removed by the patient. Prior authorization is required for reimbursement of removable partial dentures and must be submitted to the dental consultant for determination of medically necessity prior to the procedure being performed.
> ...
>
> Medicaid will not reimburse for:
>
> • Partial dentures where there are at least eight posterior teeth in occlusion; ...

26. The Findings of Fact establish petitioner has 15 posterior teeth in occlusion. No evidence was presented to challenge this number.

27. In this instant appeal, the undersigned lacks authority to waive the requirement that Medicaid will not reimburse for a partial denture when there are 8 or more posterior teeth in occlusion.

28. For a service to be approved, each criteria of medical necessity must be satisfied. The undersigned is bound by the definition of medical necessity as stated in Fla. Admin. Code R. 1.010.

29. After reviewing evidence and testimony on a comprehensive basis, petitioner has not demonstrated the partial denture is medically necessary. The following condition of medical necessity has not been satisfied:

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, petitioner's appeal is 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 4th day of November, 2015, in Tallahassee, Florida.

Frank Houston
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Judy Jacobs, Area 7, AHCA Field Office

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

[redacted]

APPEAL NO. 15F-08115

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 09 Orange
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing on November 10, 2015 at approximately 10:30 a.m.

APPEARANCES

Petitioner: [redacted]

For Respondent: Doretha Rouse
Registered Nurse Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is Respondent's partial denial of Petitioner's request for a prescription drug, [redacted] Petitioner requested 90 tablets per month, every month. Respondent approved 90 pills for one month, with a limit of a total of 120 pills for 365 days. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

Respondent presented the following witnesses:

- Jennifer Arteaga, Grievance and Appeals Coordinator II, Sunshine Health.
- Dr. David Gilchrist, Medical Director, Sunshine Health.
- Richard Plymel, Manager, Clinical Pharmacy Services, Sunshine Health.
- Dr. Philip Benjakul, Physician Adviser, NIA Magellan.

Tracy Thomas, Grievance and Appeals Coordinator II with Sunshine Health ("Sunshine") observed the hearing. Petitioner gave oral testimony, but did not move any exhibits into evidence. Respondent moved Exhibits 1 through 11 into evidence. The Hearing Officer inadvertently labeled two (2) separate exhibits as Exhibit 2. The exhibits shall now be marked for identification as "Exhibit 2A" and "Exhibit 2B." The record was held open until November 24, 2015 in order for Respondent to provide additional documentation. Respondent submitted additional evidence, entered as Exhibits 12 through 17.

Administrative notice was taken of the Florida Medicaid Provider General Handbook, July 2012.

FINDINGS OF FACT

1. Petitioner is a 57-year-old female. At all times relevant to this proceeding, Petitioner was eligible to receive Medicaid services.
2. Petitioner first enrolled with Sunshine as her Managed Medical Assistance (MMA) plan on May 1, 2012, and is currently active with the plan.
3. Petitioner's health conditions include, but are not limited to:

- [redacted]
- [redacted]
- [redacted]
- [redacted]

4. On August 10, 2015, Petitioner attempted to fill a one-month supply of 90 pills of [redacted] 350mg tablets and was denied at point-of-sale. Petitioner takes three (3) tablets every day. [redacted] is not on AHCA's Preferred Drug List.

5. On August 11, 2015, Sunshine issued a Notice of Action denying the [redacted] The reason given for the denial was "Other authority: Insufficient Information." (Respondent's Composite Exhibit 10). Specifically, the letter stated:

> The facts we used to make our decision are:
> Your request for this drug is denied. We do not have enough information about your condition to decide if it's medically necessary based upon your health plan pharmacy criteria. It would be helpful to know the following:
>
> Your doctor has been asked to provide additional information for consideration of this request for [redacted] tablet 350mg. (Sunshine Health Plan Prior Authorization Criteria).

6. On August 12, 2015, Sunshine reversed the denial in part by approving 90 tablets for 30 days. The approval was for valid for 12 months, however, the approval letter noted that the plan limits the quantity of pills to a total of 120 for every 365 days. Mr. Plymel stated this is the maximum number that can be approved according to Medicaid guidelines. (Respondent's Exhibit 17).

7. The undersigned heard two separate appeal numbers for Petitioner at the same time on November 10, 2015: 15F-07810 and 15F-08115. Appeal number 15F-07810 was requested on September 11, 2015, and appeal number 15F-08115 was requested on September 23, 2015. There was significant overlap in the proposed evidence, and therefore all of the admitted exhibits are common to both appeal numbers.

CONCLUSIONS OF LAW

8. By agreement between the Agency for Health Care Administration ("AHCA" or "Agency") and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction over this matter pursuant to § 120.80, Fla. Stat.

9. This is a Final Order, pursuant to §§ 120.569 and 120.57, Fla. Stat.

10. 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.).

11. Legal authority governing the Florida Medicaid Program is found in Chapter 409 of the Florida Statutes, and in Chapter 59G of the Florida Administrative Code. Respondent, AHCA, is the single state agency that administers the Medicaid Program.

12. The Florida Medicaid Provider General Handbook, July 2012 ("Handbook"), is promulgated into law by Chapter 59G of the Florida Administrative Code.

13. Page 1-28 of the Handbook provides that every HMO must include prescribed drug services up to the limits required by fee-for-service Medicaid.

14. The Florida Statutes, at § 409.912(8)(a)(16) states, in pertinent part: "[AHCA] shall implement a step-therapy prior authorization approval process for medications excluded from the preferred drug list...."

15. The Florida Medicaid Prescribed Drug Services Coverage, Limitations, and Reimbursement Handbook, July 2014 ("Drug Handbook") is promulgated into law by Chapter 59G of the Florida Administrative Code.

16. Page 2-4 discusses the Preferred Drug List ("PDL") and the requirements to receive medications not on the PDL. Page 2-14 states, in relevant part: "Non-PDL drugs may be approved for reimbursement upon prior authorization...." Page 2-5 continues, stating: "AHCA will publish and disseminate the additions and deletions to the PDL in a timely manner as they are adopted. The PDL and updates will be posted on the Agency website at www.ahca.myflorida.com/Medicaid/Prescribed_Drug/preferred_drug.shtml. As stated above, [redacted] is not on the current PDL.

17. Page 2-8 of the Drug Handbook addresses the quantity limitations of certain drug classes, stating:

> Medicaid limits the quantity and number of refills that may be reimbursed for certain drug classes. Medicaid also limits reimbursement for certain drug classes to recipients based upon clinical considerations of the patient's age. A current list of drug limitations can be found on the Internet at: www.mymedicaid-florida.com. Click on Public Information for Providers, then Pharmacy, then Drug Limitations.

18. Page 34 of the Summary of Drug Limitations, updated November 30, 2015, limits [redacted] (Soma) to a "Maximum 120 tablets per 365 days." This matches the limitation provided by Respondent in Exhibit 17. Respondent approved the maximum amount of [redacted] for a 12 month period.

19. Since Respondent approved the maximum amount of [redacted] under ACHA's Drug Limitations, the undersigned concludes Respondent was correct in only approving 120 pills for the 12 month period.

DECISION

Based upon the foregoing, Petitioner's Appeal is DENIED and the Agency's action is AFFIRMED.

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 30 day of December, 2015,

in Tallahassee, Florida.

Rick Zimmer

Rick Zimmer
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Judy Jacobs, Area 7, AHCA Field Office

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 09 Osceola
UNIT: 66292

RESPONDENT.
_____/

APPEAL NO. 15F-08127

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter at 11:40 a.m. on October 28, 2015, at the Department of Children and Families in Kissimmee, Florida.

APPEARANCES

For the Petitioner: [redacted] pro se

For the Respondent: Evelyn Ross, ACCESS supervisor
appeared by telephone

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny petitioner Medicaid is proper. The respondent carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

By notice dated September 24, 2015, the respondent (or the Department) notified petitioner her Medicaid application dated August 20, 2015 was denied. Petitioner timely requested a hearing to challenge the denial.

[redacted] Language Line Solutions, appeared as an interpreter for the first five minutes. [redacted] got disconnected from the call and [redacted] Language Line Solutions, appeared as an interpreter for the remainder of the hearing. [redacted] petitioner's husband, appeared and provided testimony. Pamela Vance, Hearing Officer, and Zenaida Rodriguez, ACCESS Interviewing Clerk, appeared as observers.

Petitioner submitted one exhibit, entered as Petitioner Exhibit "1". Respondent submitted four exhibits, entered as Respondent Exhibits "1" through "4". The record was closed on October 28, 2015.

FINDINGS OF FACT

1. Prior to the action under appeal, petitioner received Adult-Related (referred to SSI-Related) Medicaid. In July 2015 the respondent terminated petitioner's Medicaid.

2. On August 20, 2015, petitioner (age 47) submitted a Food Assistance and Medicaid (SSI and Family) application for herself and her husband. Medicaid for petitioner is the only issue.

3. To be eligible for Family-Related Medicaid, petitioner must have minor children in the home or be pregnant. Petitioner does not have minor children and is not pregnant. Therefore, she is not eligible for Family-Related Medicaid.

4. To be eligible for SSI-Related Medicaid, petitioner must be age 65 or older; blind or considered disabled by the Social Security Administration (SSA) or the Division of Disability Determination (DDD).

5. Petitioner described her disabilities as: [redacted]

6. On August 21, 2014, petitioner applied for disability through the SSA. The SSA denied petitioner disability on December 17, 2014. Petitioner appealed the SSA denial on April 20, 2015, through an attorney. An appeal date has not been scheduled.

7. DDD makes Medicaid disability determinations on behalf of the Department. On September 1, 2015, the Department forwarded petitioner's medical documents to DDD for review.

8. On September 21, 2015, DDD denied petitioner disability, due to adopting the December 17, 2014, SSA denial.

9. On September 24, 2015, the respondent mailed petitioner a Notice of Case Action, notifying her Medicaid application, dated August 20, 2015, was denied.

10. Petitioner stated that she does not have a worsened or new medical condition that the SSA and/or her attorney are not aware of.

CONCLUSIONS OF LAW

11. 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 Fla. Stat. § 409.285.

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

13. Florida Administrative Code R. 65A-1.703 addresses Family-Related Medicaid and in part states:

> (1) The department provides mandatory Medicaid coverage for individuals, families and children described in Section 409.903, F.S., Section 1931 of the Social Security Act and other relevant provisions of Title XIX of the Social Security Act. The optional family-related Title XIX and Title XXI coverage groups served by the department are stated in each subsection of this rule…
> (5) Medicaid for pregnant women…

14. In accordance with the above authority, to be eligible for Family-Related Medicaid petitioner must have minor children or be pregnant. Petitioner does not have minor children and is not pregnant. Therefore, she is not eligible for Family-Related Medicaid.

15. Florida Administrative Code R. 65A-1.711 addresses SSI-Related Medicaid and in part states:

> (1) For MEDS-AD Demonstration Waiver, the individual must be age 65 or older, or disabled as defined in 20 C.F.R. §416.905…

16. Title 20 Code of Federal Regulations § 416.903, addresses disability and blindness determinations and in part states:

> (b) Social Security Administration. The Social Security Administration will make disability and blindness determinations…

17. In accordance with the above authorities, to be eligible for SSI-Related Medicaid petitioner must be age 65 or older; or be considered disabled or blind.

18. The Code of Federal Regulations at 42 C.F.R. § 435.541, explains Determination of disability and in part states:

(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...
(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under 435.909.
(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.
(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except In cases specified in paragraph (c) (4) of this section.
(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist...
(4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA. and-
(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or
(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.
(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act. and-
(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or
(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

19. The above authority explains that the SSA determination is binding on the Department.

20. In accordance with the above authority, the respondent denied petitioner's August 20, 2015 Medicaid application, due to adopting the SSA December 17, 2014, denial decision.

21. Petitioner appealed the SSA denial decision and is awaiting an appeal date.

22. Petitioner does not have a worsened or new medical condition the SSA is unaware of.

23. In careful review of the cited authorities and evidence, the undersigned concludes the respondent followed Rule in denying petitioner Medicaid benefits.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the respondent's action is 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 21 day of December, 2015,

in Tallahassee, Florida.

Priscilla Peterson

Priscilla Peterson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

APPEAL NO. 15F-08149

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 15 Palm Beach
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 6, 2015 at 11:09 a.m.

APPEARANCES

For the Petitioner: [redacted]
Petitioner's Daughter

For the Respondent: Doretha Rouse
Registered Nurse Specialist

ISSUE

Whether respondent's denial of a lower partial denture (Procedure D5214) was proper. The burden of proof was assigned to the petitioner.

PRELIMINARY STATEMENT

Petitioner was present and represented by her daughter. Petitioner entered no exhibits into evidence.

Ms. Rouse appeared as both a representative and witness for the respondent.

Also present from the Agency for Health Care Administration was Lisa Sanchez, Senior Human Services Program Specialist. Present from Sunshine Health was India Smith, Grievance and Appeals Coordinator. Present from Dental Health and Wellness (DHW) were Elis Vega, Appeals Specialist and Dr. Kimberly Anderson, Dental Consultant. Karen Grahdk appeared as an observer. Respondent's exhibits "1" and "2" were accepted into evidence. The record was held open through November 12, 2015 for respondent to provide additional information. Information was received and entered as respondent's exhibit "3".

Administrative Notice was taken of the Florida Medicaid Provider General Handbook and the Dental Services Coverage and Limitations Handbook.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

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

2. Petitioner is Medicare eligible. Her Medicare services are provided by Coventry Vista (Coventry). Coventry is a health maintenance organization (HMO) and is considered petitioner's primary insurance provider.

3. Petitioner is not enrolled in respondent's Managed Medical Assistance (MMA) Program. This program focuses on medical and dental related services.

4. Petitioner is enrolled in respondent's Statewide Medicaid Managed Care Long-Term Care (LTC) Program. The LTC Program provides numerous services including

but not limited to: personal care; respite; home delivered meals; and companion services.

5. Sunshine Health is petitioner's managed care provider for the LTC Program. Sunshine Health offers "value-added benefits" to enrollees. When medically necessary, limited dental services are provided.

6. Sunshine Health allows one partial denture, including procedure D5214, once in a lifetime for each LTC Program member. The procedure requires a prior authorization.

7. DHW is Sunshine Health's dental vendor. DHW determines whether dental service requested by plan members are medically necessary and in compliance with pertinent rules and regulations.

8. On or about September 8, 2015 DHW received from petitioner's dentist an x-ray and prior authorization request for a partial lower denture. The request was then reviewed by a DHW licensed dentist.

9. On September 8, 2015 DHW issued a Notice of Action to the petitioner which denied the lower partial denture. The notice stated, in part: "All dental benefits for Sunshine Health LTC members is a value-added benefit. The member's Medicaid health plan must be billed first for dental services[1]."

10. On September 24, 2015 petitioner contacted the Office of Appeal Hearings and timely requested a fair hearing.

11. On October 19, 2015 DHW completed a secondary review and upheld the original denial. Petitioner's dentist was advised to submit the request to her primary insurance.

---

[1] It was believed petitioner was enrolled in the MMA Program.

12. Petitioner argues that due to the lack of certain teeth in the lower jaw, she cannot properly chew food.

13. Respondent argues the claim for the lower partial denture should first be submitted to Coventry. If denied, petitioner's dentist could resubmit the prior authorization to DHW. A medical necessity review would then be completed. A copy of the Coventry denial must accompany the prior authorization materials.

CONCLUSIONS OF LAW

14. 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.

15. This is a final order pursuant to § 120.569 and § 120.57, Fla. Stat.

16. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

17. The standard of proof in an administrative hearing is by a preponderance of the evidence. (See Fla. Admin. Code R. 65-2060(1).) The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

18. The Florida Medicaid Provider General Handbook (Provider Handbook) – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code R. 59G-4. The Provider Handbook states on page 1-27:

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.

Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee. Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

19. The Provider Handbook continues by stating, in part:

Page 1-12:

Third Party Liability (TPL) is the obligation of any entity other than Medicaid or the recipient to pay for all or part of the cost of the recipient's medical care. If the recipient has other coverage though a TPL source, the provider must bill the TPL source prior to billing Medicaid.
...

Medicaid is the payer of last resort. If a recipient has other insurance coverage through a third party source, such as Medicare ... the provider must bill the primary insure prior to billing Medicaid.

Page 1-13:

The exceptions to Medicaid being payer of last resort are as follows:
- Federal funds from the Individuals with Disabilities Education Act (I.D.E.A.), Part B or C;
- Victim's Compensation;
- Indian Health, 1905(b) of the Social Security Act; and
- Programs funded through state and county funds such as:

– Children's Medical Services,
– AIDS Drug Assistance program,
– Department of Health indigent drug programs,
– County Health Departments,
– Substance abuse, mental health and developmental disabilities programs funded by the Department of Children and Families and Agency for Persons with Disabilities; and
– Vocational Rehabilitation programs.

Funds from these programs may be accessed after Medicaid. A provider may bill Medicaid for a service prior to billing these programs.

Page 1-16:

> Recipients who are 65 years or older ... can have full major medical coverage through Medicare.
> ...
> Dually-eligible recipients (eligible for Medicaid and Medicare) may receive Medicare services from a Medicare Advantage Plan (Medicare HMO). A Medicare Advantage Plan is considered to be a TPL source.

20. In this matter, the greater weight of evidence does not establish that an exception to Medicaid being the payer of last resorts exists.

21. The Findings of Fact establish petitioner's Medicare is through Coventry HMO. The above authority directs Medicaid to be the payer of last resort. As such, the requested dental procedure should first be submitted to petitioner's Medicare HMO. It is not known if the plan covers the requested dental procedure. Regardless, if denied by Coventry, the request can be re-submitted to DHW for a medical necessity review.

22. After reviewing evidence and testimony on a comprehensive basis, petitioner has not demonstrated respondent's action in this matter was improper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, petitioner's appeal is 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 19 day of November, 2015,

in Tallahassee, Florida.

Frank Houston
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Judy Jacobs, Area 7, AHCA Field Office
[redacted]

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

[redacted]

APPEAL NO. 15F-08177

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 Dade
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened a telephonic administrative hearing in this matter on November 4, 2015 at 10:08 a.m.

APPEARANCES

For the Petitioner: [redacted] Mother

For the Respondent: Dianna Chirino,
Senior Human Services Program Specialist,
Agency for Health Care Administration

STATEMENT OF ISSUE

The Petitioner is appealing the Agency for Health Care Administration's (AHCA's) decision to deny the Petitioner's request for durable medical equipment (DME): 1.) power wheelchair; 2.) electric bed; and 3.) air mattress.

Because the issue under appeal involves requests for medical supplies, Petitioner carries the burden of proof.

PRELIMINARY STATEMENT

Dr. Marc Kaprow, Executive Director for Long-Term Care, and Christian Laos, Senior Compliance Analyst, both from United Healthcare (UHC), appeared as witnesses for the Respondent.

Respondent submitted an 83-page document, which was entered into evidence and marked as Respondent Exhibit 1.

Interpreter [redacted] from Proprio Language Services, provided Spanish translation for Petitioner whose mother only speaks Spanish.

FINDINGS OF FACTS

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

1. Petitioner is a 76 year-old Medicaid recipient enrolled with United Healthcare (UHC), a Florida Health Managed Care provider.

2. Petitioner has Medicare as her primary medical insurance provider.

3. UHC received a request for a power wheelchair on June 12, 2015. A Notice of Action was sent to the Petitioner on June 24, 2015 stating the Petitioner is able to get the power wheelchair through Medicare and the plan would pay any copayments for this service.

4. UHC received a request for an electric bed and air mattress on September 12, 2015. A Notice of Action was sent to September 17, 2015 also advising the Petitioner

she is able to obtain these items through Medicare and the plan would pay any copayments for these services.

5. Petitioner weights 300 pounds and is requesting a heavy duty (bariatric) wheelchair and a heavy duty (bariatric) electric bed. Petitioner is also requesting an air mattress.

6. Respondent advised that standard wheelchairs and standard hospital beds accommodate patients up to 350 pounds. Respondent noted no medical documentation had been provided to support the need for bariatric equipment.

7. Medicare has denied Petitioner's request for these durable medical supplies.

8. Medicaid and UHC accept Medicare's determination of medical necessity because Medicare is the Petitioner's primary medical insurance provider.

9. Medicaid is payor of last resort.

CONCLUSIONS OF LAW

10. By agreement between the Agency for Health Care Administration and the Department of Children and Families, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80 Florida Statutes.

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

12. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Florida Administrative Code Rule 65-2.060(1).

13. Florida Statutes 409.971 – 409.973 establishes the requirement for Medicaid recipients to be enrolled in the statewide managed medical assistance program and the minimum benefits the managed care plans shall cover.

14. § 409.912, Fla. Stat. also provides that the Agency may mandate prior authorization for Medicaid services.

15. Fla. Admin. Code R. 59G-1.010 defines "prior authorization" as:

> (226) "Prior authorization" means the approval by the Medicaid office for a Medicaid provider, or by a prepaid health plan for its affiliated providers, to deliver Medicaid covered medical or allied care, goods, or services in advance of the delivery of the care, goods, or services.

16. Fla. Admin. Code R. 59G-1.010 (166) also provides…

> "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
>
> (a) Meet the following conditions:
>
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
>
> (b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

17. The Florida Medicaid Provider General Handbook, July 2012, incorporated in Fla. Admin. Code R. 59G, provides an explanation of Medicaid limits for Medicare Cross Over claims and provides on pages 1-2 and 4-3 in relevant part:

> Responsibility For Exhausting TPL Sources
> Medicaid is the payer of last resort. If a recipient has other insurance coverage through a third party source, such as Medicare, TRICARE, insurance plans, AARP plans, or automobile coverage, the provider must bill the primary insurer prior to billing Medicaid.
> ....
> Medicaid Program Limits
> Medicaid will not pay a crossover claim if:
> Both Medicare and Medicaid cover the service, and Medicare has determined that the service is not medically necessary. **If Medicare determines that a service that Medicaid also covers is not medically necessary, it is also considered to be not medically necessary by Medicaid** [emphasis added].

18. Medicare has not approved the electric bed, air mattress, or the power wheelchair the Petitioner has requested. Therefore, Medicaid cannot cover these services either.

19. The Respondent, by a preponderance of the evidence and testimony, supported its decisions in denying Petitioner's requests for a power wheelchair, electric bed, and air mattress. The Petitioner has failed to meet her burden of proof.

DECISION

Based on the evidence presented at the final hearing and on the entire record of this proceeding, the Petitioner's appeal is denied and the Respondent's actions are affirmed.

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 23 day of December, 2015, in Tallahassee, Florida.

Warren Hunter
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal_Hearings@dcf.state.fl.us

Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

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

[redacted]

PETITIONER,

APPEAL NO. 15F-08185

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 10 Orange
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 12, 2015 at 1:49 p.m.

APPEARANCES

For the Petitioner: [redacted]
Mother of petitioner

For the Respondent: Doretha Rouse
Registered Nurse Specialist

STATEMENT OF ISSUE

Whether respondent's denial of petitioner's initial request for Pediatric Extended Care (PPEC) services was proper. The burden of proof was assigned to the petitioner.

PRELIMINARY STATEMENT

The hearing was scheduled by Hearing Officer Rick Zimmer. The actual hearing, however, was conducted by the undersigned.

Present for the petitioner was [redacted] Clinical Social Worker. Petitioner's exhibit "1" was entered into evidence.

Ms. Rouse appeared both as a witness and representative for the respondent. Present as a witness from eQHealth Solutions (eQHealth) was Dr. Darlene Calhoun, M.D. Respondent's Exhibits "1" and "2" were accepted into evidence.

Administrative Notice was taken of Fla. Stat. §400.902; Fla. Admin. Code R. 59G- 1.010; and the Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook (PPEC Handbook).

FINDINGS OF FACT

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

1. Petitioner's date of [redacted] She was eligible to receive Medicaid services at all times relevant to this proceeding.

2. Petitioner resides with her parents and one sibling. The mother is not employed outside the household.

3. Petitioner's medical diagnoses include [redacted]

4. Petitioner is prescribed no medications which must be administered only by a medical professional. At present, all medications are administered by the parents.

5. Twice daily, petitioner utilizes a chest percussion therapy (CPT) vest. By aiding in the breakup of secretions, the vest improves petitioner's lung function.

6. Petitioner receives regular nebulizer treatments.

7. Petitioner's medical status does not include:

- A gastrostomy tube for feeding
- A tracheostomy
- A ventilator
- The use of any type of catheter
- A colostomy or ileostomy
- Intravenous medications or fluids
- Skin ulcers or other conditions which require dressing changes

8. Petitioner does not, on a daily basis, require suctioning of secretions.

9. Petitioner does not require, on a regular basis, the administration of oxygen.

10. On or about September 21, 2015 petitioner's physician requested PPEC services. The PPEC Program provides skilled nursing services to children with complex medical conditions. The services are provided in a PPEC Center.

11. eQHealth is the Peer Review Organization (PRO) contracted by the respondent to perform prior authorization reviews for PPEC services.

12. An eQHealth physician, who is board certified in pediatrics, thereafter reviewed all submitted information.

13. Accompanying the request was a Plan of Care signed by petitioner's physician. The physician identified the following services to be provided at the PPEC:

- Daily hygiene
- Evaluation of developmental milestones
- Medication administration
- Evaluation of family compliance with care needs
- Family training
- Monitoring of airway clearance
- Monitoring of weight

14. On September 25, 2015, a Notice of Outcome – Denial of Prescribed Pediatric Extended Care Services was issued to the petitioner's parents and physician. The notice sent to the physician stated, in part:

> The patient is a 2 year old with [redacted] The patient wears a CPT vest twice daily. The patient has had no recent emergency room visits or hospitalizations. The patient is on daily scheduled medications and scheduled and as needed inhaled medications. The patient is on a regular diet with Zenpep administered with all meals and snacks. The clinical information provided does not support the medical necessity of the requested PPEC services. The patient does not appear to have any skilled needs.

15. On September 25, 2015 petitioner's mother contacted the Office of Appeal Hearings and requested a fair hearing.

16. Petitioner's mother wishes to return to work. As medications are administered throughout the day, it would not be possible for medication administration to occur before and after work. A regular day care would not be able to administer the medications. Additionally, a PPEC would provide socialization opportunities for the petitioner.

CONCLUSIONS OF LAW

17. By agreement between the Agency for Health Care Administration (AHCA) 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.

18. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

19. The standard of proof in an administrative hearing is by 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.).

20. The Florida Medicaid State Plan is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The program is administered by the respondent.

21. The PPEC Handbook (September 2013) has been promulgated into rule by Fla. Admin. Code R. 59G-4.260.

22. Page 1-1 of the PPEC Handbook states: "The purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) services is to enable recipients under the age of 21 years with medically-complex conditions to received medial and therapeutic care at a non-residential pediatric center."

23. Page 2-1 of the PPEC Handbook continues by stating:

> To receive reimbursement for PPEC services, a recipient must meet all of the following criteria:
>
> - Be Medicaid eligible.
> - Diagnosed with a medically complex or medically fragile condition as defined in Rule 59G-1.010, F.A.C.
> - Be under the age of 21 years.
> - Be medically stable and not present significant risk to other children or personnel at the center.
> - Require short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care due to a medically complex condition.

24. Fla. Admin. Code R. 59G-1.010 provides the following definitions:

> (164) "Medically complex" means that a person has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour-per day medical, nursing, or health supervision or intervention.
>
> (165) "Medically fragile" means an individual who is medically complex and whose medical condition is or such a nature that he is technologically dependent requiring medical apparatus or procedures to sustain life, e.g. requires total parenteral nutrition (TPN), is ventilator dependent, or is

> dependent on a heightened level of medical supervision to sustain life, and without such services is likely to expire without warning.

25. The PPEC Handbook also states on page 2-2 that "Medicaid reimburses services that are determined medically necessary, and do not duplicate another provider's service."

26. Fla. Admin. Code R. 59G-1.010(166), defines medical necessity, as follows:

> "Medically necessary" or "medical necessity" means that the medical or allied
> care, goods, or services furnished or ordered must:
>
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider...
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

27. Since the petitioner is under 21 years-old, a broader definition of medical necessity applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPDST) requirements. Fla. Stat. § 409.905, Mandatory Medicaid services, provides that Medicaid services for children include:

> (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical

> and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

28. The undersigned notes that PPEC services are available through the Florida Medicaid Program. As such, analysis is further directed to whether, in this instant appeal, the service is medically necessary.

29. The greater weight of evidence does not establish the petitioner requires around the clock nursing supervision. Medications; nebulizer treatments; and vest therapy are administered by the parents.

30. Petitioner has no medications which are administered intravenously.

31. The Findings of Fact establish petitioner does not require a ventilator to facilitate breathing.

32. Petitioner does not have a gastrostomy tube; tracheostomy or colostomy.

33. Petitioner has no skin ulcers or other conditions which require ongoing treatment.

34. When considering evidence and testimony on a comprehensive basis, petitioner's current medical status fails to rise to the exacting definition for either medically complex or medically fragile. Petitioner's medical conditions are noted. Absent the need for skilled nursing services, however, a PPEC center is not the appropriate setting to address petitioner's current care needs.

35. It is noted that page 1-2 of the PPEC Handbook states "PPEC services are not emergency services." As such, the purpose of the PPEC Program is to provide skilled

medical oversight. Supervision for the purpose to provide a skilled response should a medical emergency arise, is not a PPEC service.

36. When jointly considering the requirements of both EPSDT and Medical Necessity, the undersigned concludes the petitioner had not met the burden of proof in this matter.

37. Petitioner's request for PPEC services has not satisfied the following conditions of medical necessity:

2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider...

DECISION

Based upon the foregoing Findings of Fact and controlling authorities, petitioner's appeal is 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 19 day of November, 2015,

in Tallahassee, Florida.

Frank Houston
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Judy Jacobs, Area 7, AHCA Field Office

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 DADE
UNIT: 66701

RESPONDENT.
_____/

APPEAL NO. 15F-08193

CASE NO. [redacted]

D - DDD - Disability

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on December 16th, 2015 at 1:30 p.m. in Miami, Florida.

APPEARANCES

For the Petitioner: [redacted] pro se.

For the Respondent: Marcela Osorio, Operations Management Consultant for the Economic Self-Sufficiency program.

STATEMENT OF ISSUE

The petitioner is appealing the termination of his Medicaid benefits. The respondent carries the burden of proving its position by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing was originally scheduled to be held telephonically on November 18th, 2015. The petitioner requested that the hearing be rescheduled as an in-person forum. A continuance was granted, and the hearing convened as described above.

Petitioner's exhibits 1 through 13 were moved into evidence.

Respondent's exhibits 1 through 3 were moved into evidence.

No Notice of Case Action setting forth the issue under appeal was presented at the hearing. On September 25th, 2015, the petitioner filed an appeal to challenge the respondent's action.

The record was held open until the close of business December 23rd, 2015, to allow the respondent to submit the Notice of Case Action in question. The respondent submitted a notice dated May 13th, 2015 indicating that his Medicaid would end on May 31st, 2015. However, the Findings of Fact will show that the action under appeal was taken on July 23rd, 2015, 62 days following the date of the notice submitted. No Notice of Case Action corresponding to the July 23rd action was submitted. Therefore, the hearing officer will consider the appeal to have been timely filed, and the merits of the appeal will be addressed.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner was a recipient of SSI-related Medicaid benefits due to having been determined disabled by the Department of Health's Division of Disability Determinations (DDD).

