

Aug 15, 2016

Office of Appeal Hearings  
Dept. of Children and FamiliesSTATE OF FLORIDA  
DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-01331

PETITIONER,

Vs.

CASE NO. FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 06 Pinellas  
UNIT: 88274

D - DDD - Disability

RESPONDENT.  

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**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on June 9, 2016, at 10:00 a.m. All parties appeared telephonically from different locations. The appeal was continued from two prior scheduled hearings per petitioner's requests.

**APPEARANCES**For the Petitioner: 

For the Respondent: Ed Poutre, economic self-sufficiency specialist II.

**STATEMENT OF ISSUE**

The petitioner is appealing the respondent's action denying full Medicaid benefits for her six year-old child and enrollment in the Medically Needy Program with an estimated share of cost (SOC). Additionally, petitioner is appealing the denial of SSI-Related Medicaid for the child on the basis that she did not meet the disability criteria.

The petitioner carries the burden of proof by the preponderance of evidence in both issues.

### **PRELIMINARY STATEMENT**

During the hearing, the petitioner submitted four (4) exhibits which were accepted into evidence and marked as Petitioner's Exhibits 1 through 4. The respondent submitted 15 exhibits, which were marked as Respondent's Exhibits 1 through 15.

The record was left open through June 17, 2016 for the petitioner to provide additional information to the undersigned for review. The evidence was timely received, entered into evidence and marked as Petitioner's Exhibit 5. The record was extended through July 18, 2016 for the Department to submit any updated response on the disability reconsideration and for the petitioner to respond. The parties did not provide any additional information, nor did they contact the hearing officer for additional time. The record was closed on July 18, 2016.

### **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. Prior to the action under appeal, petitioner's daughter has been receiving Medicaid Program benefits. She last received full Medicaid benefits in February 2016.
2. On February 17, 2016, the petitioner applied for Supplemental Security Income (SSI) for her daughter through the Social Security Administration (SSA). That application was denied on April 4, 2016. A Notice of Disapproved Claim sent to the petitioner on April 12, 2016, states in part, "based on a review of her health problems she does not qualify for payment on this claim. This is because she is not disabled or

blind under our rules.” See Petitioner’s Exhibit 5. The petitioner has appealed the SSA decision through an attorney.

3. On February 18, 2016, the petitioner submitted a web application to the Department to continue her daughter’s Medicaid benefits. The petitioner’s household consists of herself and her 6 year-old daughter (DOB 10/15/09). The child is developmentally disabled, but has not been determined disabled by any agencies. Petitioner has medical insurance for herself through her employer and pays a monthly premium of \$205.28.

4. Petitioner is employed and receives earned income of \$1,555.45 biweekly and provided the Department with verification.

5. The petitioner was seeking full Medicaid for her daughter. Petitioner is a tax filer and her daughter is her tax dependent. To begin the budgeting process, the Department used a conversion factor of 2 to arrive \$3,000 as countable monthly income. This amount is considered as modified adjusted gross income (MAGI) for the household. To determine Medicaid eligibility for the child, the household’s MAGI of \$3,000 was compared to the income limit for the child based on her age group in a household size of two (\$1776).

6. As the income exceeded the maximum limit for children ages 6 through 18, the 6-year old child was found ineligible for full Medicaid. As the 6-year-old child was determined ineligible for full Medicaid, the respondent enrolled her in the Medically Needy (MN) Program effective March 2016.

7. To determine the child’s estimated SOC the Medically Needy Income Level (MNIL) of \$387 (for a standard filing unit size two) was subtracted from \$3,000, followed

by the \$205.28 medical insurance premium from the MAGI, resulting to the child's final estimated SOC of \$2,407.

8. On February 18, 2016, the Department sent the petitioner a Notice of Case Action informing her of its actions. On February 19, 2016, the petitioner timely requested an appeal challenging her daughter's denial of full Medicaid and her enrollment in the Medically Needy Program. The petitioner does not want to be referred Florida KidCare and/or the Federally Facilitated Marketplace (FFM).

9. The respondent explained that the 6-year old child is not eligible for full Medicaid because the household income exceeds the Family-Related Medicaid income limit for the household size. The child was enrolled in the Medically Needy Program because she failed to meet the income guideline for Family-Related Medicaid and that the SOC was directly related to the household gross income.

10. On March 29, 2016, the Department initiated a disability review on the child through the Department's SSI-Related Medicaid Program to continue her benefits. Information obtained from the petitioner was forwarded to DDD for review on March 30, 2016. See Respondent's Exhibits 1 through 10.

11. The Department sent the petitioner's disability packet to DDD for review. The DDD has access to Social Security information. Case notes from DDD Transmittal indicates the child's only medical condition was asthma. On April 8, 2016, DDD denied the child's claim of disability by adopting the April 2016 SSA denial citing, "Non-pay-Capacity for substantial gainful activity other work, visual impairment (N 43) and Non-pay-Capacity for substantial gainful activity, other work, no visual impairment (N-32)"

respectively. DDD did not make an independent determination, as it considered the child's medical conditions to be the same/related allegations already known to SSA.

12. The respondent explained that once the child's disability condition was known, the Department initiated a disability review and a packet was sent to DDD to make a determination. He explained that it denied the child's SSI-Related Medicaid application because SSA has determined that she was not disabled and DDD has adopted the April 2016 decision. The respondent further explained that SSA decision is binding and must be accepted by the Department as final. No notice was provided to the undersigned for consideration.

13. The petitioner did not dispute the facts presented; however, she asserted that her daughter is disabled and should get full Medicaid. She explained that her condition started since 2014 and has not changed. Petitioner believes with her daughter's medical conditions alone should make her eligible for full Medicaid benefits. She does not understand why her Medicaid has been terminated. During the hearing, petitioner referred to a recent medical evaluation of her daughter by Developmental-Behavioral Pediatrics dated April 15, 2016, which was not previously known to the Department or SSA. The report indicates that the child meets the SSI Blue Book criteria for [REDACTED] (112.10 [REDACTED]). The report was completed and signed by [REDACTED]

[REDACTED] Petitioner has not yet provided this new document to SSA for reconsideration. The respondent agreed to accept this report and forward it to DDD for reconsideration. The record was left open for the respondent to receive a response from DDD on the reconsideration and for the petitioner to submit a

written response on the outcome. As of the day of this order, the parties did not provide any additional information, nor did they contact the hearing officer for additional time.

### **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 Section 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

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

### **The Family-Related Medicaid/Medically Needy issue will be addressed first.**

16. The Family-Related Medicaid income criteria is set forth in 42 C.F.R 435.603. It 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.

(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.

17. Federal regulation 42 C.F.R. § 435.603 Application of modified gross income (MAGI) (f) defines a Household for Medicaid. It 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.

18. 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.

19. In accordance with the above controlling authorities, the Medicaid household group is the petitioner and her six year-old child (two members). The findings show the Department determined the petitioner's eligibility with a household size of two to determine Medicaid eligibility for the 6-year old child. The undersigned concludes the

Department correctly determined the petitioner's household size as two for Medicaid eligibility purposes.

20. Federal regulations at 42 C.F.R. § 435.603 Application of modified gross income (MAGI) (d) defines Household Income. It states:

(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.

21. 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).

22. The Family-Related Medicaid income standard appears in the Department's Program Policy Manual CFOP 165-22 at Appendix A-7. Effective February 16, 2016, the income limit for is \$1,776 and the Standard Disregard is \$83 for a 6 year-old child in a family size of two. It also indicates the MNIL to be \$387.

23. 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 \$3,000. Step 2: There are no deductions provided. Step 3: The total income of \$3,000 less the standard disregard of \$93 is \$2,907. Step 4: The balance of \$2,907 is greater than the income limit of \$1,776 for the 6-year old to receive full Medicaid. Step 5: With \$67 MAGI deduction applied, the countable balance remains \$2,840. This amount was still greater than the income limit of \$1,776. The undersigned concludes that the petitioner's daughter is ineligible for Medicaid. The undersigned further concludes Medically Needy eligibility must be explored for the child.

24. The Policy Manual at passage 2630.0502 Enrollment (MFAM) states:

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.

25. 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.

26. To determine the child's SOC the respondent subtracted the Medically Needy Income Level of \$387 for a standard filing unit size of two from the household MAGI of \$3,000, resulting to the daughter's estimated SOC of \$2,613. It was further reduced by the \$205.28 medical insurance premium, resulting in the final remaining SOC of \$2,407.

27. The hearing officer reviewed the SOC calculation done by the Department and found no errors. A more favorable share of cost could not be determined.

**The SSI-Related Medicaid issue will now be addressed.**

28. The Code of Federal Regulations at 42 C.F.R. § 435.000 sets forth the definition and determination of disability and states in relevant part:

§ 435.540 Definition of disability.

(a) Definition. The agency must use the same definition of disability as used under SSI...

29. Federal Regulations at 20 C.F.R. § 416.906 addresses Basic disability for children and states:

If you are under age 18, we will consider you disabled if you have a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations, and that can be expected to cause death or that has lasted or can be expected to last for a continuous period of not less than 12 months. Notwithstanding the preceding sentence, if you file a new application for benefits and you are engaging in substantial gainful activity, we will not consider you disabled. We discuss our rules for determining disability in children who file new applications in §§416.924 through 416.924b and §§416.925 through 416.926a.

30. In this instant case, SSA has determined that the child was not disabled. DDD has adopted the same decision.

31. 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.

(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 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 recipient 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 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.

32. The Policy Manual at passage 1440.1204 “Blindness/Disability Determinations

(MSSI, SFP)” states:

...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.

33. The Policy Manual at passage 1440.1205 Exceptions to State Determination of Disability (MSSI, SFP) states:

The state does not make a disability determination under the following conditions:

1. When an individual only applies to SSA (no application is filed with DCF and no SSI denial or ex parte is involved).
2. When an individual receives Title II disability or SSI benefits based on their own disability (not dependent or early retirement benefits).
3. When an earlier favorable federal or state determination of blindness/disability is still in effect and no unfavorable decision has been rendered by SSA.
4. When an individual is no longer eligible for SSI solely due to institutionalization.
5. When the applicant is appealing an earlier decision from SSA and claims no new disabling condition (condition not previously considered by SSA).
6. When the individual files an application within 12 months after the last unfavorable disability determination by SSA, and the individual alleges no new disabling condition or claims a deterioration of an existing condition previously considered by SSA. Refer the individual to SSA for disability reconsideration or appeal. Only request a disability decision from DDD if:
  - a. SSA refuses (or has already refused) to reconsider the unfavorable disability decision, or
  - b. the applicant no longer meets SSI non-disability criteria such as income or assets.

The eligibility specialist must explore eligibility for Medicaid for the individual based on other coverage criteria, e.g., family-related coverage prior to exploring eligibility for disability-related Medicaid.

34. According to the above-cited authorities, an SSA decision made within 12 months of the Medicaid application that is under appeal is controlling and binding on the State Agency unless the applicant reports a disabling condition not previously reviewed by SSA. Additionally, a worsening and deteriorating of conditions is directed to the SSA. In this instant case, SSA has determined that the daughter was not disabled based of the information it received.

35. Petitioner provided medical evidence that was not known to DDD or SSA at the time the disability applications were denied. This new medical report from a Board Certified Developmental-Behavioral Pediatrician indicating that the child meets the SSI Blue Book criteria for autism. The Department agreed to forward the report to DDD and expected a decision on the reconsideration within 30 days from the hearing date. The undersigned received no evidence of such a decision to date. Regardless of the outcome, the respondent will provide proper notice to the petitioner with appeal rights.

36. Based on the evidence and testimony presented, the above-cited rules and regulations, the hearing officer concludes that the Department's action to deny the petitioner's daughter Medicaid under the SSI-Related Medicaid coverage group is correct.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied. The respondent's actions are 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 15 day of August, 2016,

in Tallahassee, Florida.



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Copies Furnished [REDACTED], Petitioner  
Office of Economic Self Sufficiency

**FILED**

Aug 04, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 15F-03011

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 11 Dade  
UNIT: 88601

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on May 20, 2016, at 2:30 p.m., in [REDACTED]

**APPEARANCES**

For the petitioner:

[REDACTED]

For the respondent:

Leslie Hinds-St-Surin, Esq., DCF Senior Attorney

**STATEMENT OF ISSUE**

The issue is whether the Department can make a designation as to the specific Waiver Program or Programs suitable for the petitioner's individual needs after she has been determined eligible for Home and Community Based Services (HCBS) Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

### **PRELIMINARY STATEMENT**

On April 3, 2015, the petitioner requested an appeal challenging the denial of her HSBS Medicaid. Originally, this appeal started out as a denial due to excess assets but it changed to the Issue listed above.

The appeal was continued several times per petitioner's requests for the parties to reach a settlement.

██████████, petitioner's son and Personal Representative appeared as a witness on her behalf.

Sarie Estella, Designated Reviewer and Olivia Milian-Rodriguez, Economic Self-Sufficiency Supervisor for the Waiver Program, appeared as witnesses for the Respondent.

The petitioner submitted four (4) exhibits, which were marked as Petitioner's Exhibits 1 through 4. The respondent's 26 exhibits were accepted and marked as Respondent's Exhibits 1 through 26 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 December 5, 2014, the petitioner's personal representative submitted an application requesting HCBS/Waiver from the respondent.
2. Petitioner's (DOB 4/3/25) was 89 at the time of application and has been eligible Medicare for years. The case was processed and the petitioner was pended for a Level of Care (LOC) assessment and verification of assets. The Alliance for Aging determined that petitioner was eligible for an Intermediate II LOC and returned the

assessment to the Department. Petitioner's eligibility determination was continued and the case was denied due to excess assets.

3. On December 30, 2014, the Department sent a Notice of Case Action to the petitioner explaining that her December 5, 2014 Medicaid application was denied because the value of her assets was too high for this program. That notice was followed by a manually generated Notice of Case Action/Home and Community Based Services (HCBS) /Hospice dated January 9, 2015 denying petitioner's Statewide Medicaid Managed Care/Long Term Care (SMMC/LTC) application. On April 3, 2015, the petitioner requested an appeal challenging the Department's action.

4. On November 9, 2015, after conferring, the parties agreed to continue the matter to allow the petitioner to submit additional verification for consideration and reassessment of petitioner eligibility for Medicaid benefits effective December 2015.

5. In January 2016, the Department received the necessary documents and proceeded to determine that the petitioner was eligible for Medicaid benefits. A Notice of Case Action was sent on March 1, 2016 informing the petitioner of the Department's action. Additionally, the Department provided the petitioner with a manually generated Notice of Case Cation demonstrating her approval for HCBS Medicaid effective December 2015, see Respondent's Exhibit 24 -26.

6. The A/DA waiver is a Medicaid Program that provides home and community based services to eligible recipients that who, but for the provisions of these services, would require nursing facility placement. The purpose of the A/DA Waiver Program is to promote, maintain, and restore the health of eligible elders and adults with disabilities

and to minimize the effects of illness and disabilities in order to delay or prevent institutionalization.

7. The Home and Community Based Services (HCBS) waiver program allows states to provide essential services that assist individuals to maintain an independent lifestyle while residing in the community to prevent institutionalization. Most Medicaid enrollees are required to receive services through respondent's Statewide Medicaid Managed Care (SMMC) Program.

8. The Agency for Health Care Administration (AHCA) administers the Medicaid program. The Agency (AHCA) is responsible for ensuring compliance with federal program requirements, and developing Medicaid policy. Managed Care Organizations such as United Healthcare provide services to Medicaid recipients pursuant to a contract with AHCA. The Department of Elder Affairs (DOEA) performs Level of Care determinations for applicants seeking Medicaid waiver services and nursing home services.

9. The Alliance for Aging is the manager of the A/DA Waiver Program services in ██████████ County. This waiver program has Case Management Agencies and service providers; providing the care for eligible recipients. The services provided to the petitioner under this waiver program are personal care; homemaking; chore services; home delivered meals; and some supplies.

10. On March 29, 2016, Counsel for the respondent filed a STATUS UPDATE AND MOTION TO DISMISS explaining that the underlining issue has been resolved. Included with the Motion was a manual Notice of Case Action from the Department

confirming approval of the petitioner's HCBS benefits effective December 2015. The petitioner's representative disagreed and the hearing was allowed to go forward.

11. The petitioner currently receives home health services from United Health Care. Petitioner's son is not entirely satisfied the quality of service received from United Health Care, but has not yet addressed that with the agency.