2. The petitioner is a single male, [redacted] The petitioner alleges that he suffers from [redacted] which results in shortness of breath if he speaks for too long, [redacted] and [redacted] due to [redacted] Additionally, the petitioner has a [redacted] occasioned by a [redacted] and three subsequent [redacted] The petitioner also suffered a skiing accident in February of 2001, which required [redacted] The petitioner's exhibits are medical statements attesting to his various conditions.

3. On May 1st, 2011, DDD found the petitioner to be disabled, and determined that a review of the petitioner's disabling conditions would be necessary in August 2014.

4. The respondent neglected to take the appropriate timely action to review the petitioner's eligibility for ongoing Medicaid effective September 2014. Consequently, the petitioner continued to receive Medicaid through at least May 2015.

5. On June 29th, 2015, the respondent completed a disability determination interview with the petitioner. The respondent then forwarded medical records supplied by the petitioner to DDD for a determination of the petitioner's continuing eligibility for SSI-related Medicaid.

6. On July 23rd, 2015, DDD found the petitioner no longer to be disabled, and denied the petitioner's application with reason code N31, which states "Nonpay Capacity for SGA *[Substantial Gainful Activity]* – customary past work, no visual impairment."

7. There was no representative from DDD at the hearing to attest to the actions it took.

CONCLUSIONS OF LAW

8. The Department of Children and Families Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to §120.80, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

9. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

10. Hearsay is defined by § 90.801(1)(c), Fla. Stat. as "a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted."

11. Fla. Stat. § 120.57(1)(c) states in pertinent part:

> "[h]earsay evidence may be used for the purpose of supplementing or explaining other evidence, but it shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions."

12. Florida Administrative Code 28-106.213 Evidence, states in relevant part:

> (3) Hearsay evidence, whether received in evidence over objection or not, may be used to supplement or explain other evidence, but shall not be sufficient in itself to support a finding unless the evidence falls within an exception to the hearsay rule as found in Sections 90.801-.805, F.S.

13. Florida Statutes 90.803 addresses hearsay exceptions, and states in relative part:

> (6) RECORDS OF REGULARLY CONDUCTED BUSINESS ACTIVITY.- a) A memorandum, report, record, or data compilation, in any form, of acts, events, conditions, opinion, or diagnosis, made at or near the time by, or from information transmitted by, a person with knowledge, if kept in the course of a regularly conducted business activity and if it was the regular practice of that business activity to make such memorandum, report, record, or data compilation, all as shown by the testimony of the custodian or other qualified witness, or as shown by a certification or declaration that complies with paragraph (c) and s. 90.902(11), unless the sources of information or other circumstances show lack of trustworthiness. The term "business" as used in this paragraph includes a business, institution, association, profession, occupation, and calling of every kind, whether or not conducted for profit.

14. The Fla. Admin. Code R. 65-2.060 addresses burden of proof, and states as follows:

> (1) The burden of proof, except where otherwise required by statutes, is on the party asserting the affirmative of an issue. The burden is upon the Department when the Department takes action which would reduce or terminate the benefits or payments being received by the recipient. The burden is upon the petitioner if an application for benefits or payments is denied. The party having the burden shall establish his/her position, by a preponderance of evidence, to the satisfaction of the hearing officer.

15. Indisputably, the respondent took action to terminate the petitioner's Medicaid based on instruction from DDD. However, testimony regarding DDD's decision constitutes hearsay, as there was no representative from DDD to explain its decision or to address the petitioner's contentions.

16. Authorities cited above set forth the rules for assigning the burden of proof in an administrative hearing. The respondent carries the burden of proof in this appeal as

it terminated the petitioner's benefits due to DDD's decision that the petitioner was no longer disabled. However, there was no evidence or testimony that could be relied on to prove the correctness of DDD's decision. Therefore, the hearing officer concludes that the respondent failed to meet its burden of proof at the hearing that termination of Medicaid benefits was correct.

17. Given that the respondent could not explain the reason DDD determined that the petitioner was no longer disabled, the hearing officer hereby remands the appeal to the respondent. The respondent will, within ten days from the date of this order, reinstate the petitioner's Medicaid for any months lost due to its action to terminate said benefits. The respondent will also complete a new Medicaid disability determination. The petitioner will need to cooperate in this process. The respondent will then issue written notice with the outcome of the determination, and the notice will include appeal rights should the petitioner disagree with the outcome. This order does not guarantee ongoing future Medicaid eligibility for the petitioner; it merely affords the petitioner another opportunity for a complete eligibility review.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, this appeal is granted and remanded to the respondent in accordance with the above conclusions.

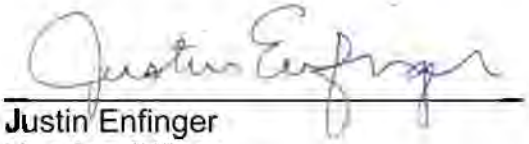
NOTICE OF RIGHT TO APPEAL

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 indigence to waive those fees. The Department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 31 day of December, 2015,

in Tallahassee, Florida.



Justin Enfinger
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

PETITIONER,

APPEAL NO. 15F-08203

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 07 St. Johns
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 23, 2015 at 10:07a.m.

APPEARANCES

For the Petitioner: pro se

For the Respondent: Sheila Broderick, registered nurse specialist

STATEMENT OF ISSUE

Whether the petitioner is eligible to receive dental services through Medicaid. The burden of proof was assigned to the petitioner.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (Agency or AHCA or respondent) administers the Florida Medicaid Program. Medicaid rules require that most recipients receive their Medicaid services through the Managed Care Plan. The Agency contracts

with numerous health care organizations to provide medical services to its program participants. United Healthcare (United) is the contracted health care organization in the instant case.

By notice dated September 8, 2015, United informed the petitioner that her request for multiple tooth extractions, bone surgery, and general anesthesia was denied in-part. United approved the tooth extractions and general anesthesia related to those extractions. United denied the bone surgery and the general anesthesia related to the bone surgery. The notice explained that bone surgery is not a covered dental benefit. In addition, the clinical information submitted was insufficient to prove that bone surgery was medically necessary.

The petitioner timely requested a hearing to challenge the denial decision on September 28, 2015.

There were no additional witnesses for the petitioner. The petitioner did not submit exhibits.

Present as witnesses for the respondent were Christian Laos, senior compliance analyst with United and Dr. Miguel Fernandez, chief medical officer with United. Respondent's Composite Exhibit 1 was admitted into evidence.

The record was held open until close of business on November 25, 2015 for the submission of additional evidence. No additional evidence was received from either party. There was no communication from either party requesting a deadline extension. The record was closed.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. The petitioner (age 57) is a Florida Medicaid recipient. The petitioner is enrolled with United HMO.

2. The petitioner's oral surgeon, [redacted] requested prior authorization from United to extract her remaining four teeth (procedure code D7210) and remove two prominent boney ridges, called tori (procedure code D7473), on the roof of her mouth in order to prepare her for a full set of dentures. [redacted] also requested general anesthesia related to the extractions and surgery (procedure codes D9220 and D9221).

3. United approved the extractions and the general anesthesia related to the extractions. United denied the bone surgery as a non-covered dental benefit. The general anesthesia related to the bone surgery was also denied.

4. The oral surgeon has performed the extractions. All of the petitioner's teeth have been removed. The boney rides have not been removed due to the denial decision. The boney ridges are large; they prevent the petitioner from being able to chew solid foods. She is limited to a soft food diet. The ridges are shredding the surrounding gum tissue; this causes the petitioner a great deal of pain.

5. Dr. Miguel Fernandez, chief medical officer with United, testified that removal of tori, in order to fit patients with dentures, is a common practice. Tori are considered part of the jaw bone, not part of the mouth. Tori removal surgery is not a covered dental benefit because the procedure cannot be performed by a general dentist. The surgery

is considered a medical benefit because the procedure must be performed by an oral surgeon. The petitioner's oral surgeon included a dental procedure code on the prior authorization request form instead of a medical procedure code. The request was denied because the provider used the wrong procedure code.

6. Dr. Fernandez testified that the bone surgery would most likely have been approved if the provider has used the correct procedure code. Dr. Fernandez noted, however, that he could not make a conclusive determination because he had not reviewed the petitioner's clinical records, nor was he involved in the initial determination.

7. Sheila Broderick, representative for the respondent, testified that AHCA's core contract with United requires that the company facilitate the coordination of medical services. Ms. Broderick asked United to describe the assistance it provided to resolve the medical versus dental procedure code issue with the petitioner.

8. United acknowledged that it had not communicated with the dental provider regarding this matter. Christian Laos, senior compliance analyst with United agreed to reach out to the oral surgeon, [redacted] after the hearing to educate him about proper procedure codes and help facilitate a new prior service authorization request. Mr. Laos was to provide a status update to the petitioner at the conclusion of his contact with the dental provider. The petitioner was to inform the hearing officer if the matter had been resolved to her satisfaction. There was no additional communication from either party.

9. The hearing record was also held open for United to provide the authorities which define its adult dental service coverage and limitations. United did not provide any additional evidence to the hearing officer.

CONCLUSIONS OF LAW

10. By agreement between the AHCA 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.

11. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

12. In accordance with Fla. Admin. Code § 65-2.060 (1), the burden of proof was assigned to the petitioner. The standard of proof in an administrative hearing is by 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.).

13. All Medicaid services must be medically necessary. The definition of medical necessity is found in the Fla. Admin Code. R. 59G-1.010 and states:

> (166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider…
> . . .
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such

> care, goods or services medically necessary or a medical necessity or a covered service.

14. Fla. Admin. Code R. 59G-4.060 addresses dental services and states, in part:

> (2) All dental services providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Dental Services Coverage and Limitations Handbook, November 2011, ... and the Florida Medicaid Provider Reimbursement Handbook, ADA Dental Claim Form, July 2008, which are incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which is incorporated by reference in Rule 59G-4.001, F.A.C. ...

15. The Florida Medicaid Dental Handbook (Dental Handbook) is incorporated by reference into Fla. Admin. Code R. 59G-4.060 and addresses covered adult services, ages 21 and over, on page 2-3:

> The adult dental program provides for the reimbursement of full and removable partial dentures. Extractions and other surgical procedures essential to the preparation of the mouth for dentures are reimbursable if the patient is to receive dentures.

16. The Dental Handbook defines oral surgery on page 2-13 and expounds on covered adult services:

> Oral surgery services include extractions as well as surgical and adjunctive treatment of diseases, injuries, deformities, and defects of the oral and maxillofacial [face or jaw bone] regions.
>
> For recipients 21 years and older, Medicaid covers extractions and other surgical procedures essential to the preparation of the mouth for dentures.

17. The cited authorities explain that surgery needed to prepare a patient for dentures is a covered service in the adult dental program.

18. The petitioner's oral surgeon requested authorization to extract her remaining teeth and surgically remove large bony ridges (tori) in her mouth in order to prepare her for dentures. The respondent denied the bone surgery as a non-covered dental benefit.

19. The controlling legal authorities state that oral surgery, including surgery to the face or jaw bone, required to prepare a patient for dentures is a covered service in the Medicaid adult dental program.

20. After carefully reviewing the evidence and the controlling legal authorities, the undersigned concludes that the respondent's decision in this matter was incorrect.

DECISION

The appeal is GRANTED. The respondent is ordered to approve the bone surgery, as well as the anesthesia required for the procedure.

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 28 day of December, 2015,

in Tallahassee, Florida.

Leslie Green
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Debbie Stokes, Area 4, AHCA Field Office Manager

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

[redacted]

APPEAL NO. 15F-08207

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 Dade
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened a telephonic administrative hearing in this matter on November 4, 2015 at 11:38 a.m.

APPEARANCES

For the Petitioner: [redacted] Daughter

For the Respondent: Dianna Chirino,
Senior Human Services Program Specialist,
Agency for Health Care Administration

STATEMENT OF ISSUE

The Petitioner is appealing the Agency for Health Care Administration's (AHCA's) decision to deny the Petitioner's request for medical supplies (underpads, gloves, ointment, and chux). Because the issue under appeal involves a request for medical supplies, Petitioner carries the burden of proof.

PRELIMINARY STATEMENT

Dr. Sloan Carver, Medical Director for Long-Term Care and Christian Laos, Senior Compliance Analyst, both from United Healthcare (UHC), appeared as witnesses for the Respondent.

Interpreter [redacted] from Proprio Language Services provided Spanish translation for Petitioner whose daughter only speaks Spanish.

Respondent submitted a 63-page document, which was entered into evidence and marked as Respondent Exhibit 1.

FINDINGS OF FACTS

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

1. Petitioner is an 89 year-old Medicaid recipient enrolled with United Healthcare (UHC), a Florida Health Managed Care provider.

2. Petitioner has Medicare as her primary medical insurance provider.

3. UHC received a request for medical supplies on September 8, 2015. A Notice of Action was sent to the Petitioner on September 16, 2015 denying the request as not medically necessary and referencing "FS 409.910(1)" as the authority for the decision.

4. Respondent advised that the Petitioner's hospice service provider, Vitas, is responsible for providing all her necessary medical supplies.

5. Petitioner receives 80 underpads per month and asserts this amount is insufficient to meet her needs. Petitioner uses five or six underpads daily and needs more than what is currently being provided by her hospice service provider.

6. Medicare covers the Petitioner's hospice services.

7. Petitioner is satisfied with the hospice care being provided but is unsatisfied with the monthly amount of medical supplies provided. She is requesting that United Healthcare provide her medical supplies.

8. Medicaid and UHC accept Medicare's determination of medical necessity because Medicare is the Petitioner's primary medical insurance provider.

9. Medicaid is payor of last resort.

CONCLUSIONS OF LAW

10. By agreement between the Agency for Health Care Administration and the Department of Children and Families, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80 Florida Statutes.

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

12. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Florida Administrative Code Rule 65-2.060(1).

13. § 409.910(1), Fla. Stat. provides in relevant part :

> It is the intent of the Legislature that Medicaid be the payor of last resort for medically necessary goods and services furnished to Medicaid recipients.

14. The Florida Medicaid Provider General Handbook, July 2012, incorporated in Fla. Admin. Code R. 59G, provides an explanation of Medicaid limits for Medicare Cross Over claims and provides on pages 1-2 and 4-3 in relevant part:

> Responsibility For Exhausting TPL Sources
> Medicaid is the payer of last resort. If a recipient has other insurance

> coverage through a third party source, such as Medicare, TRICARE, insurance plans, AARP plans, or automobile coverage, the provider must bill the primary insurer prior to billing Medicaid.
> ....
> Medicaid Program Limits
> Medicaid will not pay a crossover claim if:
> Both Medicare and Medicaid cover the service, and Medicare has determined that the service is not medically necessary. **If Medicare determines that a service that Medicaid also covers is not medically necessary, it is also considered to be not medically necessary by Medicaid** [emphasis added].

15. Medicare has approved the hospice services for the Petitioner. Vitas is providing the hospice services, including the monthly medical supplies.

16. The Respondent, by a preponderance of the evidence and testimony, supported its decisions in denying Petitioner's request for medical supplies because Medicare is Petitioner's primary health insurance provider. The Petitioner has failed to meet her burden of proof.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the Respondent's action is affirmed.

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 23 day of December, 2015,

in Tallahassee, Florida.

Warren Hunter
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

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

FILED
Dec 03, 2015
Office of Appeal Hearings
Dept. of Children and Families

[redacted]

APPEAL NO. 15F-07669
15F-08233

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 5, 2015 at 11:30 a.m. and on October 23, 2015 at 1:30 p.m.

APPEARANCES

For the Petitioner: [redacted] Petitioner

For the Respondent: Linda Latson, Registered Nurse Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the Respondent's denial of the Petitioner's requests for dental services was correct. The Petitioner has the burden of proving his case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The Petitioner had two separate hearing requests, which were combined for purposes of conducting the hearing. The Petitioner did not submit any documents as evidence for the hearing, other than his original hearing request which was already part of the record.

Appearing as witnesses for the Respondent were [redacted] Dental Consultant; [redacted] Dental Consultant; and [redacted] Grievance Specialist, from DentaQuest, which is the Petitioner's dental services organization. Also present as a witness for the Respondent was [redacted] Grievance and Appeals Specialist from Humana, which is Petitioner's managed health care organization.

Respondent submitted several documents as evidence for the hearing, which were marked as follows: For Appeal 15F-7669: Exhibit 1 – Member Information and Claim Form; Exhibit 2 – x-rays; Exhibit 3 – Denial Notices; Exhibit 4 – Criteria; Exhibit 5 – Dental Director Review Form; Exhibit 6 – Updated Determination Letter; For Appeal 15F-8233: Exhibit 1 – Member Information and Claim Form; Exhibit 2 – Authorization determination; Exhibit 3 – Notice of Action; Exhibit 4 – Updated Authorization determination; Exhibit 5 – DentaQuest reference manual; Exhibit 6 – Fee Schedule.

FINDINGS OF FACT

1. The Petitioner is a fifty-eight year old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA)

plan. He receives services under the plan from Humana, which utilizes DentaQuest for review and approval of dental services.

2. On or about August 12, 2015 and September 9, 2015, the Petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from DentaQuest to perform various dental procedures, including dental crowns, core buildup, crown lengthening, and retreatment of previous root canal. DentaQuest denied these requests on August 13, 2015 and September 10, 2015. On September 24, 2015, DentaQuest modified its prior decision and approved dental crowns on five teeth (Tooth 3, Tooth 12, Tooth 13, Tooth 14, and Tooth 19).

3. Petitioner testified that his main concern is Tooth 12. He states he has a fistula under Tooth 13 which was caused by an infection and he cannot get a crown on Tooth 12 until the infection on Tooth 13 is resolved. Petitioner stated he needs gum surgery because this is affecting his heart condition and the gum surgery is medically necessary.

4. The Respondent's expert witness, [redacted] testified that some of the services requested by the Petitioner are non-covered services. The crown-lengthening procedure (Code D4249) is used to expose more of the tooth surface to allow placement of a crown on the tooth, but this is a non-covered service. [redacted] also stated that retreatment of a prior root canal, which is another of the services requested by Petitioner, would treat the fistula under Tooth 13 but this is also a non-covered service.

5. [redacted] from DentaQuest testified there may have been some prior confusion regarding what services had been approved and what had been denied

because two different providers submitted similar service requests and one was denied because it did not contain sufficient clinical information and one was approved since it contained more detailed information.

6. Services under the Medicaid State Plan in Florida are provided in accordance with the Respondent's Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012 and the Dental Services Coverage and Limitations Handbook ("Dental Handbook"), effective November 2011.

.

CONCLUSIONS OF LAW

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

8. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

9. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

10. The standard of proof in an administrative hearing is a preponderance of the evidence, in accordance with Rule 65-2.060 (1), Fla. Admin. Code. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

11. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the Respondent. The Medicaid Handbook and the Dental Handbook are incorporated by reference in Chapter 59G-4, Florida Administrative Code.

12. The Medicaid Handbook and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

> "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide;
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
> . . .
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

13. The Florida Medicaid Program provides limited dental services for adults. The Dental Handbook describes the covered services for adults as follows on page 2-3:

> The adult dental program provides for the reimbursement of full and removable partial dentures. Extractions and other surgical procedures essential to the preparation of the mouth for dentures are reimbursable if the patient is to receive dentures. Procedures relating to dentures such as repairs, relines and adjustments are reimbursable.
>
> Medicaid will reimburse for medically-necessary emergency dental procedures to alleviate pain and or infection for eligible adult Medicaid recipients 21 years of age or older. Emergency dental care shall be limited to emergency problem-focused evaluations, necessary radiographs to make a diagnosis, extraction, and incision and drainage of abscess.

14. Managed care plans, such as Humana, may provide more generous benefits but cannot be more restrictive than the Medicaid guidelines contained in the Dental

Handbook. Petitioner's managed care plan has approved several dental crowns for the Petitioner but denied the remaining requested services as being non-covered services.

15. Petitioner stated his requested services are medically necessary and he needs gum surgery because of his heart condition.

16. Respondent's witnesses did not admit or deny that the services requested by Petitioner are medically necessary, but stated that the requested services are non-covered services.

17. After considering the evidence and testimony presented, the undersigned concludes that the Petitioner has not demonstrated that the requested services should have been approved by DentaQuest or Humana. Although the services may be medically necessary, the services requested (core buildup, crown lengthening, and retreatment of prior root canal) are non-covered services for adults under the Medicaid guidelines referenced above and under the Humana Medicaid dental plan. Therefore, the hearing officer cannot make a determination that these services must be covered by the Petitioner's plan.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is 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 agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 03 day of December, 2015,

in Tallahassee, Florida.

Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662

Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 12 Sarasota
UNIT: 88326

RESPONDENT.
_____/

APPEAL NO. 15F-08266

CASE NO. [redacted]

FINAL ORDER

The undersigned convened a telephonic administrative hearing in the above-referenced matter on October 26, 2015 at 1:05 p.m.

APPEARANCES

For Petitioner: [redacted] petitioner

For Respondent: Signe Jacobson, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether respondent's action to deny petitioner's application for SSI-Related Medicaid benefits is correct. The burden of proof is assigned to the petitioner by the preponderance of the evidence.

PRELIMINARY STATEMENT

Petitioner was present and testified. Petitioner submitted no exhibits at the hearing. Respondent was represented by Signe Jacobson with the Department of Children and Families (hereafter "DCF", "Respondent" or "Agency"). Ms. Jacobson

testified. Respondent submitted eight exhibits, which were accepted into evidence and marked as Respondent's Exhibits "1" through "8". The record closed on October 26, 2015.

FINDINGS OF FACT

1. On May 5, 2015, the petitioner applied for Supplemental Security Income (SSI) benefits from the Social Security Administration (SSA). On August 24, 2015, SSA denied petitioner's SSI application using the code N32. N32 means "Non-pay-Capacity for substantial gainful activity – other work, no visual impairment". On September 9, 2015, petitioner appealed the denial of her SSI application.

2. On July 20, 2015, the petitioner submitted an application for Food Assistance (FA) and Medicaid benefits. FA benefits are not an issue. The application listed petitioner as not disabled; as a [redacted]year old female; as applying for Social Security; and as requiring medical assistance as she does not have any money for out of pocket medical expenses.

3. On September 30, 2015, the respondent mailed petitioner a Notice of Case Action that indicated petitioner's Medicaid application dated July 20, 2015 was denied as, "You or a member(s) of your household do not meet the disability requirement and No household members are eligible for this program".

4. Respondent determined petitioner not eligible for Family-Related Medicaid benefits as she has no children under the age of eighteen living with her or is not pregnant; and is not eligible for SSI-Related Medicaid benefits as she is under the age of 65 and has not been found disabled by SSA.

5. Petitioner requires medications, various treatments, and physician visits for her medical conditions. On July 30, 2015 the petitioner had [redacted] The [redacted] is the only new condition claimed by the petitioner and the surgery is known to the SSA. Furthermore, petitioner cannot fill her prescriptions or see her physicians without the Medicaid benefits.

CONCLUSIONS OF LAW

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

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

8. The Fla. Admin. Code R. 65A-1.705(7)(c) Family-Related Medicaid General Eligibility Criteria, in part states:

> If assistance is requested for the parent of a deprived child, the parent and any deprived children who have no income must be included in the SFU. Any deprived siblings who have income, or any other related fully deprived children, are optional members of the SFU. If the parent is married and the spouse lives in the home, income must be deemed from the spouse to the parent. For the parent to be eligible, there must be at least one child under age 18, with or without income, in the SFU, or who would be in the SFU if not receiving SSI…

9. According to the above authority, to be eligible for Family-Related Medicaid benefits, petitioner must have a minor child under age 18 living in the household with her or she must be pregnant. Since petitioner does not have a minor child under age 18 living in the household and since she is not pregnant, she does not meet the technical

requirements to be eligible for Family-Related Medicaid benefits.

10. Fla. Admin. Code R. 65A-1.710 sets forth the rules of eligibility for SSI-Related Medicaid Coverage Groups. The MEDS-AD Demonstration Waiver is a coverage group for aged and disabled individuals (or couples), as provided in 42 U.S.C. § 1396a(m). For an individual less than 65 years of age to receive benefits, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905 and states, in part:

> (a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see § 416.960(b)) or any other substantial gainful work that exists in the national economy.

11. Pursuant to the above authority, to be eligible for SSI-Related Medicaid, petitioner must be deemed disabled by DDD as she is under the age of 65 and is currently not considered disabled by the SSA.

12. Federal Regulation at 42 C.F.R. § 435.541 provides standards for state disability determinations and states, in part:

> (a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.
> ....
>
> (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under §435.909.

(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.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.

(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:

(1) The individual applies for Medicaid as a non-cash beneficiary and has not applied to SSA for SSI cash benefits, whether or not a State has a section 1634 agreement with SSA; or an individual applies for Medicaid and has applied to SSA for SSI benefits and is found ineligible for SSI for a reason other than disability.

(2) The individual applies both to SSA for SSI and to the State Medicaid agency for Medicaid, the State agency has a section 1634 agreement with SSA, and SSA has not made an SSI disability determination within 90 days from the date of the individual's application for Medicaid.

(3) The individual applies to SSA for SSI and to the State Medicaid agency for Medicaid, the State does not have a section 1634 agreement with SSA, and either the State uses more restrictive criteria than SSI for determining Medicaid eligibility under its section 1902(f) option or, in the case of a State that uses SSI criteria, SSA has not made an SSI disability determination in time for the State to comply with the Medicaid time limit for making a prompt determination on an individual's application for Medicaid.

(4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and—

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

13. Petitioner was denied SSI benefits on August 24, 2015 pursuant to code N32. On July 20, 2015, the petitioner applied for Medicaid benefits with the respondent. Respondent determined petitioner not to be disabled and denied her application for SSI-Related Medicaid benefits as the respondent adopted SSA's denial decision.

14. Petitioner is appealing her SSA denial; therefore, SSA is reconsidering its denial of petitioner's SSA application through its appeal process. Petitioner has a new medical condition, but it is known to the SSA. Under these circumstances, the controlling authorities preclude the respondent from rendering an independent disability determination. Accordingly, the SSA federal determination remains binding on the respondent.

15. Therefore, the respondent was correct to adopt SSA's denial decision as petitioner's SSI denial was within twelve months of her Medicaid application and petitioner also has a new medical condition known to the SSA.

16. In careful review of the cited authorities and evidence, the undersigned concludes that petitioner has not met her burden of proof to indicate the respondent incorrectly denied her July 20, 2015 application for SSI-Related Medicaid benefits.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is DENIED.

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 29 day of December, 2015, in Tallahassee, Florida.

Mary Jane Stafford

Mary Jane Stafford
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 12 Sarasota
UNIT: 88326

RESPONDENT.
_____/

APPEAL NO. 15F-08267

CASE NO. [redacted]

FINAL ORDER

The undersigned convened a telephonic administrative hearing in the above-referenced matter on October 26, 2015 at 2:02 p.m.

APPEARANCES

For Petitioner: [redacted]

For Respondent: Signe Jacobson, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether respondent's action to deny petitioner's application for SSI-Related Medicaid benefits is correct. The burden of proof is assigned to the petitioner by the preponderance of the evidence.

PRELIMINARY STATEMENT

[redacted] (hereafter "petitioner") was present and testified; however, petitioner was represented by his mother, [redacted] who testified. Petitioner

submitted no exhibits at the hearing. Respondent was represented by Signe Jacobson with the Department of Children and Families (hereafter "DCF", "Respondent" or "Agency"). Ms. Jacobson testified. Respondent presented one witness who testified: Lauren Coe, Program Operations Administrator with the Department of Health, Division of Disability Determination (hereafter "DDD"). Respondent submitted seven exhibits, which were accepted into evidence and marked as Respondent's Exhibits "1" through "7". The record closed on October 26, 2015.

FINDINGS OF FACT

1. On July 20, 2015, the petitioner submitted an application for SSI-Related Medicaid on the basis of disability. The application listed petitioner as [redacted] as a [redacted] year old male; and as not currently employed.

2. Petitioner does not have a current application pending with the Social Security Administration (SSA).

3. On July 27, 2015, the respondent submitted the Disability Determination and Transmittal form along with petitioner's medical records to the Department of Health, Division of Disability Determinations (DDD) to complete an independent disability review on petitioner.

4. On September 16, 2015, [redacted] reviewed petitioner's medical records and determined petitioner's mental allegations as not severe. [redacted] also reviewed petitioner's ability to complete his Activities of Daily Living (ADL) and determined his medical conditions do not affect his ability to complete his ADLs as petitioner has no physical limitations; is able to drive; is able to complete grooming and other related activities; and is able to complete household chores.

5. [redacted] determined petitioner's Medical Diagnosis as [redacted] and [redacted] Furthermore, [redacted] determined the petitioner's disorders are a direct result of his [redacted] and as long as he receives medication maintenance, his disorders are not severe.

6. DDD listed the petitioner's primary diagnosis as [redacted] with [redacted] and listed his secondary diagnosis as [redacted]

7. On September 18, 2015, DDD determined petitioner not disabled using code (N30). Decision code N30 indicates petitioner has a [redacted] meaning it is not severe. Furthermore, DDD determined petitioner was not disabled at step two of the five-steps of the sequential evaluation process.

8. On September 25, 2015, the respondent mailed petitioner a Notice of Case Action indicating his SSI-Related Medicaid application dated July 20, 2015 was denied as "you or a member(s) of your household do not meet the disability requirement and no household members are eligible for this program".

9. Petitioner alleged he also suffers from [redacted] and [redacted] Furthermore, he has suffered years from his medical conditions. DDD did not consider the aforementioned Disorders in petitioner's independent disability review.

10. Petitioner currently receives [redacted] and treatment for his medical conditions and requires Medicaid benefits to pay for his medications, various treatments, and physician visits.

11. Petitioner alleged his medical conditions affect his ability to complete his ADLs as he cannot function outside of the home; can only drive if another person is with him; can

complete chores around the home to occupy his time; and requires his mother to attend physician appointments with him.

CONCLUSIONS OF LAW

12. 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.

13. This proceeding is a de novo proceeding pursuant to Florida Administrative Code § 65-2.056.

14. Fla. Admin. Code R. 65A-1.710 sets forth the rules of eligibility for SSI-Related Medicaid Coverage Groups. The MEDS-AD Demonstration Waiver is a coverage group for aged and disabled individuals (or couples), as provided in 42 U.S.C. § 1396a(m). For an individual less than 65 years of age to receive benefits, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905 and states, in part:

> (a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see § 416.960(b)) or any other substantial gainful work that exists in the national economy.

15. Federal Regulation 42 C.F.R. § 435.541 provides that a state Medicaid determination of disability must be in accordance with the requirements for evaluating evidence under the SSI program specified in 20 C.F.R. §§ 416.901 through 416.998.