12. The Respondent's witnesses explained that once SMMC/LTC eligibility is established, the recipient is picked up by a managed care provider that delivers the necessary services based on the recipient's needs. They explained that the Department is not involved in the service delivery process. The respondent maintains that petitioner's request for the Department to make a designation as to the specific waiver program (s) and associated services suitable for the petitioner's individual needs is not within the Department's jurisdiction.

13. The son argued as follows: That the waiver program should not be turned over to managed care agencies to manage. That managed care agencies are rationing care to keep the state's money. He explained that his mother was diagnosed with [REDACTED], is legally blind and requires more hours than receiving from United. Petitioner believes that waiver participants would be better served if the program was not outsourced to the managed care agencies. He is requesting that the state take control of the waiver program to better serve the affected population.

#### **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

Section 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

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

16. Section 409.979, Fla. Stat., 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).

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

18. The petitioner requested a fair hearing because she believes her services under the Program should be increased.

19. A managed care plan is defined at Section 409.962 (9), Fla. Stat. as: “an eligible plan under contract with the agency to provide services in the Medicaid program.”

20. In regard to enrollment in the SMMC Program, Section 409.965, Fla. Stat. states:

Mandatory enrollment.—All Medicaid recipients shall receive covered services through the statewide managed care program, except as provided by this part pursuant to an approved federal waiver. 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.

21. Regarding mandatory and voluntary enrollment in the SMMC Program, Section 409.972, Fla. Stat. states, in part:

(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.

22. Based on the above authorities, petitioner is not exempt for participating the SMMC Program. The Findings of Fact do not establish petitioner meets any of the above exemption criteria for mandatory managed care enrollment.

23. Petitioner has failed to demonstrate by the required evidentiary standard that she meets any of the statutory criteria to be exempt for enrollment in the SMMC Program.

As such, respondent's action in this matter is proper.

24. The Centers for Medicare & Medicaid Services' State Medicaid Manual, publication #45, states in part:

2900 FAIR HEARINGS AND APPEALS

Section 1902(a)(3) of the Social Security Act requires that States 'provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness.' Regulations implementing this section of law are found at 42 CFR 431 Subpart E. In addition, certain court decisions further amplify and modify the law and regulations governing the provision of notices and hearings to Medicaid applicants and recipients. Where appropriate, those decisions are cited.

2900.1 Basic Responsibility (42 CFR 431.200 and 431.205).— Establish policies and procedures for assuring a system of fair hearings that meet all the requirements of the regulations and instructions. Notify and make available to the applicant or recipient the hearing procedures required by regulations and these instructions, if any of the following events occur:

- denial of eligibility,
- the claim is not acted upon with reasonable promptness,
- termination of eligibility or covered services,
- suspension of eligibility or covered services, or
- reduction of eligibility or covered service

25. The above federal authority explains that an opportunity for a hearing must be granted to a recipient when a Medicaid claim for service has been denied or when a recipient believes the agency has taken an action erroneously. The State Medicaid Manual further explains the recipient's right to a hearing when either Medicaid eligibility or a claim for a service under Medicaid is denied, terminated, reduced or delayed.

26. There is no evidence that a claim for service under Medicaid has been denied, terminated, reduced or delayed in the instant case. The quality of health care Medicaid recipients receive is very important. However, after carefully reviewing the controlling legal authorities, the undersigned concludes that this issue is not within the jurisdiction of the Office of Appeal Hearings.

27. The Fla. Admin. Code R. 65-2.056 explains the basis of hearings:

The Hearing shall include consideration of:

(1) Any Agency action, or failure to act with reasonable promptness, on a claim of Financial Assistance, Social Services, Medical Assistance, or Food Stamp Program Benefits, which includes delay in reaching a decision on eligibility or in making a payment, refusal to consider a request for or undue delay in making an adjustment in payment, and discontinuance, termination or reduction of such assistance.

(2) Agency's decision regarding eligibility for Financial Assistance, Social Services, Medical Assistance or Food Stamp Program Benefits in both initial and subsequent determination, the amount of Financial or Medical Assistance or a change in payments.

(3) The Hearing Officer must determine whether the department's decision on eligibility or procedural compliance was correct at the time the decision was made. The hearings are de novo hearings, in that, either party may present new or additional evidence not previously considered by the department in making its decision.

28. The cited authority explains that the fair hearing process addresses issues involving the denial, termination, or reduction of benefits. The respondent has approved the requested HCBS waiver effective the retroactive period requested by the petitioner. The issue under appeal is now moot.

29. By requesting DCF to take over management from the managed care agencies, petitioner is seeking to change waiver rules. Petitioner argued that Medicaid recipients would have been better served if DCF did not outsource the program to the managed care agencies. Challenges to rules are conducted in accordance with s. 120.56 F.S. by an administrative law judge from the Division of Administrative Hearings. Nothing precludes the petitioner from challenging the agency's policy pursuant to s. 120.56 F.S. The Office of Appeal Hearings does not have the authority to change Medicaid rules.

**DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, petitioner's appeal is dismissed

**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 04 day of August, 2016,

in Tallahassee, Florida.



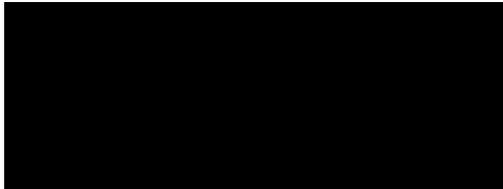
Roosevelt Reveil  
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Copies Furnished To: [REDACTED], Petitioner  
Office of Economic Self Sufficiency  
[REDACTED]

Jul 01, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 15F-08653

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 04 Nassau  
UNIT: 88324

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned reconvened a telephonic administrative hearing in the above-referenced matter on June 29, 2016 at 9:00 a.m.

**APPEARANCES**

For the Petitioner: 

For the Respondent: Jane Almy-Loewinger, Assistant General Counsel for the Department of Children and Families (DCF).

**ISSUE**

At issue is the Department's action to not exclude as income 100 percent of the petitioner's retirement income in calculating the patient responsibility.

The petitioner holds the burden of proof by a preponderance of the evidence.

**PRELIMINARY STATEMENT**

The hearing was originally scheduled to convene on November 24, 2015 at 9:00 a.m. On November 17, 2015, the petitioner's representative requested a continuance. The respondent did not object. The petitioner's representative's request was granted and the hearing was rescheduled to January 4, 2016 at 10:00 a.m.

On December 28, 2015, the petitioner's representative requested another continuance without objection from the respondent. The petitioner's request was granted and the hearing was rescheduled to March 4, 2016 at 10:15 a.m.

On March 4, 2016 the hearing convened as scheduled.

Appearing as witnesses for the petitioner was the petitioner, [REDACTED] and [REDACTED]

Appearing as observers for the petitioner were [REDACTED] petitioner's daughter [REDACTED] petitioner's son-in law, and [REDACTED] petitioner's ex-wife.

Appearing as a witness for the respondent was Matthew Lynn, Economic Self-Sufficiency Specialist II for the Department of Children and Families (DCF).

The petitioner presented new evidence for the respondent to review. The hearing was rescheduled to convene on March 24, 2016 at 10:15 a.m.

On March 17, 2016, the petitioner's representative requested a continuance to allow the petitioner to obtain an attorney. The respondent did not object and the hearing was rescheduled to May 5, 2016 at 9:00 a.m.

On May 5, 2016, the Department's representative requested a continuance as its legal counsel had a family emergency. The petitioner's representative did not object and the hearing was rescheduled to May 16, 2016 at 9:00 a.m.

Evidence was submitted and entered as the Petitioner's Exhibit 1 and the Respondent's Exhibits 1 through 2.

The hearing was digitally recorded for purposes of a permanent record. Upon review, the undersigned discovered the loss of the recording of the first scheduled hearing and therefore, there is no record of testimony for the first hearing. The appeal was reopened and scheduled to reconvene on June 29, 2016 at 9:00 a.m. to obtain a recording of the appeal at issue.

All parties, with the exception of [REDACTED] appeared for the reconvened hearing on June 29, 2016.

Additional evidence was submitted and entered as the Respondent's Exhibit 3.

The record was closed on June 29, 2016.

#### **FINDINGS OF FACT**

1. The petitioner is a resident of [REDACTED] located in [REDACTED]. He has no community spouse or children.

2. The petitioner receives \$1724.90 in Social Security income and \$1745 from his pension from the Navy, for a total income of \$3469.

3. The Department determined that the petitioner's patient responsibility by including his total gross income of \$3469 and subtracting the personal needs allowance in the amount of \$105 to result in a patient responsibility in the amount of \$3364.

4. The petitioner's representative argued that the petitioner's ex-wife was awarded 100 percent of the petitioner's pension in the divorce settlement. The petitioner's representative believes that 100 percent of the petitioner's pension should be excluded in the Department's calculations. The petitioner argues that the military stipulates that only 50 percent of the petitioner's retirement is allowed to be paid directly to the petitioner's wife while the other 50 percent is to be paid directly to the petitioner. The petitioner does not agree with including the \$953.20 of his pension because he deposits the amount into his ex-wife's bank account.

5. The Department recalculated the patient responsibility and excluded \$791.80 of the petitioner's pension that is paid directly to the petitioner's wife. The Department included the remaining \$953.20 in retirement that is paid by the petitioner directly to his ex-wife and the \$1724 in Social Security income, for a total income of \$2677.20. The Department further reduced the petitioner's income by deducting the \$105 personal needs allowance, and allowing a \$236.80 unreimbursed medical expense (UME), for a patient responsibility in the amount of \$2335.40.

6. The Department explained that the income must be paid directly from the source and must be irrevocable from the source in order for the remaining \$953.20 to be excluded as income.

7. The petitioner believes the \$935.20 is irrevocable because his ex-wife is not willing to waive her right to 100 percent of his pension. The Petitioner's Exhibit 1 includes a letter written by the petitioner's ex-wife and states in part: "I will not revoke my right to receive 100% of MLP's military retirement benefit." The letter was signed by

the petitioner's ex-wife. The petitioner's representative argues that the income should not be treated as alimony because the petitioner and his ex-wife agreed to award his entire pension as part of the division of assets in their divorce settlement.

8. The Department's position is that only the \$791.80 can be excluded as income because it is paid directly from the source and is irrevocable at the source and that the above memorandum supports its inclusion of the remaining \$953.20; the \$935.20 is not paid directly from the source and is not irrevocable at the source.

### **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 Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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:

(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 435.231 Institutional benefits include institutional provider payment or payment of Medicare coinsurance for skilled nursing facility care.

12. Fla. Admin Code R. 65A-1.7141 states:

After an individual is determined eligible for Hospice, Institutional Care Program (ICP), Program of All-Inclusive Care for the Elderly (PACE),

Cystic Fibrosis waiver, Individual Budgeting (iBudget ), or Statewide Medicaid Managed Care Long-Term Care (SMMC-LTC) Program, 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.

...

(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:

### 13. Fla. Admin. Code R.65A-1.713, SSI-Related Medicaid Income Eligibility

Criteria states:

(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 (2007) (incorporated by reference) et seq., including exclusionary policies regarding Veterans Administration benefits such as VA Aid and Attendance, unreimbursed Medical Expenses, and reduced VA Improved pensions, to determine what counts as income and what is excluded as income with the following exceptions:

(a) In-kind support and maintenance is not considered in determining income eligibility.

(b) Exclude total of irregular or infrequent earned income if it does not exceed \$30 per calendar quarter.

(c) Exclude total of irregular or infrequent unearned income if it does not exceed \$60 per calendar quarter.

(d) Income placed into a qualified income trust is not considered when determining if an individual meets the income standard for ICP, institutional Hospice program or HCBS.

(e) Interest and dividends on countable assets are excluded, except when

determining patient responsibility for ICP, HCBS and other institutional programs.

(3) When Income Is Considered Available for Budgeting. The department counts income when it is received, when it is credited to the individual's account, or when it is set aside for their use, whichever is earlier.

14. Federal Regulations at 20 CFR § 416.1120, What is unearned income

states:

Unearned income is all income that is not earned income. We describe some of the types of unearned income in § 416.1121. We consider all of these items as unearned income, whether you receive them in cash or in kind.

15. Federal Regulations at 20 CFR § 416.1121, Types of unearned income

states:

Some types of unearned income are—

(a) *Annuities, pensions, and other periodic payments.* This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veterans benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits.

16. Federal Regulations at 20 CFR § 416.1123, How we count unearned

income.

(a) *When we count unearned income.*

We count unearned income at the earliest of the following points: When you receive it or when it is credited to your account or set aside for your use. We determine your unearned income for each month. We describe an exception to the rule on how we count unearned income in paragraph (d) of this section.

(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 § 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.

**(2) We also include more than you actually receive if amounts are withheld from unearned income because of a garnishment, or to pay a debt or other legal obligation, or to make any other payment such as payment of your Medicare premiums (emphasis added).**

17. The Department's Memorandum "Qualified Domestic Relations Order, Gross vs. Net Pay" dated August 16, 2004 states:

A Qualified Domestic Relations Order is a specific type of court order that awards a portion of an employee's retirement benefit to an "alternate payee". For a court ordered amount to be excluded from the Medicaid eligibility determination..., two conditions must be met. The payment must be paid directly from the source to the former spouse and the change must be irrevocable at the source.

18. The above authority explains that unearned income includes retirement benefits. The Department may include more income than actually received if the amount of the withheld unearned income is to pay a legal obligation. In this case, the petitioner receives retirement income from the military. The findings show that 100 percent of the petitioner's retirement income is to be paid to the petitioner's ex-wife according to the divorce settlement. The policy clearance included in the Department's memorandum clarifies the domestic relations order and explains that for a court-ordered amount to be excluded as income, the income must be paid directly from the source and must be irrevocable at the source.

19. The petitioner argues that the Department has excluded the portion of his retirement income that is direct-deposited to his ex-wife's bank account; therefore, it should exclude the other portion that he is required to send directly to his ex-wife, per court order. The petitioner's arguments and situation is recognized; however, based on

the above authorities, the undersigned concludes that the Department is correct to include as income the petitioner's remaining portion of retirement in the amount of \$953.20 as it does not meet the exception as specified in its aforementioned memorandum.

**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 01 day of July, 2016,

in Tallahassee, Florida.



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Paula Ali  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
Office: 850-488-1429  
Fax: 850-487-0662  
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FINAL ORDER (Cont.)

15F-08653

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Copies Furnished To: [REDACTED] Petitioner  
Office of Economic Self Sufficiency  
Jane Almy-Loewinger  
[REDACTED]

Jul 19, 2016

Office of Appeal Hearings  
Dept. of Children and FamiliesSTATE OF FLORIDA  
DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGS

APPEAL NO. 15F-10215

PETITIONER,

vs.

CASE NO

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 03 Madison  
UNIT: 88369RESPONDENT.  

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**FINAL ORDER**

Pursuant to notice, an administrative hearing in the above-captioned matter convened in Lake City, Florida before Hearing Officer Patricia Antonucci on March 22, 2016 at approximately 1:02 p.m.

**APPEARANCES**

For the Petitioner:

For the Respondent: Matthew Lynn, ESS Specialist II,  
Department of Children and Families**STATEMENT OF ISSUE**

At issue is whether Respondent, the Department of Children and Families (DCF or 'the Department'), via the Division of Disability Determinations (DDD) unit, 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**

This matter was previously scheduled to convene telephonically, then rescheduled for in-person hearing, at Petitioner's request. At final hearing, Petitioner appeared as her own representative. Petitioner noted that she was represented by an attorney in her appeal to the Social Security Administration (SSA); however, she confirmed that she had not retained counsel for the instant appeal. Petitioner's ex-husband [REDACTED] appeared as a witness. Respondent was represented by Matthew Lynn, ESS Specialist II, who appeared via teleconference. Lynn Dann, ESS Supervisor with the Department, appeared in person. No additional witnesses appeared on behalf of either party.

Respondent's Exhibits 1 through 7, inclusive, and Petitioner's Exhibits 1 through 35, inclusive, were entered into evidence. After securing testimony at hearing, the record was held open so that both Respondent and Petitioner might supplement the record with additional documentation, including the SSA denial letter upon which Respondent based its adopted denial. No supplements were received from either party by the assigned deadline.

Via Order for Supplemental Evidence, the parties were again instructed to provide additional information, copied to the opposing party, so as to complete the record in this appeal. Their respective responses have been marked and entered as follows:

Respondent's Exhibit 8: Narrative explaining review process (one page)

Petitioner's Exhibit 36: Narrative response and medical records (10 pages)

The SSA denial letter was not furnished by either party.