16. Federal Regulation 20 C.F.R. § 416.920, Evaluation of Disability of Adults,

explain the five-step sequential evaluation process used in determining disability and states, in part:

> (a) General—(1) Purpose of this section. This section explains the five-step sequential evaluation process we use to decide whether you are disabled, as defined in § 416.905.
>
> (2) Applicability of these rules. These rules apply to you if you are age 18 or older and you file an application for Supplemental Security Income disability benefits.
>
> (3) Evidence considered. We will consider all evidence in your case record when we make a determination or decision whether you are disabled.
>
> (4) The five-step sequential evaluation process. The sequential evaluation process is a series of five "steps" that we follow in a set order. If we can find that you are disabled or not disabled at a step, we make our determination or decision and we do not go on to the next step. If we cannot find that you are disabled or not disabled at a step, we go on to the next step. Before we go from step three to step four, we assess your residual functional capacity. (See paragraph (e) of this section.) We use this residual functional capacity assessment at both step four and at step five when we evaluate your claim at these steps. These are the five steps we follow:
>
> (i) At the first step, we consider your work activity, if any. If you are doing substantial gainful activity, we will find that you are not disabled. (*See* paragraph (b) of this section.)
>
> (ii) At the second step, we consider the medical severity of your impairment(s). If you do not have a severe medically determinable physical or mental impairment that meets the duration requirement in § 416.909, or a combination of impairments that is severe and meets the duration requirement, we will find that you are not disabled. (*See* paragraph (c) of this section.)
>
> (iii) At the third step, we also consider the medical severity of your impairment(s). If you have an impairment(s) that meets or equals one of our listings in appendix 1 to subpart P of part 404 of this chapter and meets the duration requirement, we will find that you are disabled. (See paragraph (d) of this section.)

> (iv) At the fourth step, we consider our assessment of your residual functional capacity and your past relevant work. If you can still do your past relevant work, we will find that you are not disabled. (See paragraph (f) of this section and § 416.960(b).)
>
> (v) At the fifth and last step, we consider our assessment of your residual functional capacity and your age, education, and work experience to see if you can make an adjustment to other work. If you can make an adjustment to other work, we will find that you are not disabled. If you cannot make an adjustment to other work, we will find that you are disabled. (See paragraph (g) of this section and § 416.960(c).)

17. In evaluating the first step, it was determined petitioner is not engaging in SGA. The first step is considered met.

18. In evaluating the second step, the respondent must determine if petitioner's mental impairments are considered severe and would last more than a year.

19. Pursuant to the above authority, during the second step of an independent disability review, DDD is to rate petitioner's mental impairments based on the extent they interfere with his functional limitations, which include Activities of Daily Living, social functioning, concentration, persistence or pace, and episodes of decompensation.

20. In order to determine if the impairment is not severe, step two is a threshold inquiry that allows only claims based on the most trivial impairments to be rejected.

> The claimant's burden at step two is mild. An impairment is not severe only if the abnormality is so slight and its effect so minimal that it would clearly not be expected to interfere with the individual's ability to work, irrespective of age, education or work experience. Claimant need show only that her impairment is not so slight and its effect is not so minimal." [1]

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[1] McDaniel v. Bowen 800 F.2d 1026,1031 (1986)

Muckenthaler v. Department of Children and Families, (732 So. 2d 362, 362, (Fla. 1999)), explains that a claimant's burden to meet step two is that the impairments are not so slight and its effects on claimant's ability to work more than minimal.

21. Respondent argued petitioner's medical conditions do not affect his ability to complete his Activities of Daily Living and his medical conditions are a direct result of his [redacted] However, petitioner argued his medical conditions affect his ability to complete his Activities of Daily Living and his ability to function outside of the home. Petitioner's impairments meet the threshold requirements of step two.

22. Furthermore, petitioner's impairment must be expected to last longer than a year to meet the complete requirements of step two. Petitioner has had these impairments for years, thus meeting the durational requirement of step two.

23. The respondent also did not consider petitioner's diagnosis of [redacted] during the independent disability review; therefore, the respondent did not determine if petitioner's [redacted] meets the threshold requirements of step two.

24. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner has met his burden of proof to indicate he meets step two of the sequential evaluation process used in determining disability as his impairments are considered mild and affect his ability to function in and outside of the home; and the impairments shall last more than twelve months. Respondent also did not consider if all of petitioner's medical conditions meet the threshold requirements of step two.

25. The respondent was incorrect to deny petitioner's July 20, 2015 application for SSI-Related Medicaid benefits at step two of the sequential evaluation process. The undersigned remands the case to the respondent for further development. Respondent

is hereby ordered to redetermine petitioner's independent disability review in accordance with the controlling legal authorities. The evaluation is to determine if petitioner meets the criteria of steps three and four, and possibly of step five, of the sequential evaluation process. Respondent is also ordered to determine if all of petitioner's medical conditions meet the threshold requirements of step two. Respondent is to issue a Notice of Decision when the review is completed; the notice should include appeal rights.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is GRANTED and REMANDED to the Department for further development as explained in the conclusions. Once the new review is completed, the respondent is to issue written notice, to include appeal rights.

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 29 day of December, 2015,

in Tallahassee, Florida.

Mary Jane Stafford

Mary Jane Stafford
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 Lake
UNIT: 88585

RESPONDENT.
_____/

APPEAL NO. 15F-08268
15F-08269

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on October 29, 2015 at 9:03 a.m. and reconvened on December 1, 2015 at 1:00 p.m. All parties appeared telephonically from different locations.

APPEARANCES

For the petitioner: [redacted] pro se.

For the respondent: Sharon Ashley, ACCESS Supervisor.

STATEMENT OF ISSUE

Petitioner is appealing the Department's failure to make a determination on his application for Temporary Cash Assistance (TCA) benefits. Petitioner is also appealing the Department's action to deny his SSI-Related Medicaid application. The petitioner carries the burden of proof by the preponderance of evidence on both issues.

PRELIMINARY STATEMENT

By notice dated August 4, 2015, the respondent notified the petitioner that he was denied Medicaid. The respondent did not issue a notice to the petitioner to inform him that he was denied TCA benefits. The respondent explained that because the petitioner doesn't meet the eligibility requirements for the TCA program, their computer system doesn't create those benefits in order for them to generate a denial notice. The petitioner timely requested this administrative hearing to challenge the Department's actions.

The petitioner presented a total of 62 pages of evidence for the undersigned to consider, which was entered into the record as Petitioner's Composite Exhibits 1 and 2. The Department presented a total of 54 pages of evidence for the undersigned to consider, which was entered into the record as Respondent's Exhibits 1 through 9. The record was closed on December 1, 2015.

FINDINGS OF FACT

1. The petitioner's household consists of the petitioner [redacted] his wife [redacted] and their son [redacted]

2. On July 13, 2015 the petitioner submitted an online application for TCA, Food Assistance Program (FAP), and Medicaid benefits. He indicated on this application that he was disabled.

3. The petitioner filed a disability application with the Social Security Administration (SSA) on May 6, 2014. SSA denied the petitioner's disability claim on August 18, 2014. On October 15, 2014, the petitioner requested a reconsideration of his disability denial through SSA. On December 4, 2014, SSA sent a Notice of

Reconsideration to the petitioner notifying him that he was "not eligible for SSI." Said notice states in part: "You asked us to take another look at your claim for Supplemental Security Income (SSI) payments. Someone who did not make the first decision reviewed your case, including any new facts we received, and found that the first decision was correct." The petitioner filed an appeal on February 3, 2015 for the SSA denial and that appeal is currently pending.

4. On July 30, 2015, the respondent forwarded the information obtained from the petitioner to the Division of Disability Determination (DDD), which conducts disability determinations for the Department.

5. DDD did not conduct an independent review; instead, it denied the petitioner's disability claim by adopting the December 4, 2014 SSA denial.

6. The Disability Determination and Transmittal returned from DDD indicates the petitioner's primary diagnosis as [redacted] and his secondary diagnosis as [redacted] The denial code is "N32" which means "impairment of insufficient severity to preclude individual's engaging in all Substantial Gainful Activities (SGA)."

7 The petitioner disagreed with the diagnoses listed on the Disability Determination and Transmittal from DDD.

8. The petitioner describes his disabling conditions as severe [redacted] All these conditions have left him unable to work. The petitioner submitted a new statement from his psychiatrist dated August 17, 2015 confirming these conditions. The petitioner has reported all of these conditions and new information to the SSA.

9. The petitioner alleges his disabling conditions have worsened as he has not been able to seek the necessary medical treatment.

10. The respondent did not make an independent disability decision on the petitioner's SSI-Related Medicaid application; it adopted the SSA decision and denied the petitioner's application as he did not meet the technical requirements of age (at least age 65) or disability.

11. The petitioner argued that SSA incorrectly denied his disability application and that the respondent must make an independent disability determination and approve his Medicaid benefits.

12. The petitioner asserted the respondent did not follow their own rules which state cash assistance must be provided to disabled individuals.

13. The respondent explained that to be eligible for TCA benefits (cash assistance), an applicant must have a minor child in the home or be pregnant and in the ninth month of pregnancy. The petitioner is male and not pregnant. He does not have any children that meet this requirement; therefore, he is not eligible for TCA benefits.

CONCLUSIONS OF LAW

14. 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 Fla. Stat. § 409.285.

15. This proceeding is a de novo proceeding pursuant to Florida Administrative Code R. 65-2.056.

TEMPORARY CASH ASSISTANCE ISSUE

16. Fla. Stat. § 414.095, Determining eligibility for temporary cash assistance states in relevant part:

> (1) ELIGIBILITY.—An applicant must meet eligibility requirements of this section before receiving services or temporary cash assistance…
> (2) (a) To be eligible for services or temporary cash assistance and Medicaid:
> 1. An applicant must be a United States citizen, or a qualified noncitizen, as defined in this section.
> 2. An applicant must be a legal resident of the state.
> 3. Each member of a family must provide to the department the member's social security number of shall provide proof of application for a social security number. An individual who fails to provide a social security number, or proof of application for a social security number, is not eligible to participate in the program.
> 4. **A minor child must reside with a parent or parents…** [emphasis added]
> 5. **Each family must have a minor child and meet the income and resource requirements of the program.** [emphasis added]

17. Fla. Stat. § 414.0252 defines a minor child as "a child under 18 years of age, or under 19 years of age if the child is a full-time student in a secondary school or at the equivalent level of career training, and does not include anyone who is married or divorced."

18. The petitioner's son is [redacted] old and does not meet the definition of a minor child as defined by the above regulation.

19. The Department's Policy Manual, CFOP165-22, passage 3420.0205, Notification of Case Action/Denial (TCA) states "the individual must be notified when an application is denied. The notice will also provide the reason assistance was denied."

20. According to the above cited authorities, to be eligible for TCA benefits, an applicant must have a minor child. The petitioner does not meet this eligibility

requirement; therefore, he is not eligible for TCA benefits. Although the undersigned finds the Department erred in not issuing a denial notice to the petitioner informing him he was not eligible for TCA benefits, there is no remedy for this error since the petitioner does not qualify for TCA benefits.

SSI-RELATED MEDICAID ISSUE

21. Florida Administrative Code, Section 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. For an individual to receive Medicaid who are less than 65 years of age, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. The regulation states, in part:

> (a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work or any other substantial gainful work that exists in the national economy...

22. The Code of Federal Regulations at 42 C.F.R. § 435.541 Determination of Disability states:

> (a) *Determinations made by SSA.* The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.
> (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under § 435.909.
> (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**. [emphasis added]
> (ii) If the SSA determination is changed, the new determination is also binding on the agency.
> (2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.
> (c) *Determinations made by the Medicaid agency*. The agency must make a determination of disability in accordance with the requirements of this section if any of following circumstances exist…
> (4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and-
> (i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or
> (ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.
> (iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—
> (A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or
> (B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

23. The above federal regulation explains that the respondent may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.912 on the same issues presented in the Medicaid application. The respondent is bound by the federal agency's decision unless there is evidence of a new disabling condition not reviewed by SSA. The petitioner confirmed all of his medical conditions have been reported to SSA. SSA denied the petitioner's disability claim on August 18, 2014 because it determined he was not disabled. The petitioner filed a reconsideration request with SSA on October 15, 2014

and informed SSA of his new medical conditions. SSA reviewed the petitioner's disability claim and issued him a Notice of Reconsideration on December 4, 2014 informing him that "someone who did not make the first decision reviewed your case, **including any new facts we received,** and found that the first decision was correct." The petitioner disagreed with the action taken by SSA and has filed an appeal with SSA, which is still pending. The respondent adopted SSA's decision and denied the petitioner's Medicaid application.

24. In careful review of the evidence and controlling legal authorities, the undersigned concludes that the respondent followed rule in adopting the SSA disability denial from December 4, 2014 and denying the petitioner's Medicaid disability application.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are denied and the Department's actions are 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 30 day of December, 2015,

in Tallahassee, Florida.

Brandy Ricklefs

Brandy Ricklefs
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 01 Escambia
UNIT: 88630

RESPONDENT.
_____/

APPEAL NO. 15F-08296

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on November 19, 2015 at 8:33am.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Katherine Stevens, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of September 15, 2015 that did not approve the petitioner for Medicaid for October 2014. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

[redacted] petitioner, and [redacted] petitioner's wife, were present for the hearing on November 19, 2015. Gregory Watson, hearing officer was present as an observer.

The hearing was reconvened on December 11, 2015. [redacted] the Department Representative appeared for the reconvened hearing. The petitioner and his wife gave testimony during the first hearing and did not appear at the reconvened hearing. [redacted] was present to represent petitioner and the reconvened hearing proceeded.

The Department submitted evidence on November 10, 2015 that was entered as Respondent Exhibit 1. The Department submitted additional evidence on November 20, 2015, which was entered as Respondent Exhibit 2.

[redacted] submitted evidence on November 20, 2015 that was entered as Petitioner Exhibit 1.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. MedAssist filed an application for SSI-Related Medicaid for the petitioner on October 7, 2014.

2. [redacted] submitted a Financial Information Release (CF-ES 2613) signed by the petitioner only, as well as an Authorization to Disclose Information (CF-ES 2514), and Appointment of a Designated Representative (CF-AA 2505) on October 7, 2014.

3. The Department completed a passive review of the case with this application. The Department did not complete an interview with the petitioner for this application.

4. The Department issued a Notice of Case Action to both the petitioner and [redacted] on October 9, 2014 (Respondent Exhibit 2, page 5) requesting "both you and [redacted] *[sic]* need to sign and return the financial release by 10/20/2014" The Department explained the notice was sent to both the petitioner and [redacted] The Department only provided a copy of the notice as mailed to [redacted]

5. The petitioner reported he did not receive a copy of the notice cited above. The petitioner has difficulty receiving mail at this home. The mail delivery in his rural community is unreliable. He does receive some of his mail, but mail is often misdirected to neighbors and he does not receive it. Misdirected mail may be returned to the post office for correct delivery or may be thrown away depending on who receives it. The petitioner did not dispute the Department issuing a notice requesting both he and his wife sign and return the form, only that he did not receive the notice.

6. [redacted] reported the notice in question was not received. [redacted] explained they generally do not see a "Notice of Case Action" regarding denials on any case. [redacted] confirmed the address listed on the notice is the correct mailing address. [redacted] reported no problems with receiving mail at the address other than delays in receiving mail. MedAssist was keeping paper files in October 2014 but has switched to electronic files. There is not a log or other record of the documents received on each case. [redacted] provided a copy of all the documents they have

received on the petitioner's file. The representative from [redacted] did not think the mail was misfiled in their office, but could not speak for the actions of others.

7. The Department explained that mail is scanned into the Department's electronic records upon receipt including returned mail. The Department's electronic record of the petitioner's case file does not show any mail as returned from either the petitioner or [redacted] between October 2014 and December 2014. The Department advised that when mail is returned, the procedure is to resend a notice if a new or updated address is provided. The Department will presume a letter to be received by the addressee if there is no mail returned on the Departmental logs.

8. Due to the discrepancy of whether or not the Notice of Case Action was received by the petitioner, the undersigned must make a finding. The Department mailed these notices separately from its headquarters' office following proper business practice. The notices to the petitioner were not returned to the Department. The reported mail delivery problems in the petitioner's community support his claim of non-receipt. The petitioner's prompt action upon receipt of the notice in the July evidence demonstrates his responsiveness to information requests. The undersigned finds the petitioner's argument persuasive and that he did not receive the notice requesting additional information.

9. Due to the discrepancy of whether or not the Notice of Case Action was received by [redacted] the undersigned must make a finding. The Department mailed these notices separately from its headquarters' office following proper business practice. The notices for [redacted] were not returned to the Department. [redacted] keeps no log of documents in a customer's file or the date received. [redacted] did not

report any issue with mail not being delivered to their office at all, only that mail was not always delivered timely. The undersigned relies on the presumption that correspondence properly mailed and not returned with no clear rebuttal evidence received (Brown v. Giffen Industries, Inc., Fla. 1973, 281 So.2d 897, 1973 Fla.SCt 997) to make the finding that [redacted] did receive the Notice of Case Action at issue.

10. The Department issued a Notice of Case Action on November 7, 2014 to the petitioner's wife. The notice denied the petitioner's application dated October 7, 2014 for not returning the financial consent for all required individuals.

11. [redacted] did not contact the Department following submission of the application to ensure all documentation was properly filed and there was nothing additional required.

12. The Department does not make additional attempts to resolve cases with the hospital representatives. If the petitioner or the provider does not respond to the pending notice, no follow up is completed.

CONCLUSIONS OF LAW

13. 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.

14. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code § 65-2.056.

15. Fla. Admin. Code § 65A-1.205 "Eligibility Determination Process" states in relevant part:

(c) If the eligibility specialist determines during the interview or at any time during the application process that the applicant must provide additional information or verification, or that a member of the assistance group must comply with Child Support Enforcement or register for employment services, the eligibility specialist must give the applicant written notice to provide the requested information or to comply, allowing ten calendar days from request or the interview, whichever is later. For all programs, verifications are due ten calendar days from the date of written request or the interview, or 60 days from the date of application, whichever is later. In cases where the applicant must provide medical information, the return due date is 30 calendar days following the written request or the interview, or 60 days from the date of application, whichever is later. If the due date falls on a holiday or weekend, the deadline is the next working day. If the applicant does not provide required verifications or information by the deadline date the application will be denied, unless the applicant requests an extension or there are extenuating circumstances justifying an additional extension.

16. The petitioner's representative, [redacted] was properly notified by the Department of the need for the petitioner's wife to sign the Financial Information Release. The undersigned concludes the Department, following the above controlling authority, denied the petitioner's application for Medicaid properly when the requested information was not received.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied.

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 22 day of December, 2015,

in Tallahassee, Florida.

Melissa Roedel

Melissa Roedel
Hearing Officer
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Office of Economic Self Sufficiency

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

FILED
Dec 04, 2015
Office of Appeal Hearings
Dept. of Children and Families

[redacted]

APPEAL NO. 15F-08300

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 19 St. Lucie
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 19, 2015 at 11:02 a.m.

APPEARANCES

For the Petitioner: [redacted]
Pro Se

For the Respondent: Lisa Sanchez
Senior Human Services Program Specialist

ISSUE

Whether respondent's denial of petitioner's request for a mover; storage; and hotel accommodations through the Statewide Long Term Managed Care Program (LTC Program) was proper. The burden of proof was assigned to the petitioner.

PRELIMINARY STATEMENT

Present for the petitioner was Latonya Luster, Property Manager. Petitioner entered no exhibits into evidence.

Ms. Sanchez appeared as both a representative and witness for the respondent. Present from United Health Care (UHC) were: Dr. Sloan Karver, M.D., Long Term Care Medical Director and Christian Laos, Senior Compliance Analyst. Respondent's exhibits "1" and "2" were entered into evidence.

The record was held open through November 30, 2015 for respondent to provide contract definitions of LTC Program services. Information was timely received and entered as respondent's exhibit "3".

Administrative notice was taken of Fla. Stat. §409.978.

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. Petitioner is 65 years of age and resides by herself. She is diagnosed with [redacted] She has experienced two strokes and uses a wheelchair.

2. Respondent administers Florida's Medicaid Program and contracts with Health Maintenance Organizations (HMOs) to provide comprehensive, cost-effective medical services to Medicaid recipients in the LTC Program.

3. Required LTC services are enumerated by Fla. Stat. § 409.98. The services are: nursing facility care; assisted living; hospice; adult day care; medical equipment and supplies; personal care; home accessibility adaptation; behavior management; home-delivered meals; case management; certain therapies; skilled nursing; medication administration; medication management; nutritional assessments; caregiver training; respite care; transportation; personal emergency response systems.

4. LTC services are defined by contract.

5. A LTC provider may offer expanded services beyond those identified by Statute.

6. Petitioner's LTC services are provided by United Health Care. Petitioner is approved to receive personal care; homemaker; home delivered meals; and a personal emergency response system.

7. Petitioner's apartment is scheduled to be painted and new flooring installed. The time frame to complete the work is approximately two days. The apartment owner will not move petitioner's furniture. Petitioner requested UHC cover the cost of moving her furniture; furniture storage; and hotel expenses while she vacates the apartment.

8. On August 18, 2015 UHC issued a Notice of Action which denied movers, storage, and hotel accommodations. The notice stated, in part: "The facts that we used to make our decision are: You asked for movers and storage of furniture and hotel for 24 hours. The long term care health plan does not cover this. It is not a covered benefit. The request is not approved."

9. UHC completed a second review of the requests on September 18, 2015 and upheld the original decision.

10. The notices of August 18, 2015 and September 18, 2015 both informed petitioner of fair hearing rights.

11. On October 2, 2015 petitioner contacted the Office of Appeal Hearings and timely requested a fair hearing.

12. Petitioner states she has no one to assist her with moving; storage; and living accommodations while the apartment is renovated.

13. Storage; moving; and hotel accommodations are not expanded LTC Program services provided by UHC. As such, respondent argues a medical necessity review was not warranted.

CONCLUSIONS OF LAW

14. By agreement between the Agency for Health Care Administration (AHCA) 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.

15. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

16. The standard of proof in an administrative hearing is by 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.).

17. LTC Program service definitions are part of respondent's contract with UHC. The definitions are found at: http://ahca.myflorida.com/Medicaid/statewide_mcplans.shtml.

18. The above list contains 26 service definitions. No definition includes moving and storage of furniture. Additionally, no definition includes hotel accommodations while work is done in the residence of a LTC Program enrollee.

19. It is noted that the definition for Homemaker services states, in part: "Chore services, including heavy chore services and pest control may be included in this service." Regardless, if a homemaker could assist with moving functions, no service definitions includes payment for either furniture storage or hotel accommodations.

20. When a LTC enrollee requests an allowable service, a medical necessity review is completed. In this instant appeal, the services requested by the petitioner are neither

required by Florida Statute or represent an expanded services provided by UHC. As such, a medical necessity review was not warranted.

21. Petitioner has presented no authority which justifies approval of the requested services under Medicaid. The undersigned lacks jurisdiction to mandate services not required by Statute.

22. After considering all evidence and testimony, petitioner has not met the required evidentiary burden in this matter. As such, respondent's action was proper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, petitioner's appeal is 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 04 day of December, 2015,

in Tallahassee, Florida.

Frank Houston

Frank Houston
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Judy Jacobs, Area 7, AHCA Field Office

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

[redacted]

APPEAL NO. 15F-08302

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 05 Citrus
UNIT: 88002

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 8:15 a.m. on October 26, 2015.

APPEARANCES

For the Petitioner: [redacted] pro se

For the Respondent: Joseph Corredor, ACCESS Supervisor

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny petitioner Medicaid is proper. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

By notice dated September 30, 2015, respondent notified petitioner that her Medicaid application, dated August 10, 2015, was denied. Petitioner timely requested a hearing to challenge the denial.

Petitioner did not submit exhibits. Respondent submitted six exhibits, entered as Respondent Exhibits "1" through "6". The record was held open until October 28, 2015 for petitioner to submit an exhibit. The exhibit was received timely and entered as Petitioner Exhibit "1". The record was closed on October 28, 2015.

FINDINGS OF FACT

1. Petitioner, age [redacted] submitted a SSI-Related Medicaid application on August 10, 2015. The application indicates petitioner is disabled.

2. To be eligible for SSI-Related Medicaid, petitioner must be age 65 or older, blind or considered disabled.

3. In 2002 petitioner was involved in an automobile accident. As a result, petitioner alleges she suffers from a [redacted] injury. In 2013 petitioner fell; causing her automobile injuries to worsen. Petitioner also suffers from [redacted] and [redacted]

4. Petitioner applied for disability through the Social Security Administration (SSA) in 2014 and was denied in October 2014. Petitioner, through her legal counsel, appealed the SSA denial the first part of 2015; petitioner is unsure of the date.

5. The Department of Health Division of Disability (DDD) is responsible for determining Medicaid disability eligibility on behalf of the Department.

6. On September 15, 2015, the Department notified DDD of petitioner disability request.

7. On September 28, 2015, DDD notified the Department that they were denying petitioner Medicaid; because they were adopting the SSA October 2014 denial decision.

8. On September 30, 2015, the respondent mailed the petitioner a Notice of Case Action, notifying her Medicaid application, dated August 10, 2015, was denied; due to not meeting the disability requirements.

9. Petitioner alleges that her medical condition has worsened since the SSA denial. And she has the following new medical conditions: [redacted]

10. Petitioner's legal counsel is aware of her worsened and new medical condition. Petitioner's attorney advised her not to submit her worsened and new medical condition documents to the SSA, because he will present the documents at the appeal hearing.

CONCLUSIONS OF LAW

11. 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 Fla. Stat. § 409.285.

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

13. The Code of Federal Regulations at 42 C.F.R. § 435.541, Determination of Disability in part states:

> (a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...
> (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under 435.909.
> (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.
(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except In cases specified in paragraph (c) (4) of this section.
(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist…
(4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA. and-
(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or
(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.
(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act. and-
(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or
(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

14. In accordance with the above authority, respondent denied petitioner's August 10, 2015 Medicaid application; due to adopting the SSA October 2014 denial decision.

15. The above authority states the Department must make a determination of disability if the individual "alleges a disabling condition different from, or in addition to, that considered by the SSA in making its determination".

16. Petitioner alleges that her medical condition has worsened and she has new medical conditions since the SSA denial. However, petitioner's attorney is aware of her worsened and new medical conditions. Petitioner's attorney advised petitioner not to

submit her worsened and new medical condition documents to the SSA; because he will present the documents at the appeal hearing.

17. In careful review of the cited authority and evidence, the undersigned concludes the respondent followed Rule in denying petitioner Medicaid due to adopting the SSA disability denial.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the respondent's action is 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 29 day of December, 2015, in Tallahassee, Florida.

Priscilla Peterson

Priscilla Peterson
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

APPEAL NO. 15F-08320
15F-10224

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 20 Charlotte
UNIT: 88287

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on November 16, 2015 at 1:58 p.m. in Fort Myers, Florida.

APPEARANCES

For Petitioner: [redacted]

For Respondent: Signe Jacobson, Economic Self-sufficiency Specialist II

STATEMENT OF ISSUE

The petitioner is appealing the Department's action (1) to deny her full Medicaid benefits and instead enroll her into the Medically Needy Share of Cost Program with an effective begin date of September 2015, (2) to deny the Medicare Savings Program (MSP) benefits, and (3) to begin Medically Needy enrollment effective September 2015, as the petitioner would like the Medicaid/Medically Needy and MSP benefits to begin

April 2015. The petitioner disputes the share of cost determination, as the Department is counting her husband's income in the budget. The petitioner is asserting the affirmative and bears the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

[redacted] the petitioner's daughter, appeared as a witness for the petitioner.

The petitioner submitted thirteen (13) exhibits that were accepted into evidence and marked as Petitioner's Exhibits "1" through "13" respectively.

The respondent submitted twenty-six (26) exhibits that were accepted into evidence and marked as Respondent's Exhibits "1" through "26" respectively.

The record was held open until the close of business on November 23, 2015 for the respondent to supplement the record. The petitioner declined an opportunity to review any additional evidence provided by the respondent prior to closing the record. The respondent timely provided the additional documentation, which were accepted into evidence and marked as Respondent's Exhibits "27". The record closed on November 23, 2015.

FINDINGS OF FACT

1. On September 8, 2015, the petitioner submitted a paper application to add Medicaid benefits to an existing Food Assistance case.

2. Previous to the September application, the petitioner submitted a paper application on June 17, 2015. The Medicaid benefits and the MSP benefits were denied per a Notice of Case Action sent on July 20, 2015.

3. The two-person household consist of the petitioner (age 67) and her husband, [redacted] (age 66). The petitioner receives Social Security Administration (SSA) gross income of $898.90 and her husband receives SSA gross income of $1,323.90. The income is received monthly. The petitioner and her husband are both Medicare recipients of Parts A and B. The Part B premium is $104.90 for each recipient. The Department presented a Data Exchange printout from SSA confirming the income and the Medicare benefits.

4. For the Share of Cost determination, the respondent determined the total countable income of $2,201 (Total household's gross SSA income of $2,221 minus the $20 unearned income disregard) and subtracted the Medically Needy Income Limit of $241 to equal the Share of Cost of $1,960. Additionally, the respondent subtracted the total Medicare premium of $209.80 for a remaining Share of Cost of $1,750.

5. The MSP is a Medicaid Buy-in Program in which the State of Florida pays the Medicare premiums. There are three types of MSPs with different income limits: Qualified Medicare Beneficiaries (QMB), income limit of 100% of the Federal Poverty Limit (FPL); Special Low Income Medicare Beneficiary (SLMB), income limit of 120% of the FPL; and Qualifying Individual 1 (QI1), income limit of 135% of the FPL.

6. To be eligible for the MSP, a couple's combined income (minus any applicable income disregards) cannot exceed the following income standards for a couple: QMB - $1,328, SLMB - $1,593, and QI-1 $1,793.

7. On September 22, 2015, the Department mailed a Notice of Case Action to the petitioner. The petitioner and her husband were enrolled in the Medically Needy

Program with a $1,750 Share of Cost effective September 2015 and ongoing. The QI1 Program was denied with the reason, "(y)our household income is too high to qualify for this program."

8. The petitioner timely requested a hearing on September 28, 2015.

9. The petitioner alleges that she was receiving Medicaid benefits and MSP benefits in California prior to moving to Florida this year. The petitioner states that she requires medical services and is currently neglecting treatment as she is unable to pay the co-pays required.

CONCLUSIONS OF LAW

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

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

The Medicaid/Medically Needy issue will be addressed first:

12. The Fla. Admin. Code R. 65A-1.701 sets forth:

> (20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services.

13. There is no evidence to reflect that the petitioner nor the petitioner's husband is enrolled in Medicaid covered institutional care services, hospice services, or home and community based services. According to the above controlling authority, the petitioner is ineligible to receive full Medicaid as she is a Medicare recipient and does not fit one of the exclusions of a Medicare recipient. The undersigned concludes that the Department was correct in its action to deny full Medicaid.

14. Fla. Admin. Code R. 65.A-1710, SSI-Related Medicaid Coverage Groups, states in part, the Medically Needy Program is "(a) Medicaid coverage group, as allowed by 42 U.S.C.§§ 1396a and 1396d, for aged, blind or disabled individuals (or couples) … who do not qualify for categorical assistance."