Because Petitioner did not include a Certificate of Service that her 10 pages of supplemental evidence was copied to Respondent, the undersigned has attached a copy of same to this Final Order. Respondent is encouraged to include said documentation in Petitioner's case file.

**FINDINGS OF FACT**

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

1. Petitioner is an adult female with a medical history that includes, but is not limited to,

[REDACTED]

She has undergone numerous assessments and surgeries, sees multiple, treating physicians, and takes over 15 medications per day.

2. Prior to the state/Medicaid action at issue, Petitioner applied for disability benefits with the Social Security Administration (SSA). On or about July 25, 2014, SSA issued a notice to Petitioner, informing her that her application was denied.

3. On or about January 20, 2015, Petitioner filed an appeal of SSA's determination. Petitioner advises that she is represented by an attorney in her SSA case, for which final hearing is currently pending.

4. In June of 2015, Petitioner filed an application for disability-based Medicaid with DCF. The Department's Running Record (CLRC) Comments from June 17, 2015 note, "SHE WAS DENIED SSA AND IS IN APPEALS, SSA LETTERS ON DOC IMAG

[document imaging]. DDD HELD FOR NEW CONDITIONS 6/17/15.” (capitalization original)

5. In September of 2015, Petitioner contacted the Department, noting that she received a denial letter based upon her failure to respond; however, said letter had been sent to the wrong address, such that she obtained it late. Petitioner stated that she had updated her mailing address with the Department over a year prior, to which the case worker responded, “THE INFO WAS OBTAINED FROM CNSS WHICH HAS THE OLD ADDRESS—IT ISN’T COMING DIRECTLY FROM US,” (capitalization original).

Petitioner requested a hearing to challenge this denial. It is unclear whether this appeal was pursued.

6. On November 23, 2015 (over one year after her SSA denial), Petitioner again applied for SSI-based Medicaid. Within said application, Petitioner noted that she had been denied by SSA in October of 2014, stated that she was appealing this denial, and responded “Yes” when asked “Health condition changed since Denial?.” Petitioner also signed an authorization permitting the Department to obtain her medical information for review.

7. Per Running Record (CLRC) Comments from November 30, 2015, following Petitioner’s application, she was “PEND[ED] FOR FOOD STAMP AND DDD INTERVIEWS, 2514, VERIFICATION OF NON INCOME PRODUCING PROPERTY, STATEMENT OF NEW CONDITION SINCE DDD/SSDI DENIAL.” Notations from a December 2, 2015 DDD interview do not contain any reference to Petitioner’s medical conditions, or note what was discussed during her DDD interview, but state that Petitioner was denied as “OVER ASSETS,” (all capitalization original).

8. Additional CLRC notes document that on December 7, 2015 and December 14, 2015, Petitioner again contacted the Department to request a hearing, and asked to speak with a supervisor. On December 29, 2015, someone from the Department attempted to contact Petitioner, but did not get through to her. On January 6, 2016, Petitioner again called the Department to clarify her assets, and was pended for verification of same.

9. On January 12, 2016, the Running Record reflects, "DD PACKET SENT TO TALLY." A notation from January 15, 2016 states "NEGATIVE DDD DECISION, MMS DENIED."

10. On January 15, 2016, Lauren Coe of DDD affixed her stamp to a DDD Determination and Transmittal ("DD Transmittal"), denying Petitioner's Medicaid application with the handwritten notation "Hankerson 12/14 same/related allegations, hearing pending." Ms. Coe also checked a box on the DD Transmittal to indicate that DDD staff had not found Petitioner disabled after reviewing a primary diagnosis of "01 Back D/O" and secondary diagnosis of "12 Anxiety." No SSI dates were noted, nor did DDD notate the date on which Petitioner's claim was received. Ms. Coe marked the denial code as N32(J1).

11. On January 19, 2016, per the CLRC, the Department returned a call to Petitioner "IN RESPONSE TO ESCALATION." During this call, Petitioner noted that she failed to report one of her conditions to DCF, had attempted to call the Department on many occasions to update her case, but never received a return call. She again asked to speak to a supervisor. It is not clear whether she was transferred to a supervisor, but the CLRC reflects that she called the Department, again, later that same date.

12. During her second call on January 19, 2016, Petitioner was told that her Medicaid benefits were denied. She again requested a hearing, stating that her case was “DENIED IN ERROR AS THE CASEWORKER DOES NOT HAVE ALL THE REQUIRED INFORMATION.” The caseworker who took Petitioner’s call then sent a request to a supervisor to call Petitioner back, so as to properly address her needs.

13. Is it not clear whether a supervisor ever got back to Petitioner, as no further notations of DDD interviews were proffered; however, a CLRC entry from January 20, 2016 states, “INVALID ESC/DDD DECISION MADE BY TALLY, NOT PROCESSOR.”

14. Via Notice of Case Action dated January 19, 2016, Respondent notified the Petitioner, “Your Medicaid application/review dated January 6, 2016 is **denied**... Reason: You or a member(s) of your household do not meet the disability requirement” (emphasis original).

15. 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. The Department representative testified that, as to the best of his understanding, when an application for SSI-based Medicaid is filed with DCF, a local unit reviews the application, requests supporting documentation, and forwards same to DDD in Tallahassee. DDD then compares Petitioner’s application and records with SSA reports. If no new condition exists, DDD adopts the SSA denial.

16. In review of the denial codes, Respondent noted that the Department’s online view screen for SSI showed that Petitioner was denied by SSA under the denial code of N04 (identified by Respondent as “non-excludable resources”). DDD, itself, denied

Petitioner's Medicaid application using the code N32 (identified by Respondent as "non-pay/substantial gainful activity"). It is unclear why DDD purports to have adopted the decision by SSA, but utilized a separate denial code for same.

17. No witness from DDD was present at hearing to testify regarding their review process. As such, the only evidence regarding DDD's evaluation of Petitioner's case is uncorroborated hearsay testimony from Department representatives, who have no first-hand knowledge of what records were examined, or how these were compared to records from SSA.

18. Petitioner testified that she encountered much frustration in trying to work with the Department over the course of her case review. She noted numerous calls that were not returned, and stated that she asked many times to speak with supervisors, to no avail. It was her position that she had *both* worsening *and* new conditions since her SSA denial in 2014. Specifically, Petitioner stated that both [REDACTED] and [REDACTED] were diagnosed *after* her SSA denial, but *prior* to her application for Medicaid.

19. Review of Petitioner's documentary evidence reflects voluminous medical records, including many records from physician's visits and exams that occurred between July 25, 2014 (SSA denial) and November 23, 2015 (application for Medicaid). Between these dates, alone, the following conditions are referenced within Petitioner's documentation: [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

20. Petitioner contends that she has provided the attorney handling her SSA appeal with all additional medical records, and believes the attorney has kept SSA up to date regarding all new diagnoses and treatments.

21. Following hearing, Petitioner supplemented the record with a narrative explaining which of her conditions have worsened since the SSA denial, as well as which conditions had worsened (or arisen) since Respondent's denial of Medicaid.

22. Respondent supplemented the record with a statement, which reads:

Update to my understanding of the process for DDD Hankerson denials. According to DDD unit supervisor Sherry Seymore-Green, when the DDD packet is sent to Tallahassee for review, it is received by the review team who then works with Social Security on what conditions the client was denied for. If no new conditions exist, Social Security informs DCF of that fact and the DCF review team in Tallahassee send the denial back to the DDD unit. DCF never receives a Social Security denial letter.

23. Review of the record reflects contradictory information regarding whether the Department obtained a copy of the SSA letter (see reference to the letter on document imaging, per CLRC entry dated June 17, 2015), what code was used for denial, and how DDD evaluated Petitioner's case. It is also unclear what documentation and/or alleged conditions DDD reviewed, as the only reference contained within its transmittal is to the primary diagnosis of [REDACTED] and secondary diagnosis of [REDACTED].

#### **CONCLUSIONS OF LAW**

24. 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.

25. 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, which was 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.

26. 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.

27. 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; 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.

(underlined emphasis added)

28. Petitioner's application for disability-based Medicaid (November 23, 2015) was filed more than 12 months after her most recent SSA denial (July 25, 2014). On said application, Petitioner stated that her condition had changed. Petitioner alleges that she has both new and worsening conditions, which need to be reviewed. In this situation, the above-cited authority clearly indicates that the Department must conduct its own review for disability. This is particularly true given the CFR specifies that an *allegation* – not substantiated proof – of new conditions is sufficient to trigger review.

29. DDD/DCF contend that they had sufficient information available to determine the conditions Petitioner was alleging were the same as those reviewed by SSA; however, none of this documentation was proffered for

comparison. Respondent purports that it did not obtain the SSA denial letter (although DCF records state that the letter was uploaded to document imaging), and no one from DDD who participated in the actual review was present to testify at hearing. Notations from the Department's CLRC reflect significant issues in communicating with Petitioner, and a lack of meaningful response to questions regarding her case.

30. Additionally, the denial codes given by DDD to support denying Medicaid do not match the code given for SSA denial. This makes it difficult to conclude that DDD simply adopted what SSA decided. Further, DDD's denial is based upon primary diagnoses [REDACTED]; however, Petitioner's medical records document multiple conditions, which appear both new and unrelated to her back or anxiety issues.

31. The undersigned hearing officer does not have sufficient information to complete an independent evaluation of Petitioner's disability claim. The Department, which holds Petitioner's Authorization to Disclose and may request medical documents, is in the best position to undertake this task.

WHEREFORE, the undersigned hereby 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 19 day of July, 2016,

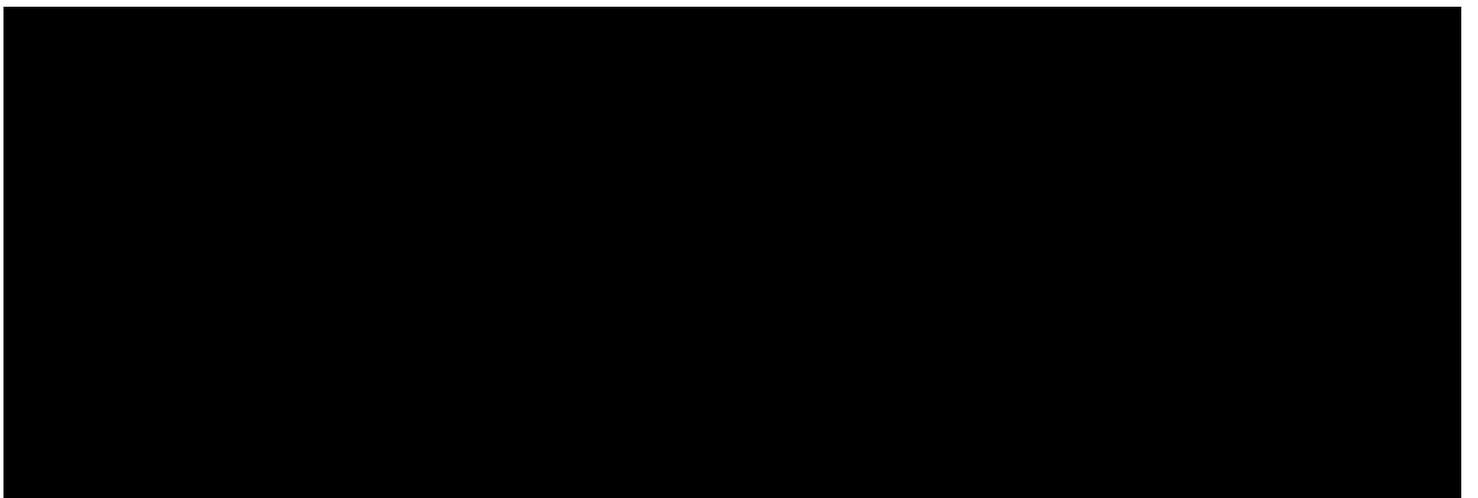
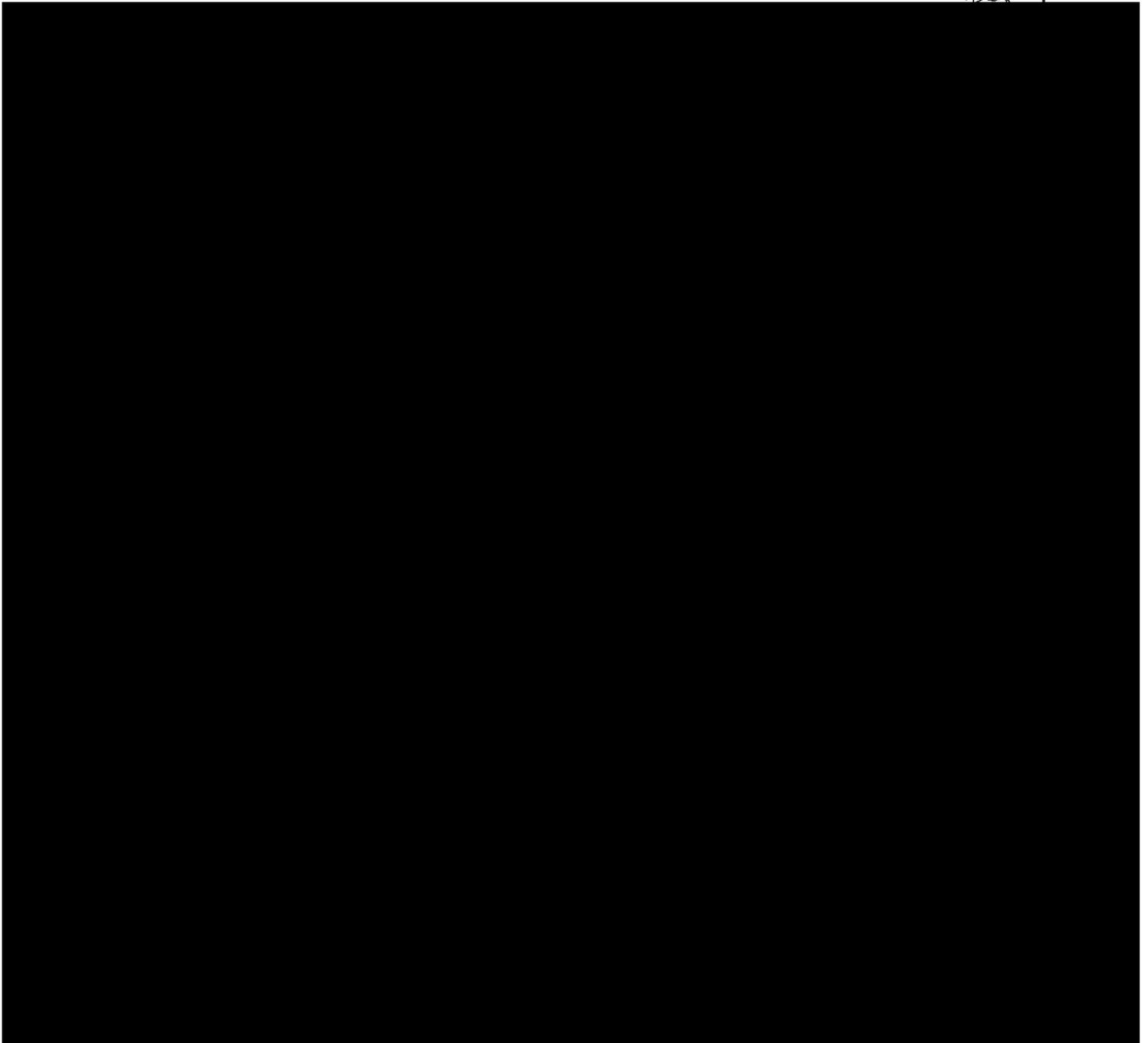
in Tallahassee, Florida.