15. The Department's Program Policy Manual, CFOP 165-22 (Policy Manual), at section 2240.0604.03 Income of Spouse of Eligible Individual (MSSI, SFP) states:

> The policy in this section is applicable only to MEDS-AD, Medically Needy, Protected Medicaid, Working Disabled, QMB, SLMB, QI-1, OSS, and HCDA.
> Each individual who is at least age 65, blind, or disabled, and whose countable income and assets do not exceed certain prescribed limits will be an eligible individual. If such an eligible individual is living in the same household with a spouse, who is neither aged, blind, nor disabled, the income and assets of the spouse (whether or not available to the individual) are considered in determining the eligible individual's income and assets, except in circumstances where this is deemed inequitable. An aged, blind, or disabled individual who has an eligible spouse may only qualify as an eligible individual if the combined countable income and assets of the couple do not exceed the income and asset limits specified for such couples.

16. Pursuant to the above authority, petitioner's SSA income, and her husband's SSA income must be included in the determination of their monthly SOC amounts and the MSPs.

17. Federal regulation at 20 C.F.R. § 416.1124 (c) (12) establishes a $20 disregard for "the first $20 of any unearned income in a month". Respondent deducted $20 from petitioner's $2,221 to arrive at $2,201 countable income.

18. Fla. Admin. Code R. 65A-1.716(2) indicates the Medically Needy Income Level (MNIL) for a family size of two as $241. Respondent deducted $241 from the petitioner's countable income of $2,201 for a Share of Cost of $1,960.

19. The Policy Manual at passage 2640.0506.03, Recognized Health Insurance Costs, states in part, "(h)ealth insurance is primarily established for payment of medical costs. … The following expenses related to health insurance are considered allowable medical expenses: 1. Medical premiums…" The respondent deducted the total Medicare premiums of $209.80 for a Remaining Share of Cost of $1,750.

20. The petitioner and the petitioner's husband were correctly enrolled in the Medically Needy Program with a monthly Share of Cost effective September 2015.

The denial of the Medicare Savings Program will now be addressed:

21. Fla. Admin. Code R. 65A-1.702 Special Provisions explains the MSPs and in part states:

> (12) Limits of Coverage.
> (a) Qualified Medicare Beneficiary (QMB). Under QMB coverage, individuals are entitled only to Medicare cost-sharing benefits, including payment of Medicare premiums.
> (b) Special Low-Income Medicare Beneficiary (SLMB). Under SLMB coverage, individuals are entitled only to payment of the Part B Medicare premium. If eligible, AHCA shall pay the premium for up to three months retroactive to the month of application…
> (d) Part B Medicare Only Beneficiary (QI1). Under QI1 coverage, individuals are only entitled to payment of their Medicare Part B premium. (This is coverage for individuals who would be eligible for QMB or SLMB coverage except their income exceeds limits for those programs.)…

22. Fla. Admin. Code R. 65A-1.713 SSI-Related Medicaid Income Eligibility Criteria in part states:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows…
> (b) For QMB, income must be less than or equal to the federal poverty level…
> (g) For SLMB, income must be greater than 100 percent of the federal poverty level but equal to or less than 120 percent of the federal poverty level…
> (j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. QI1 is eligible only for payment of the Part B Medicare premium through Medicaid…

23. The Policy Manual at Appendix A-9, identifies MSP income standards for a couple as follows:

July 2015		
QMB,	SLMB	QI1
$1,328	$1,593	$1,793

24. Federal regulation at 20 C.F.R. § 416.1124 (c) (12) establishes a $20 disregard for "the first $20 of any unearned income in a month". The $20 disregard is deducted from petitioner's $2,221 to arrive at $2,201 countable income. The total countable income exceeds all of the MSP income standards.

25. The petitioner and the petitioner's husband were correctly denied the MSPs as their total countable income exceeded the established income standards.

The effective begin dates for the benefits will now be addressed:

26. The Policy Manual at passage 0640.0509, Retroactive Medicaid (MSSI), states in part:

> This policy does not apply to QMB.
> 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.
> When the request for retroactive Medicaid for an unpaid bill(s) is for only one member of a SFU, determine Medicaid eligibility for the entire AG. Determine eligibility for each month there were unpaid medical services provided; do not consider the month the bill was issued. Accept the individual's statement that a member of the SFU has an unpaid bill.

27. In the petitioner's case, the findings show that she applied for benefits on June 17, 2015 and September 8, 2015. Pursuant to the authority above, the petitioner may request the Department to determine eligibility for retroactive Medicaid at any time for the three months preceding the application. For the September 2015 application, the months of June 2015, July 2015 and August 2015 may be considered for a determination of eligibility. For the June 2015 application, the months of May 2015 and April 2015 may also be considered.

28. In careful review of the cited authorities, evidence and testimonies, the undersigned concludes that the respondent (1) correctly denied Medicaid and instead enrolled the petitioner and the petitioner's husband in the Medically Needy Program with a monthly share of cost amount and (2) correctly denied the MSP benefits. In regards to the eligibility for Medicaid/Medically Needy and MSP benefits effective from April 2015,

the appeal is remanded to the respondent to complete the retroactive Medicaid eligibility determination from the months between and including April 2015 and August 2015. This determination of eligibility will include Medically Needy, SLMB and the QI1 programs. The QMB program does allow for a retroactive Medicaid benefits.

29. This Order does NOT guarantee that the petitioner will be eligible for Medicaid benefits or MSP benefits. Once the determination is completed, the respondent is to mail /or denial of Medicaid, Medically Needy, or MSP benefits for the months of April 2015, May 2015, June 2015, July 2015 and August 2015.

DECISION

The appeal relating to the eligibility for full Medicaid benefits and the subsequent enrollment into the Medically Needy Program with a monthly share of cost of $1,750 and the denial of MSP benefits, is denied.

The appeal for Medicaid/Medically Needy benefits and the MSP benefits beginning in April 2015, is granted and remanded in accordance with the Conclusion of Law. The respondent will complete the retroactive Medicaid eligibility determination from the months between and including April 2015 and August 2015. This determination of eligibility will include Medically Needy, SLMB and the QI1 programs. As the QMB program does allow for a retroactive Medicaid benefits, no determination of QMB is necessary. Once the determination is completed, the respondent is to mail the petitioner a Notice of Case Action, with appeal rights, identifying the approval/enrollment and/or denial of Medicaid, Medically Needy, or MSP benefits for the months of April 2015, May 2015, June 2015, July 2015 and August 2015.

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 18 day of December, 2015,

in Tallahassee, Florida.

Raymond Muraida

Raymond Muraida
Hearing Officer
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Office of Economic Self Sufficiency

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

[redacted]

PETITIONER,

APPEAL NO. 15F-08325

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 07 Volusia
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 21, 2015 at 1:10 p.m.

APPEARANCES

For the Petitioner: [redacted] mother

For the Respondents: Sheila Broderick, registered nurse specialist

ISSUE

Whether it is medically necessary for the petitioner to receive 12 hours of personal care services (PCS) daily. The burden of proof was assigned to the petitioner because this is an initial service request.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (AHCA or Agency or respondent) administers the Florida Medicaid program. The respondent contracts eQ Health

Solutions (eQ) to perform prior service authorizations for Medicaid home health services. eQ took the action currently under challenge.

By notice dated July 31, 2015, eQ informed the petitioner that his request for 16 hours of PCS was denied in-part. eQ approved 6 hours of PCS daily. The petitioner requested reconsideration. By notice dated August 10, 2015, eQ informed the petitioner that the initial decision was upheld.

The petitioner timely requested a hearing to challenge the decision. The petitioner's PCS certification period was set to expire in October 2015. However, services have been continued pending the outcome of the hearing.

Nilda Fres, waiver support coordinator with the Agency for Persons with Disabilities (APD), was present as a witness for the petitioner. The petitioner submitted documentary evidence which was admitted into the record at Petitioner's Composite Exhibit 1.

Dr. Rakesh Mittal, physician consultant with eQ, was present as a witness for the respondent. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. The petitioner (age 15) is a Florida Medicaid recipient.
2. The petitioner's suffers from [redacted] and [redacted] The petitioner is 55 inches tall and

weighs 112 pounds. The petitioner non-verbal and wheelchair bound. He is incontinent of bowel and bladder. The petitioner is primarily fed by g-tube. He requires total assistance with the activities of daily living (ADLs). The petitioner attends school weekdays from 8:30 a.m. to 2:00 p.m. A school nurse cares for the petitioner while he is at school.

3. The petitioner's father was his primary caretaker. The father committed suicide recently. The mother is now the petitioner's primary caretaker. The petitioner and the mother live alone in the family home. The mother works at Walgreens as a team leader. She works one week on, one week off, 12 hour shifts, 7:30 p.m. to 7:30 a.m. The mother suffers from arthritis, fibromyalgia, and ruptured disk in her back. She is unable to lift the petitioner due to her back issues; however, she is able to assist with all other ADLs.

4. The petitioner's treating physician submitted a Medicaid prior service authorization request for 16 hours of PCS daily. The petitioner's mother is actually seeking 12 hours of PCS daily to care for the petitioner while she is working. She asserted that the physician's office erred when completing the request form.

5. The petitioner has multiple seizures daily (3 to 5 daily, lasting approximately 4 minutes each). The petitioner is at risk of choking during seizures, he requires supervision to ensure that his airway is not blocked. The petitioner loses control of his bowel and bladder during the seizure activity. He must be cleaned and redressed after each seizure. In addition, he requires supervision and monitoring.

6. APD provides support services to individuals with developmental disabilities through the Home and Community Based Developmental Disabilities Waiver (DD Waiver). The petitioner applied for emergency support services with APD after the death of his father. APD approved the petitioner for crisis services so the mother could continue to work. APD currently provides 12 hours of PCS on the days that the mother works. Nilda Fres, the petitioner's APD waiver support coordinator, testified that the current level of APD funded PCS is temporary, pending the outcome of the hearing. APD has not determined the level of ongoing support it will be able to provide to the petitioner.

7. All home health services must be medically necessary as determined through a prior service authorization process. AHCA contracts with eQ to perform prior service authorizations for home health services.

8. Dr. Rakesh Mittal, a physician consultant with eQ, appeared as a witness during the hearing. Dr. Mittal explained that PCS provides assistance with ADLs (bathing, dressing, grooming, feeding, toileting, etc.). The level of service provided by Medicaid is based on numerous factors, including recipient's medical condition, support needs and natural supports.

9. eQ determined that the petitioner's ADL needs can be met with six hours of PCA daily. A provider can come into the home three times daily in two hour increments to take care of the petitioner's ADLs. eQ concluded that additional PCS hours were in excess of the petitioner's needs. Medicaid rule prohibits the provision of goods and services in excess of the needs of the recipient.

10. Medicaid rule expands the definition of medical necessity for children under age 21 to include the provision all goods and services necessary to treat the child's medical condition. Dr. Mittal testified that this broader definition of medical necessity was taken into consideration in the instant case. Dr. Mittal maintained that the petitioner's need for assistance with ADLs can be met with six hours of PCS daily.

CONCLUSIONS OF LAW

11. By agreement between AHCA 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.

12. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

13. At issue is a request for additional Medicaid services. In accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof was assigned to the petitioner.

14. The standard of proof in an administrative hearing is by a preponderance of the evidence (See Fla. Admin. Code R. 65-2.060(1)). The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

15. The Florida Medicaid Program is authorized by Fla. Stat. Chapter 409 and Fla. Admin. Code Chapter 59G. The Medicaid Program is administered by the respondent. Section 409.905, Fla. Stat. addresses mandatory Medicaid services under the State Medicaid Plan:

> Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the

> Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law…
>
> (4) HOME HEALTH CARE SERVICES.--The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home…
> (b) The agency shall implement a comprehensive utilization management program that requires prior authorization of all private duty nursing services, an individualized treatment plan that includes information about medication and treatment orders, treatment goals, methods of care to be used, and plans for care coordination by nurses and other health professionals. The utilization management program shall also include a process for periodically reviewing the ongoing use of private duty nursing services. The assessment of need shall be based on a child's condition, family support and care supplements, a family's ability to provide care, and a family's and child's schedule regarding work, school, sleep, and care for other family dependents; and a determination of the medical necessity for private duty nursing instead of other more cost-effective in-home services.
> (c) The agency may not pay for home health services unless the services are medically necessary …

16. The definition of medically necessary is found in the Fla. Admin Code. R 59G-1.010 which states:

> (166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and

> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider...
> . . .
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

17. The petitioner is under 21, a broader definition of medically necessary applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) requirements. Section 409.905, Fla. Stat., *Mandatory Medicaid services*, defines Medicaid services for children to include:

> (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.—The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, ...

18. The Medicaid Home Health Services Coverage and Limitations Handbook (The Medicaid Handbook) is incorporated by reference in Rule Division 59G, F.A.C.

19. The Medicaid Handbook addresses PCS services on page 1-2:

> Personal care services provide medically necessary assistance with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL) that enable the recipients to accomplish tasks that they would normally be able to do for themselves if they did not have a medical condition or disability. Medicaid reimburses for these services provided to eligible recipients under the age of 21 years.
> ADLs include:
> • Eating (oral feedings and fluid intake)
> • Bathing
> • Dressing
> • Toileting
> • Transferring

• Maintaining continence (examples include taking care of a catheter or colostomy bag or changing a disposable incontinence product when the recipient is unable to control his bowel or bladder functions)

IADLs (when necessary for the recipient to function independently) include:
• Personal hygiene
• Light housework
• Laundry
• Meal preparation
• Transportation
• Grocery shopping
• Using the telephone to take care of essential tasks (examples include paying bills and setting up medical appointments)
• Medication management
• Money management

Skilled interventions that may be performed only by a licensed health professional are not considered personal care services.

20. The discussion of PCS services is further addressed on pages 2-24 and 2-25:

Medicaid reimburses personal care services for recipients under the age of 21 who meet all of the following criteria:

• Have a medical condition or disability that substantially limits their ability to perform their ADLs or IADLs
• Have a physician's order for personal care services
• Require more individual and continuous care than can be provided through a home health aide visit
• Do not have a parent or legal guardian able to provide ADL or IADL care.

Personal care services must be all of the following:
• Documented as medically necessary
• Prescribed by the attending physician if provided through a home health agency
• Supervised by a registered nurse if provided through a home health agency
• Supervised by the parent or legal guardian if provided by a non-home health agency

> • Supervised by the recipient if the services are provided by a non-home health agency and the recipient is a legal adult between the ages of 18 and 21 with no legal guardian
> • Provided by a home health aide or independent personal care provider
> • Consistent with the physician approved plan of care
> • Authorized prior to providing services
>
> Personal care services can be authorized to supplement care provided by parents and legal guardians. Parents and legal guardians must participate in providing care to the fullest extent possible. Where needed, the home health service provider must offer training to enable parents and legal guardians to provide care they can safely render without jeopardizing the health or safety of the recipient. The home health services provider must document the methods used to train a parent or legal guardian in the medical record.

21. The cited authorities explain that home health services must be medically necessary. The level of service provided by Medicaid is based on numerous factors, including recipient's medical condition, support needs and natural supports. The authorities also explain that Medicaid services cannot be in excess of a recipient's needs.

22. The petitioner requested 12 hours daily of PCS to assist with ADLS and to monitor for seizure activity. The respondent approved 6 hours daily. The respondent determined that this was sufficient time to address the petitioner's ADLs. Monitoring and supervision are not Medicaid covered services.

23. After careful review, the undersigned concludes that the respondent's decision in this matter was correct. Medicaid rules state the PCS provides assistance with ADLs and IADLs. The petitioner did not prove by a preponderance of the evidence that it is medically necessary for him to receive 12 hours of PCS daily. The evidence proves that the petitioner needs someone to be in the home to provide supervision and

monitoring. Medicaid rules do not include a provision for these services unrelated to the provision of ADLs and IADLs.

DECISION

The appeal is 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 29 day of December, 2015, in Tallahassee, Florida.

Leslie Green

Leslie Green
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished To: [redacted] Petitioner
Debbie Stokes, Area 4, AHCA Field Office Manager

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

[redacted]

APPEAL NO. 15F-08326

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 19 Martin
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing in the above referenced matter was convened in West Palm Beach, Florida on December 7, 2015 at 9:20 a.m.

APPEARANCES

For the Petitioner: [redacted]
Petitioner's sister

For the Respondent: Linda Latson
Registered Nurse Specialist

ISSUE

Whether respondent's partial approval of outpatient Speech Therapy services was proper[1] and whether a $1500.00 cap on outpatient services should be lifted. The burden of proof was assigned to the petitioner.

[1] Petitioner requested the service twice per week for 8 weeks. Respondent approved the service twice per week for 6 weeks.

PRELIMINARY STATEMENT

Petitioner was present and represented by his sister. Also present was petitioner's mother, [redacted] Petitioner's exhibit "1" was accepted into evidence.

Ms. Latson appeared as both a witness and representative for the respondent. Present from Sunshine Health by telephone were Tiffany Smith, Registered Nurse/Grievance and Appeals Coordinator II and Dr. Ernest Burtha, Medical Director. Respondent's exhibit "1" was accepted into evidence.

Administrative notice was taken of the Florida Medicaid Therapy Services Coverage and Limitations Handbook.

The record was held open through December 14, 2015 for respondent to provide an authority capping outpatient services for individuals over the age of 21 at $1500.00 per year. Information was timely received and entered as respondent's exhibits "2" and "3".

The record was held open through December 21, 2015 to allow petitioner to submit a written response to respondent's post hearing submission. A response was not received.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

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

2. In 2013 petitioner experienced a [redacted] Following the injury, a coma was induced. For approximately six weeks, petitioner was on a respirator. It is believed he also suffered [redacted]

3. After hospitalization petitioner was transferred to a skilled nursing facility for approximately six months. In May 2014 he moved to his sister's residence. The sister is the primary caregiver.

4. Petitioner no longer requires a respirator.

5. Petitioner is primarily wheelchair bound.

6. Petitioner's medical services are provided through respondent's Statewide Medicaid Managed Care Program. Since July 1, 2014 these services have been provided by Sunshine Health.

7. Sunshine Health has also approved outpatient physical and occupational therapy.

8. Respondent's contract with Sunshine Health caps the combined amount of outpatient therapy each year to $1500.00. The year is based on the date of enrollment with the Plan.

9. Mammograms and obstetric ultrasounds are the only outpatient services which do not count toward the $1500.00 yearly cap.

10. Petitioner is also enrolled in respondent's Long Term Managed Care Program (LTMC Program). Those services are provided by United Healthcare. Petitioner was approved for in-home speech therapy through the Long Term Care Program.

11. On September 2, 2015 petitioner requested outpatient speech therapy services from Sunshine Health. The requested frequency was twice per week for eight weeks.

12. Outpatient therapies are provided at a location other than the recipient's place of residence.

13. The requested outpatient speech therapy does not pertain to the provision for an augmentative and alternative communication system.

14. On September 10, 2015 Sunshine Health issued a Notice of Action which partially denied the request. The notice stated, in part: "Request for Speech Therapy (a treatment to help a person talk better) for 2 times a week for 8 weeks is PARTIALLY DENIED. Approve for 2 times a week for 6 weeks. To approve more visits your therapist must send your reevaluation to the health plan." The Notice of Action also stated the requested frequency was not medically necessary.

15. On September 30, 2015 the Office of Appeal Hearings received from petitioner's representative a written request for a Fair Hearing. The correspondence stated, in part:

> I was able to get Outpatient PT, OT, and ST approved through Sunshine for 36 visits of PT, 36 visits of OT and 16 visits of ST (which was partially denied).
>
> The time allotted for these visits is unreasonable: PT & OT expire on 9/30/15. ST not eligible until 10/1/15, due to expire 11/15 ...
>
> Sunshine has placed a $1500.00 CAP on outpatient services, which my brother used in 2 weeks!
>
> Why approve these visits, and then end them, because he reached the cap.

16. Petitioner argues with the approval of outpatient physical and occupational therapy, the $1500.00 cap will be met. As such, not enough funding exists for speech therapy. Petitioner's representative requests the $1500.00 cap be lifted to address needed outpatient speech therapy.

17. Petitioner asserts outpatient speech therapy would, in part, address swallowing issues.

CONCLUSIONS OF LAW

18. By agreement between the Agency for Health Care Administration (AHCA) 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.

19. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

20. The standard of proof in an administrative hearing is by 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.).

21. The Florida Medicaid Therapy Services Coverage and Limitations Handbook (Therapy Handbook) is incorporated by reference in the Medicaid Services Rules by Fla. Admin. Code R. 59G-4.320. The Therapy Handbook states, in relevant part:

> Page 1-4:
>
> Speech-language pathology services involve the evaluation and treatment of speech-language disorders.
> Services include the evaluation and treatment of disorders of verbal and written language, articulation, voice, fluency, phonology, mastication, deglutition, cognition, communication (including the pragmatics of verbal communication), auditory processing, visual processing, memory, comprehension and interactive communication as well as the use of instrumentation, techniques, and strategies to remediate, maintain communication functioning, acquire a skill set, restore a skill set, and enhance the recipient's communication needs, when appropriate. Services also include the evaluation and treatment of oral pharyngeal and laryngeal sensorimotor competencies.
>
> Examples are techniques and instrumentation to evaluate the recipient's condition, remedial procedures to maximize the recipient's oral motor

> functions and communication via augmentative and alternative communication (AAC) systems.
>
> Page 2-1:
>
> Medicaid reimburses for the physical therapy (PT), occupational therapy (OT), respiratory therapy (RT), and speech-language pathology (SLP) services described in this handbook. The Florida Medicaid Therapy Services Program reimburses only for the therapy services listed on the Procedure Codes and Maximum Fee Schedule in Chapter 3, Appendix A of this handbook.
>
> Medicaid reimburses for medically necessary therapy services that are provided to Medicaid recipients under the age of 21. Medicaid also reimburses limited services to recipients age 21 and older, specifically: SLP services pertaining to the provision of augmentative and alternative communication systems and PT and OT services pertaining to wheelchair evaluations and fittings. These are the only services in the therapy program that Medicaid reimburses for adults.

22. The Findings of Fact establish the requested outpatient speech therapy does not pertain to the provision of an augmentative and alternative communication system.

23. Page 2-2 of the Therapy Handbook also states services are to be provided only when medically necessary and do not duplicate another provider's service.

24. The definition of medically necessary is found in Fla. Admin. Code R. 59G-1.010 which states:

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
> . . .
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods, or services medically necessary or a medical necessity or a covered service.

25. Sunshine Health's action did not deny the requested weekly frequency of outpatient speech therapy. The service was approved for two visits a week. The issue is that six weeks were approved as opposed to the requested eight weeks.

26. Issuing a partial denial establishes the outpatient speech therapy is medically necessary. Compelling evidence, however, was not presented to establish six weeks v. the requested eight weeks was medically necessary. It is noted that Sunshine Health's Notice of Action stated the request could be reevaluated.

27. The Findings of Fact establish petitioner has accessed in home speech therapy through the LTMC Program.

28. Petitioner has not met the required evidentiary standard to establish the respondent's action of approving outpatient speech therapy twice a week for six weeks as opposed to twice a week for eight weeks was improper.

29. Analysis is next directed to the $1500.00 cap associated with outpatient services.

30. Respondent's Hospital Services Coverage and Limitations Handbook (Hospital Handbook) is incorporated by reference in Fla. Admin. Code R. 59G-5.020.

31. The Hospital Handbook states on page 2-14: "Adult recipients, 21 years of age and older, are limited to $1,500 entitlement per fiscal year for outpatient hospital services.

32. Florida Statute §409.908 (1) also states:

> 3.(b): Reimbursement for hospital outpatient care is limited to $1,500 per state fiscal year per recipient, except for:
> 1. Such care provided to Medicaid recipients under age 21, in which case the only limitation is medical necessity.
> 2. Renal dialysis services.
> 3. Other exceptions made by the agency.

33. The Findings of Fact establish petitioner is not under the age of 21.

34. The Findings of Fact establish the only exceptions to the $1500.00 cap are services related to mammograms and obstetric ultrasounds.

35. No authority was presented or is known by the undersigned which allows an administrative hearing officer to lift the $1500.00 outpatient cap.

36. Petitioner has not established the $1500.00 cap can be lifted for any reason as enumerated by Florida Statute.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, petitioner's appeal is 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 31 day of December, 2015,

in Tallahassee, Florida.

Frank Houston

Frank Houston
Hearing Officer
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1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Judy Jacobs, Area 7, AHCA Field Office

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

[redacted]

APPEAL NO. 15F-08432

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 18 Brevard
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on November 24, 2015 at approximately 1:30 p.m.

APPEARANCES

Petitioner: [redacted]

For Respondent: Lissette Knott
Program Administrator
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is Respondent's denial of Petitioner's request for a root canal. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

The following individuals were present as witnesses for Respondent:

- Christian Laos – Senior Compliance Analyst – United Healthcare
- Lori Eubanks – Dental Account Manager – United Healthcare
- Dr. Brittany Vo – Dental Consultant – United Healthcare

Petitioner moved Exhibits 1 and 2 into evidence. Respondent moved Exhibits 1 through 4 into evidence at the hearing. The undersigned took administrative notice of the Florida Medicaid Provider General Handbook, July 2012.

FINDINGS OF FACT

1. Petitioner is a 60-year-old female. At all times relevant to this proceeding, Petitioner was eligible to receive Medicaid services.
2. Petitioner is enrolled with United Healthcare ("United") as her Managed Medical Assistance (MMA) plan.
3. On September 25, 2015, Petitioner's dentist submitted a prior authorization request for a root canal/nerve treatment, code D3320, for tooth # 5.
4. On September 28, 2015, United sent a Provider Prior Authorization Fax Notice to Petitioner's dentist, denying the root canal on the basis that it is not a covered benefit under her plan. United sent a Notice of Action to Petitioner on September 29, 2015, informing her of same.
5. Petitioner experiences pain any time she drinks something hot or cold.
6. Petitioner's gums sometimes become infected due to the poor condition of the tooth.
7. Petitioner is a [redacted]. She frequently takes antibiotics in order to prevent the infection from spreading, which could cause severe complications. Petitioner is concerned that her frequent use of antibiotics is going to cause her to build up a tolerance to them, rendering them ineffective.

8. Petitioner's dentist wants to save the tooth by performing a root canal. Petitioner would prefer to have the tooth extracted because she wants all of her teeth out in order to get dentures.

9. United's contract with the Agency for Health Care Administration ("AHCA" or "Agency") requires them to provide "medically-necessary, emergency dental procedures to alleviate pain or infection to enrollees age twenty-one (21) and older." (Respondent's Exhibit 2). The contract also requires United to "comply with provisions of the Medicaid Dental Services Coverage and Limitations Handbook" ["Dental Handbook"]. United's coverage limitations and exclusions cannot be more stringent than those in the Dental Handbook.

10. Per Respondent's Exhibit 2, United's MMA plan covers the following expanded dental services beyond those required by AHCA:

> Two (2) exams per year; two (2) x-rays per year; two (2) cleanings per year; maximum nine (9) amalgam fillings; one (1), two (2) and three (3) surface(s); three fillings each every thirty-six (36) months; one (1), two (2) and (3) surface(s), three (3) fillings each every thirty-six (36) months; Comprehensive LTC enrollees excluded.

11. Dr. Vo testified that an emergency extraction is a covered benefit under Petitioner's plan, but that a root canal is not. She said Petitioner's testimony indicates the situation is not an emergency, but she suggested that Petitioner should consult another dentist to see if there is an emergency situation regarding the tooth's condition that would necessitate extraction. Petitioner said she has contacted other providers, but they do not take her insurance.

12. Dr. Vo stated if Petitioner is unable to find another provider who takes her insurance she can contact dental schools or health clinics.

CONCLUSIONS OF LAW

13. By agreement between AHCA and the Department of Children and Families ("DCF"), the Office of Appeal Hearings has jurisdiction to conduct this hearing pursuant to Section 120.80, Fla. Stat.

14. The hearing was held as a *de novo* proceeding, in accordance with Florida Administrative Code Rule 65-2.056.

15. This is a Final Order, pursuant to Sections 120.569 and 120.57, Fla. Stat.

16. The standard of proof in an administrative hearing is a preponderance of the evidence. Fla. Admin. Code R.65-2.060(1). The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

17. Legal authority governing the Florida Medicaid Program is found in Fla. Stat. Chapter 409, and in Chapter 59G of the Florida Administrative Code. AHCA is the single state agency that administers the Medicaid Program.

18. The Dental Handbook is promulgated into law by Chapter 59G of the Florida Administrative Code.

19. Page 2-3 of the Dental Handbook states, in pertinent part:

> Medicaid will reimburse for medically-necessary emergency dental procedures to alleviate pain and or infection for eligible adult Medicaid recipients 21 years of age or older. Emergency dental care shall be limited to emergency problem-focused evaluations, necessary radiographs to make a diagnosis, extraction, and incision and drainage of abscess.

20. The definition of medically necessary is found in Fla. Admin. Code R.59G-1.010, which states:

(166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods or services furnished or ordered must:
(a) Meet the following conditions:
1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
. . . .

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods, or services medically necessary or a medical necessity or a covered service.

21. According to Dr. Vo, it is possible that Petitioner's situation qualifies as an emergency and thus medically necessary, but Petitioner's testimony makes it sound like it is not. The request submitted by Petitioner's dentist does not indicate an emergent situation.

22. Even if Petitioner's condition is an emergency, the solution requested by her dentist is not a covered benefit. The Dental Handbook covers extractions to correct an emergency, but does not cover root canals. United also does not cover root canals as an expanded benefit under its MMA plan.

23. Because root canals are not a covered benefit under both the Dental Handbook and United's MMA plan, the undersigned must conclude that denying the procedure was correct.

24. Petitioner is encouraged to follow Dr. Vo's suggestions and to work with United in order to find another dentist to reassess her condition to determine whether or not it constitutes an emergency, which would warrant an extraction.

DECISION

Based upon the foregoing, Petitioner's appeal is DENIED and the Agency's action is AFFIRMED.

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 30 day of December, 2015, in Tallahassee, Florida.

Rick Zimmer

Rick Zimmer
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Judy Jacobs, Area 7, AHCA Field Office

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

[redacted]

APPEAL NO. 15F-08569
15F-09533

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 18 Seminole
UNIT: 55207

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 9:35 a.m. on November 13, 2015.

APPEARANCES

For the Petitioner: [redacted] pro se

For the Respondent: Enid Quinones, ACCESS Supervisor

STATEMENT OF ISSUE

At issue is whether respondent's action to: 1) decrease petitioner's Food Assistance (FA) benefits and 2) terminate her full Medicaid and instead enroll her in the Medically Needy (MN) Program with a $1,049 Share of Cost (SOC) is proper. The burden of proof by the preponderance of evidence is assigned to the petitioner for the FA issue and to the respondent for the Medicaid issue.

PRELIMINARY STATEMENT

By notice dated September 23, 2015, the respondent (or Department) notified petitioner that her FA benefits would remain the same and she was enrolled in MN with an estimated $1,049 SOC. Petitioner timely requested a hearing to challenge the FA amount and enrollment in the MN Program.

Pamela Vance, Hearing Officer, appeared as an observer. Petitioner did not submit exhibits. Respondent submitted four exhibits, entered as Petitioner Exhibits "1" through "4". Petitioner did not receive the respondent's exhibits and elected to proceed with the hearing without the exhibits. The record was held open until November 16, 2015, for the respondent to submit an additional exhibit. The exhibit was received timely and entered as Respondent Exhibit "5". The record was closed on November 16, 2015.

FINDINGS OF FACT

1. Petitioner's FA benefits were reduced from $194 to $16 effective in July 2015.

2. Petitioner previously received Supplemental Security Income (SSI). As a result, petitioner received full Medicaid through the Social Security Administration (SSA).

3. In May 2015, petitioner's husband passed away; resulting in SSA terminating her SSI. Therefore, petitioner was no longer eligible for full Medicaid through the SSA. Instead, petitioner started receiving Social Security Widow Disability Income (SSWDI).

4. On August 28, 2015, petitioner submitted a recertification application for FA and Medicaid benefits for herself. The application lists $1,249 income from Social Security.

5. To be eligible for Adult-Related (referred to as SSI-Related) Medicaid, petitioner's income cannot exceed the $864 income limit. Petitioner's $1,249 SSWDI exceeds the $864 income limit. The next available program is MN with a SOC.

6. Respondent determined petitioner's SOC as follows:

$1,249	SSWDI
-$ 20	unearned income disregard
-$ 180	Medically Needy Income Level (MNIL)
$1,049	SOC

7. Respondent calculated petitioner's FA benefits as follows:

$1,249.00	SSWDI
-$ 155.00	standard deduction
$1,094.00	adjusted income
$ 472.66	rent/shelter
-$ 345.00	standard utility deduction
$ 817.66	shelter/utility cost
-$ 547.00	50% adjusted income ($1,094/2)
$ 270.66	excess shelter deduction
$1,094.00	adjusted income
-$ 270.66	excess shelter deduction
$ 823.34	adjusted income after deductions

30% of $823.34 = $247 round up (benefit reduction)

8. The maximum FA benefits a single person household can receive are $194; which is more than the $247 FA benefit calculation determined above (#7). However, since petitioner's income is less than $1,962 (the 200% gross income limit for a household size of one) she is eligible to receive the $16 minimum FA benefit amount.

9. On September 23, 2015, the respondent mailed petitioner a Notice of Case Action, notifying her FA ($16) would remain the same and she was enrolled in MN with a $1,049 SOC.

CONCLUSIONS OF LAW

10. 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 Fla. Stat. § 409.285.

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

MEDICAID VS MEDICALLY NEEDY ISSUE

12. The Fla. Admin. Code R. 65A-1.713, SSI-Related Medicaid Income Eligibility Criteria states in part:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
> (a) For MEDS-AD Demonstration Waiver, income cannot exceed 88 percent of the federal poverty level…
> (h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses…
> (4)(c) Medically Needy. The amount by which the individual's countable income exceeds the Medically Needy income level, called the "share of cost", shall be considered available for payment of medical care and services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical costs. If countable income exceeds the Medically Needy income level the department shall deduct allowable medical expenses in chronological order, by day of service…To be deducted the expenses must be unpaid, or if paid, must have been paid in the month for which eligibility is being determined or incurred and paid during the three previous calendar months to the month for which eligibility is being determined but no earlier than the three retroactive application months…

13. The above authority explains to be eligible for full Medicaid; income cannot exceed 88 percent of the federal poverty level. And MN provides coverage for individuals who do not qualify for full Medicaid due to income.

14. The Department's Program Policy Manual, CFOP 165-22, appendix A-9 (July 2015), identifies $864 as 88 percent of the federal poverty level for a household size of one.

15. Petitioner's $1,249 SSWDI exceeds the $864 income limit to be eligible for full Medicaid. Therefore, petitioner is not eligible for full Medicaid.

16. Federal Regulations at 20 C.F.R. § 416.1124 explain unearned income not counted and states in part "(c) Other unearned income we do not count... (12) The first $20.00 of any unearned income in a month..."

17. The Fla. Admin. Code R. 65A-1.716 sets forth the MNIL at $180 for a family size of one.

18. In accordance with the authorities, respondent deducted $20 unearned income and $180 MNIL from petitioner's $1,249 SSDI to arrive at $1,049 SOC.

FOOD ASSISTANCE ISSUE

19. Federal Regulation at 7 C.F.R § 273.9, defines income and in part states:

> (b)(2) Unearned income shall include, but not be limited to...
> (ii) Annuities; pensions; retirement, veteran's, or disability benefits; worker's or unemployment compensation including any amounts deducted to repay claims for intentional program violations as provided in §272.12; old-age, survivors, or social security benefits...

20. In accordance with the above authority, the respondent included petitioner's $1,249.00 SSWDI in the FA calculations.

21. Federal Regulation at 7 C.F.R § 273.9, defines allowable deductions and in part states:

> (d) Income deductions. Deductions shall be allowed only for the following household expenses:
> (1) Standard deduction…
> (6) Shelter costs…
> (ii) Excess shelter deduction. Monthly shelter expenses in excess of 50 percent of the household's income after all other deductions…
> (C) The cost of fuel for heating; cooling (i.e., the operation of air conditioning systems or room air conditioners); electricity or fuel used for purposes other than heating or cooling; water; sewerage; well installation and maintenance; septic tank system installation and maintenance; garbage and trash collection; all service fees required to provide service for one telephone…
> (iii) Standard utility allowances…Only utility costs identified in paragraph (d)(6)(ii)(C) of this section must be used in developing standards…

22. Policy Manual, CFOP, Appendix A-1, sets forth for a household size of one the following:

$ 194	maximum FA allotment
$ 16	minimum FA allotment
$ 155	standard deduction
$ 345	standard utility allowance
$1,962	monthly 200% gross income limit

23. Federal Regulations at 7 C.F.R. § 273.10, explains income and deduction calculations:

> (i) To determine a household's net monthly income, the State agency shall…
> (A) Add the gross monthly income earned by all household members and the total monthly unearned income of all household members…
> (C) Subtract the standard deduction…
> (H) Total the allowable shelter costs…Subtract from total shelter costs 50 percent of the household's monthly income after all the above deductions have been subtracted. The remaining amount, if any, is the excess shelter cost…
> (I) Subtract the excess shelter cost...
> (2) Eligibility and benefits…

> (ii)(A)... the household's monthly allotment shall be equal to the maximum food stamp allotment for the household's size reduced by 30 percent of the household's net monthly income ...

24. The cited authorities set forth income and allowable deductions in the FA benefit determination. In accordance with the authorities, respondent included petitioner's $1,249 SSWDI and allowable deduction (standard deduction, shelter and utilities) in the FA calculations.

25. The Department's TRANSMITTAL NO. C-13-10-0007, dated October 11, 2013, addresses the FA minimum amount and in part states:

> ...based on recent clarification from the Food and Nutrition Service, that all one and two member assistance groups (AGs) are eligible for the minimum monthly food assistance benefit allotment, which is 8% of the maximum allotment for a one person household.
>
> Minimum Benefit Policy
> The AG is eligible for the minimum monthly food assistance benefit allotment if the assistance group meets all regular eligibility requirements and:
> • The AG has income less than or equal to the 200% gross income limit...

26. In accordance with the above transmittal, petitioner is eligible for the $16 minimum FA amount; due to her income being less than the $1,962 monthly 200% gross income limit.

HEARING OFFICER'S CONCLUSION

27. In careful review of the cited authorities and evidence, the undersigned concludes the respondent followed Rule in authorizing petitioner in MN Program with a $1,049 SOC and $16 monthly in FA benefits.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are denied and the respondent's actions are 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 09 day of December, 2015, in Tallahassee, Florida.

Priscilla Peterson

Priscilla Peterson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 17 Broward
UNIT: 88249

RESPONDENT.
_____/

APPEAL NO. 15F-08586

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on November 10, 2015, at 12:03 p.m., in Fort Lauderdale, Florida.

APPEARANCES

For the Petitioner: [redacted] petitioner's husband.

For the Respondent: Ashley Brunelle, economic self-sufficiency specialist supervisor.

STATEMENT OF ISSUE

At issue is the denial of full Medicaid benefits for the petitioner and enrollment in the Medically Needy Program with an estimated share of cost (SOC) effective October 2015. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

On October 9, 2015, the petitioner requested a hearing to challenge the Department's action of enrolling his wife in the Medically Needy Program. The petitioner is seeking full Medicaid and/or a lower SOC.

During the hearing, the petitioner did not provide any evidence for the undersigned to consider. The Department's 11 exhibits were accepted into evidence and marked as Respondent's Exhibits 1 through 11 respectively.

FINDINGS OF FACT

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

1. On June 8, 2015, the petitioner's wife submitted an online application for Food Assistance and Family-Related Medicaid benefits for her household. On that application (ACCESS # [redacted], she reported five members in her household: herself, her husband and their three mutual children: [redacted], [redacted] and [redacted]. She reported that her household was receiving Social Security benefits. Petitioner reported the following expenses: rent $1,400 and electricity $220. Petitioner's [redacted]year-old daughter [redacted] does not reside at home and was not listed on the application, *see* Petitioner's Exhibit 4.

2. The petitioner is disabled. His gross monthly Social Security disability (SSD) income is $1,352.10. He is eligible for Medicare benefits, but is responsible for his Medicare Part B premiums ($104.90). His monthly SSD benefit after deduction is $1,247. Petitioner's wife and their two minor children each receives $225 monthly, *see* Petitioner's Exhibit 8. Petitioner's household incomes and expenses are not in dispute.

3. The respondent processed the application with a household of six (3 adults and 3 children) and, based on the information provided, approved full Medicaid benefits for the minors. Petitioner and his wife were enrolled in the Medically Needy Program with a SOC.

4. On July 9, 2015, the Department sent a Notice of Case Action to the petitioner informing her that her June 8, 2015 FAP application was approved and that her Medically Needy Share of Cost would increase to $1,190 effective August 1, 2015, *see* Respondent Exhibit 2.

5. The medical conditions of Family-Related Medicaid recipients are not a factor for eligibility. The petitioner's wife suffers from serious allergies, but has never applied for disability through the Social Security Administration (SSA). She does not have any outstanding medical bills.

6. Originally, the Department considered six (6) members in the Family-Related Medicaid standard filing unit (SFU), including F. C.

7. Household's gross household income of $2,078.10 was derived by adding F.C's $500 earned income to the couple's Social Security benefits. To determine Medicaid eligibility for the adults, the household income of $2,078.10 was compared to the income limit for an adult with a household size of six, $487. As the income exceeded the maximum limit, they were found ineligible for full Medicaid benefits.

8. As the wife was determined ineligible for full Medicaid, the respondent enrolled her in the Medically Needy (MN) Program. To determine the estimated SOC the Medically Needy Income Level (MNIL) of $783 (for a standard filing unit size of six) was subtracted from the $2,078.10 gross monthly household income, resulting to the

petitioner estimated SOC of $1,295. It was further reduced by a $104.90 medical insurance premium, resulting in $1,190 remaining SOC, *see* Respondent's Exhibit 5.

9. The case was reviewed and F.C. was removed from the household. In the corrected budget, five (5) members were considered in SFU.

10. Petitioner's gross household income of $1,576.90 was derived by adding together the couple's Social Security benefits. To determine Medicaid eligibility for the adults, the household income of $1,576.90 was compared to the income limit for an adult with a household size of five, $426. As the income exceeded the maximum limit, they were found ineligible for full Medicaid benefits. Petitioner's is only challenging his wife's SOC.

11. To determine the wife's estimated SOC the respondent, the Medically Needy Income Level (MNIL) of $684 for a standard filing unit size of five was subtracted from the $1,576.90 gross monthly household income, resulting to the wife's estimated SOC of $892. It was further reduced by a $104.90 medical insurance premium, resulting in $787 remaining SOC, *see* Respondent's Exhibit 6. No Notice of Case Action was sent to the petitioner informing him of the respondent's most recent action.

12. The respondent explained that the petitioner is not eligible for full Medicaid because her household income exceeds the Family-Related Medicaid income limit for the household size. She explained that FC was removed from the case and the SOC recalculated, resulting in the wife being enrolled in the Medically Needy Program with a reduced SOC effective October 2015. The new SOC was not made retroactive from the month of application.

13. The petitioner did not dispute the facts presented by the respondent. He asserted that his wife is in poor health and needs constant medical care. He acknowledged that he understands the benefits provided by the respondent are income-based, but believes that it is not fair for his wife who suffers from [redacted] The petitioner maintains his wife cannot meet her share of cost on a monthly basis without going to the emergency room. Petitioner asserts he has no money left after expenses, therefore his wife cannot afford any medical care.

14. As of the date of this hearing, the petitioner is aware of the reduced SOC. He is requesting full Medicaid benefits, or a lower SOC for his wife. Petitioner declined retroactive SOC adjustment from date of application, stating it does not change anything if not full Medicaid.

CONCLUSIONS OF LAW

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

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

17. The petitioner's wife did not report to be disabled. Her eligibility was considered under the Department's Family-Related Medicaid coverage category.

18. The Family-Related Medicaid income criteria is set forth in 42 C.F.R 435.603.

> (a) Basis, scope, and implementation. (1) This section implements section 1902(e)(14) of the Act.

> (2) Effective January 1, 2014, the agency must apply the financial methodologies set forth in this section in determining the financial eligibility of all individuals for Medicaid, except for individuals identified in paragraph (j) of this section and as provided in paragraph (a)(3) of this section.
> (d) Household income—(1) General rule. Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household.

19. Federal regulation 42 C.F.R. § 435.603 Application of modified gross income (MAGI) (f) defines a Household for Medicaid and states:

> (3) Rules for individuals who neither file a tax return nor are claimed as a tax dependent. In the case of individuals who do not expect to file a Federal tax return and do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made, or who are described in paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, the household consists of the individual and, if living with the individual—
> (i) The individual's spouse;
> (ii) The individual's natural, adopted and step children under the age specified in paragraph (f)(3)(iv) of this section; and
> (iii) In the case of individuals under the age specified in paragraph (f)(3)(iv) of this section, the individual's natural, adopted and step parents and natural, adoptive and step siblings under the age specified in paragraph (f)(3)(iv) of this section.
> (iv) The age specified in this paragraph is either of the following, as elected by the agency in the State plan—
> (A) Age 19; or
> (B) Age 19 or, in the case of full-time students, age 21.
> ...
> (5) For purposes of paragraph (f)(1) of this section, if, consistent with the procedures adopted by the State in accordance with §435.956(f) of this part, a taxpayer cannot reasonably establish that another individual is a tax dependent of the taxpayer for the tax year in which Medicaid is sought, the inclusion of such individual in the household of the taxpayer is determined in accordance with paragraph (f)(3) of this section.

20. The Department's Program Policy Manual CFOP 165-22 (the Policy Manual), at 2230.0400 Standard Filing Unit (MFAM) states:

> For tax filers, the Standard Filing Unit (SFU) is the tax filing group for the tax year in which eligibility is being determined. Eligibility is determined by

> each individual using the tax filing group's income. Individuals cannot receive Medicaid benefits under more than one coverage group, but can have their income included in more than one SFU.
> For individuals who neither file a federal tax return nor are claimed as a tax dependent (non-filers), the Standard Filing Unit consists of the individual and, if living with the individual, their spouse, their natural, adopted, and step children under age 19, or 19 and 20 if in school full-time.

21. In accordance with the above controlling authorities, the Medicaid household group is the petitioner, his wife and their 3 children (five members). The findings show the Department determined the wife's eligibility with a household size of six (6) and most recently with a household of five (5) for Medicaid. The undersigned concludes the Department correctly determined the petitioner's household size as five for Medicaid eligibility purposes.

22. Federal regulations at 42 C.F.R. § 435.603 Application of modified gross income (MAGI) (d) defines Household Income:

> (1) General rule. Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household.
> (2) Income of children and tax dependents. (i) The MAGI-based income of an individual who is included in the household of his or her natural, adopted or step parent and is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined, is not included in household income whether or not the individual files a tax return.
> (ii) The MAGI-based income of a tax dependent described in paragraph (f)(2)(i) of this section who is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined is not included in the household income of the taxpayer whether or not such tax dependent files a tax return.
> (3) In the case of individuals described in paragraph (f)(2)(i) of this section, household income may, at State option, also include actually available cash support, exceeding nominal amounts, provided by the person claiming such individual as a tax dependent.

(4) Effective January 1, 2014, in determining the eligibility of an individual using MAGI-based income, a state must subtract an amount equivalent to 5 percentage points of the Federal poverty level for the applicable family size only to determine the eligibility of an individual for medical assistance under the eligibility group with the highest income standard using MAGI-based methodologies in the applicable Title of the Act, but not to determine eligibility for a particular eligibility group.

23. The Policy Manual at 2630.0108 Budget Computation (MFAM), states:

Financial eligibility for Family-Related Medicaid is determined using the household's Modified Adjusted Gross income (MAGI). The MAGI is the household's adjusted gross income as calculated by the Internal Revenue Service plus any foreign earned income and interest income exempt from tax.
In computing the assistance group's eligibility, the general formula is:
Step 1 - (Gross Unearned + Gross Earned) = (Total Gross Income).
Step 2 - Deduct any allowable income tax deductions (lines 23-35 from 1040). Deduct any allowable deductions for financial aid or self-employment to obtain the Modified Adjusted Gross Income.
Step 3 - Deduct the appropriate standard disregard. This will give the countable net income.
Step 4 - Compare the total countable net income to the coverage group's income standard.
If less than or equal to the income standard* for the program category, STOP, the individual is eligible. If greater than the income standard for the program category, continue to Step 5.
Step 5 - Apply a MAGI deduction (5% of the FPL based on SFU size).
If the 5% disregard would make the individual eligible, include the disregard. Otherwise the individual is ineligible for Medicaid.
Individuals determined ineligible for Medicaid will be enrolled in Medically Needy and referred, as appropriate, to Florida KidCare and/or the Federally Facilitated Marketplace (FFM).

24. The Eligibility Standards for Family-Related Medicaid Program appear in the Department's Program Policy Manual CFOP 165-22 (the Policy Manual), Appendix A-7. It indicates an Adult Income Limit of $426 and a Standard Disregard of $ 258 for Family-Related Medicaid Program with a family size of five.

25. In accordance with the above controlling authorities, the undersigned reviewed the Medicaid eligibility for the petitioner. Step 1: The total income counted in the

budget is $1,576.90. Step 2: There are no deductions provided as there was no tax return. Step 3: The total income of $1,576.90 less the standard disregard of $258 is $1,318.90. Step 4: The balance of $1,318.90 is greater than the income limit of $426 for the petitioner or his wife to receive full Medicaid. Step 5: With no MAGI disregard, the countable balance remains $1,318.90. This amount was greater than the income limit of $426. The undersigned concludes the wife is ineligible for Medicaid. The undersigned further concludes Medically Needy eligibility must be explored for her.

26. The Policy Manual at passage 2630.0502 Enrollment (MFAM) sets forth:

> If an individual meets the Medically Needy Program's technical eligibility criteria, he is enrolled into the program. There is no income limit for enrollment. The individual is only eligible (entitled to Medicaid) when he has allowable medical bills that exceed the SOC.
> The income for an enrolled assistance group need not be verified. Instead, an estimated SOC is calculated for the assistance group. If after bill tracking, it appears the assistance group has met his "estimated" SOC, the unverified income must be verified before the Medicaid can be authorized. An individual is eligible from the day their SOC is met through the end of the month.

27. The Policy Manual at passage 2630.0500 Share of Cost (MFAM) states:

> The Share of Cost (SOC) refers to the amount of medical bills which an individual enrolled in the Medically Needy Program must incur in any given month before Medicaid coverage may be authorized.
> Eligibility must be determined for Medically Needy any time the assistance group meets all technical factors but the income exceeds the appropriate income limit for Medicaid.
> To calculate the share of cost, compare the countable net income to the Medically Needy Income Level based on the size of the standard filing unit. The difference is the assistance group's share of cost.

28. Effective January 2015, Appendix A-7 indicates that for a household of five, the MNIL is $684.

29. To determine the SOC the respondent determined the petitioner's household monthly income to be $1,576.90. The Medically Needy Income Level of $684 for a standard filing unit size of five was subtracted resulting to the wife's estimated SOC of $892. It was further reduced by a $104.90 medical insurance premium, resulting in $787 remaining SOC.

30. The hearing officer found no exception to this calculation. It is concluded that a more favorable share of cost could not be determined. Eligibility for full Medicaid was not found.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied. The respondent's most recent action is upheld.

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 30 day of December, 2015,

in Tallahassee, Florida.

Roosevelt Reveil

Roosevelt Reveil
Hearing Officer
Building 5, Room 255
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Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

APPEAL NO. 15F-08621

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 15 Palm Beach
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, a telephonic administrative hearing in the above referenced matter was convened on November 24, 2015 at 8:40 a.m.

APPEARANCES

For the Petitioner: [redacted]
Petitioner's Mother

For the Respondent: Lisa Sanchez
Senior Human Services Program Specialist

ISSUE

At issue is whether respondent's denial of petitioner's request for the following dental procedures was correct:

- D8070: Full braces
- D8220: Harmful habit appliance
- D8670: Monthly brace adjustments

The burden of proof was assigned to the petitioner.

PRELIMINARY STATEMENT

Petitioner was not present but represented by his mother. No exhibits were entered into evidence.

Ms. Sanchez appeared as both the representative and witness for the respondent. Present from Sunshine Health was Jennifer Arteaga, Grievance and Appeals Coordinator. Present from Dental Health and Wellness (DHW) was Dr. Kimberly Anderson, Dental Consultant. Respondent's exhibits "1" and "2" were accepted into evidence. Administrative notice was taken of the Florida Medicaid Provider General Handbook.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

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

2. Petitioner's Medicaid services are provided through the Statewide Medicaid Managed Care Program. Since August 1, 2014 his Medicaid services have been provided by Sunshine Health.

3. On October 9, 2015 petitioner's orthodontist submitted a prior authorization request for braces; orthodontic treatments; and a harmful habit appliance. The request was submitted to Sunshine Health's dental vendor, DHW.

4. Orthodontic procedures, when medically necessary, are available to Florida Medicaid recipients who are under the age of 21.

5. A harmful habit appliance is used to prevent thumb sucking or tongue thrusting. When medically necessary, the appliance can also be approved for Medicaid recipients under the age of 21.

6. In support of the request, petitioner's orthodontist submitted an Initial Assessment Form (IAF) and dental x-rays.

7. The IAF is used to determine the severity of dental conditions, including the malocclusion of teeth. Scoring is assigned by both diagnostic observation and dental measurement.

8. An IAF score of "26" or more may indicate braces are medically necessary.

9. The treating orthodontist is not required to provide IAF scoring when one of the following conditions exist:

- Cleft palate deformities
- Deep impinging overbite. When lower incisors are destroying the soft tissue (more than an indention)
- Crossbite of individual anterior teeth. When destruction of soft tissue is present
- Severe traumatic deviations
- Overjet greater than 9mm with incompetent lips or reverse overjet greater than 3.5 mm with reported masticatory and speech difficulties

10. For each of the above, the IAF directs the treating dentist to "Indicate an 'X' if present and score no further". When present, these conditions are indicative of a need for orthodontic treatment.

11. As petitioner's orthodontist did not identify any of the above dental conditions, the remainder of the IAF was scored.

12. The orthodontist identified:

- Anterior crowding. The scoring was "5".
- Overjet in mm: The scoring was "1"

- Overbite in mm: The scoring was "1"
- Labio-lingual spread in mm: The scoring was "2"

13. Petitioner's total IAF scoring was "9".

14. Other than the IAF and x-rays, no additional information was submitted regarding the need for a harmful habit appliance.

15. A licensed DHW dentist thereafter reviewed all submitted information. On October 15, 2015 a Notice of Action was issued to the petitioner denying braces; orthodontic treatment; and the harmful habit appliance. The notice stated, in part:

> The request for braces is denied. Braces are medically necessary if there is information showing severe orthodontic abnormality resulting in a HLD Index score of 26 or greater. The information sent by your dentist did not this condition [*Sic*].
>
> The request for habit appliance is denied. Habit appliance is medically necessary if documentation describes a condition of thumb sucking or tongue thrusting. Information sent by your dentist did not show one of these conditions.
>
> The request for periodic orthodontic treatment is denied. Periodic orthodontic treatment is medically necessary when there is documentation of an active orthodontic case and the date of the retention visit.

16. Petitioner's mother thereafter contacted the Office of Appeal Hearings and timely requested a fair hearing.

17. Upon receipt of the request for a hearing, a second DHW licensed dentist reviewed all submitted information. On November 5, 2015 petitioner was notified the original decision was upheld.

18. Petitioner has not experienced a head injury which contributed to the need for braces.

19. Petitioner does not have a speech problem due to the malposition of teeth.

20. Petitioner's mother argues braces will allow his teeth to be properly aligned. Concern was specifically addressed to lateral and central incisor teeth.

21. Respondent agrees petitioner's teeth are misaligned. The severity of the misalignment, however, does not meet Medicaid requirement for braces. Additionally, no information was presented which documented the need for a harmful habit appliance.

CONCLUSIONS OF LAW

22. By agreement between the Agency for Health Care Administration (AHCA) 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.

23. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

24. Fla. Admin. Code R. 59G-4.060 addresses dental services and states, in part:

> (2) All dental services providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Dental Services Coverage and Limitations Handbook, November 2011, … and the Florida Medicaid Provider Reimbursement Handbook, ADA Dental Claim Form, July 2008, which are incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which is incorporated by reference in Rule 59G-4.001, F.A.C.
>
> (3) The following forms that are included in the Florida Medicaid Dental Services Coverage and Limitations Handbook are incorporated by reference: Medicaid Orthodontic Initial Assessment Form (IAF), …

25. The Florida Medicaid Dental Services Coverage and Limitations Handbook (Dental Handbook) states, on page 2-2, "Medicaid reimburses for services that are determined medically necessary …"

26. In regard to medical necessity, the definition is found in Fla. Admin Code. R.

59G-1.010 and states:

> (166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider...
> . . .
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

27. As the petitioner is under 21 years of age, Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements apply to the evaluation of the petitioner's eligibility for orthodontic services. Section 409.905, Fla. Stat., *Mandatory Medicaid services*, defines Medicaid services for children to include:

> (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.–The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems ...

28. In regard to EPSDT requirements, The State Medicaid Manual, published by the Centers for Medicare and Medicaid Services states, in part:

> 5110. Basic Requirements…
> …Services under EPSDT must be sufficient in amount, duration, or scope to reasonably achieve their purpose. The amount, duration, or scope of EPSDT services to recipients may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. **Appropriate limits may be placed on EPSDT services based on medical necessity** [Emphasis Added].

29. The Findings of Fact establish, when medically necessary, orthodontic procedures and harmful habit appliances are allowed for Medicaid recipients under the age of 21. The issue before the undersigned, therefore, focuses upon whether the requested orthodontic services and appliance meet medical necessity criteria.

30. Regarding braces and follow up treatment, analysis is directed to the Dental Handbook. Page 2-15 states:

> Prior authorization is required for all orthodontic services. Orthodontic services are limited to those recipients with the most handicapping malocclusion. A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the patient by causing impaired mastication, dysfunction of the temporomandibular articulation, susceptibility to periodontal disease, susceptibility of dental caries, and impaired speech due to malposition of the teeth.

31. Pages 2-16 through 2-18 continues by stating:

> Orthodontic procedures are limited to recipients under age 21 whose handicapping malocclusion creates a disability and impairment to their physical development.
>
> Criteria for approval is limited to one of the following conditions:
>
> - Correction of severe handicapping malocclusion as measured in the Medicaid Orthodontic Initial Assessment Form (IAF) …
> - Syndromes involving the head and maxillary or mandible jaws such as cleft lip of cleft palate
> - Cross-bite therapy, with the exception of one posterior tooth that is causing no occlusal interferences;
> - Head injury involving traumatic deviation; or

- Orthognathic surgery, to include extractions, required or provided in conjunction with the application of braces.

...

The Medicaid Orthodontic Initial Assessment Form (IAF) is to be completed by the orthodontic provider at the initial evaluation of the recipient.

The IAF is:

- Designed for use as a guide by the provider in the office to determine whether a prior authorization (PA) request should be sent to the Medicaid orthodontic consultant; and
- A means by which the orthodontic provider may communicate to Medicaid's orthodontic consultant all the distinctive details pertaining to an individual case. ...

...

A score of 26 or greater may indicate that treatment of the recipient's condition could qualify for Medicaid reimbursement, and the orthodontic provider should submit a prior authorization request to Medicaid for consideration of orthodontic services. A score of 26 or greater on the IAF is not a guarantee of approval. It is used by the provider to determine whether diagnostic records should or should not be sent to the orthodontic consultant.

...

A score of less than 26 indicates that treatment of the recipient's condition may not qualify for Medicaid reimbursement, and the request for prior authorization may be denied.

This does not say that such cases do not represent some degree of malocclusion, but simply that the severity of the malocclusion does not qualify for coverage under the Florida Medicaid Orthodontic Program.

32. The Findings of Fact establish petitioner's orthodontist completed an IAF with a score total of "9".

33. The IAF did not established the petitioner has a cleft palate; deep impinging overbite; crossbite of anterior teeth; severe traumatic deviations; or overjet greater than 9mm.

34. The IAF did not establish petitioner met the requirements of the Medicaid Program for braces.

35. It is not disputed the petitioner has a misalignment of teeth. The greater weight of evidence does not establish petitioner's orthodontic status rises to the stringent requirement of a "most handicapping malocclusion" as defined the Dental Handbook.

36. As the medical necessity for braces has not been established, the need for periodic adjustments is moot.

37. Petitioner's orthodontist provided no information specific to why a harmful habit appliance was needed. The existing conditions which necessitate the need for an appliance are not known. Without this information, a thorough medical necessity review cannot be completed. As such, respondent's action in this matter was not improper.

38. The petitioner's request for braces and a harmful habit appliance have not satisfied the following condition of medical necessity:

> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program ...

39. The undersigned has reviewed EPSDT and medical necessity requirements and applied such to the totality of the evidence. The petitioner has not established, by the greater weight of the evidence, that respondent's actions in this matter were incorrect.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is 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 10 day of December, 2015,

in Tallahassee, Florida.

Frank Houston

Frank Houston
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Judy Jacobs, Area 7, AHCA Field Office

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 01 Escambia
UNIT: 88630

RESPONDENT.
_____/

APPEAL NO. 15F-08727

CASE NO. [redacted]

ORDER OF DISMISSAL

Pursuant to Notice, the undersigned convened an administrative hearing in the above styled matter on November 13, 2015 at 1:07 pm. The petitioner was present and represented by [redacted] patient services representative at [redacted] with [redacted] Jeanette Fountain, Economic Self-Sufficiency Specialist II, represented the Department. Observing the hearing was hearing officer Patricia Antonucci. Petitioner and Respondent both consented to Ms. Antonucci observing the hearing.

The petitioner identified the issue as disputing the denial of Medicaid eligibility for her children that she received notice of on February 20, 2015. The petitioner filed an appeal on October 14, 2015.

The Petitioner testified that she received the notice of case action in late February 2015.

The Petitioner and her representative both testified that there has been no appeal hearing or request for supervisory review made prior to October 14, 2015.