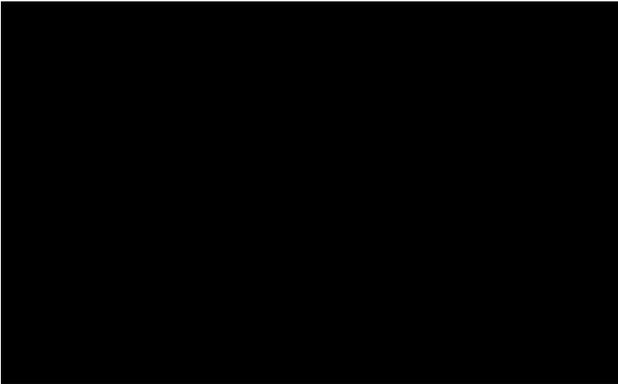
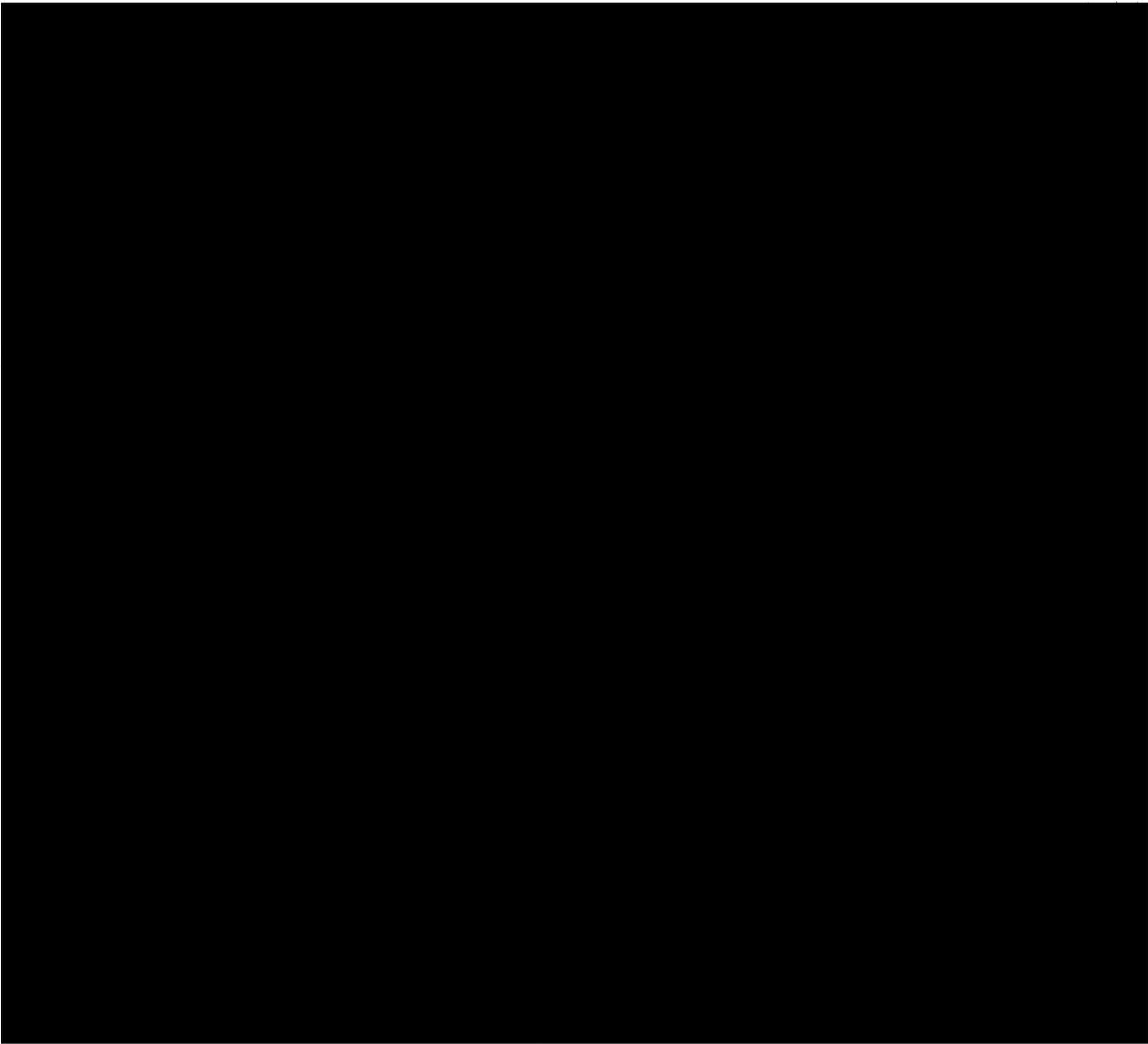
Patricia C. Antonucci  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
Office: 850-488-1429  
Fax: 850-487-0662  
Email: appeal.hearings@myflfamilies.com

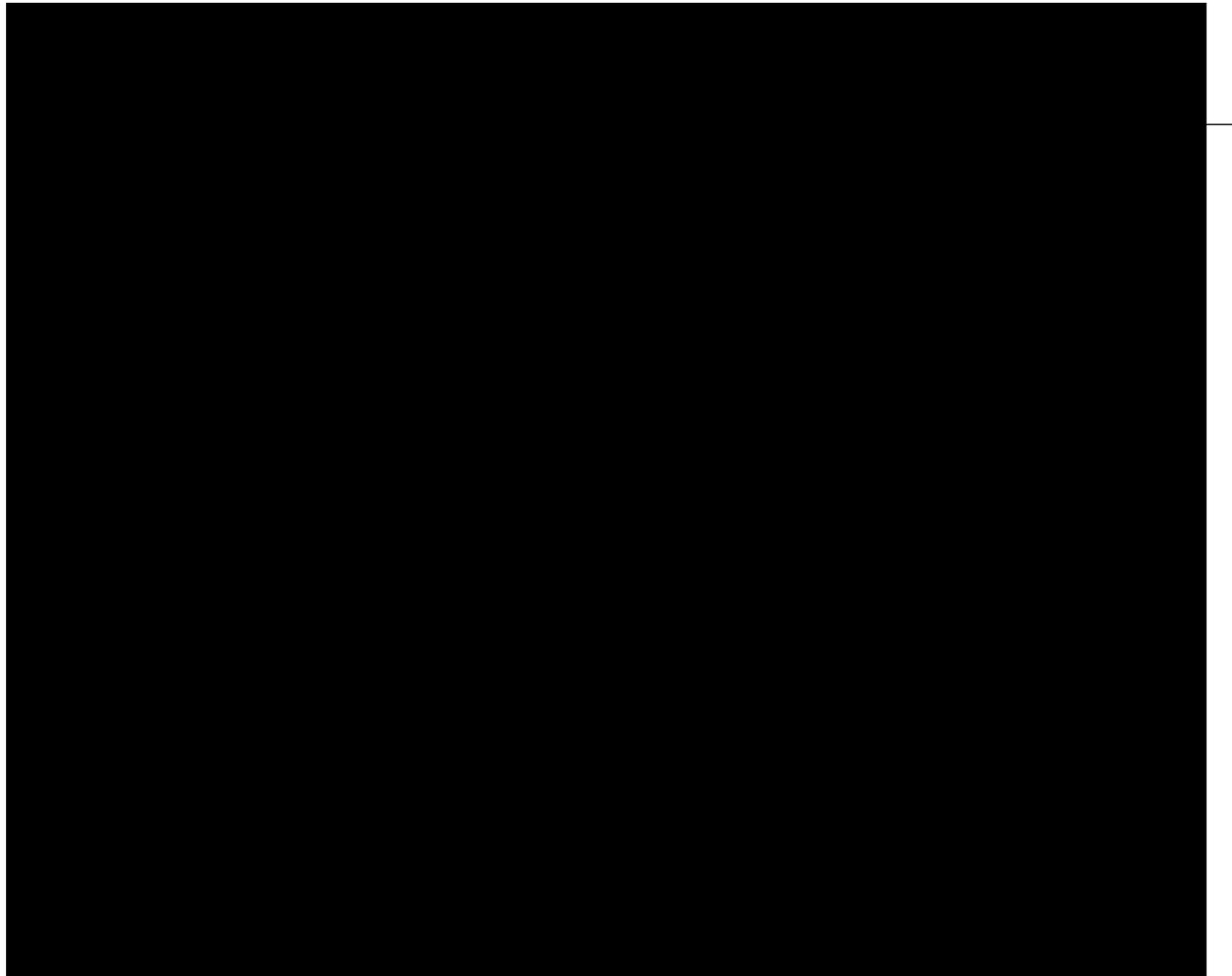
Copies Furnished To: [REDACTED] Petitioner  
Office of Economic Self Sufficiency

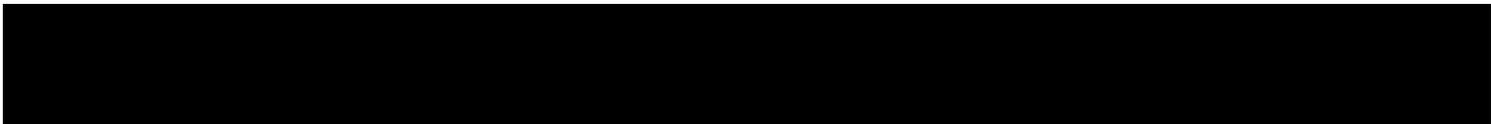
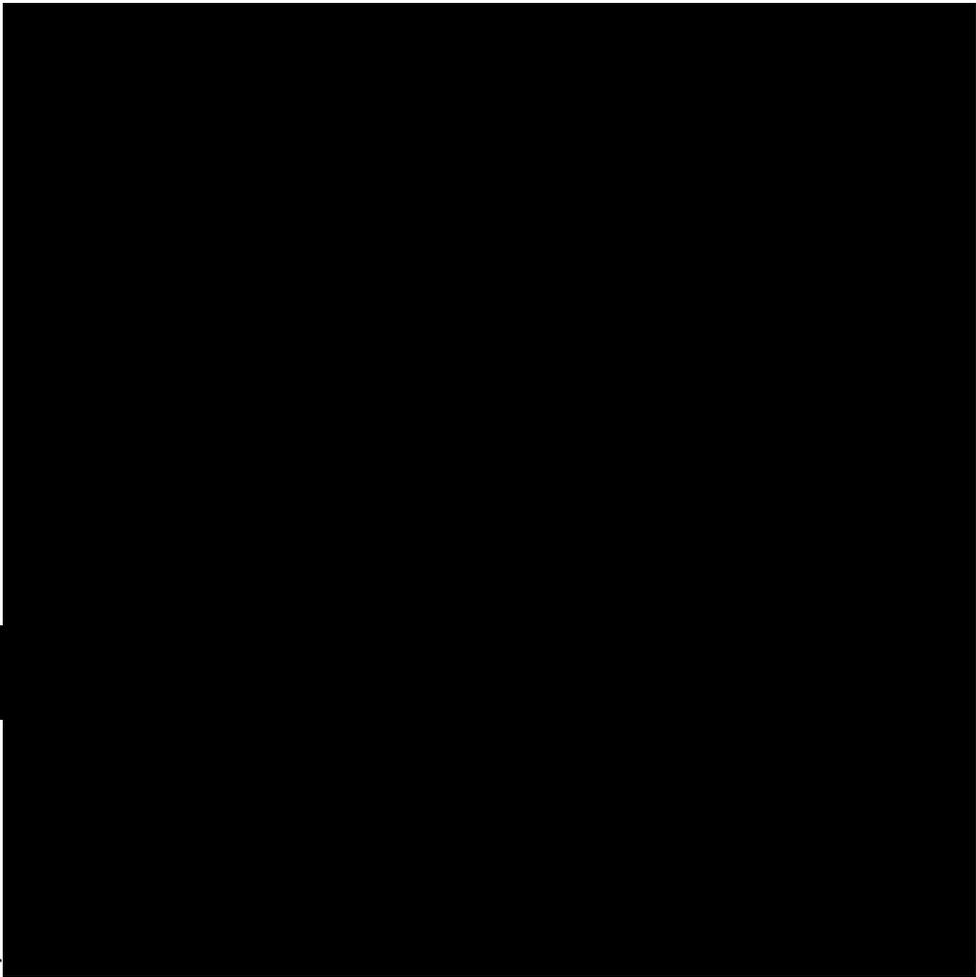
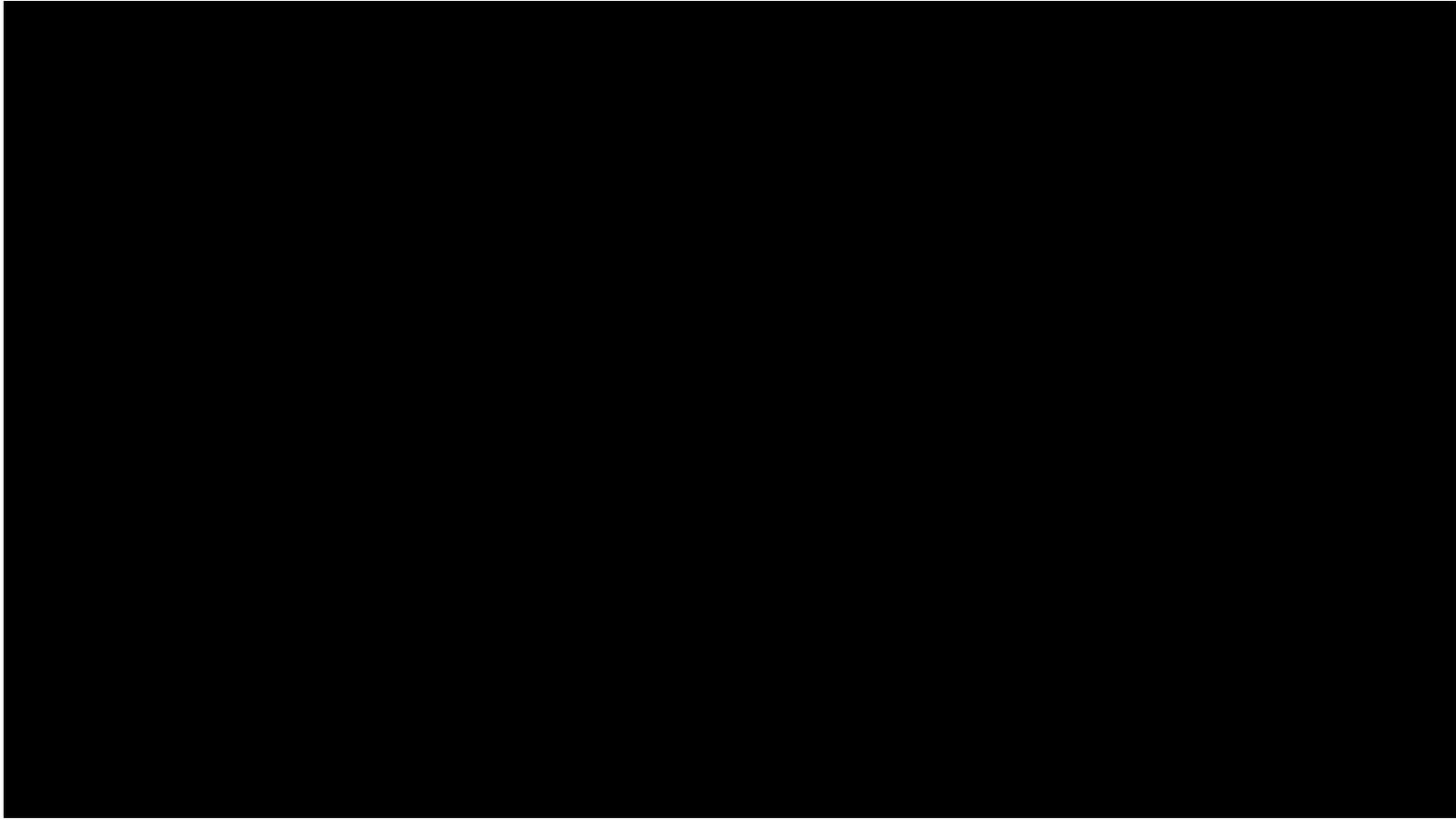
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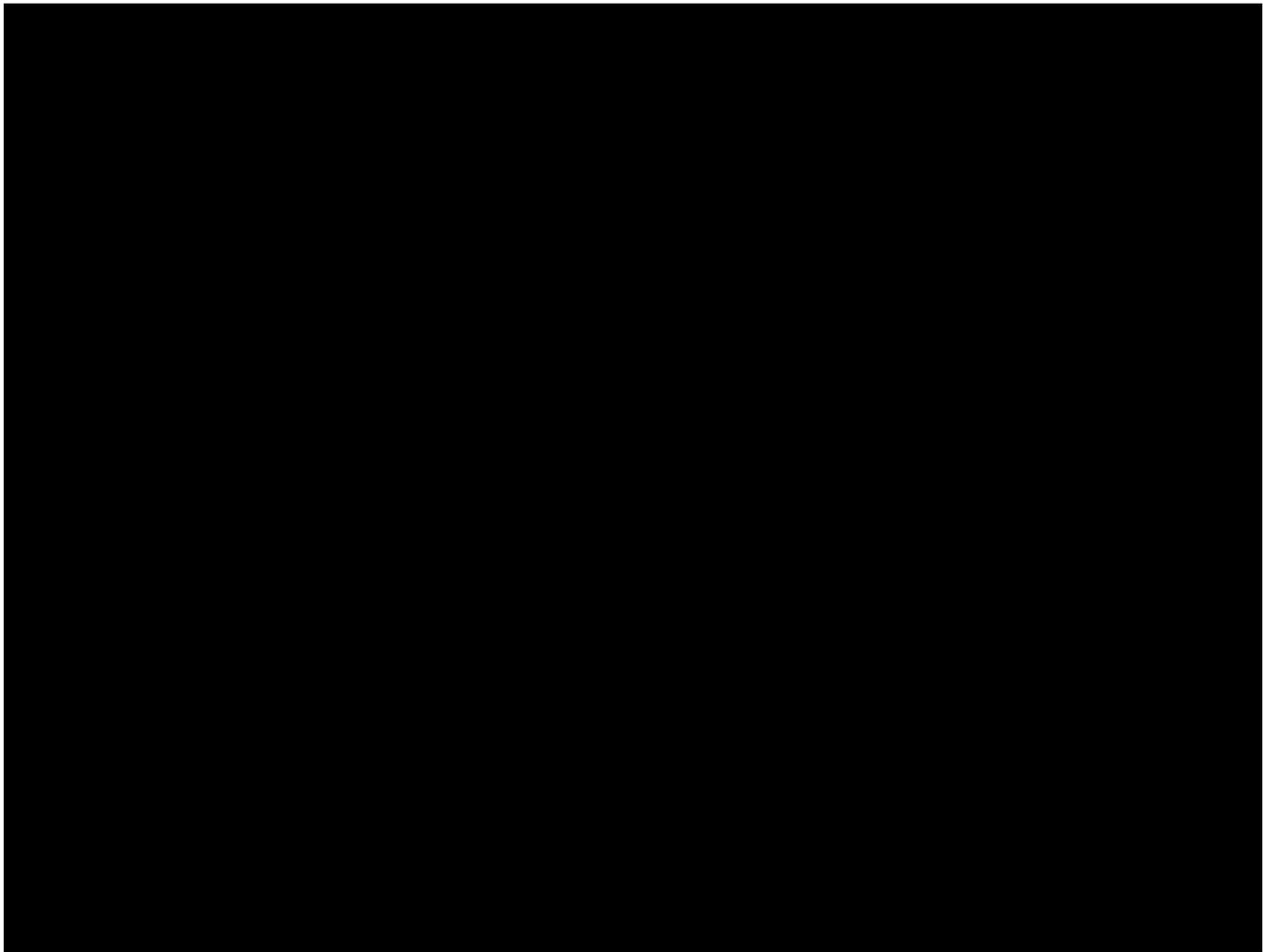