Fla. Admin. Code 65-2.046 "Time Limits in Which to Request a Hearing" states in relevant part:

> (1) The appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs. Additionally, in the Food Stamp Program, a household may request a fair hearing at any time within a certification period to dispute its current level of benefits. 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.

The undersigned concludes the appeal was requested 236 days following the date of the disputed notice. The appeal is dismissed as untimely filed.

DONE and ORDERED this 20 day of November, 2015, in Tallahassee, Florida.

Gregory Watson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner, C/O [redacted] (Mother)
Office of Economic Self Sufficiency
[redacted]

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

[redacted]

APPEAL NO. 15F-08762

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 15 Palm Beach
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in West Palm Beach, Florida on December 10, 2015 at 10:08 a.m.

APPEARANCES

For the Petitioner: [redacted]
Petitioner's Daughter

For the Respondent: Linda Latson
Registered Nurse Specialist

ISSUE

Whether respondent's denial of petitioner's request for overnight care through the Statewide Long Term Managed Care Program (LTMC Program) was proper. The burden of proof was assigned to the petitioner.

PRELIMINARY STATEMENT

At the onset of the hearing, respondent requested a conference with the petitioner. The conference took place outside the presence of the hearing officer.

At the conclusion of the conference, the parties requested that the hearing proceed.

Appearing in person for the petitioner was her daughter [redacted]. Petitioner's exhibits "1" through "3" were accepted into evidence.

Ms. Latson appeared in person for the respondent. Present by telephone from United Healthcare were Christian Laos, Senior Compliance Analyst and Dr. Marc Kaprow, Executive Director for the LTMC Program. Respondent's exhibit "1" was accepted into evidence.

The record was held open through December 17, 2015 for respondent to provide definitions of services offered through the LTMC Program and to respond in writing to evidence entered by the petitioner at the time of hearing. Respondent provided the entire LTC contract as opposed to contract language specific to service definitions. Due to the size of the electronic file, service definitions were viewed at the website cited in respondent's Notice of Action dated September 11, 2015.

The record was also held open through December 24, 2015 for petitioner to provide a written response to respondent's post hearing submissions. Each party was also allowed through December 24, 2015 to submit additional written closing comments. Numerous e-mail responses were received from the petitioner. The e-mails were entered as petitioner's composite exhibit "4.[1]

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] As it was not clear whether some of the e-mails were shared with the respondent, a Notice of Ex Parte Communication was issued on December 28, 2015. Attached to the notice were those e-mails of concern.

1. Petitioner is 82 years of age and resides by herself in a one bedroom apartment. Her daughter resides in the same complex; her apartment is several doors away from the petitioner's.

2. Petitioner is diagnosed with [redacted] Other diagnoses include [redacted] and [redacted]

3. At all times relevant to this proceeding, petitioner was Medicaid eligible.

4. Respondent administers Florida's Medicaid Program and contracts with Health Maintenance Organizations (HMOs) to provide comprehensive, cost-effective medical services to Medicaid recipients in the LTMC Program.

5. Respondent does not have a promulgated Coverage and Limitations Handbook for the LTMC Program. LTMC services descriptions are defined by contract.

6. Petitioner's LTMC services are provided by United Healthcare.

7. On September 3, 2015 a United Healthcare represented completed a functional assessment. Based on petitioner's assessment, the following Finding of Facts are made:

- Ambulates without assistance.
- Requires various levels of assistance with all activities of daily living (i.e. bathing; dressing; grooming; and toileting).
- Total assistance is required with household tasks (i.e. cleaning; cooking; shopping, etc.).

8. Petitioner is authorized to receive the following LTMC services:

Personal Care Services:	9 hours per week
Companion Services:	2 hours per week
Homemaker Services:	4 hours per week
Adult Day Care:	32.5 hours per week

9. Petitioner attends Adult Day Care each weekday from 8:30 a.m. to 4:00 p.m.

10. Personal care; companion; and homemaker services are provided Monday through Thursday from 7:15 p.m. to 9:30 p.m. and Sunday 12:00 p.m. to 6:00 p.m.

11. Due to concerns the petitioner might elope at night or otherwise injure herself in the apartment, a request for overnight care was received by United Healthcare on September 10, 2015. The requested coverage was from 11:00 p.m. to 6:00 a.m.; seven days per week.

12. On September 11, 2015 United Healthcare issued a Notice of Action. The notice denied the request for overnight care and stated "The requested service is not a covered benefit."

13. On November 14, 2015 the Office of Appeal Hearings received petitioner's request for a Fair Hearing. When requesting the hearing, petitioner's representative referenced a denial for additional companion hours in the evening[2].

14. Regarding the rationale for denial, respondent's position changed at the hearing. The revised position is overnight care can be provided if medically necessary. Respondent asserts the overnight coverage is not medically necessary for the following reasons:

- Adult Protect Services conducted an investigation. Although a report has not been received, the petitioner remains in her apartment
- There is no task that can be performed while the petitioner sleeps.
- The services through the LTMC Program are not provided to address an emergency that might arise.
- Overnight coverage in addition to services in place would be in excess of petitioner's need.
- A door or bed alarm could be considered.
- A camera could be considered.

[2] Case notes completed by United Healthcare personnel also reference companion services for the overnight care.

15. Petitioner's representative has attempted to bring the petitioner to her apartment at night. Petitioner became aggressive and the police were called. When the petitioner returned to sleeping in her own apartment, the behavioral issues ended.

16. Petitioner's representative argues her mother does not know the difference between day and night. There is a lake behind the apartment and she has concerns the petitioner might leave the apartment and get into the lake or somehow be injured through other means. Because of the [redacted] disease, petitioner should not be left alone. An assisted living facility would only upset her mother.

17. Regarding the petitioner, her representative also states:

- Has started to hallucinate
- The level of confusion has increased
- Security cameras in the apartment are not affordable
- Frequency of incontinency has increased
- Supervision is need at all times

CONCLUSIONS OF LAW

18. By agreement between the Agency for Health Care Administration (AHCA) 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.

19. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

20. The standard of proof in an administrative hearing is by 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.).

21. Regarding the LTMC Program, § 409.978, Fla. Stat. states:

> (1) ... the agency shall administer the long-term care managed care program ...
>
> (2) The agency shall make payments for long-term care, including home and community-based services, using a managed care model.

22. Regarding the LTMC Program, United Healthcare and the respondent entered into a contractual relationship. The contract identifies 26 services that are to be offered.

23. Florida Medicaid, which includes the LTMC Program, only covers those services determined to be medically necessary. See § 409.905 (4) (c), Fla. Stat.

24. The definition of medical necessity is found in Fla. Admin Code. R. 59G-1.010 and states:

> (166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider...
> . . .
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

25. Respondent's denial notice of September 11, 2015 references "overnight care".

When requesting the hearing, petitioner's representative referenced companion services. Internal case notes from United Healthcare also describe the requested additional hours are for companion services.

26. Analysis is first directed to companion services for the additional overnight hours.

27. The contract provides the following definition:

> (1) Adult Companion Care — Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discreet services. The provision of companion services does not entail hands-on nursing care. This service includes light housekeeping tasks incidental to the care and supervision of the enrollee.

28. At night, the greater weight of evidence does not establish a companion provider would be supervising or assisting the petitioner with any type of task. Additionally, between 11:00 p.m. and 6:00 a.m. it does not appear the service would be for socialization purposes.

29. In regard to personal care and homemaker services, the contract provides the following definitions:

> (11) Homemaker Services — General household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control may be included in this service.
>
> (19) Personal Care — A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

30. Other than periodic assistance with toileting, the evidence does not demonstrate personal care services are continuously medically necessary each day between 11:00 p.m. and 6:00 a.m.

31. Neither the definition of homemaker or personal care identifies supervision as a component of the service. Rather, each service is task oriented.

32. The greater weight of evidence does not establish personal care; companion; or homemaker services are, based on the service definition, medically necessary on a continuous basis each day between 11:00 p.m. and 6:00 a.m.

33. The undersigned has also considered whether "overnight staff" might be addressed by attendant care. The contract defines this service as follows:

> (5) Attendant Care — Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by state law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.

34. The greater weight of evidence does not demonstrate petitioner is physically handicapped. Petitioner's arthritic condition is noted. She does, however, ambulate independently. Petitioner's [redacted] is also noted. Medical documentation, however, did not establish the degree of visual impairment.

35. Attendant care first requires the individual to be physically handicapped. The greater weight of evidence does not establish a significant physical handicap making overnight care medically necessary.

36. A facility based assisted living program is also service identified by contract. The contract states, in part: "This service includes twenty-four (24) hour onsite response

staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity independence, and to provide supervision, safety and security."

37. Petitioner's representative feels assisted living is not an appropriate service to address her mother's [redacted]

38. A medically necessary service need must also match a service definition. The undersigned has considered those services identified by contract. In particular companion; homemaker; personal care; and attendant care. Medical necessity for overnight care continuously between 11:00 p.m. and 6:00 a.m. has not been demonstrated.

39. If additional services identified by contract are needed, petitioner is afforded the opportunity to request those services.

40. After considering all evidence and testimony, petitioner has not met the required evidentiary standard that respondent's action in this matter was improper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, petitioner's appeal is 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 31 day of December, 2015,

in Tallahassee, Florida.

Frank Houston

Frank Houston
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Judy Jacobs, Area 7, AHCA Field Office

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 88999

RESPONDENT.
_____/

APPEAL NO. 15F-08836
15F-08938

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 17, 2015 at 9:45 a.m.

APPEARANCES

For the petitioner: [redacted] pro se

For the respondent: Tiffany Ware, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the termination of Food Assistance Program (FAP) benefits. The respondent carries the burden of proof by the preponderance of evidence.

Petitioner is also appealing the respondent's action to deny his application, dated March 17, 2015, for Medicaid Assistance Program benefits. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

By notice dated September 18, 2015, the respondent notified the petitioner that his FAP benefits ended on August 2015 due to his "household's income is too high to qualify for this Program". The petitioner timely requested a hearing to challenge the respondent's action to exclude and remove his children as part of his household, which affected his eligibility.

On record and as the hearing began, petitioner indicated he last submitted an application for Medicaid Assistance on March 17, 2015, which was denied sometime on March 2015. Petitioner was notified by mail that the respondent denied his Medicaid Assistance application on March 2015. Therefore, the undersigned lacks jurisdiction to review the matter as the request was made outside of the time allowed for a timely hearing request.

Pamela Vance, Hearing Officer with the Office of Hearing Appeals observed.

The petitioner did not submit any exhibits. The respondent submitted five exhibits, which were accepted into evidence and marked as Respondent Exhibits "1" through "5". The record was held open until close of business on November 30, 2015 for the respondent to supplement the record. The respondent timely provided the additional documentation, which was accepted into evidence and marked as Respondent Exhibit "6". The record closed on November 30, 2015.

FINDINGS OF FACT

1. Prior to the action under appeal, petitioner was receiving FAP benefits for himself and his two children, ages 6 and 8, since the last application he submitted on March 17,

2015. Prior to March 2015, the children were receiving only Medicaid benefits in their mother's case.

2. On August 18, 2015, petitioner submitted an on line application to reapply for FAP benefits for his household which included his children.

3. The petitioner shares custody of his children with the children's mother. During the application process, the petitioner submitted court documents. On September 4, 2015, the petitioner submitted a copy of the Ninth Judicial Circuit Court, in and for Orange County, FINAL JUDGMENT OF PATERNITY AND ORDER ON REPORT OF GENERAL MAGISTRATE. The Order indicates that the parties agree to equally share their time with the minor children. A Child Support Guidelines Worksheet shows petitioner spends 50.14% time with the children on overnight stays and 49.86% for the mother.

NON-CUSTODIAL PARENT CLAIMING ONE CHILD AS A DEPENDANT

CHILD SUPPORT GUIDELINES WORKSHEET

Number Of Children	2	0	2
Taxable Income Amounts	**COMBINED**	**WIFE**	**HUSBAND**
Self Employment Taxable Income	0.00	0.00	0.00
Social Security Taxable Income	3,619.78	1,503.78	2,116.00
Other Taxable Income	0.00	0.00	0.00
Taxable Spousal Support Income	0.00	0.00	0.00
Non Taxable Income	0.00	0.00	0.00
GROSS INCOME	3,619.78	1,503.78	2,116.00
Spousal Support Payments			
Deductible This Marriage	0.00	0.00	0.00
Deductible Prior Marriage	0.00	0.00	0.00
Non Deductible	0.00	0.00	0.00
TOTAL SPOUSAL SUPPORT	0.00	0.00	0.00
Taxes			
FICA - Social Security	224.42	93.23	131.19
FICA - Medicare			

Percentage Share Of Support	100.00%	39.98%	60.02%
	COMBINED	**WIFE**	**HUSBAND**
Minimum Child Support Need	1,194.00	477.36	716.64
Shared Support Need	1,791.00	716.04	1,074.96
Number of Overnights With	365	182	183
Percentage of Overnights	100.00%	49.86%	50.14%
Payment Share to Other		359.02	535.98
Pre Adjustment Transfer		0.00	176.96
Child Care Costs Paid	260.00	260.00	0.00
Uncovered Ins/Med/Dental Costs Paid	0.00	0.00	0.00
Day Care/Ins/Med/Dental Costs Share	260.00	103.95	156.05
Day Care/Ins/Med/Dental Share Adjust		0.00	156.05
Presumed Amount To Be Paid	SHARED	0.00	333.01
Adjustments			

4. On September 18, 2015, the respondent removed the petitioner's children from his FAP case and terminated his FAP benefits due to being over the income standard for a

household size of one. On September 24, 2015, the respondent added the children back to the petitioner's FAP case and approved $39.00 in FAP benefits for September 2015 and $120.00 ongoing (on October 21, 2015, the respondent issued an auxiliary of $199.00 FAP benefits for September and October 2015). However, on October 20, 2015, the respondent again removed the children from the petitioner's FAP case and calculated the FAP benefits based on a household size of one, ending the FAP benefits for the petitioner's household effective October 31, 2015.

5. The respondent explained that prior to the petitioner's initial application on March 17, 2015, the children were active under their mother's case, and should not have been added to the petitioner's case.

6. The respondent explained that according to the Department's guidelines in viewing the share custody policy for the FAP, the respondent recommended the petitioner seek a modification through the Clerk of Court on joint custody. Joint custody is only a factor for Temporary Cash Assistance (TCA) and Medicaid Assistance Programs. The issue is not TCA.

7. The respondent explained if a child is already active in the FAP household with one of the parents; the child should not be removed from the case. The children were only receiving Medicaid benefits in their mother's case. The respondent further explained that it had erred in removing the petitioner's children from their mother's case and adding them to the petitioner's FAP case in March 2015. The petitioner received FAP benefits for the children until August 2015 when he was due to recertify. He submitted

his application on August 18, 2015. However, the children were added to the mother's case as of September 2015.

8. On November 30, 2015, the hearing officer received an email regarding a resolution action to the appeal. Said letter explained that after further evaluation, the Department agrees that the children are to be removed from the mother's case and placed back in the petitioner's case. No Notice of Case Action was submitted to the undersigned in regards to adding the children back to the petitioner's FAP benefits.

CONCLUSIONS OF LAW

9. 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.

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

MEDICAID ISSUE

11. Fla. Admin. Code R. 65-2.046 sets a 90-day time-period to request a hearing, as follows:

> (1) The appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs. Additionally, in the Food Stamp Program, a household may request a fair hearing at any time within a certification period to dispute its current level of benefits. 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.

12. According to the above authority, the individual must request a fair hearing within 90 days from the date of the notice sent by the Department. This notice informs the applicant or recipient of the decision on an application, the reduction or termination of program assistance, the denial, or other action that aggrieves the petitioner. In this case, the last action taken on an application requesting Medicaid Assistance was on March 17, 2015. The respondent sent notice to the petitioner on March 31, 2015. The petitioner did not request a hearing to appeal that denial until October 19, 2015, which is beyond the 90-day time period. The 90th-day time to appeal was until June 30, 2015.

13. Based on the above authority, the undersigned does not have jurisdiction over this matter.

FOOD ASSISTANCE ISSUE

14. The Code of Federal Regulations 7 C.F.R. § 273.1 defines household concept and states in relevant part:

> (a) General household definition. A household is composed of one of the following individuals or groups of individuals, unless otherwise specified in paragraph (b) of this section:
> ..
> (b) Special household requirements—(1) Required household combinations. The following individuals who live with others must be considered as customarily purchasing food and preparing meals with the other, even if they do not do so, and thus must be included in the same household, unless otherwise specified.
> ...
> (ii) A person under 22 years of age who is living with his or her natural or

adoptive parent(s) or step-parents(s);

15. 7 C.F.R. § 273.3(a) defines residency requirements and states, **"no individual may participate as a member of more than one household...in any month."** (Emphasis added)

16. The Department publishes a Knowledge Bank, which includes questions and answers on policy details not included in the Department's Program Policy Manual, CFOP 165-22. The relevant question and answer from the Department's Knowledge Bank is, "[Question] if parents have joint custody of a child, can the child be included in the food stamp benefits? [Answer] Yes, as long as the other parent is not receiving food stamps for the child."

17. The Department's FAP policy has no rule regarding who can receive FAP benefits for a child whose parents have joint custody; verification of custody or court order in an attempt to verify which parent is the primary caretaker is under the Temporary Cash Assistance (TCA) and Medicaid Assistance Programs Policy.

18. The authorities cited set forth household requirements as well non-duplication of FAP benefits. The controlling federal regulation is very clear that no individual may be included and receive FAP benefits in more than one household at a time; therefore, the petitioner's children cannot receive FAP benefits in both of the parents' cases. It is the respondent's testimony that the respondent erred in its removal of the petitioner's children from the mother's case and in adding the children to the petitioner's FAP case. However, the respondent further evaluated the case and agreed that when the petitioner applied for his children on March 17, 2015, it had correctly determined FAP

benefits for him and the children. Therefore, when he submitted his application on August 18, 2015, he was rightfully entitled to include his children and have his FAP eligibility determined for a household size of three instead of one.

19. After further evaluation, the respondent indicated that the children should be removed from their mother's case and placed back in the petitioner's FAP case. However, the respondent did not submit any evidence to indicate it had taken corrective action to resolve the petitioner's FAP issue. The undersigned agrees with the respondent's recommendation and remands the matter back to the Department to add the petitioner's children back to his FAP benefits effective November 2015 and determine his eligibility based on a household size of three. Once an eligibility determination is made, the respondent is to issue a new Notice of Case Action to the petitioner including his appeal rights

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Medicaid appeal (15F-08938) is dismissed as non-jurisdictional.

The FAP appeal (15F-08836) is granted and remanded back to the respondent to take corrective action as specified in the Conclusions of Law.

ANY FOOD STAMP BENEFITS DUE APPELLANT PURSUANT TO THIS ORDER MUST BE AVAILABLE WITHIN (10) TEN DAYS OF THIS DECISION OR WITHIN (60) DAYS OF THE REQUEST FOR THE HEARING. ANY BENEFITS DUE WILL BE OFFSET BY PRIOR UNPAID OVERISSUANCES.

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 31 day of December, 2015,

in Tallahassee, Florida.

Cassandra Perez

Cassandra Perez
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

APPEAL NO. 15F-08877
15F-09482

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 05 Hernando
UNIT: 88003

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 10:50 a.m. on November 12, 2015.

APPEARANCES

For the Petitioner: [redacted] pro se

For the Respondent: Margaret Head, ACCESS supervisor

STATEMENT OF ISSUE

At issue is whether the respondent's action to: 1) deny petitioner Food Assistance (FA) benefits and 2) terminate petitioner's wife's full Medicaid and instead enroll her in the Medically Needy (MN) Program with a Share of Cost (SOC) is proper. The burden of proof by the preponderance of evidence is assigned to the petitioner for the FA issue and to the respondent for the Medicaid issue.

PRELIMINARY STATEMENT

By notice dated October 7, 2015, the respondent (or the Department) notified petitioner FA application dated October 5, 2015 was denied and petitioner's wife was enrolled in the MN Program with a $666 SOC. Petitioner timely requested a hearing to challenge the FA denial and his wife's enrollment in the MN Program.

Pamela Vance, Hearing Officer, appeared as an observer. Petitioner did not submit exhibits. Respondent submitted four exhibits, entered as Respondent Exhibits "1" through "4". Petitioner did not receive the respondent's exhibits and elected to proceed with the hearing without the exhibits. The record was held open until November 18, 2015, for the respondent to submit an additional exhibit. The exhibit was received timely and entered as Respondent Exhibit "5". The record was closed on November 18, 2015.

FINDINGS OF FACT

1. Prior to the action under appeal, petitioner's household received FA benefits and petitioner's wife received full Family-Related Medicaid.

2. On October 5, 2015, petitioner submitted a redetermination FA and Medicaid application for himself, wife and two minor children. All household members are in the same tax filing unit (petitioner and his wife file jointly and the children are dependents). The application lists income from child support for the children and Social Security (SS) for petitioner and the children. The issue is Medicaid for petitioner's wife and FA for the household.

3. The Department verified the following SS income: $1,053 Social Security Disability Income (SSDI) for petitioner, $242 (SS) for each child due to petitioner receiving SSDI and $461 Supplemental Security Income (SSI) for each child.

4. The Department also verified the children receive $75 biweekly child support.

5. The Department converted the biweekly child support income to monthly income by multiplying $75 by 2.15 to arrive at $161.25 ($75 X 2.15 = $161.25). Then they divided $161.25 by two (children), resulting in $80.63 for one child and $80.62 for the other child.

6. The total household income is:

$1,053.00	SSDI
+$ 242.00	SS for one child
+$ 242.00	SS for second child
+$ 461.00	SSI for one child
+$ 461.00	SSI for second child
+$ 80.63	child support for one child
+$ 80.62	child support for second child
$2,620.25	Total household income

7. The Department used $2,619.89 as the total household income instead of $2,620.25 in the FA calculation.

$2,619.89	total household income
-$ 168.00	standard deduction
$2,451.89	adjusted income
$ 893.00	rent/shelter
+$ 345.00	standard utility allowance
$1,238.00	total shelter and utilities
-$1,225.94	50% of adjusted income ($2,451.89/2)
$ 12.06	excess shelter deduction
$2,451.89	adjusted income
-$ 12.06	excess shelter deduction
$2,439.83	adjusted income after deductions

8. The net income limit for a household size of four to be eligible for FA benefits is $2,021. Petitioner's $2,439.83 monthly household income exceeds $2,021; therefore, the household is not eligible for FA benefits.

9. Respondent's representative explained that the Department erred in petitioner's FA calculation at the last certification; which is the reason they received FA benefits. The Department also erred by not including petitioner's SSDI in his wife's Medicaid eligibility determination; which is the reason his wife received full Medicaid.

10. For petitioner's wife to be eligible for full Family-Related Medicaid, petitioner's household income cannot exceed the $364 income limit for a household size of four. Petitioner's $1,053 SSDI income (not including the children's income) exceeds $364; therefore, petitioner's wife is not eligible for full Medicaid. The next available program is the MN with a SOC.

11. The Department did not count the children's income from child support or from SS in petitioner's wife's SOC calculation.

12. The respondent determined petitioner's wife's SOC as follows:

$1,053	petitioner's SSDI
-$ 387	Medically Needy Income (MNIL) for household size of two
$ 666	SOC

13. On October 7, 2015, the respondent mailed petitioner a Notice of Case Action, notifying FA application dated October 5, 2015 was denied, due to the household income being too high to qualify. And petitioner's wife was enrolled in the MN Program with a $666 SOC.

CONCLUSIONS OF LAW

14. 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 Fla. Stat. § 409.285.

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

FOOD ASSISTANCE ISSUE

16. Federal Regulations at 7 C.F.R. § 273.09, defines income and in part states:

> (b)(2) Unearned income shall include, but not be limited to…
> (i) Assistance payments from Federal or federally aided public assistance programs, such as supplemental security income (SSI)…
> (ii) Annuities; pensions; retirement, veteran's, or disability benefits; worker's or unemployment compensation including any amounts deducted to repay claims for intentional program violations as provided in §272.12; old-age, survivors, or social security benefits…
> (iii) Support or alimony payments made directly to the household from nonhousehold members.

17. In accordance with the above authority, the Department included petitioner's SSDI, the children's income from SS, SSI and child support income in the FA calculation.

18. Federal Regulations at 7 C.F.R. § 273.10, explains monthly income and in part states:

> (c) (2) Income only in month received. (i) Income anticipated during the certification period shall be counted as income only in the month it is expected to be received, unless the income is averaged. Whenever a full month's income is anticipated but is received on a weekly or biweekly basis, the State agency shall convert the income to a monthly amount by multiplying weekly amounts by 4.3 and biweekly amounts by 2.15…

19. In accordance with the above authority, the Department converted petitioner's biweekly child support income to monthly income; using a 2.15 conversion factor.

20. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, Appendix A-1, sets forth for a household size of four the following:

$ 649	maximum FA benefit
$ 168	standard deduction
$ 345	standard utility allowance
$2,021	net income limit

21. The evidence establishes that the Department used $2,619.89 as petitioner's total household income instead of $2,620.25. The additional $0.36 makes $2,440.38 as petitioner's adjusted income after deductions instead of $2,439.83. Both of petitioner's adjusted income exceeds the $2,021 net income limit to be eligible for FA benefits.

MEDICAID VS MEDICALLY NEEDY ISSUE

22. Federal Regulations at 42 C.F.R. § 435.603 "Application of modified adjusted gross income (MAGI)" states:

> (a) Basis, scope, and implementation. (1) This section implements section 1902(e)(14) of the Act.
> (2) Effective January 1, 2014, the agency must apply the financial methodologies set forth in this section in determining the financial eligibility of all individuals for Medicaid, except for individuals identified in paragraph (j) of this section and as provided in paragraph (a)(3) of this section.
> (b) Definitions. For purposes of this section—
> *Child* means a natural or biological, adopted or step child.
> *Code* means the Internal Revenue Code.
> *Family size* means the number of persons counted as members of an individual's household....
> *Parent* means a natural or biological, adopted or step parent.
> *Sibling* means natural or biological, adopted, half, or step sibling....
> (f) Household—(1) Basic rule for taxpayers not claimed as a tax dependent. In the case of an individual who expects to file a tax return for the taxable year in which an initial determination or renewal of eligibility is being made, and who does not expect to be claimed as a tax dependent by another taxpayer, the household consists of the **taxpayer** and, subject

> to paragraph (f)(5) of this section, **all persons whom such individual expects to claim as a tax dependent**...(emphasis added)

23. The above authority explains petitioner, his wife and both children are counted in the Medicaid eligibility determination for petitioner's wife.

24. Fla. Admin. Code R. 65A-1.707 Family-Related Medicaid Income and Resource Criteria, states in part:

> (1) Family-related Medicaid income is based on the definitions of income, resources (assets), verification and documentation requirements as follows:
> (a) Income. Income is earned or non-earned...

25. Fla. Admin. Code R. 65A-1.716 Income and Resource Criteria explains:

> (2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows:

Family Size	Income Level
4	$364

26. The above authority explains for petitioner's wife to be eligible for full Family-Related Medicaid benefits the income for a household size of four cannot exceed $364 monthly. Petitioner's $1,053 SSDI exceeds $364; therefore, petitioner's wife is not eligible for full Medicaid.

27. Fla. Admin. Code R. 65A-1.707 Family-Related Medicaid explains

> (a)...For Medically Needy coverage groups, the amount by which the gross income exceeds the applicable payment standard income level is a share of cost...

28. The above authority explains the SOC is determined by subtracting the income level from the gross income.

29. The Department's TRANSMITTAL NO. P-15-09-0009, dated September 18, 2015, explains Medically Needy Budgeting for Family-Related Medicaid and in part states: "A

child with countable income must be excluded from the Family-Related Medically Needy AG if inclusion is not beneficial to the individual whose eligibility is being determined."

30. Policy Manual, Appendix A-7, sets forth the MNIL at $387 for a household size of two and $585 for a household size of four.

31. The Department determined petitioner's wife MN SOC by subtracting the $387 MNIL for a household size of two from petitioner's $1,053 SSDI to arrive at $666.

HEARING OFFICER'S CONCLUSION

32. In careful review of the cited authorities and evidence, the undersigned concludes the respondent followed Rule in denying petitioner FA benefits; due to the household income exceeding the $2,021 net income for a household size of four.

33. In accordance with Federal Regulations at 42 C.F.R. § 435.603 (#22) petitioner's children are also to be included in petitioner's wife's MN SOC determination. And in accordance with the Department's TRANSMITTAL NO P-15-09-0009 (#29) the children's income is excluded in petitioner's wife's MN SOC calculation.

34. Subtracting $585 MNIL (for a household size of four) from petitioner's $1,053 SSDI results in $468 as the MN SOC for petitioner's wife.

35. In careful review of the cited authorities and evidence, the undersigned concludes the respondent erred by subtracting the $387 MNIL (for a household size of two) instead of $585 (for a household size of four) in petitioner's wife's MN SOC calculation.

36. Therefore, the Department is to correct petitioner's wife's MN SOC to $468, effective November 2015.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are denied and partially granted. Denied in that petitioner's household is not eligible for FA benefits and petitioner's wife is not eligible for full Family-Related Medicaid. And partially granted in that petitioner's wife's SOC is reduced from $666 to $468.

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 14 day of December, 2015,

in Tallahassee, Florida.

Priscilla Peterson

Priscilla Peterson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

PETITIONER,

Vs.

APPEAL NO. 15F-08895

CASE NO. [redacted]

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 09 Osceola
UNIT: 88999

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on December 2, 2015 at 1:41 p.m. All parties appeared in different locations by phone.

APPEARANCES

For Petitioner: [redacted] petitioner's daughter

For Respondent: Nydia Galarza, ACCESS Supervisor

STATEMENT OF ISSUE

At issue is the Department's action to deny the petitioner's application for Medicaid. The petitioner is asserting the affirmative and bears the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The respondent submitted six (6) exhibits that were accepted into evidence and marked as Respondent's Exhibits "1" through "6" respectively. The record was held open until the close of business on December 4, 2015 for the petitioner and the respondent to supplement the record. The petitioner timely provided the additional documentation, which was accepted into evidence and marked as Petitioner's Exhibits "1" through "3". The respondent also timely provided the additional documentation, which was accepted into evidence and marked as Respondent's Exhibits "7". The record closed on December 4, 2015.

FINDINGS OF FACT

1. On September 24, 2015, the petitioner submitted an electronic application for Food Assistance, Cash Assistance and Medicaid benefits.

2. The petitioner is 88 years old.

3. The petitioner is from the country of [redacted] The petitioner first became a Lawful Permanent Resident (LPR) in 1977. The petitioner then returned to [redacted] in 1986. In 1988, the petitioner returned to the United States and then back to [redacted] The LPR status remained current until mid-1989 when it expired. The petitioner remained in [redacted] until 2015 when she returned to the United States and regained her LPR status effective September 1, 2015.

4. The Department provided a document from the Department of Homeland Security that confirmed the petitioner's date of entry as September 1, 2015 and her status as an LPR.

5. The Department indicates that even though the petitioner had been in the United States prior to August 22, 1996, she did not remain continuously in the United States. Additionally, since her current LPR status is effective September 1, 2015, which is later than the date of August 22, 1996, the petitioner's LPR status must be at least five years from the status date of September 1, 2015, in order to be potentially eligible for Medicaid.

6. On September 28, 2015, the Department mailed a Notice of Case Action denying the petitioner's application for Medicaid with the reason, "(n)o household member meets the requirements for this program."

7. The petitioner's daughter asserts that her mother has gone back and forth between the United States and [redacted] due to medical issues. The petitioner needs medical care and her daughter is unable to provide her assistance with her healthcare but she provides for all of her mother's other needs.

CONCLUSIONS OF LAW

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

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

10. Fla. Admin. Code R. 65A-1.301, Citizenship, states in part:

> (1) The individual whose needs are included must meet the citizenship and noncitizen status established in: P.L. 104-193, The Personal Responsibility and Work Opportunity Reconciliation Act of 1996; P.L. 105-

> 33, the Balanced Budget Act of 1997; P.L. 105-185, the Agricultural Research, Extension, and Education Reform Act of 1998; P.L. 105-306, the Noncitizen Benefit Clarification and Other Technical Amendments Act of 1998; P.L. 109-171, the Deficit Reduction Act of 2005; and, the Immigration and Nationality Act....
> (3) The eligibility specialist must verify the immigration status of noncitizens through the United States Citizenship and Immigration Service (USCIS), formerly the United States Bureau of Citizenship and Immigration Services. Verification will be requested electronically using the alien number, or based on a USCIS or prior Immigration and Naturalization Services (INS) document provided by the applicant. The system of verification is known as the Verification Information System-Customer Processing System (VIS-CPS), which is part of the Systematic Alien Verification for Entitlements (SAVE) Program...

11. The Code of Federal Regulations at 42 C.F.R. § 435.406, Citizenship and alienage sets forth:

> (a) The agency must provide Medicaid to otherwise eligible residents of the United States who are—
> (1) Citizens: (i) Under a declaration required by section 1137(d) of the Act that the individual is a citizen or national of the United States; and
> (ii) The individual has provided satisfactory documentary evidence of citizenship or national status, as described in § 435.407.
> (iii) An individual for purposes of the declaration and citizenship documentation requirements discussed in paragraphs (a)(1)(i) and (a)(1)(ii) of this section includes both applicants and beneficiaries under a section 1115 demonstration (including a family planning demonstration project) for which a State receives Federal financial participation in their expenditures, as though the expenditures were for medical assistance.
> (iv) Individuals must declare their citizenship and the State must document the individual's citizenship in the individual's eligibility file on initial applications and initial redeterminations effective July 1, 2006.
> (v) The following groups of individuals are exempt from the requirements in paragraph (a)(1)(ii) of this section:
> (A) Individuals receiving SSI benefits under title XVI of the Act.
> (B) Individuals entitled to or enrolled in any part of Medicare.
> (C) Individuals receiving disability insurance benefits under section 223 of the Act or monthly benefits under section 202 of the Act, based on the individual's disability (as defined in section 223(d) of the Act).
> (D) Individuals who are in foster care and who are assisted under Title IV-B of the Act, and individuals who are beneficiaries of foster care maintenance or adoption assistance payments under Title IV-E of the Act.

> (2)(i) Except as specified in 8 U.S.C. 1612(b)(1) (permitting States an option with respect to coverage of certain qualified aliens), qualified aliens as described in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641) (including qualified aliens subject to the 5-year bar) who have provided satisfactory documentary evidence of Qualified Alien status, which status has been verified with the Department of Homeland Security (DHS) under a declaration required by section 1137(d) of the Act that the applicant or beneficiary is an alien in a satisfactory immigration status.
> (ii) The eligibility of qualified aliens who are subject to the 5-year bar in 8 U.S.C. 1613 is limited to the benefits described in paragraph (b) of this section.
> (b) The agency must provide payment for the services described in § 440.255(c) of this chapter to residents of the State who otherwise meet the eligibility requirements of the State plan (except for receipt of AFDC, SSI, or State Supplementary payments) who are qualified aliens subject to the 5-year bar or who are non-qualified aliens who meet all Medicaid eligibility criteria, except non-qualified aliens need not present a social security number or document immigration status.

12. The Department's Program Policy Manual, CFOP 165-22 (Policy Manual), passage 1440.0106, Lawful Permanent Resident (MSSI), states in part:

> A lawful permanent resident (LPR) is a noncitizen who lawfully immigrates to the U.S. and has permission to live and work in the U.S. LPRs may be eligible for Medicaid based on citizenship if they entered the U.S.:
> 1. prior to 8/22/96 and have remained continuously present,
> …
> 3. on or after 8/22/96 and have lived in the U.S. as a qualified noncitizen for at least five years.
> …
> Note: LPRs who entered after 8/22/96 are subject to the five-year ban, unless otherwise noted.
> LPRs who are in the five-year ban may be eligible for Emergency Medicaid for Aliens, (EMA).

13. The Policy Manual, at passage 1440.0114 addresses Verification Requirements for Noncitizens (MSSI, SFP) states, "(t)he eligibility specialist must verify the immigration status of all non-citizens applying for or receiving Medicaid through the U.S. Citizenship and Immigration Services (USCIS)."

14. According to the above authority and policy, a non-citizen who entered the U.S. after August 22, 1996, must have resided in the United States as a Legal Permanent Residence (LPR) for a period of five years to be eligible for Medicaid benefits. The petitioner resided in the United States as a LPR as of September 1, 2015.

15. Though the petitioner had a prior LPR status before August 22, 1996, she did not remain continuously in the United States.

16. Based on the immigration documentation presented, the petitioner is not eligible for Medicaid according to the above authority. The petitioner must meet the five-year requirement, which she will complete as of September 1, 2020.

17. In careful review of the cited authorities and policy, the undersigned concludes the respondent followed the rules and correctly denied Medicaid benefits for the petitioner.

18. The petitioner would be eligible for Emergency Medicaid Assistance for Aliens (EMA) benefits and may apply for that benefit at any time.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the Department's action is 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 29 day of December, 2015,

in Tallahassee, Florida.

Raymond Muraida

Raymond Muraida
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

FILED
Dec 18, 2015
Office of Appeal Hearings
Dept. of Children and Families

[redacted]

PETITIONER,

APPEAL NO. 15N-0065

VS.

ADMINISTRATOR
[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 21st, 2015 at 10:10 a.m. in [redacted] Florida. The hearing reconvened on November 6th, 2015 at 1:35 p.m. in [redacted] Florida.

APPEARANCES

August 21st, 2015: For the petitioner: [redacted] pro se.

For the respondent: Maria Mayor, Administrator for the facility.

November 6th, 2015: For the petitioner: [redacted] pro se, by telephone.

For the respondent: Laura Llorente, Esq. and Laura Wade, Esq.

STATEMENT OF ISSUE

The petitioner is appealing the respondent's intention to discharge him from the facility.

PRELIMINARY STATEMENT

Appearing as a witness for the petitioner on both hearing dates was [redacted] District Ombudsman Manager. Appearing as a witness for the petitioner on November 6th, 2015 was [redacted] the petitioner's mother.

Appearing as witnesses for the respondent on August 21st, 2015 were Laverne Jeremiah, Associate Director of Nursing/Risk Manager; Jim Dorvil, Admissions Counselor; Elaine Sangster, Nurse Manager; Yuvonne Martin, Advanced Registered Nurse Practitioner, and Lynn Hernandez, Social Worker.

Appearing as witnesses for the respondent on November 6th, 2015 were Maria Mayor, Administrator for the facility; Lynn Hernandez, Social Worker; Laverne Jeremiah, Associate Director of Nursing/Risk Manager, and Idel Benjamin, Director of Patient Care Services.

Diane Moore, Supervisor for Long-Term Care, with the Agency for Health Care Administration appeared as a non-testifying witness at both hearings.

Respondent's Exhibits 1 was admitted into evidence on August 21st, 2015. Petitioner's objection was noted. Respondent's Exhibits 2 through 14 (tabbed as 1-13) were admitted into evidence on November 6th, 2015.

On August 21st, 2015, partial testimony from the respondent was taken. The hearing was adjourned because after going on record, the petitioner expressed his wish to have his mother present as a witness, and she was not available on that date. The hearing was scheduled to reconvene on September 16th, 2015. However, the petitioner claimed that he did not receive the Notice of Hearing; consequently, neither he nor the district ombudsman was aware of the hearing date. The hearing was rescheduled for

October 20th, 2015. However, on October 15th, 2015, the hearing officer was apprised of the fact that the petitioner had been transferred to [redacted] Hospital due to an involuntary commission under the Baker Act, and that the hearing would need to be conducted there. The hearing was necessarily rescheduled in order to allow ample notice informing the parties of the change of venue.

The record was left open until November 20th, 2015 in order to allow counsel for the respondent to submit a Proposed Final Order. This was received within the allowed time frame and the record was closed.

By way of Notice of Discharge dated June 18th, 2015, the respondent informed the petitioner of its intention to effectuate a discharge on July 18th, 2015. The two reasons stated on the notice are "Your needs cannot be met in this facility" and "The safety of other individuals in this facility is endangered." (See Respondent's Exhibit 4.) On June 22nd, 2015, the petitioner filed a timely appeal to challenge the respondent's action.

FINDINGS OF FACT

1. The petitioner, 32 years of age, was admitted to the facility on June 11th, 2014 due to incomplete quadriplegia with impaired physical functioning (spinal cord injuries). The petitioner also arrived with a history of recurring ulcers.

2. From at least January 2015 through March 2015, the facility documented various incidents of the petitioner's behavior (much of which the petitioner denied) which included disrespectful demeanor toward staff and other resident's, violations of the facility's smoking policy (i.e. smoking in non-designated areas), disturbing other residents with loud and offensive music, and violation of residents' pass privileges. As a

result of this, the facility initiated a Nursing Home Discharge procedure on February 23rd, 2015; the petitioner filed an appeal to challenge this action, and a fair hearing was scheduled for April 8th, 2015.

3. However, on March 19th, 2015, the petitioner signed an agreement wherein the petitioner agreed to comply with the facilities requirements. Such included, in part, the petitioner's agreement to: seek the appropriate permission (pass) to leave the facility; to use STS (Special Transportation Services) when leaving the facility; to return to the facility at the designated time; to advise the facility in the event that STS causes a delay in the petitioner's designated return time (which was 8:00 p.m., a policy recently-established for all residents due to an incident from earlier in the year where a resident, away with a pass, was fatally injured in an accident); to refrain from the use of illegal drugs; to refrain from the use of profanity toward staff during when care is rendered; address his concerns with a respective tone, and to play his music in such a way that it does not disturb other residents. Visitors would be allowed to visit the petitioner upon providing proper identification.

4. The facility, in turn, rescinded its intention to discharge the petitioner, and on May 6th, 2015, the appeal was duly dismissed.

5. The facility administrator asserted that during the weekend of May 16th, 2015, she was contacted by facility security at her home after hours. It was reported that the petitioner was not in compliance with the facility's curfew requirement. The petitioner countered that he was denied access to the facility when he tried to return.

6. On June 10th, 2015, the petitioner signed a refusal of care for a wound. Specifically, he refused to remain on bed rest to allow a wound to heal. The respondent

asserted that the petitioner not only refused to remain on bed rest, but also he remained in his wheelchair for three consecutive days, causing his wound to worsen.

7. The Advanced Registered Nurse Practitioner asserted that during a visit from the petitioner's mother in June 2015, the petitioner displayed suicidal tendencies. The petitioner's mother expressed concern to the ARNP about this. The ARNP was obligated to follow up on this allegation. Consequently, the petitioner was committed under the Baker Act and transferred to [redacted] Hospital, where the results of lab work performed on June 12th, 2015 showed a finding of "presumptive" to tests of "cocaine and metabolites, alcohol, cannabinoid, and benzodiazepine class." (See Respondent's Exhibit 13, 1st page of the report.) The petitioner denied the use of any illegal drugs except for one occasion "a long time ago." There was no expert witness or qualified custodian of records available at either hearing to attest to the validity of the report, or the results contained therein.

8. Upon receipt of this report, the facility requested that the petitioner agree (upon return to the facility) to random drug-testing, as the petitioner takes multiple prescribed medications that, if combined with illegal drugs, could lead to cardiac arrest. The petitioner refused consent to random drug-testing. The petitioner did not dispute this at the hearing.

9. The petitioner's social worker asserted that during a discussion with the petitioner on July 22nd, 2015, the petitioner became aggressive and threatened that he would have the staff's eyes "looking like fifty-cent pieces." The petitioner did not dispute this, but stated that he did not mean anything harmful or threatening by the remark.

10. On or around July 24th, 2015, residents of the facility reported to staff that they had seen the petitioner rolling marijuana on the facility grounds. The petitioner admitted that he "smoked pot".

11. On Friday, August 14th, 2015, the facility administrator received a telephone call from the facility security at 12:15 a.m. The petitioner had left the facility without authorization, and had yet to return. The administrator instructed the staff to contact the police; however, no police report could be filed, as the petitioner had not been gone for 24 hours. The petitioner admitted that on the preceding Thursday, he left the facility without authorization to join a cousin at a tattoo shop for an appointment that had been made for after shop hours (to minimize the time away from the facility). The petitioner was unable to return to the facility until 3:30 a.m. on that Friday due to transportation issues.

12. The respondent alleged that in addition to the above-mentioned incident, the petitioner left the grounds without authorization on numerous occasions, supposedly to visit family members and friends, but did not provide specific details regarding the dates and circumstances of these incidents.

13. The respondent's intention is to transfer the petitioner to a facility further away, where the petitioner will not be as easily exposed to the "external elements" that are detrimental to his well-being.

CONCLUSIONS OF LAW

14. Jurisdictional boundaries to conduct this hearing have been assigned to the Department by Federal Regulations appearing at 42 C.F.R. § 431.200. Florida Statute

400.0255 addresses "Resident transfer or discharge; requirement and procedures; hearing..." with section (15) (b) informing that the burden of proof is one of clear and convincing evidence. Federal regulations limit the reason for which a discharge may occur and provide for involuntary and certain emergency discharge procedures.

15. Additional regulations at 42 C.F.R. § 483.12(a) address nursing facility "Admission, transfer and discharge rights" for residents, in relevant part as follows:

> (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--
>
> (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
>
> (ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
>
> (iii) The safety of individuals in the facility is endangered;
>
> (iv) The health of individuals in the facility would otherwise be endangered;
>
> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
>
> (vi) The facility ceases to operate.
>
> (3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by--
>
> (i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and
>
> (ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.

(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must--

(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

(ii) Record the reasons in the resident's clinical record; and

(iii) Include in the notice the items described in paragraph (a)(6) of this section.

(5) Timing of the notice.

(i) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(ii) Notice may be made as soon as practicable before transfer or discharge when--

(A) the safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section…

16. The regulations inform that there are several reasons justifying discharge, including safety endangerment of other individuals. In this situation, the respondent contends that the petitioner's needs cannot be met at the facility, and that the safety of other individuals at the facility is endangered. Discharge was planned for those reasons.

17. Hearsay is defined by § 90.801(1)(c), Fla. Stat. as "a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted."

18. Fla. Stat. § 120.57(1)(c) states in pertinent part:

"[h]earsay evidence may be used for the purpose of supplementing or explaining other evidence, but it shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions."

19. Florida Statutes 90.803 addresses hearsay exceptions, and states in relative part:

> (6) RECORDS OF REGULARLY CONDUCTED BUSINESS ACTIVITY.- (a) a memorandum, report, record, or data compilation, in any form, of acts, events, conditions, opinion, or diagnosis, made at or near the time by, or from information transmitted by, a person with knowledge, if kept in the course of a regularly conducted business activity and if it was the regular practice of that business activity to make such memorandum, report, record, or data compilation, all as shown by the testimony of the custodian or other qualified witness, or as shown by a certification or declaration that complies with paragraph (c) and s. 90.901(11), unless the sources of information or other circumstances show lack of trustworthiness. The term "business" as used in this paragraph includes a business, institution, association, profession, occupation, and calling of every kind, whether or not conducted for profit.

20. The respondent's position that a lab report from June 2015 indicated that the petitioner tested "presumptive" for cocaine and metabolites, alcohol, cannabinoid, and benzodiazepine class is considered hearsay, as there was no expert witness (or in the absence thereof, a certification of authenticity) to define this result, or to address the petitioner's rebuttal to this result. Therefore, the hearing officer cannot afford any consideration to this report.

21. Nonetheless, the hearing officer recognizes that the respondent must afford serious consideration to this result. Therefore, the hearing officer affirms the respondent's request that the petitioner submit to random drug-testing while at the facility. The (possible) use of illegal drugs, in combination with prescribed medications, places the petitioner's health at great risk. The petitioner's refusal to submit to random

drug-testing only serves to greatly reduce the respondent's ability to monitor the petitioner's health.

22. The findings show that the facility has a policy that residents who wish to leave the grounds may only do so with an authorized pass. The findings show that the petitioner signed an agreement on March 19th, 2015 to follow this policy. The findings also show that the facility has a curfew policy of 8:00 p.m. which was implemented for the safety of the residents as established above.

23. The findings show that the petitioner violated these policies on at least one occasion (August 13th, 2015), the petitioner left the grounds without a pass, and did not return until 3:00 a.m. on Friday, August 14th, 2015.

24. The findings show that the petitioner signed an agreement on March 19th, 2015, to refrain from using any illegal drugs while on facility grounds. The findings show that the petitioner admitted to smoking pot on the facility grounds on at least one occasion (on or around July 24th, 2015).

25. The findings show that on at least one occasion (July 22nd, 2015), the petitioner made what was construed to be a threatening remark to the facility staff. The petitioner's argument regarding the innocence of the meaning of his remark was noted, but not persuasive.

26. The hearing officer notes that the above-mentioned incidents, with the exception of the request that the petitioner submit to random drug-testing, post-date the Nursing Home Transfer and Discharge Notice of June 18th, 2015 (which is the notice

that prompted the hearing request). (Allegations of other incidents that pre-date this notice were unsubstantiated.) Therefore, the hearing officer concludes that notice to discharge for these reasons was premature.

27. However, based on the petitioner's refusal in June 2015 to submit to random drug-testing in order to allow the respondent to properly monitor the effects of his prescription drugs, the hearing officer concludes that the respondent met its burden of proof that discharge is justified, as the respondent is no longer able to meet the petitioner's needs.

28. Establishing that reason for discharge is lawful is just one step in the discharge process. The nursing facility must also provide discharge planning, which includes identifying an appropriate transfer or discharge location and sufficiently preparing the affected resident for a safe and orderly transfer or discharge from the facility. The hearing officer in this case cannot and has not considered either of these issues. The hearing officer has considered only whether the discharge is for a lawful reason.

29. Any discharge by the nursing facility must comply with all applicable federal regulations, Florida Statutes, and Agency for Health Care Administration requirements. Should the resident have concerns about the appropriateness of the discharge location or the discharge planning process, the resident may contact the AHCA health care facility complaint line at (888) 419-3456.

DECISION

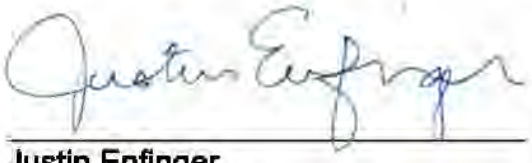
Based on the foregoing Findings of Fact and Conclusions of Law, this appeal is denied. The respondent's intention to discharge the petitioner is upheld.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party 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 party 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 department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 18 day of December, 2015,

in Tallahassee, Florida.



Justin Enfinger
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
[redacted] Respondent
Ms. Arlene Mayo-Davis, FO, Agency for Health Care Administration
[redacted] Ombudsman

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

[redacted]

PETITIONER,

Vs.

APPEAL NO. 15N-0077

ADMINISTRATOR
[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative nursing home discharge hearing was convened before the undersigned on October 20th, 2015 at 9:35 a.m. at the [redacted] Florida.

APPEARANCES

For the petitioner: [redacted] pro se.

For the respondent: Michelle Rousseau, Risk Manager and Certified Patient Safety Officer for the facility.

STATEMENT OF ISSUE

The petitioner is appealing the respondent's intention to discharge her from the facility. The petitioner remains as a resident of the facility pending the outcome of the hearing.

PRELIMINARY STATEMENT

Appearing as a witness for the petitioner was [redacted] Petitioner's friend and Power of Attorney.

Appearing as witnesses for the respondent were Bridgette Wilson, Business Office Manager, and Brenith Delson, Director of Nursing. During the hearing, James Reiss, Administrator of the facility, made a brief appearance.

The hearing was originally scheduled for September 30th, 2015. A continuance was granted at the request of the petitioner, and the hearing convened as described above.

Petitioner's Composite Exhibit 1 was moved into evidence.

Respondent's Exhibits 1 through 2 were moved into evidence.

By way of a Nursing Home Transfer and Discharge Notice dated July 15th, 2015, the respondent informed the petitioner of its intention to discharge her from the facility effective August 15th, 2015. The reason stated on the notice is "Your needs cannot be met in this facility." Notably, the copy of the discharge notice submitted into evidence (Respondent's Exhibit 1) indicates that the notice was signed by the facility and administrator and the attending physician on July 15th, 2015, but was not signed by the petitioner.

On July 28th, 2015, the petitioner filed a timely appeal to challenge the respondent's action.

FINDINGS OF FACT

1. The petitioner was admitted to the facility on March 4th, 2015. At the time of her admittance, the petitioner was diagnosed with [redacted] The petitioner takes multiple medications; the petitioner was also, and continues to be on [redacted]

2. The respondent alleged that the petitioner initially developed a pattern of refusal to take medications as well as a refusal of medical care (dialysis). The respondent alleged that multiple conferences were held to discuss the petitioner's plan of care. These conferences included visits from a physician and a nephrologist to discuss the impact that the petitioner's actions were taking on her health. The petitioner countered that there were medications that she did not wish to take because adverse side effects outweighed the benefits of the medications.

3. At the request of the petitioner, the petitioner's first attending physician, "Dr. M." terminated his services with her. A second physician, "Dr. A." reviewed the petitioner's file, but upon noting the petitioner's refusals described above, declined the petitioner as a patient. The petitioner is currently under the temporary care of the facility's medical director, who had no choice other than to accept the petitioner as a patient while she finds her own physician.

4. The respondent claimed that since the facility's medical director assumed the (temporary) care of the petitioner, the petitioner has been fully compliant in taking her medications and going for dialysis, thereby rendering moot the reason for discharge as issued on the notice of July 15th, 2015. The only remaining issue at the time of the

hearing was for the petitioner to find a "permanent" physician to accept her as a patient. The petitioner has not been given any type of official deadline by which to do so.

5. The respondent alleged that since the July 15th, 2015 discharge notice was issued, other issues related to the petitioner's conduct have arisen; therefore, discharge is still warranted. However, as no discharge notice has been issued on this matter, the respondent's allegations on this subject will not be addressed.

CONCLUSIONS OF LAW

6. Jurisdictional boundaries to conduct this hearing have been assigned to the Department by Federal Regulations appearing at 42 C.F.R. § 431.200. Florida Statute 400.0255 addresses "Resident transfer or discharge; requirement and procedures; hearing..." with section (15) (b) informing that the burden of proof is one of clear and convincing evidence. Federal regulations limit the reason for which discharge may occur and provide for involuntary and certain emergency discharge procedures.

7. Additional regulations at 42 C.F.R. § 483.12(a) address nursing facility "Admission, transfer and discharge rights" for residents, in relevant part as follows:

> ...(2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--
>
> (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
>
> (ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(iii) The safety of individuals in the facility is endangered;

(iv) The health of individuals in the facility would otherwise be endangered;

(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(vi) The facility ceases to operate.

(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by--

(i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and

(ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.

(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must--

(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

(ii) Record the reasons in the resident's clinical record; and

(iii) Include in the notice the items described in paragraph (a)(6) of this section.

(5) Timing of the notice.(i) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(ii) Notice may be made as soon as practicable before transfer or discharge when--

(A) the safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section...

8. The regulations inform that there are several reasons justifying discharge. In this situation the respondent contends that the petitioner's needs could no longer be met at the facility. Discharge was planned for those reasons.

9. Establishing the reason for discharge is lawful is just one step in the discharge process. The nursing facility must also provide discharge planning, which includes identifying an appropriate transfer or discharge location and sufficiently preparing the affected resident for a safe and orderly transfer or discharge from the facility. The hearing officer in this case cannot and has not considered either of these issues. The hearing officer has considered only whether the discharge is for a lawful reason.

10. The findings show that although the petitioner may have been non-cooperative with her attending physician which resulted in the respondent's decision that it could no longer meet the petitioner's needs, the undisputed testimony is that the petitioner is now fully cooperating with instructions from her current physician (the facility's medical director). Therefore, this reason is no longer applicable. The hearing officer notes the respondent's contention that the medical director's care is only temporary pending the petitioner's finding a permanent physician on her own. However, after review of the regulations cited above, the hearing officer finds that discharge for this reason alone is not justified.

11. In sum, based on a review of the evidence in its totality, the hearing officer concludes that the respondent did not meet its burden of proof in its position that it can

no longer meet the needs of the petitioner, and therefore, the action described in its Nursing Home Transfer and Discharge Notice of July 15th, 2015 is not upheld.

12. Any discharge by the nursing facility must comply with all applicable federal regulations, Florida Statutes, and Agency for Health Care Administration requirements. Should the resident have concerns about the appropriateness of the discharge location or the discharge planning process, the resident may contact the AHCA health care facility complaint line at (888) 419-3456.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, this appeal is hereby granted. The respondent may not proceed with its intent to discharge the petitioner based on the above-mentioned notice.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party 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 party 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 indigence to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 13th day of November, 2015,

in Tallahassee, Florida.

Justin Enfinger
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.hearings@myFLfamilies.com

Copies Furnished To: [redacted] Petitioner

[redacted] Respondent

Ms. Arlene Mayo-Davis, FO, Agency for Health Care Administration

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

[redacted]

PETITIONER,

Vs.

Administrator

[redacted]

RESPONDENT.
_____/

APPEAL NO. 15N-00079

CASE NO.

FINAL ORDER

Pursuant to notice, an administrative hearing was convened in the above-styled matter on September 16, 2015 at 9:08 a.m. at the respondent's facility.

APPEARANCES

For the Petitioner: [redacted] petitioner's daughter

For the Respondent: Kevin Shavel, administrator

ISSUE

At issue is the facility's intent to discharge the petitioner from the respondent's facility due to non-payment of bill for services. The facility has the burden of proof to establish by clear and convincing evidence that the discharge is appropriate under federal regulations found in 42 C.F.R. § 483.12.

PRELIMINARY STATEMENT

Petitioner was not present and was represented by [redacted] who testified. Petitioner presented two witnesses who testified: [redacted] and [redacted]

both certified Ombudsmen. Petitioner submitted four exhibits, which were accepted into evidence and marked as Petitioner's Exhibits "1" through "4". Respondent was represented by Kevin Shavel, who testified. Respondent presented one witness who testified: Richard Horton, Social Services Director. Respondent submitted one exhibit, which was accepted into evidence and marked as Respondent's Exhibit "1". The record closed on September 16, 2015.

FINDINGS OF FACT

1. Petitioner became a resident of the facility on May 2, 2012.

2. Petitioner's Institutional Care Program (ICP) Medicaid benefits ended effective November 30, 2014.

3. Petitioner's Medicare benefits paid for services rendered for the month of November 2014 and for part of December 2014 (December 1, 2014 through December 6, 2014).

4. Petitioner has been continuously paying her patient responsibility each month since December 2014. She paid $316.13 for December 2014 and $392 per month for January 2015 and ongoing.

5. Once petitioner's ICP Medicaid benefits ended, she became a private pay individual who is responsible for the total amount of the facility's bill for services rendered.

6. On April 4, 2015, the respondent's facility completed an application for ICP benefits on behalf of petitioner with the Department of Children and Families (DCF) ACCESS Program. Petitioner was pended for proof of spend down of her assets as she was over the asset limit for ICP Medicaid.

7. On May 28, 2015, DCF denied petitioner's April 2015 ICP Medicaid application as she did not submit the necessary information to determine her eligibility.

8. On July 31, 2015, the respondent issued petitioner a Nursing Home Transfer and Discharge Notice that indicated petitioner would be discharged from the facility effective August 8, 2015 based on non-payment of bill for services. The discharge location listed was the [redacted] Petitioner requested an appeal challenging the discharge action. Petitioner remains a resident of the nursing facility pending the outcome of this appeal decision.

9. As of July 31, 2015, petitioner's past due balance was $49,042.43 for the months of December 2014 through July 31, 2015.

10. On August 26, 2015, the respondent's facility completed an application for ICP Medicaid benefits on behalf of petitioner with the DCF ACCESS Program. As of the date of the hearing, petitioner's August 26, 2015 ICP Medicaid application was pending and petitioner's ICP Medicaid eligibility had not yet been determined. Petitioner's daughter asserted she requested the necessary documents from her mother's bank and should receive them shortly to submit to DCF so her mother's ICP Medicaid eligibility can be determined.

CONCLUSIONS OF LAW

11. The jurisdiction to conduct this hearing is conveyed to the Department of Children and Families by Federal Regulations appearing at 42 C.F.R. 431.200. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to s. 400.0255(15), Fla.

Stat. In accordance with that section, this order is the final administrative decision of the Department of Children and Families.

12. Federal Regulations appearing at 42 C.F.R. § 483.12, Admission, transfer and discharge rights, sets forth the limited reasons a Medicaid or Medicare certified nursing facility may involuntary discharge a resident and states in part:

> (a)(2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--
> (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
> (ii) The transfer or discharge is appropriate because the president's health has improved sufficiently so the resident no longer needs the services provided by the facility;
> (iii) The safety of individuals in the facility is endangered;
> (iv) The health of individuals in the facility would otherwise be endangered;
> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid...

13. Petitioner currently has an ICP Medicaid application pending as she is seeking benefits to pay for the facility's unpaid charges. It is unknown when and if petitioner's ICP Medicaid benefits will be approved or the effective date of her ICP Medicaid benefits. As a result it is unknown if petitioner would still owe payments to the facility. Furthermore, petitioner has been faithfully paying her patient responsibility each month since her ICP Medicaid benefits were terminated on November 30, 2014.

14. The Department of Health and Human Services, Centers for Medicaid and Medicare Services, State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities states in part:

> A resident cannot be transferred for non-payment if he or she has submitted to a third party payor all the paperwork necessary for the bill to be paid. Non-payment would occur if a third party payor, including Medicare or Medicaid, denies the claim and the resident refused to pay for his or her stay.

15. Pursuant to the above authority, the aforementioned guidance to the Agency for Health Care Administration surveyors allows the reviewing of a discharge notice due to non-payment to be considered in this appeal. In this instance, petitioner had a pending ICP Medicaid application when the facility issued their unpaid billing notices to her. Petitioner's August 26, 2015 ICP Medicaid application has not been denied; therefore, it is unknown if Medicaid will not pay for petitioner's unpaid bills for any services rendered since December 2014. Since there is a pending ICP Medicaid application, this discharge is premature. Respondent must wait until the August 26, 2015 ICP Medicaid application is processed before proceeding with this discharge action.