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Pg 7



# APPOINTMENT OF A DESIGNATED REPRESENTATIVE

[Redacted] \_\_\_\_\_  
Case Number

[Redacted] \_\_\_\_\_  
Customer's Name

### Completed by Customer

I would like for [Redacted] \_\_\_\_\_ to act on my behalf in determining my eligibility for public assistance from the Department of Children and Families.

[Redacted] \_\_\_\_\_

[Redacted]

### Completed by Representative

I understand that by accepting this appointment, I am responsible to provide or assist in providing information needed to establish this person's eligibility for assistance. I understand that I may be prosecuted for perjury and/or fraud if I withhold information or intentionally provide false information.

[Redacted]

### Self-Appointment by Representative

I am acting for [Redacted] \_\_\_\_\_ in providing information to establish eligibility for assistance because he/she is unable to act on his/her own behalf. I will provide information to the best of my knowledge. I understand that if I withhold information or if I intentionally provide false information, I may be prosecuted for perjury and/or fraud. I agree to immediately report any change in

[Redacted]

pg 8



## APPOINTMENT OF A DESIGNATED REPRESENTATIVE

[Redacted]

[Redacted]

### Completed by Customer

I would like for [Redacted] to act on my behalf in determining my eligibility for public assistance from the Department of Children and Families.

Name of Representative

[Redacted]

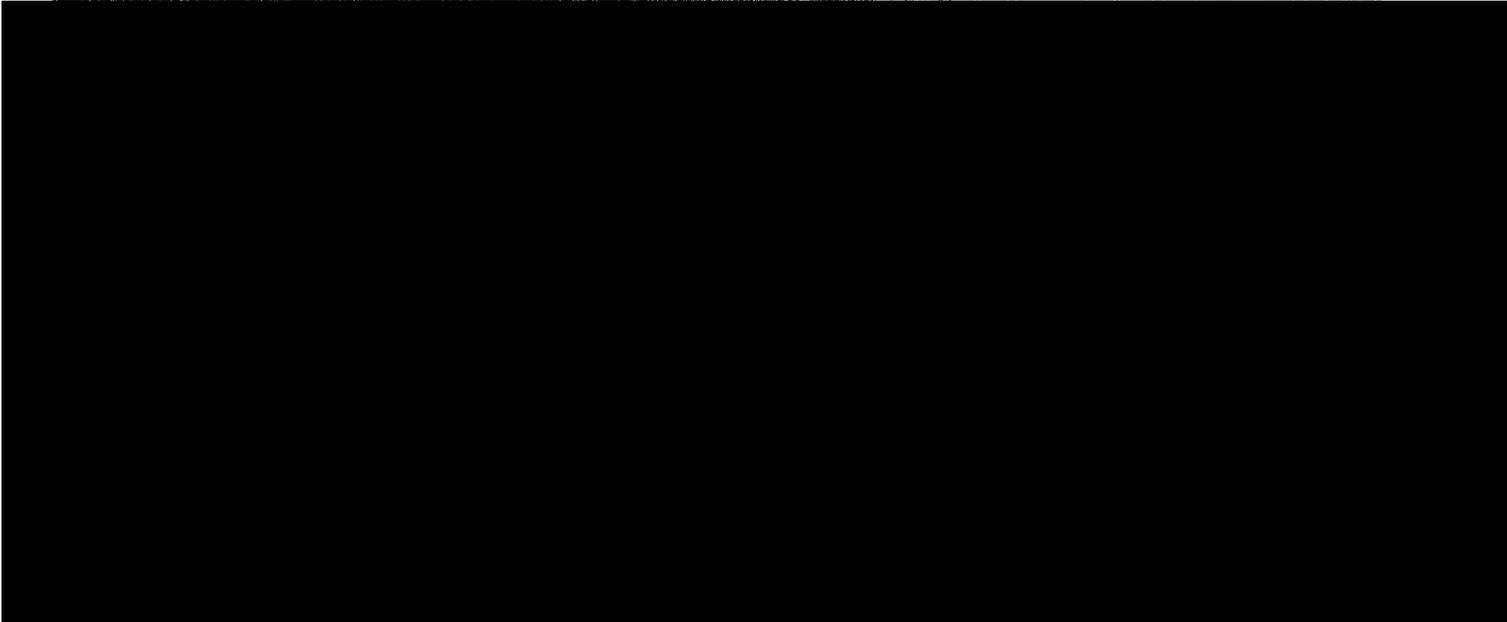
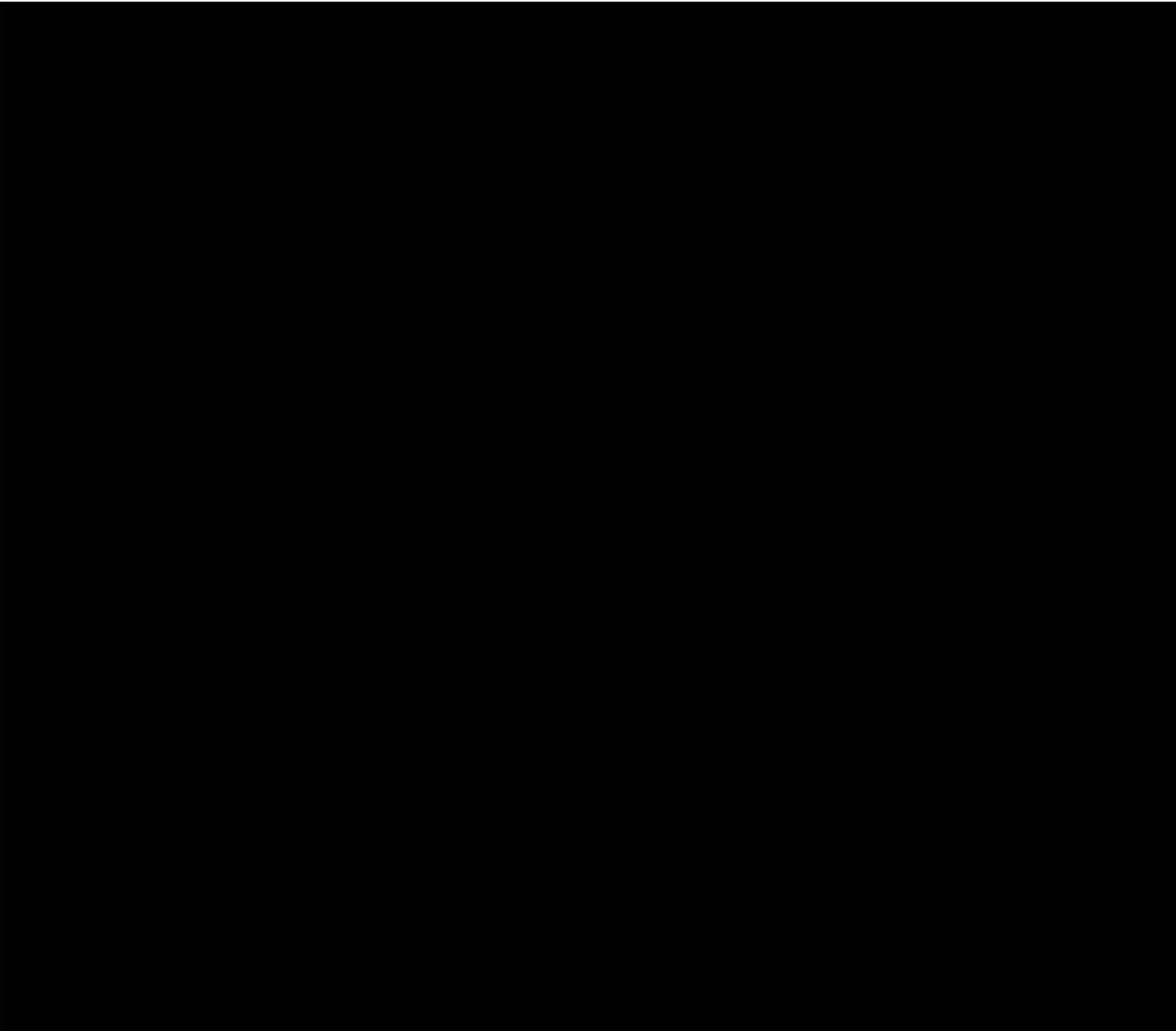
### Completed by Representative

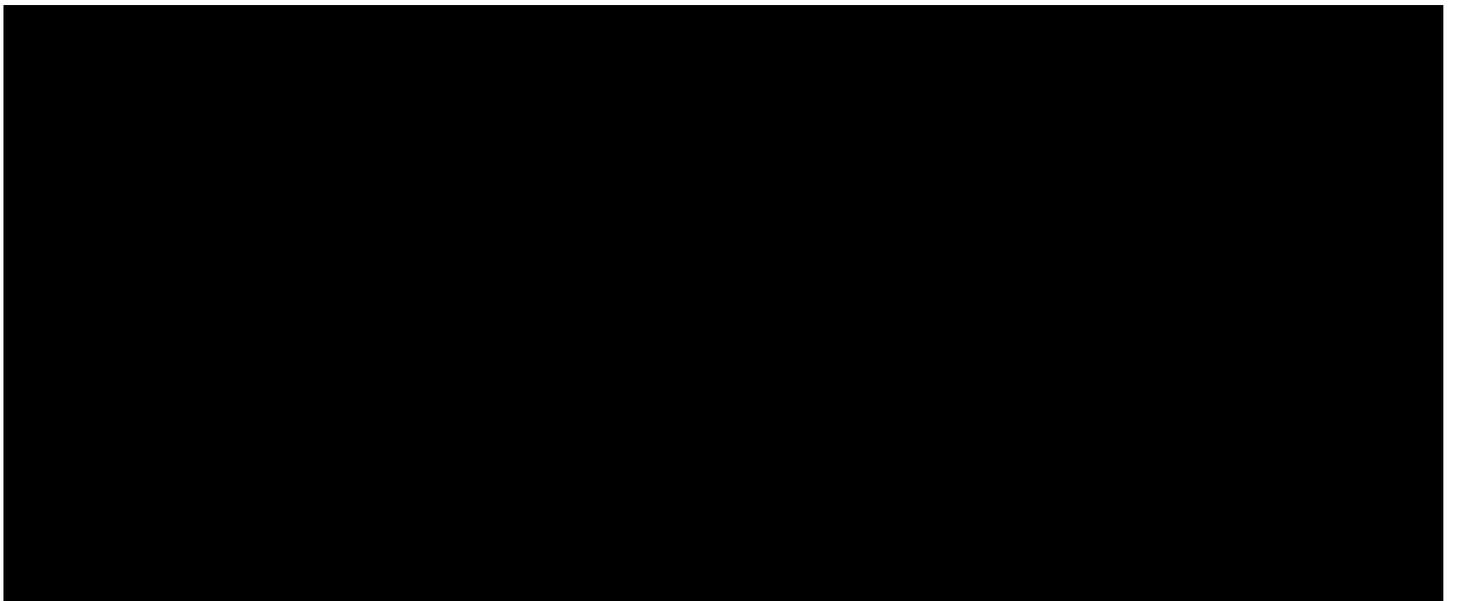
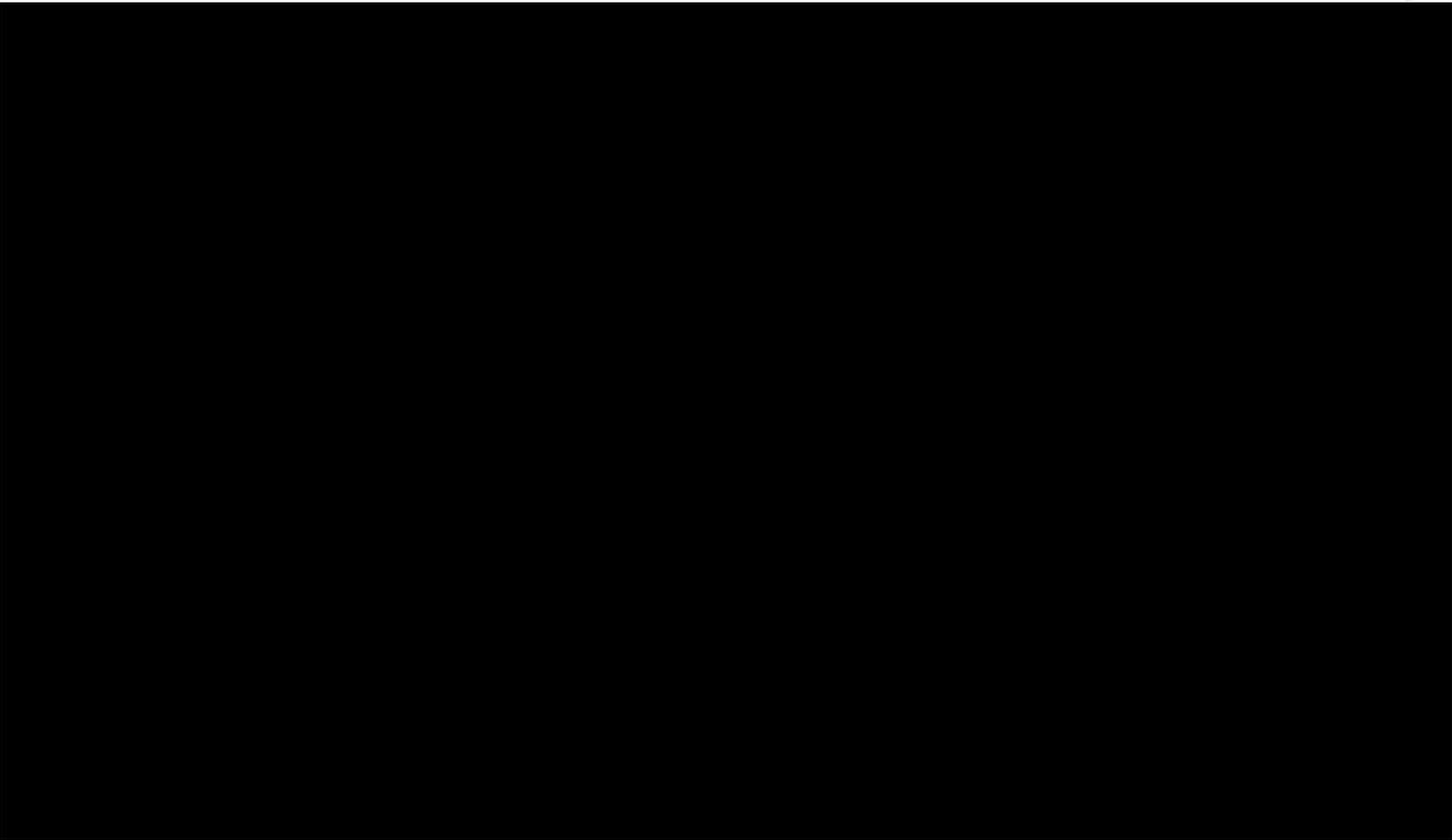
I understand that by accepting this appointment, I am responsible to provide or assist in providing information needed to establish this person's eligibility for assistance. I understand that I may be prosecuted for perjury and/or fraud if I withhold information or intentionally provide false information.

[Redacted]

Self-Appointment by Representative

[Redacted]





**FILED**

Feb 23, 2016

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

Office of Appeal Hearings  
Dept. of Children and Families



APPEAL NO. 16F-00017  
APPEAL NO. 16F-01120

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 15 Palm Beach  
UNIT: 88242

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 2, 2016, at 1:34 p.m.

**APPEARANCES**

For Petitioner:



For Respondent:

Corrie Driscoll, supervisor

**STATEMENT OF ISSUE**

At issue is whether the respondent's action to deny the petitioner's application for Food Assistance (FA) benefits is correct. The petitioner carries the burden of proof in the FA appeal by a preponderance of the evidence.

The petitioner is also appealing the termination of full Medicaid and the enrollment of her two children in the Medically Needy Program with an estimated share

of cost. She is seeking full Medicaid. The burden of proof was originally assigned to the petitioner but after review, the burden of proof was reassigned to the Department.

### **PRELIMINARY STATEMENT**

The respondent submitted one exhibit which was entered into evidence and marked as Respondent's Composite Exhibit 1. The petitioner submitted one exhibit which was entered into evidence and marked as Petitioner's Exhibit 1. The record was held open until February 9, 2016, for the respondent to provide the Medicaid budget. The Department provided one additional exhibit which was entered into evidence and marked as Respondent's Exhibit 2. The petitioner also provided one additional exhibit which was accepted, entered into evidence and marked as Petitioner's Exhibit 2. The record was closed on February 9, 2016.

### **FINDINGS OF FACT**

1. On December 16, 2015, the petitioner completed a recertification application for FA benefits. The application listed the household members as the petitioner (age 36) and her two children (ages 1 and 5). She reported rent of \$800 and electricity of \$100. She also reported she was employed at [REDACTED] and was paid on a monthly basis.
2. The petitioner provided paystubs as verification of her income. The Department updated her case with the income and expenses and did not find eligibility for FA benefits.
3. The Department calculated petitioner's gross monthly earned income as \$3,601.25 by adding paystubs dated October 30, 2015 of \$1,400 and November 13, 2015 of \$1,950, dividing by two and then multiplying by conversion factor of 2.15 to

determine the monthly income. The Department compared it to the gross income limit for three persons of \$3,349 and found the petitioner's gross monthly income was more than the monthly gross income allowed for her assistance group size.

4. On December 30, 2015, the Department mailed the petitioner a Notice of Case Action informing her that her application from December 2015 was denied. The reason for the denial was that her income was too high for the program (Respondent's Composite Exhibit 1).

5. The Department added the petitioner's two paystubs to get her monthly gross income of \$3,350 in Medicaid budget. The respondent determined the petitioner's household income exceeded the income limit for full Medicaid benefits and enrolled her in the Medically Needy Program with a share of cost (SOC).

6. The respondent performed the following budget calculations when it determined the petitioner's estimated SOC. It used her income of \$3,350 and subtracted the Medically Needy Income Limit of \$486 for a household size of three, resulting to \$2,864 as her children's SOC.

7. By notice dated December 30, 2015, the Department notified the petitioner that Medicaid benefits for her two children would end on January 31, 2016. On the same notice the Department informed her that her two children were enrolled in the Medically Needy program with an estimated SOC of \$2,864.

8. At the hearing, the petitioner explained she works as an adjunct teacher and is paid according to the classes she is contracted to teach. The Department used her paystubs dated October 30, 2015 of \$1,400 and November 13, 2015 of \$1,950 to determine her FA eligibility. The petitioner does not agree with the respondent's

calculation of her income. She argued the Department inflated her income as she only earned \$24,750 for the year 2015 and provided her W2 showing \$24,750 as the gross income for 2015.

9. The hearing officer finds that the petitioner's is paid on a biweekly basis as the paychecks she provided states, "Pay Number: Bi weekly 22" and "Pay Number: Bi weekly 23." The paycheck number 22 covers the period October 10, 2015 through October 23, 2015 and paycheck number 23 covers the period October 24, 2015 through November 06, 2015.

10. The Department explained the petitioner's children already received a full year of Medicaid benefits therefore they are not eligible for any additional months of Medicaid.

#### **CONCLUSION 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 § 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

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

#### **The Food Assistance benefits will be addressed first.**

13. The Code of Federal Regulations 7 C.F.R. § 273.9 define income and states, in part:

(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. Households which contain an elderly or disabled member shall meet the net income eligibility standards for the Food Stamp Program...

(b) *Definition of income...*

(1) Earned income shall include: (i) All wages and salaries of an employee...

14. Pursuant to the above authority, the petitioner's monthly earned income must be included in the determination of her FA benefits.

15. The FAP standards for gross income and net income and deductions appear in the Department's Program Policy Manual CFOP-165-22 (Policy Manual), at Appendix A-1. Effective October 2015, the maximum gross income for a three person assistance group is \$3,349.

16. The Code of Federal Regulations at 7 C.F.R. § 273.10 explains income calculation and conversion in the Food Assistance Program and states in part:

(c) *Determining income*—(1) *Anticipating income.* (i) For the purpose of determining the household's eligibility and level of benefits, the State agency shall take into account the income already received by the household during the certification period and any anticipated income the household and the State agency are reasonably certain will be received during the remainder of the certification period. If the amount of income that will be received, or when it will be received, is uncertain, that portion of the household's income that is uncertain shall not be counted by the State agency. For example, a household anticipating income from a new source, such as a new job or recently applied for public assistance benefits, may be uncertain as to the timing and amount of the initial payment. These moneys shall not be anticipated by the State agency unless there is reasonable certainty concerning the month in which the payment will be received and in what amount. If the exact amount of the income is not known, that portion of it which can be anticipated with reasonable certainty shall be considered as income. In cases where the receipt of income is reasonably certain but the monthly amount may fluctuate, the household may elect to income average. Households shall be advised to report all changes in gross monthly income as required by §273.12. .

(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, use the State Agency's PA conversion standard, or use the exact monthly figure if it can be anticipated for each month of the certification period.

Nonrecurring lump-sum payments shall be counted as a resource starting in the month received and shall not be counted as income...

17. The Policy Manual at section 2410.0201 addresses Prospective Budgeting (FS)

and states:

Prospective budgeting is a method by which eligibility and benefit levels are based on the assistance group's composition and income circumstances, as they exist in the month for which assistance group's composition and income circumstances, as they exist in the month for which benefits are being calculated. This can be either a current or future month. When budgeting prospectively for a future month, the estimated anticipated income and circumstances may be based on what occurred in prior months if those months are considered representative of the assistance group's continued situation. Prospective budgeting may also be based on the amount the individual can anticipate to receive. When a budget is completed for a month that has already passed, the actual income and circumstances are used. A past month is defined as any month prior to the month of the interview. All assistance groups are subject to prospective budgeting.

18. The Policy Manual at section 2410.0204, Determining Monthly Income (FS)

states:

Several factors are involved in determining a gross amount of monthly income to be budgeted. These are:

1. anticipating and projecting income,
2. averaging income, and
3. converting the income to a monthly amount.

Once an average amount of income is computed, several factors must be considered to arrive at the gross amount of monthly income. These factors are:

1. When income is received more often than monthly, it will be converted to a monthly amount.
2. When averaging income, use the most recent consecutive four weeks or the best available information when it is representative of the individual's future earnings.

19. The petitioner was paid on a biweekly basis. The Department also argued that since the petitioner was paid on a biweekly basis her income is to be converted to monthly income using the biweekly factor of 2.15 in order to anticipate her ongoing monthly income.

20. Pursuant to the above authorities, the respondent converted the petitioner's biweekly income to monthly income by adding the two bi-weekly checks, then dividing the sum by two, and then multiplying the sum by 2.15. The undersigned concludes the Department correctly calculated petitioner's monthly gross earned income amount. Since the petitioner's earned income is above the monthly gross earned income limit, she is ineligible for FA benefits.

**Medicaid Benefits will now be addressed**

21. Federal Medicaid Regulations 42 C.F.R. § 435.218 Individuals with MAGI-based income above 133 percent FPL (Federal Poverty Level) states in part:

(a) *Basis*. This section implements section 1902(a) (10) (A) (ii) (XX) of the Act.

(b) *Eligibility*—(1) *Criteria*. The agency may provide Medicaid to individuals who:

(i) Are under age 65;

(ii) Are not eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part;

(iii) Are not otherwise eligible for and enrolled for optional coverage under a State's Medicaid State plan in accordance with section 1902(a)(10)(A)(ii)(I) through (XIX) of the Act and subpart C of this part, based on information available to the State from the application filed by or on behalf of the individual; and

(iv) Have household income that exceeds 133 percent FPL but is at or below the income standard elected by the agency and approved in its Medicaid State plan, for the applicable family size.

(2) *Limitations*. (i) A State may not, except as permitted under an approved phase-in plan adopted in accordance with paragraph (b)(3) of this section, provide Medicaid to higher income individuals described in

paragraph (b)(1) of this section without providing Medicaid to lower income individuals described in such paragraph.

(ii) The limitation on eligibility of parents and other caretaker relatives specified in § 435.119(c) of this section also applies to eligibility under this section.

22. Family-Related Medicaid income criteria is set forth in 42 C.F.R. 435.603 and states:

(a) (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.

(3) In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid coverage to begin on or before December 31, 2013, application of the financial methodologies set forth in this section will not be applied until March 31, 2014 or the next regularly-scheduled renewal of eligibility for such individual under §435.916 of this part, whichever is later.

(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. In the case of determining the family size of a pregnant woman, the pregnant woman is counted as herself plus the number of children she is expected to deliver. In the case of determining the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted, at State option, as either 1 or 2 person(s) or as herself plus the number of children she is expected to deliver....

(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.

23. The Policy Manual at section 2430.0204 addresses Determining Monthly Income (MFAM), and states:

The process of computing the amount of income to be considered in determining financial eligibility and the coverage group(s) is called “budgeting”. When determining financial eligibility, one or more budget calculations will be completed. The best estimate of the standard filing unit’s income and circumstances is used to determine eligibility. When determining eligibility benefits for a past month, the SFU’s actual income and circumstances are used. The income is compared to the appropriate income limit to determine the coverage group.

24. The Policy Manual at section 2430.0509, Income More Often than Monthly (MFAM), states:

The following procedure to calculate the average of earned or unearned income received in varying amounts more frequently than monthly is the same for all programs:

1. Add the gross income amounts for the past four weeks to get the total.
2. If income is received weekly, add four pay periods and divide by four to get the weekly average.
3. If income is received biweekly, add two pay periods and divide by two to get the biweekly average.
4. If income is received semimonthly, add two pay periods and divide by two to get the semimonthly average.

5. If income is received monthly, use the most recent month if representative.

The result of the above is called the averaged amount. With the exception of monthly amounts, the averaged amount described above must be converted to a monthly amount.

25. The above instructs the Department to add the two biweekly pay periods and divide by two to determine the biweekly average.

26. The Policy Manual at Appendix A-7 indicates the Family-Related Medicaid Income Limit for a child between ages one and five in a household size of three is \$2,227, the Standard Disregard is \$117, and the Medically Needy Income Limit (MNIL) is \$486 and the MAGI Disregard is \$84.

27. The Policy Manual at passage 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 Kid Care and/or the Federally Facilitated Marketplace (FFM).

28. In accordance with the above controlling authorities, the undersigned calculated eligibility for Medicaid for the petitioner's two children and did not find the children eligible for full Medicaid as the petitioner's modified adjusted gross income is more than the income limit of \$2,227, for a household of three. Step 1: The petitioner's two paychecks were added to get the modified adjusted gross income of \$3,350. Step 2: There are no deductions provided, as there was no tax return. Step 3: The total income of \$3,350 less the standard disregard of \$117 is \$3,233. Step 4: The total countable net income of \$3,233 was compared with the income standard for two of \$2,227. Step 5: Since it was greater than the income standard, the MAGI disregards of \$84 was subtracted, resulting to \$3,149. This was compared to the income limit of \$2,227 for full Medicaid. The petitioner's household income was greater than the income limit for full Medicaid. The undersigned concludes the petitioner's two children were ineligible for full Medicaid. The undersigned further concludes Medically Needy eligibility must be explored for the petitioner.

**The Medically Needy share of cost will now be addressed**

29. 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".

30. The methods of determining the share of cost for Medically Needy Program benefits is set forth in the Fla. Admin. Code R. 65A-1.713. It states:

(1) (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 cost...

31. The above cited authorities and policies address income standards and limits, calculating countable income, and income budgeting in the Family-Related Medically Needy Program.

32. The undersigned carefully reviewed the Department's determination of the children's share of cost budget and did not find any errors with the Department's calculation. The household's modified adjusted gross income of \$3,350, less the MNIL of \$486 resulted to the children's SOC of \$2,864.

33. The undersigned concludes the respondent's action to deny full Medicaid benefits and to enroll the petitioner in the Medically Needy Program was correct.

34. In careful review of the cited authorities and evidence, the undersigned concludes, the Department used the best available information to determine FA and Medicaid eligibility. The petitioner did not meet the burden of proof in establishing that the Department incorrectly denied FA benefits. The undersigned did not find the petitioner's children eligible for full Medicaid benefits or a lower share of cost.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, both appeals are denied and the respondent's actions are 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 23 day of February, 2016,

in Tallahassee, Florida.



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Christiana Gopaul-Narine  
Hearing Officer  
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Copies Furnished To: [REDACTED] Petitioner  
Office of Economic Self Sufficiency

Jul 18, 2016

Office of Appeal Hearings  
Dept. of Children and FamiliesSTATE OF FLORIDA  
DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-00682

PETITIONER,

Vs.

CASE NO. FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 06 Pinellas  
UNIT: 88266RESPONDENT.  

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**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing by phone in the above-referenced matter on May 23, 2016 at 9:11 a.m. Two continuances were granted for the petitioner.

**APPEARANCES**For Petitioner: 

For Respondent: Mary Lou Dahmer, Economic Self Sufficiency Specialist II

**STATEMENT OF ISSUE**

At issue is whether respondent's action to deny petitioner's request for SSI-Related Medicaid benefits for the months of November 2011; March 2012; May 2012, June 2012; September 2012; April 2014; May 2014; July 2014; February 2015; and September 2015 through November 2015 is correct. The burden of proof is assigned to the petitioner by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

Petitioner was not present but was represented by [REDACTED] owner of [REDACTED], who testified. Petitioner submitted no exhibits at the hearing. Respondent was represented by Mary Lou Dahmer with the Department of Children and Families (hereafter “DCF”, “Respondent” or “Agency”). Ms. Dahmer testified. Respondent submitted nine exhibits, which were entered and marked as Respondent’s Exhibits “1” through “9”.