DECISION

The appeal is GRANTED. The facility may not proceed with the discharge at this time. The facility must wait until the August 26, 2015 ICP Medicaid application has been disposed of and must give the petitioner adequate notice of any amounts due after any possible reductions as a result of payments from Medicaid.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party 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 party 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 department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 2 day of November, 2015,

in Tallahassee, Florida.

Mary Jane Stafford
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
[redacted] Respondent
Ms. Patricia Reed Caufman
Agency for Health Care Administration
[redacted]

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

[redacted]

APPEAL NO. 15N-00084

PETITIONER,

vs.

Administrator
[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing in the above-referenced matter convened on October 14, 2015, at approximately 2:30 p.m. in [redacted] Florida. All parties appeared in-person.

APPEARANCES

For Petitioner: [redacted] Petitioner

For Respondent: Terrye Dubberly, Administrator,
[redacted]

ISSUE

Respondent seeks to discharge Petitioner from its nursing home facility (NHF), alleging that "the safety of other individuals in this facility is endangered" by Petitioner. Respondent bears the burden of proving, by clear and convincing evidence, that this discharge is appropriate per federal regulations (42 C.F.R. § 483.12).

PRELIMINARY STATEMENT

Via Nursing Home Transfer and Discharge Notice dated August 14, 2015, Respondent notified Petitioner that he was to be discharged from its NHF effective September 14, 2015, due to an asserted safety risk. On or about August 21, 2015, the Petitioner requested a hearing to challenge the Respondent's action.

Terrye Dubberly, Administrator of [redacted] represented the Respondent. Ms. Dubberly presented six additional witnesses from the NHF: Angela Dees, Social Services Director; Sheila Cooper, Social Services Specialist I; Allison Prieto, RN, Unit Manager; Susan Rose, Director of Therapy; Violet Sotelo, RN, Unit Manager; and Karen Callahan, RN, Assistant Director of Nursing.

The Petitioner acted as his own representative. Petitioner expected his sister to join the hearing via teleconference; however, when she failed to do so, Petitioner confirmed that he wished to proceed without her. Petitioner noted he had requested Respondent provide him with a copy of any documentation to be used at hearing, and was denied same. Respondent did not initially intend to introduce documentary evidence, but decided to do so as the hearing progressed. Petitioner was provided a copy of same and given time to review the documents before they were accepted into evidence.

Deborah Allison, Health Facility Evaluator with the Agency for Health Care Administration (AHCA), observed the proceedings via teleconference. Respondent's Exhibits 1 through 4, inclusive, Petitioner's Exhibit 1, and a composite Hearing Officer Exhibit were entered into evidence.

FINDINGS OF FACT

1. The Petitioner has been a resident of Respondent's facility since August 12, 2015. He was admitted for wound care and pain management, following discharge from the hospital. He underwent amputation surgery in April of 2014, and hoped to begin physical therapy while in the facility to assist in preparation for a prosthesis.

2. Although the facility was unable to state Petitioner's admitting diagnoses, Petitioner stated that he is diagnosed with [redacted] He was admitted as (and remains) a Medicare patient, and is competent, with neither a guardian advocate nor a power of attorney designated to act on his behalf.

3. On or about August 12, 2015, Petitioner signed a "Genesis HealthCare Admission Agreement." Petitioner's signature is not dated, and there are no initials in the designated space for receipt of an Admission Packet. The only portions of the Admission Agreement completed include check boxes where Petitioner indicates that he gives the facility permission to do his laundry, but does *not* give permission for the NHF to open his financial or personal mail, arrange for salon, telephone, television, cable, other services, or bill him for fees associated with those services. The Admission Agreement makes no mention of a smoking policy.

4. On or about August 14, 2015 (two days after Petitioner was admitted), [redacted] issued to Petitioner a Nursing Home Transfer and Discharge Notice, checking a box to indicate that the reason for discharge was "The safety of other individuals in this facility is endangered," and typing in an explanation which states:

> Safety of others at risk due to smoking in room. Failure to execute admission/financial disclosure documents.

5. The Discharge Notice was signed by the NHF Administrator on August 13, 2015 (perhaps misdated), and given to Petitioner on August 14, 2015. However, because the reason stated in the Notice (safety of other individuals endangered) requires a physician's signature, the NHF obtained said signature from Robert Kitos, MD, on August 18, 2015. It does not appear that Petitioner was issued a copy of the Notice that includes the physician signature.

6. On or about August 21, 2015, the facility assisted Petitioner with completing a request for hearing. The transcribed reason for challenging the discharge notes:

> They are trying to illegally discharge me for refusing the sign an arbitration agreement. The admissions office said my "packet wasn't complete" for that reason, but it is illegal for them to require me to sign an arbitration agreement waiving my right to a jury trial in the event of litigation. They are also trying to discharge me for keeping my vapor pens in my room when in fact, vapor pens are not cigarettes, nor do they emit smoke. They are only water vapor, and have no effects on any one at all. So that is illegal too!

7. At hearing, Respondent clarified that it did not intend to proceed with discharge based on failure to execute documentation, but did wish to pursue discharge due to Petitioner's smoking, and also due to behavioral issues exhibited by the Petitioner. Since the behavioral issues were not included on the Discharge Notice, the undersigned informed both parties that the hearing would proceed with regard to the smoking issue, only.

8. It is Respondent's position that Petitioner violated Oakhurst's smoking policy on 11 separate occasions by having smoking equipment in his possession and/or by smoking an e-cigarette indoors. Of these 11 alleged violations (mostly hearsay, as discussed, below), four purportedly occurred on August 12, 2015, three on August 17,

2015, and the remainder on or after August 21, 2015. Of note, the only violations alleged to occur prior to Respondent's Notice of Discharge were those on August 12, 2015 – the day Petitioner was admitted to the facility.

9. The facility was unable to produce evidence that the facility has a written smoking policy of any kind, but claimed Petitioner underwent a Smoking Evaluation upon admission (discussed further, below). Respondent provided testimony to indicate Oakhurst's policy is that no one is permitted to smoke (regular cigarettes or e-cigarettes) indoors, and that smoking equipment is to be kept at the nurse's station. In general, residents are required to pick up their cigarettes, lighters, etc. from the nurse's station prior to exiting the facility to smoke outdoors, and are to return all equipment to the nurse's station once they have finished their smoke break.

10. Respondent noted that Petitioner was informed of the smoking policy upon his admission to the facility, verbalized understanding of same, and surrendered one of his two e-cigarettes to be held at the nurse's station. However, Respondent also testified that after Petitioner complained about the facility taking his e-cigarette, and accused them of losing it, facility staff returned it to him. On a separate occasion, the facility also allowed Petitioner to keep a pack of regular cigarettes on his person. It appears that despite having returned both a pack of cigarettes and the e-cigarette to Petitioner, thus giving him permission to possess both, staff continued to report him for having smoking equipment in his room.

11. In support of its position that Petitioner knew of and willfully violated its smoking policy, Respondent submitted into evidence the Admission Agreement (discussed, above), a Smoking Evaluation, and an Interdisciplinary Health Education Record.

12. On or about August 25, 2015 (11 days after Discharge Notice), Respondent completed a "Smoking Evaluation" form, erroneously checking the box to indicate that this evaluation was completed upon admission. Allison Prieto, as the NHF evaluator, assessed Petitioner as follows (all emphasis original):

MEDICAL	**YES**	**NO**
Does the patient use oxygen?		√
COGNITIVE	**YES**	**NO**
Does the patient have dementia?		√
Does the patient have poor memory?		√
Is the patient unable to demonstrate the location of the designated smoking area?	√	
BEHAVIOR	**YES**	**NO**
Does the patient have a history of fire setting or arson?		√
Does the patient have a history of unsafe smoking habits?		√
Does the patient have a history of sharing/selling cigarettes or smoking material?		√

On the same form, following this checklist, is the statement:

> **Supervised smoking is required if any "Yes" answers above. Check one below.**
>
> √ Independent smoking is allowed.
> Supervised smoking is required.
> Patient is not allowed to smoke.

Although the question "Is the patient unable to demonstrate the location of the designated smoking area?" was marked "Yes," the NHF still determined that Petitioner was permitted to smoke independently.

13. The bottom portion of the Smoking Evaluation contains the following information:

OBSERVATION	YES	NO
Is the patient able to safely hold a cigarette?	√	
Does the patient have the ability to light a cigarette?	√	
Does the patient properly dispose of ashes or butts?	√	
Can the patient smoke safely without use of a smoking apron?	√	

> I understand that by my signature, I am acknowledging the Center smoking policy and the outcome of my smoking evaluation. I further understand that failure to comply with the smoking rules may result in termination of my smoking privileges and/or initiation of a discharge plan.

The form is signed, not by Petitioner, but by Allison Prieto, RN.

14. On an unknown date, Ms. Prieto also completed an "Interdisciplinary Health Educator Record." Ms. Prieto testified at hearing that such records are completed when a patient requires additional education regarding health care or facility procedures. The record submitted into evidence notes the "educational need" to be "safety precaution" and the method of education to be discussion between Ms. Prieto and the Petitioner. Two hand-written notes by Ms. Prieto are included on this form. The first, undated note states:

> Discussed [with] Resident on admission about facility policy & protocol on e-cigarettes & not being able to use them indoors. Res. verbalized understanding.

Ms. Prieto testified that this was written upon Petitioner's admission, August 12, 2015. The second note, dated September 17, 2015 states:

> Resident education on skin care, not spending more than 2 hours in the w/c at any given time, comply [with] turning & repositioning, refrain from digging & scratching skin to promote wound healing.

15. Ms. Prieto testified that she believed she'd conducted additional education sessions with the Petitioner, one after each alleged violation. However, the facility did not have any records documenting same.

16. Out of the 11 alleged smoking violations, only two were directly observed by one of the seven facility employees present at hearing. The first was an incident upon admission (August 12, 2015), during which Petitioner was observed with e-cigarettes, allegedly educated as to Oakhurst's smoking policy, then found to be smoking one of the e-cigarettes later that same day. Petitioner was moved to a different unit within the facility on August 14, 2015. The second alleged violation (smoking the e-cigarette in his room) was witnessed on August 17, 2015. All other incidents remain unsubstantiated, as Respondent offered neither testimony from those who had witnessed the acts, nor business records to corroborate same.

17. Respondent argues that use of e-cigarettes is a danger to others in the facility, as some patients within Oakhurst utilize oxygen and oxygen is stored at various locations in the NHF. Respondent is concerned that the flame from regular cigarettes and/or combustion from e-cigarettes might ignite oxygen tanks and cause a fire.

18. Petitioner argues that e-cigarettes are not harmful, as they are purely water vapor with nicotine, which help to calm his nicotine cravings. He states that they are operated by batteries and do not ignite by combustion. He has never received any written smoking policy, but does recall a couple of discussions with Ms. Prieto regarding smoking rules. Petitioner contends that there is a personality conflict between himself and some of the NHF staff, and alleges that he does not get along with some of the

individuals who testified against him at hearing. He is unhappy with the service and care he has received while residing at [redacted]

CONCLUSIONS OF LAW

19. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to § 400.0255(15), Fla. Stat. In accordance with that section, this Order is the final administrative decision of the Department of Children and Families.

20. The burden of proof (clear and convincing evidence) is assigned to the Respondent.

21. Federal Regulations appearing at 42 C.F.R. § 483.12, set forth the reasons a facility may involuntary discharge a resident as follows:

> Admission, transfer and discharge rights.
>
> (a)(2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--
> (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
> (ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
> (iii) The safety of individuals in the facility is endangered;
> (iv) The health of individuals in the facility would otherwise be endangered;
> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
> (vi) The facility ceases to operate.

22. Per documentation and testimony, Petitioner was admitted to Respondent's facility for wound care and pain management. While Respondent

asserts that Petitioner was educated regarding [redacted] smoking policy upon admission, the smoking policy, itself, appears rather vague. In fact, it seems that the facility varies its policy based upon patient response, as once Petitioner complained, he was permitted to keep both regular and e-cigarettes in his possession, despite the purported policy of keeping all smoking paraphernalia at the nurse's station.

23. As [redacted] smoking policy is not formalized in writing, and seems subject to change, it is also unclear how patients would be able to refer back to the policy to ensure compliance with same, or how staff are guided in determining whether a particular incident actually constitutes a violation. Indeed, written policy is a requirement of federal law. Per 42 C.F.R. § 483.10:

> (b) Notice of rights and services.
> (1) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under section 1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.
> (emphasis added)

24. Although Petitioner signed the facility's Admission Agreement, he did not initial to acknowledge receipt of the "Admission Packet," and neither the list of documents contained within the packet nor the agreement, itself, make mention of any smoking policy.

25. Although all of Petitioner's witnessed violations occurred prior to completion of his Smoking Evaluation when Respondent completed said evaluation on August 25, 2015, it found Petitioner fit to smoke independently, without supervision. It is unclear why the facility would wait so long after admission to evaluate a known smoker, or why it would then permit independent smoking if it felt Petitioner had a demonstrated lack of ability to comply with the NHF's unwritten smoking policies.

26. Of note, the evaluator completed the Smoking Evaluation form in contravention to the instructions on the form, itself. More importantly, although the Smoking Evaluation contains a designated space for a patient to sign and confirm understanding of a smoking policy, said form is signed, *not* by the Petitioner, but by the facility nurse.

27. Review of all of Respondent's documentary evidence reflects a lack of thoroughness in completion and maintenance of records. The Admission Agreement, Smoking Evaluation, and Interdisciplinary Health Education Record are incomplete, undated, contain errors, or remain unsigned by Petitioner. Even the Notice of Discharge reflects an issuance date of August 14, 2015, is signed by the NHF Administrator on August 13, 2015, and was executed by the physician on August 18, 2015. To the degree that the forms are poorly executed, reliability of both the forms, themselves, and the testimony based upon the events reported, therein, is called into question.

28. While the undersigned makes no ruling as to the inherent danger of utilizing e-cigarettes within the facility, she is unable to conclude that the facility has any clear, universally disseminated smoking policy, that the policy is uniformly enforced, or that Petitioner had sufficient notice of and/or was reminded of the policy so as to remain in

compliance with same. Nonetheless, Petitioner is strongly encouraged to exercise good judgement and cautioned *not* to utilize this Order as justification for or permission to smoke e-cigarettes or regular cigarettes while within the facility.

29. After considering the entire record, the undersigned concludes that Respondent has not met its burden to prove, by clear and convincing evidence, that the Petitioner presents a continued risk to the safety of his fellow residents.

30. The undersigned has no jurisdiction to review Petitioner's complaints regarding the care he is receiving at [redacted] Should Petitioner wish to pursue further action related to these complaints, or to follow up with the Agency for Health Care Administration (AHCA), he is directed to the following:

- AHCA's Health Care Facility Complaint Line: 888-419-3456
- AHCA's Alachua Field Office: 386-462-6201.

DECISION

Based upon the foregoing Findings of Fact and Conclusion of Law, the Petitioner's appeal is GRANTED. The facility has not established, at this time, that discharge is permissible under federal regulations.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party 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 party 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 department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 16th day of November, 2015,

in Tallahassee, Florida.

Patricia C. Antonucci

Patricia C. Antonucci
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: appeal.hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner

[redacted]

Respondent
Ms. Kriste Mennella, Agency for Health Care Administration

[redacted]

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

[redacted]

APPEAL NO. 15N-00088

PETITIONER,

Vs.

Administrator
[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned at 2:29 p.m. on October 22, 2015 at the [redacted] at [redacted] in [redacted] Florida.

APPEARANCES

For the Petitioner: The petitioner was present and was represented by her son, [redacted]

For the Respondent: Larry Lake, administrator for the [redacted]

ISSUE

At issue is whether or not the nursing home's action to transfer and discharge the petitioner is an appropriate action based on the federal regulations. The nursing home is seeking to discharge the petitioner because her "needs cannot be met in this facility."

The facility has the burden of proof to establish by clear and convincing evidence that the discharge is appropriate under federal regulations found in 42 C.F.R. § 483.12 (a) and Section 400.0255, Florida Statutes.

PRELIMINARY STATEMENT

By notice dated August 27, 2015, the respondent informed the petitioner that it was seeking to discharge/transfer her from its facility because her needs could not be met in the facility. The petitioner timely requested a hearing on the matter. The notice was signed by the attending physician.

Present as a witnesses for the petitioner were [redacted] North Regional manager for Long Term Care Ombudsmen Council, and caretaker, [redacted]

Present as witnesses for the respondent were Lynda Hezel, LPN unit manager, Sharon Arsenault, social services coordinator, Michelle Yorio Greenier, director of admissions, Anne Guenther, vice president of operations and assistant administrator, and Linda Fitzpatrick, director of nursing.

Kelley Foster, Registered Nurse consultant, appeared by telephone as a witness for the Agency for Health Care Administration (AHCA).

A letter dated October 6, 2015 from the AHCA indicated that it found the facility in violation. This was entered as the Hearing Officer Exhibit I. The administrator requested for the undersigned to make note that there was a follow-up letter to the original letter from AHCA. The Respondent Exhibit 4 includes the follow-up letter from AHCA with a report of the status of the review completed regarding the correction of the deficiencies of the Nursing Home Transfer and Discharge Notice. The follow-up letter

states that the facility has corrected the deficiencies of the Nursing Home Transfer and Discharge Notice.

The AHCA representative explained that the facility failed to include location upon discharge of the facility and believes the notice was premature; AHCA opined that the facility would be required to complete another notice to allow the petitioner an additional 30 days notification. The plan of correction was accepted as the facility rehabilitated the Nursing Home Transfer and Discharge Notice by adding a discharge location.

The facility's administrator objected to the AHCA representative's opinion that an additional 30 days be given in this case. The undersigned concludes that an additional 30 days was not required in this case as the facility rehabilitated its notice and there appears to be no harm as petitioner remains in the facility.

A notice was provided to the petitioner and the petitioner's representative. Based on that notice the petitioner representative requested a hearing. Evidence was presented by both sides for the hearing officer to make a proper ruling on the case based on the evidence. The ombudsman argues that the Nursing Home Transfer and Discharge Notice was deficient and believes due to the deficiency, the hearing should not have taken place; he believes the petitioner was not allowed due process due to the deficient notice. The facility supplemented the Notice Home and Discharge Notice on October 21, 2015 with a location for the petitioner's discharge. Therefore, the hearing officer cannot conclude the petitioner was harmed by the notice not including the discharge location.

The record was held open until 5:00 p.m. on October 27, 2015 to allow the petitioner to submit additional evidence.

On October 27, 2015, the ombudsmen submitted the Notice of Supplemental Authority and requested for the undersigned to take judicial notice of a decision made by the administrative law judge (ALJ) in Docket No. 1293 A-211, Washington State Office of the Administrative Hearings for the Department of Social and Health Services. In this case, the ALJ ruled that the facility was able to meet the petitioner's needs and did not allow the discharge action sought by the facility. The ombudsman also requested for the undersigned to take judicial notice on a Final Order made under Appeal Number 11N-0024 from the Office of Appeal Hearings for the Department of Children and Families, in which the hearing officer concluded that the facility did not provide clear and convincing evidence that it could not meet the petitioner's needs. The undersigned concludes that the petitioner's situation in this case is similar to the residents' situations in the cases provided by the ombudsman. For this reason, Judicial Notice has been taken by the undersigned.

FINDINGS OF FACT

1. The petitioner, 88, has been a resident in the facility since May 2015 when she suffered a stroke. The petitioner was admitted as a short term rehabilitation patient until she was further assessed and admitted for long term care.

2. The respondent contends that its facility is unable to meet the petitioner's needs due to her attention-seeking behaviors; its medical director, Dr. Carames, recommended discharge and included explanation on the Nursing Home Transfer and

Discharge Notice which states, [redacted] exacerbated by environmental factors would benefit from a decreased sensory input environment, i.e. a small facility." Dr. Carames signed the discharge notice.

3. The facility's management team concluded that the petitioner's needs cannot be sufficiently met in the facility. The respondent contends that the petitioner has behavioral problems and the facility cannot provide the proper care to her. The facility's administrator contends that the facility's physician believes the petitioner needs a facility that is better able to handle the particular behavioral problems.

4. The facility's business records included in Respondent Exhibits 2 and 3 contain entries dated between July 21, 2015 and October 19, 2015 documenting the petitioner's attention seeking behaviors.

5. On July 21, 2015, the "Skilled Daily Nurses Note" reports that the petitioner was "sitting in hallway yelling and screaming...yelling for Xanax" and that the petitioner yelled, "I'll cont to yell unless someone is stilling right here with me." The notes state one on one was provided by a supervisor and the petitioner was quiet until the supervisor left; the notes state the petitioner began screaming again. The notes state the staff was unable to satisfy and that one-on-one supervision was provided by another staff member.

6. On July 25, 2015, the "Skilled Daily Nurses Note" reports that the petitioner was "up to wheelchair waiting to go to bed...pt was yelling "I want to go to bed now." The notes also report that the petitioner cursed at the nurse administering her medication. The "Skilled Daily Nurses Note" entry dated July 27, 2015 include notes

stating the petitioner was in the dining room eating her lunch and yelled that the food was too stringy and refused to eat.

7. The respondent contends that the petitioner called 9-1-1 on October 19, 2015 to report that she did not have her call light (Respondent Exhibit 5). The respondent believes that the petitioner's attention seeking behaviors cause other residents to become agitated, especially when she yells in the dining room where other residents are trying to eat. The respondent contends that the petitioner's behavior causes other residents to no longer want to eat.

8. The respondent explained that prior to the discharge notice being issued, the interdisciplinary team met with the petitioner's family, and the petitioner's Medicaid case manager with United Healthcare and all agreed that the petitioner was not doing well in the current facility. The respondent believes the meeting concluded with all parties being in agreement that a new environment with new staff would be in the petitioner's best interest.

9. The facility's physician opines that the petitioner's stay at the current facility exacerbates her behavioral problems and is not conducive to the patient's care.

10. The facility contends that its staff has observed significant shifts in the petitioner's behavior; sometimes the petitioner is very cordial, charming and easy to get along with but can change rather rapidly into someone being very difficult. The respondent contends that the petitioner is sometimes not compliant with dietary orders which lead to a significant risk for choking.

11. The respondent referred to the page "Chart Documentation" included in the Respondent Exhibit 5, which indicates some of the behaviors displayed by the petitioner beginning on September 16, 2015 through October 18, 2015 taken directly from the "Nurses Notes" to indicate that the petitioner has extreme behavior problems.

12. The respondent believes that the petitioner's condition has deteriorated since the Discharge Notice has been issued. The respondent contends that others who normally do not get involved in the petitioner's care have assisted in her care. The respondent contends that the family seems to not be satisfied in the petitioner's care that has been provided. The respondent contends that it has also paid for one on one care but does not seem to make any difference.

13. The respondent believes petitioner has attention seeking behaviors which cause other residents in the facility to not receive the proper care. The respondent contends that the facility provided care to the petitioner but her behavior affects the care of others, as more attention is given to the petitioner and care is taken away from other residents. The respondent believes for the petitioner's needs to be met by this facility, the care to other residents will be negatively impacted. The respondent contends that its records indicate that there were 27 entries in one shift which shows the number of times staff tended to the petitioner's needs. The petitioner's care takes away from other patients and impacts the petitioner and others around her. The director of nursing contends that the staff tries to redirect the petitioner and remove her to a different location in order to appease the other residents, but it does not appear to improve the petitioner's behavior.

14. The respondent contends that the petitioner has not worked out in the facility and the facility cannot meet the petitioner's needs.

15. The ombudsman argues that the petitioner cannot be discharged for not working out in the facility, and that he believes the current facility can meet her needs.

16. The respondent explained that it cannot answer the petitioner's call light every three minutes. The respondent argues that its records indicate that the petitioner and her family requested for one on one to be removed because it invaded her privacy. The respondent contends that even with one on one, the petitioner's needs were not met because the petitioner was not satisfied with how the care was provided and was not satisfied with the staff member providing care; she would then ring the call button again with a staff member in the room with her.

17. The petitioner's son believes his mother's behavior is common and is also displayed in other patients residing in other facilities. The petitioner's son acknowledges that there have been bad feelings between his mother and the director of nursing and that his mother has been very vocal. The petitioner's son acknowledges his mother can be very difficult to deal with at time but believes she has made progress.

18. The petitioner's son believes the facility should work with his mother which will improve the quality of care the facility provides. The petitioner's son believes if his mother can play the piano for other residents and staff in the facility, she will have something to look forward to, which will cause an improvement in her behavior. The petitioner's son contends that his mother does get frustrated at times but is able to calm herself within minutes.

19. The petitioner's caretaker believes there is a barrier to communication between shifts because staff is not aware of the care to be provided to the petitioner. The petitioner's caretaker believes a behavior modification care plan was not established as recommended by the psychologist and it was agreed upon by all the members attending the meeting (consistency, give her rewards and not punishment, etc.).

20. The petitioner's caretaker contends that the psychologist recommended for the staff to give her rewards and not punishment. The petitioner's caretaker argues that the petitioner's dining room privilege was taken away from her and believes that is not the proper action for behavior modification. The petitioner's caretaker argues that the facility staff writes on the petitioner's chart the times when she has inappropriate behaviors; she believes that the petitioner's inappropriate behaviors should not be written on the chart on the wall since it upsets the petitioner.

21. The respondent acknowledges that there are other residents who exhibit similar behaviors as the petitioner's but believes the other residents are unaware of their behaviors. The respondent believes the petitioner is aware of what she says and does. The respondent points out that the petitioner's family has acknowledged the behavior issues and has asked the petitioner to behave herself.

22. The respondent also referred to an incident that happened in the dining room on September 16, 2015 when the petitioner removed her colostomy bag, which posed a safety risk to the other residents.

23. The petitioner's son acknowledges that the petitioner has removed her colostomy bag on occasion but that has not happened recently.

24. The ombudsman argues that the Nursing Home Transfer and Discharge Notice for the petitioner does not include, "the health and safety of other individuals in this facility is endangered" as a reason for discharge and should not be addressed.

25. The respondent contends that the documentation in the chart indicate that the petitioner stated on a few occasions that she did not want to reside in the facility but it fluctuates dependent on the day and the happenings. The director of nursing contends that the petitioner stated she is not happy at the current facility; she believes another type of staff may be able to understand her condition a little better. The respondent does not understand why the petitioner would want to stay at the facility if she is unhappy with the director of nursing and the other staff.

26. The petitioner's son explained that his mother was happy while residing in her home with an assisted living aide coming into her home three times a week but is now unable to do so after having a stroke. The petitioner's son believes, in general, no one wants to live in a nursing home and that his mother's statement that she does not want to reside in the facility is not to be taken personally by the facility.

27. The petitioner expressed during the hearing that she does not wish to leave the facility.

28. The respondent further explained that the petitioner is somewhat younger and higher functioning in some ways than some of the other residents. The discharge/new facility accepts patients from 53 and older and accepts patients with

behavioral disturbances and complex behaviors. The respondent believes that the petitioner and her family prefers a non-locked unit based on its records. The new facility does not have a locked unit and protects with a wander-guard system throughout the facility.

29. The respondent explained that the petitioner is not in a locked, certified dementia unit for elopement purposes; she is there because that's where an available bed was located for long term care. The respondent contends that the petitioner has been in the locked unit since her arrival in May 2015; long term unit is on the second floor and the short term rehabilitation is on the first floor. The petitioner would have to enter a code to leave the floor. The petitioner was initially admitted into the facility for short-term rehabilitative services but when she was assessed further, she was admitted for long term care as new medical conditions had arisen.

30. The petitioner expressed during the hearing that she likes living on the second floor.

31. The petitioner's son questions if another facility will be able to provide better care than the current facility is providing. The petitioner's son questioned if the new facility will be able to meet her needs with a lower health grade than the current facility. The petitioner's son believes it is not a good thing to remove the petitioner from the current facility away from her friends and support system.

32. The respondent believes the facility's duty is to also meet the emotional, and psychosocial needs and not only the medical needs of every patient. The facility's staff has concern for the psychological well-being of a resident when a patient expresses

dissatisfaction, frustration, and dislike in the majority of the staff members providing his or her care and questions if the facility is a good fit for the particular resident. The respondent was unable to answer the question as to whether or not the new facility would be able to meet the petitioner's needs and believes the petitioner would need to be placed in the new facility to know for sure.

CONCLUSIONS OF LAW

33. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to § 400.0255(15), Fla. Stat. In accordance with said authority, this order is the final administrative decision of the Department of Children and Families.

34. Federal Regulations appearing 42 C.F.R. § 483.12, sets forth the reasons a facility may involuntary discharge a resident as follows: Admission, transfer and discharge rights.

> (a)(2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--
> (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
> (ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
> (iii) The safety of individuals in the facility is endangered;
> (iv) The health of individuals in the facility would otherwise be endangered;
> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a

facility, the facility may charge a resident only allowable charges under Medicaid; or
(vi) The facility ceases to operate.

35. Florida Statute 400.0255 "Resident transfer or discharge; requirements and procedures; hearings.—" states in relevant part, "(7)(a) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility, and the circumstances are documented in the resident's medical records by the resident's physician; ..."

36. Establishing that the reason for a discharge is lawful is just one step in the discharge process. The nursing home must also provide discharge planning, which includes identifying an appropriate transfer or discharge location and sufficiently preparing the affected resident for a safe and orderly transfer or discharge from the facility. The hearing officer in this case cannot and has not considered either of these issues. The hearing officer has considered only whether the discharge is for a lawful reason.

37. Any discharge by the nursing facility must comply with all applicable federal regulations, Florida Statutes, and Agency for Health Care Administration requirements. Should the resident have concerns about the appropriateness of the discharge location or the discharge planning process, the resident may contact the Agency for Health Care Administration's health care facility complaint line at (888) 419-3456.

38. The respondent bears the burden of proof, by clear and convincing evidence, to show that the facility is unable to meet the petitioner's needs. The undersigned concludes that the respondent's position that the petitioner has an

excessive need for attention that cannot be met at its facility does not, in and of itself appear to meet the intent of the allowable discharge reasons in the Federal Regulations, specifically that a discharge is necessary due to the facility's inability to meet her needs. The federal regulation is clear the intent of a discharge under this stated reason is when the transfer or discharge is necessary for the resident's welfare **and** the resident's needs cannot be met in the facility.

39. Although the physician signed the Nursing Home Transfer and Discharge Notice indicating a smaller facility would resolve the issue, the respondent did not provide any evidence to show that another facility would be more suitable to meet the petitioner's needs (i.e., is there a smaller facility with a decreased input sensory environment that could improve one's behavior) or that the discharge is necessary for the resident's welfare. This is both a federal and state law requirement.

40. Based upon the evidence presented, the undersigned concludes that the nursing facility has failed to establish by clear and convincing evidence that the petitioner's needs cannot be met **and** the discharge is necessary for the petitioner's welfare. The undersigned concludes that the respondent's intent to discharge the petitioner from its facility is not consistent with the above controlling authorities.

DECISION

Based upon the foregoing Findings of Fact and Conclusion of Law, the Petitioner's appeal is granted. The facility has not established that discharge is permissible under federal or state regulations.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party 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 party 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 department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 04 day of December, 2015,

in Tallahassee, Florida.

Paula Ali

Paula Ali
Hearing Officer
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Tallahassee, FL 32399-0700
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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
[redacted] Respondent
Mr. Robert Dickson, AHCA
[redacted]