### **FINDINGS OF FACT**

1. On May 27, 2014, the petitioner applied for Supplemental Security Income (SSI) benefits from the Social Security Administration (SSA). On July 29, 2014, SSA denied the petitioner’s SSI application using the code N32. N32 means “Non-pay-Capacity for substantial gainful activity – other work, no visual impairment”. Petitioner never appealed the denial of his May 27, 2014 SSI application.
2. On November 16, 2015, the petitioner submitted an application for Medicaid benefits. The application listed petitioner as the only individual applying for benefits; petitioner as fifty-one years old; petitioner answered “yes” to the question of him claiming to be disabled and not already been determined disabled by SSA or the State of Florida; petitioner as not having an SSI application denied within the last ninety days; and petitioner requesting past medical bills to be paid.
3. On November 19, 2015, the respondent submitted both the Disability Determination and Transmittal form (Respondent’s Exhibit 5) and a packet of medical information to the Department of Health Division of Disability Determination (hereafter “DDD”) to determine if petitioner met the criteria to be considered disabled.

4. On December 2, 2015, DDD determined petitioner not disabled using the denial code N32. The Disability Determination and Transmittal form had "Hankerson 7/14 same/related allegations" handwritten on it. The document also listed petitioner's primary diagnosis as PAD (Periphery Artery Disease); and listed petitioner's secondary diagnosis as Substance Abuse.
5. On December 7, 2015, the respondent denied petitioner's November 16, 2015 Medicaid application as DDD determined petitioner not to be disabled.
6. On December 8, 2015, the respondent mailed petitioner a Notice of Case Action indicating petitioner's Medicaid application dated November 16, 2015 was denied effective September 2015 as "No household members are eligible for this program".
7. Petitioner submitted applications for Medicaid benefits on May 27, 2014; August 28, 2014; March 31, 2015; June 16, 2015; September 22, 2015; and December 4, 2015.
8. Petitioner requested the appeal be remanded to the respondent so DDD can complete an independent disability determination on him. To the date of the hearing, the petitioner has been hospitalized since July 2014; however, the petitioner does not know if SSA knows about the hospitalizations and does not know if he has a new/worsening condition.
9. Respondent determined petitioner not eligible for retroactive Medicaid months for the period of November 2011; March 2012; May 2012; June 2012; and September 2012 as the petitioner did not submit applications that covered the aforementioned months.
10. Respondent determined petitioner not eligible for Family-Related Medicaid benefits as he had no children under the age of 18 living with him; and not eligible for

SSI-Related Medicaid benefits as he was under the age of 65 and had not been determined disabled by SSA.

### **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 § 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

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(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...

14. 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 him. Since petitioner does not have a minor child under age 18 living in the household, he does not meet the technical requirement to be eligible for Family-Related Medicaid benefits.

15. 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 Medicaid 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. 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 (see § 416.960(b)) or any other substantial gainful work that exists in the national economy.

16. 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 has not been deemed disabled by SSA.

17. 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 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.

...

(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—
- (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...

18. Petitioner applied for SSI benefits on May 27, 2014 and was denied SSI benefits on July 29, 2014 pursuant to code N32. Petitioner never appealed his SSI denial with SSA. On December 2, 2015, DDD determined petitioner not disabled by adopting a July 2014 SSI denial. On December 7, 2015, the respondent denied petitioner's application for SSI-Related Medicaid benefits as DDD adopted a SSA decision from July 2014.

19. Petitioner is not appealing his SSI denial with SSA and his SSI denial is over twelve months; however, petitioner did not allege a new and/or worsening condition since his last SSI denial. Under these circumstances, the controlling authorities preclude the respondent from rendering an independent disability determination. Petitioner is encouraged to reapply for SSI if he has any new and/or worsening conditions not known by SSA.

20. Therefore, the respondent was correct to adopt SSA's denial decision for any requested retroactive Medicaid months for May 2014 and ongoing as the petitioner's

SSI denial is over twelve months and he has not alleged a new and/or worsening medical condition.

21. Petitioner requested six retroactive Medicaid months that were prior to his May 27, 2014 SSI application.

22. The Fla. Admin. Code R. 65A-1.702, Medicaid Special Provisions, states in relevant part:

(2) Date of Eligibility. The date eligibility for Medicaid begins. This was formerly called the date of entitlement. The date of eligibility includes the three months immediately preceding the month of application (called the retroactive period)...

23. Pursuant to the above authority, Medicaid eligibility includes three months prior to the month of application. Petitioner is requesting retroactive SSI-Related Medicaid for the months of November 2011; March 2012; May 2012, June 2012; September 2012; and April 2014.

24. Petitioner applied for retroactive SSI-Related Medicaid benefits on May 27, 2014; August 28, 2014; March 31, 2015; June 16, 2015; September 22, 2015; and December 4, 2015.

25. The three retroactive months for petitioner's aforementioned SSI-Related Medicaid applications are February 2014 to July 2014; and December 2014 to November 2015.

26. Respondent determined petitioner not eligible for retroactive SSI-Related Medicaid for the months of November 2011; March 2012; May 2012, June 2012; and September 2012 as petitioner did not submit applications that would cover the aforementioned months.

27. Respondent correctly denied petitioner's request for retroactive SSI-Related Medicaid benefits for the months of November 2011; March 2012; May 2012, June 2012; and September 2012 as the petitioner never submitted applications for SSI-Related Medicaid benefits in the one to three months that follow the aforementioned months.

28. In careful review of the cited authorities and evidence, the undersigned concludes that petitioner has not met his burden of proof to indicate the respondent incorrectly denied his request for retroactive SSI-Related Medicaid benefits for the period of November 2011; March 2012; May 2012; June 2012; September 2012; April 2014; May 2014; July 2014; February 2015; and September 2015 through November 2015.

**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   18   day of   July  , 2016,

in Tallahassee, Florida.

*Mary Jane Stafford*

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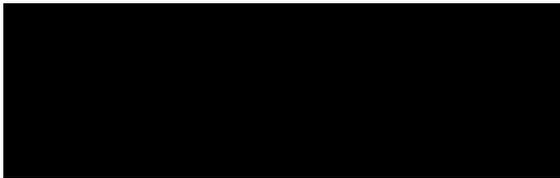
Mary Jane Stafford  
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Copies Furnished To: [REDACTED], Petitioner  
Office of Economic Self Sufficiency

Jul 22, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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

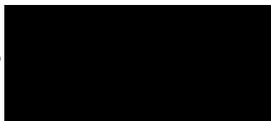


APPEAL NO. 16F-01090

PETITIONER,

Vs.

CASE NO.



FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 02 Leon  
UNIT: 88313

RESPONDENT.

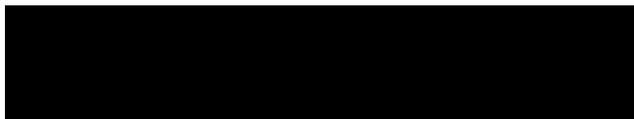
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**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter in \_\_\_\_\_ on June 13, 2016 at 3:16 p.m.

**APPEARANCES**

For the Petitioner:



For the Respondent:

Camille Larson, esq.  
Assistant Region Counsel, Northwest Region

**STATEMENT OF ISSUE**

Petitioner is appealing the Department's action of September 10, 2015 closing her Qualified Medicare Beneficiaries (QMB) eligibility and approving her for Special Low-Income Medicare Part B Medicaid (SLMB). The petitioner believes she is eligible to receive the QMB benefit. The respondent carries the burden of proof by the preponderance of evidence.

### **PRELIMINARY STATEMENT**

The hearing was scheduled as a telephonic hearing on April 11, 2016. The petitioner requested rescheduling of the hearing to an in-person hearing. The undersigned rescheduled the hearing as an in-person hearing for April 11, 2016. The petitioner then requested rescheduling of the hearing while she obtained legal counsel. The petitioner confirmed she and her counsel would be available on May 23, 2016 for an in-person hearing and the hearing was scheduled. The petitioner subsequently notified the undersigned that her counsel was unavailable for May 23, 2016. The undersigned rescheduled the in-person hearing for June 13, 2016 at 3:00 p.m.

The petitioner was present. The petitioner presented evidence prior to hearing that was entered as Petitioner's Exhibit 1. Sherry Lynn Taylor, Operations Management Consultant I, and Antoinette Santillo, ACCESS Supervisor, appeared as witnesses for the Department. The Department submitted evidence prior to the hearing, which was entered as Respondent's Exhibit 1. The record remained open at the petitioner's request until July 5, 2016 for additional information from the petitioner to be received.

Ursula Robinson, Hearing Officer, appeared as an observer to the hearing proceeding with no objection from the petitioner.

The last Notice of Case Action on this case was issued September 10, 2015. The petitioner requested this appeal on February 10, 2016. The Department stipulated this was a timely requested appeal. The Department also reported that QMB benefits were continued pending the outcome of the hearing.

The Department provided Chapter 2600 of their Program Policy Manual, CFOP 165-22, post hearing. The undersigned takes judicial notice of this document. The

petitioner submitted additional documentation on June 22, 2016. This was entered as Petitioner's Exhibit 2. The Department submitted an affidavit from Ms. Taylor on July 1, 2016 regarding her review of the documentation provided by the petitioner post hearing. This affidavit was entered as Respondent's Exhibit 2.

The record closed on July 5, 2016.

### **FINDINGS OF FACT**

1. The petitioner filed an application on September 1, 2015 for recertification. The application was marked only for Food Assistance.
2. The Department completed the recertification of the petitioner's Medicare Savings Program (MSP) benefits as well.
3. The petitioner receives Social Security Disability Income (SS DI) in the gross amount of \$1,034 per month.
4. The Department discovered at the previous certification the only income included was \$647.
5. The Department updated the petitioner's case to include her correct SS DI gross income of \$1,034.
6. The Department explained there are three categories of eligibility for MSP based on income level. Qualified Medicare Beneficiaries (QMB) has the lowest income limit of \$981 effective April 2015 and \$990 beginning July 2016. QMB pays the Medicare premium as well as copays. Special Low-Income Medicare Part B Medicaid (SLMB) is the second level of the MSP with income limits of \$1,177 effective April 2015 and \$1,188 beginning July 2016. Qualifying Individuals 1 (QI 1) is the third level with

income limits of \$1,325 effective April 2015 and \$1,337 effective July 2016. SLMB and QI 1 do not pay copays.

7. The Department issued a Notice of Case Action on September 10, 2015 approving the petitioner for SLMB and closed her QMB eligibility based on her income eligibility.

8. The Department explained that due to the incorrect income being included in the petitioner's case at the last recertification, the Department erroneously approved for QMB at that time.

9. The Department reported the petitioner's Medicare premium continues to be paid by the state through the SLMB benefit. The petitioner is no longer eligible for the copays to be paid, as that is not a covered benefit of SLMB.

10. The petitioner believes her medical expenses should be an allowable expense, which she believes would make her eligible for QMB.

#### **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 Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

13. Fla. Admin. Code R. 65A-1.702 "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. 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.)

14. Fla. Admin. Code R. 65A-1.713 "SSI-Related Medicaid Income Eligibility

Criteria" states in relevant 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:

...

(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.

15. Federal Regulations at 20 C.F.R. § 416.1121 "Types of unearned income" states: "(a) Annuities, pensions, and other periodic payments. This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veterans benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits."

16. 20 C.F.R § 416.1123 “How we count unearned income” states: “(a) When we count unearned income. We count unearned income at the earliest of the following points: when you receive it or when it is credited to your account or set aside for your use.”

17. 20 C.F.R. § 416.1124 “Unearned income we do not count” states in relevant part:

(c) Other unearned income we do not count. We do not count as unearned income—

...

(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.

18. The Department’s Program Policy Manual, CFOP 165-22, Appendix A-9 effective July 1, 2015 lists the income limit for an individual to receive QMB is \$981 and SLMB is \$1,177. Appendix A-9 was updated effective April 1, 2016 to reflect the new income limit for an individual to receive QMB is \$990 and SLMB is \$1,188.

19. The findings show the petitioner’s income is Social Security income of \$1,034. The above controlling authorities identify this income type as unearned income. The above controlling authority allows \$20 of this income to be excluded. The undersigned concludes the petitioner’s countable income is \$1,014 ( $\$1,034 - \$20 = \$1,014$ ). The undersigned concludes the petitioner’s countable income exceeds the income limit for the QMB program under the standards in effect as of July 1, 2015 and April 1, 2016. The undersigned further concludes the petitioner’s countable income

does not exceed the income limit for the SLMB program under the standards in effect as of July 1, 2015 and April 1, 2016.

20. The undersigned reviewed all applicable rules and regulations and found no allowable deduction for medical expenses in the QMB or SLMB eligibility determination. Therefore, the undersigned concludes the Department's action to terminate the petitioner's QMB and approve SLMB effective October 1, 2015 was correct.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied. 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 22 day of July, 2016,  
in Tallahassee, Florida.



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Melissa Roedel  
Hearing Officer  
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Office: 850-488-1429  
Fax: 850-487-0662  
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Copies Furnished To: [REDACTED] Petitioner  
Office of Economic Self Sufficiency  
[REDACTED]  
Camille Larson

**FILED**

Aug 09, 2016

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

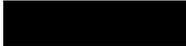
Office of Appeal Hearings  
Dept. of Children and Families



APPEAL NO. 16F-01140

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 04 Duval  
UNIT: 88324

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned reconvened a telephonic administrative hearing in the above-referenced matter on July 5, 2016 at 2:48 p.m.

**APPEARANCES**

For the Petitioner: The petitioner is deceased and was represented by her daughter, 

For the Respondent: Matthew Lynn, Economic Self-Sufficiency Specialist II for the Department of Children and Families (DCF).

**ISSUE**

At issue is the respondent's denial of the petitioner's request for Institutionalized Hospice Medicaid coverage for the months of June 2015 to present.

The petitioner holds the burden of proof by a preponderance of the evidence.

**PRELIMINARY STATEMENT**

The hearing originally scheduled to convene on March 29, 2016 at 1:30 p.m. On March 28, 2016, the petitioner's representative contacted the undersigned to request for the hearing to be rescheduled to allow more time to prepare for the hearing. Her request was granted and the hearing was rescheduled to April 28, 2016 at 10:15 a.m.

The hearing convened as scheduled on April 28, 2016. The petitioner's representative reported during the hearing that she submitted information to the Department. The Department representative did not have the additional information at the time of the hearing and requested a continuance to allow time to receive and review the information. The petitioner's representative did not object and the hearing was rescheduled to May 24, 2016 at 10:15 a.m.

The hearing convened as scheduled on May 24, 2016. The Department's representative received the petitioner's representative's information that was submitted but its legal team did not review the documents submitted. The Department's representative requested another continuance to allow this to be done. The petitioner's representative did not object and the hearing was scheduled to reconvene on July 5, 2016 at 2:45 p.m.

Appearing as witnesses for the petitioner were [REDACTED] daughter to the petitioner, [REDACTED] Business Office Manager for [REDACTED] and [REDACTED] Assistant Business Office Manager for [REDACTED]

Evidence was received and entered as the Respondent's Exhibits 1 through 3.

The hearing record was closed on July 5, 2016.

**FINDINGS OF FACT**

1. The petitioner (age 89) was admitted into the [REDACTED] nursing facility in June 2015. The petitioner passed away on May 31, 2016.

2. The petitioner's daughter believes she applied for Hospice Medicaid in April 2015. The petitioner's daughter argues that she was asked to provide a copy of the power of attorney (POA), along with other verifications; however, the POA is the point of contention. The petitioner's daughter argues that the POA was provided.

3. The Department's representative pointed out that the notice of case action was mailed to the petitioner on May 4, 2015 and requested for the petitioner to provide the last three months bank statements for all accounts. The Department's records show that the Notice of Case Action to inform of the denial of the petitioner's application for Hospice Medicaid dated April 2015 was mailed on June 9, 2015 to the hospice and to the petitioner's address in Bradenton.

4. The petitioner's daughter's contention is that she was not notified until December 28, 2015 that the POA was not structured properly to give her the authority to open a qualifying income trust (QIT) account, which was six months after the application was completed in later. The petitioner's daughter contends that when the Department received the documents, she was informed that the petitioner was over the income limit, which required an opening of the QIT account.

5. The petitioner received \$1141.80 and \$125.70 in retirement benefits and \$1027 in Social Security income, for a total income of \$2294.50, which was over the Hospice income limit, for an individual, in the amount of \$2199.

6. The petitioner's daughter contends that she consulted with an attorney to set up the QIT account in May 2015 but he did not properly structure the POA. The petitioner's daughter contends that the petitioner did not initial the POA to give her the authority to set up the QIT account. The petitioner's daughter argues that the Department had a copy of the POA from May 2015 through December 2015 but did not notify the petitioner's family it was not structured.

7. The petitioner's daughter believes the Department had an opportunity in June 2015 to inform her that the POA was not structured properly. The petitioner's daughter was informed that the QIT account was labeled incorrectly. Therefore, the petitioner's attorney corrected the name of the QIT account from "Medicaid Qualified Trust" to "Medicaid Qualified QIT Account" in July 2015. The petitioner's daughter was making monthly deposits into the irrevocable QIT account. The petitioner's daughter questions why she was not informed prior to December 2015 that the POA was not correct. The petitioner's daughter argues that the Department also discovered in December 2015 that the petitioner had a savings account ending in 1638.

8. The petitioner's daughter submitted an updated POA, with the petitioner's signature, to the Department on April 27, 2016. The petitioner's representative believes the original POA was completed in 2013.

9. The petitioner's daughter contends that she took a leave of absence in May 2015 and June 2015 to care for the petitioner in [REDACTED], Florida and was unaware of the denial of the April 2015 application until she returned to [REDACTED] Florida. The

petitioner's daughter contends that she did not communicate with the Department at this time to get a status of the April 2015 application.

10. The petitioner's daughter contends that her sister was ill and was unable to assist with the application process. The petitioner's daughter believes hospice received the denial notice but told her that it did everything it could to get the requested papers to DCF.

11. The Department's records show that all correspondence sent regarding the April 2015 application was sent to Community Hospice; Community Hospice was listed on the application but the petitioner's daughter's address was not. The Department's representative contends that the data exchange revealed the savings account ending in 1638; this was not discovered until after the application process had started.

12. The petitioner's representative argues that she was not aware of account ending in 1638 and that the Department did not notify her that she needed to provide verification of the account. The petitioner's representative contends that she provided to the Department the bank statements for account ending in 1638 on April 27, 2016. The petitioner's representative believes the Department's legal team was responsible for informing her that the POA was not sufficient.

13. The Department's representative contends that it is the responsibility of the petitioner's representative to be knowledgeable of all of the petitioner's assets and income, and to provide the verifications. The Department may assist in obtaining verifications, if necessary. The Department's representative contends that after other information was returned, and after the data exchange process was initiated, it was

discovered that the petitioner had the account ending in [REDACTED]. The data exchange report came back on November 11, 2015. The Department's representative pointed out that the petitioner was asked to provide the bank statements for the specific account when the Notice of Case Action was mailed on December 18, 2015.

14. The Respondent's Exhibit 2, page 11, includes the Running Record Comments (CLRC) dated December 22, 2015. The CLRC dated December 22, 2015 states, "I received an e-mail from Joane Humberg in legal who stated that a POA legal assignment is needed because the POA executed the QTIT [*sic*] for this cl. I called (NE) at her office phone # with community hospice do [*sic*] to me not having her email & left a message to e-mail me the POA to be sent to legal..." The Department did not have an answer to explain why it took until December 2015 to submit the POA to its legal team for review.

15. The Department's representative explained that Hospice Medicaid cannot be approved if it cannot determine eligibility. The Department's representative explained that it needs to have a reason to forward the POA to its legal team. The Department will not forward the POA to its legal team without the QIT; once the QIT is received, the POA will be forwarded to its legal team. The Department acknowledges that the QIT was received in June 2015 but cannot explain why the petitioner's POA and QIT was not sent to its legal team at that time for review.

16. The Department explained that it contacted Community Hospice to inform of the need for the QIT account to be correctly titled to "Irrevocable Income Trust"

(Respondent's Exhibit 2, page 22). The petitioner completed another application on September 30, 2015, October 29, 2015, and December 11, 2015.

17. The Department's representative contends that the case worker is not allowed to review a POA and inform a customer that it is not sufficient because that is considered to be practicing law. The Department explained that only its legal team can review the POA and determine if structured properly. The Department did not dispute the petitioner's daughter's testimony that the POA was signed by the petitioner on April 26, 2016.

18. Due to the revised POA, the Department's legal team approved the petitioner's trust account as a qualified trust. The Department subsequently approved the petitioner's application for ICP Hospice Medicaid effective April 2016 but was unable to approve retroactive months of June 2015 through March 2016. The Department's evidence did not include a copy of the income trust or power of attorney.

#### **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 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

21. Fla. Admin. Code R.65A-1.710 SSI-Related Medicaid Coverage Groups states:

The Department covers all mandatory coverage groups and the following optional coverage groups:

...

(3) Hospice Program. A coverage group for terminally ill individuals (or couples) who elect hospice services and who meet all categorical or Medically Needy eligibility criteria, and who also meet special Medicaid hospice requirements as provided in 42 U.S.C. § 1396d(a), subsection 65A-1.711(3) and Rule 65A-1.713, F.A.C.

22. Fla. Admin. Code R.65A-1.713 SSI-Related Medicaid Income Eligibility

Criteria states:

...

(f) For hospice services, income cannot exceed 300 percent of the SSI federal benefit rate or income must meet Medically Needy eligibility criteria, including the share of cost requirement. Effective October 1, 1998, institutionalized individuals with income over this limit may qualify for institutional hospice services by establishing an income trust which meets criteria set forth in subsection 65A-1.702(15), F.A.C.

23. Section 709.2102 (7)(9), Florida Statutes defines "Power of Attorney" as, "a writing that grants authority to an agent to act in the place of the principal, whether or not the term is used in that writing and "Principal" as "an individual who grants authority to an agent in a power of attorney."

24. Section 709.2105, Florida Statutes, "Qualifications of agent; execution of power of attorney", states:

(1) The agent must be a natural person who is 18 years of age or older or a financial institution that has trust powers, has a place of business in this state, and is authorized to conduct trust business in this state.

(2) A power of attorney must be signed by the principal and by two subscribing witnesses and be acknowledged by the principal before a notary public or as otherwise provided in s. 695.03.

25. Section 709.2106(1), Florida Statutes, "Validity of power of attorney" states "A power of attorney executed on or after October 1, 2011, is valid if its execution complies with s. 709.2105."

26. Section 709.2108(1), Florida Statutes, "When power of attorney is effective" states, "Except as provided in this section, a power of attorney is exercisable when executed."

27. The above Florida Statutes explain that the principal is an individual who gives his or her authority to an agent in a power of attorney. A power of attorney gives an agent the authority to act as the principal. A power of attorney that has been executed on or after October 1, 2011 is valid if it has been signed and acknowledged by the principal in order to be valid. Based on the statutes, the undersigned concludes that the power of attorney in the petitioner's case became exercisable and valid on April 26, 2016, when it was signed by the petitioner.

28. 42 U.S.C. §1396p. Liens, adjustments and recoveries, and transfer of assets states:

(d) Treatment of trust amounts states:

(1) For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, subject to paragraph (4), the rules specified in paragraph (3) shall apply to a trust established by such individual.

(2)(A) For purposes of this subsection, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will:

(i) The individual.

(ii) The individual's spouse.

(iii) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.

(iv) A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

29. The Department's Program Policy Manual, CFOP 165-22, passage 1840.0110 Income Trusts (MSSI) states:

The following policy applies only to the Institutionalized Care Program (ICP), institutionalized MEDS-AD, institutionalized Hospice, Home and Community Based Services (HCBS) and PACE. It does not apply to Community Hospice.

To qualify, an individual's gross income cannot exceed 300 percent of the SSI federal benefit rate (refer to Appendix A-9 for the current income standard). If an individual has income above the ICP income limit, they may become eligible for institutional care or HCBS if they set up and fund a qualified income trust. A trust is considered a qualified income trust if:

1. it is established on or after 10/01/93 for the benefit of the individual;
2. it is irrevocable;
3. it is composed only of the individual's income (Social Security, pensions, or other income sources); and
4. the trust stipulates the state will receive the balance in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on their behalf.

The eligibility specialist must forward all income trusts to their Region or Circuit Program Office for review and submission to the Circuit Legal Counsel for a decision on whether the trust meets the criteria to be a qualified income trust. Refer to Appendix A-22.1, Guidance for Reviewing Income Trusts, for instructions on processing income trust cases...

30. The Department's Program Policy Manual, Appendix A-9, effective April 2015, sets the income standard for an individual at \$2199 for Hospice Medicaid.

31. The above authorities explain that a QIT account may be established by the individual, the individual's spouse, or a person with legal authority to act on the individual's behalf. The QIT must be forwarded to the Department's Program office for review and submitted to its legal team for a decision as to whether the account meets the criteria. In this case, the Department's legal team determined in December 2015

that the petitioner's original POA was not properly structured as it did not include her signature in order to authorize her daughter to establish the QIT account.

32. In this case, the petitioner was admitted into hospice in June 2015. The petitioner's daughter applied for Hospice Medicaid in April 2015 and was denied in May 2015. The petitioner's daughter reapplied for Hospice Medicaid in September 2015, October 2015, and December 2015. The petitioner's income exceeded the income guidelines; therefore, the petitioner's daughter established an irrevocable QIT account for the petitioner.

33. The findings show that the Department's legal team determined in December 2015 that the original POA was not structured properly to give the petitioner's daughter the authorization to establish the QIT account; therefore the QIT account was not approved by the Department's legal team. The petitioner's daughter is requesting coverage from June 2015 to March 2016.

34. The findings show that the petitioner's daughter provided the Department with the updated the POA, including the petitioner's signature, on April 27, 2016. The QIT was approved by the Department's legal team and the petitioner's application for Hospice Medicaid was approved effective April 2016.

35. The petitioner's daughter argues that the Department should grant a hardship in the petitioner's case and approve the requested months as it failed to notify her from June 2015 through December 2015 that the POA was not properly structured. The undersigned concludes that the Department delayed in its submission of the QIT to its legal team. The petitioner's daughter's arguments are recognized. However, the

Florida statutes explain that the POA must be signed by the petitioner in order for it to be valid and to give the petitioner's daughter the authority to conduct trust business in the state of Florida. The petitioner's attorney updated the POA to include petitioner's signature on April 26, 2016, giving authorization for the petitioner's daughter to establish the QIT account. Therefore, the undersigned concludes that the POA signed by the petitioner became valid and exercisable on April 26, 2016 to allow the Department's legal team to approve the QIT account. Therefore, the undersigned cannot conclude that the Department is in error for not approving Hospice coverage for the requested months of June 2015 through March 2016.

### **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.

FINAL ORDER (Cont.)

16F-01140

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DONE and ORDERED this 09 day of August, 2016,

in Tallahassee, Florida.



Paula Ali

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

Jul 21, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-01220  
16F-03603

PETITIONER,

Vs.

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

And

UNITED HEALTHCARE

RESPONDENTS.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above matters on June 17, 2016 at approximately 8:30 a.m.

**APPEARANCES**

For the Petitioner:



For the Respondents:  
Medical/Healthcare  
Agency

Diana Chirino  
Program Analyst  
for Healthcare Administration

Christian  
Senior  
United

Laos  
Compliance Analyst  
Healthcare

### **ISSUES**

16F-01220: Whether the denial of petitioner's request for ultra-underwear was proper. The burden of proof was assigned to the petitioner.

16F-03603: Whether the denial of petitioner's request for an additional seven hours per week of companion; homemaker; and personal care services was proper. The burden of proof was assigned to the petitioner.

The standard of proof in an administrative hearing is by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

Fair Hearing 16F-01220 was first scheduled for March 28, 2016 by Hearing Officer Rafael Centurion. Petitioner's representative failed to appear. The representative thereafter requested the matter be rescheduled. The matter was re-scheduled for April 28, 2016. Petitioner's representative failed to appear. Petitioner's representative thereafter requested the matter be rescheduled. Hearing Officer Centurion re-scheduled for May 26, 2016. Both respondents failed to appear. The matter was then transferred to the undersigned to be heard at the same time as 16F-03603.

An interpreter from [REDACTED] Language Services provided English and Spanish translation.

A request from United Healthcare to be added as a party to both hearings was granted.

Petitioner was not present and no exhibits were entered into evidence.

Present for the respondents from United Healthcare was Dr. Sloan Karver, Long Term Care Medical Director. Respondents entered the following exhibits into evidence:

- 16F-01220: Respondent's Exhibit "1"
- 16F-03603: Respondent's Exhibit "1"

### **SHARED 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 enrolled in respondents Long Term Managed Care (LTMC) Program. Services are provided by United Healthcare.
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 LTMC Program.
3. Petitioner was, at all times relevant to this proceeding, Medicaid eligible.
4. Petitioner is 78 years of age and resides with her daughter and granddaughter. The daughter is petitioner's primary caregiver and representative in this matter. She works 20-25 hours per week outside the household.
5. Petitioner diagnoses include: [REDACTED]  
[REDACTED]  
[REDACTED]
6. Services approved for petitioner through the LTMC Program include:
  - Personal Care: 14 hours per week (2 hours seven days/week)
  - Homemaker: 7 hours per week (1 hour seven days/week)
  - Companion: 7 hours per week (1 hours seven days/week)
7. Supplies approved for petitioner through the LTMC Program include:

- Disposable Underwear: Extra Absorbency
- Personal Cleansing Wipes
- Disposable Underpads

#### **16F-01220 – Ultra-Underwear**

8. On or about January 25, 2016 a request was submitted to United Healthcare for ultra-underwear. Ultra-underwear is a brand of disposable briefs once provided by United Healthcare.
9. On January 28, 2016 United Healthcare issued a Notice of Action which denied the request. The rationale was that ultra-underwear is not a covered benefit.
10. On February 16, 2016 petitioner's request for a fair hearing was timely received by the Office of Appeal Hearings.
11. Regarding the petitioner, the representative argues:
- She must be carried to the toilet to save on the amount of briefs used.
  - When she urinates in the disposable brief, her skin is burned.
12. Respondents argues two cases of disposable extra absorbency briefs are provided monthly. Other brands carried by United Healthcare can also be considered. If more briefs are needed, a quantity and rationale should be submitted for review.
13. United Healthcare will have petitioner's case manager provide further assistance.

#### **16F-03603 – Additional Service Hours**

14. On April 27, 2016 United Healthcare received petitioner's request for an additional seven hours per week of companion; personal care; and homemaker services.
15. On May 2, 2016 United Healthcare issued a Notice of Actin which denied the request as not being medically necessary. The notice stated, in part:

You have asked for 35 hours of care at home a week.

You are getting 28 hours of care a week.

Your care plan for help is based on how much help you need. Needs in Florida Medicaid are defined by the law. For a service to be needed it must treat a problem. It must also be common practice. It must also be just for you. It must also not be in excess of your needs. It must also be safe. It must also be the least costly treatment in the state that meets your needs. It must also not be for the convenience of you or another person. The fact that a doctor orders a services does not make it needed or covered.

The health plan will not cover the other hours you asked for. The other hours are in excess of your needs. Hours in excess of your needs are not medically necessary.

16. On May 9, 2016 petitioner's request for a fair hearing was timely received by the Office of Appeal Hearings.

17. The representative argues petitioner requires a high level of supervision.

Difficulty is experienced securing appropriate supervision due the representative's work schedule. The representative is exhausted.

18. Respondent asserts respite could be requested.

#### **CONCLUSIONS OF LAW**

19. 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.

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

21. 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, 7<sup>th</sup> Ed.).

22. Florida Statute § 409.978 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.

23. Florida Medicaid, which includes the LTMC Program, covers only 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.

**16F-01220: Ultra-Underwear**

25. Respondent's contract with United Healthcare provides the following definition:

(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** [Emphasis Added]. 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.

26. The Findings of Fact establish United Healthcare is currently providing two cases of extra absorbency disposable briefs each month.

27. Compelling evidence or testimony was not provided as to why the extra absorbency disposable briefs provided by United Healthcare are not adequate.

Additionally, no evidence was presented that other extra absorbency briefs were tried.

28. It is noted the issue focuses on the type of brief and not the quantity. Should petitioner need more than two cases a month, that matter should be pursued with the case manager at United Healthcare. If that quantity should be denied, hearing rights would be associated with the denial.

29. Petitioner's request for ultra-underwear 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;
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...

...

**16F-03603 – Additional Service Hours**

30. Definitions relevant to the above hearing request are:

(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. The service includes light housekeeping tasks incidental to the care and supervision of the enrollee.

(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.

31. The Findings of Fact establish petitioner is approved for 28 hours per week of direct care services through the LTMC Program. This equates to 5.6 hours per day; five days a day; or four hours a day; seven days per week.

32. The request for an addition seven service hours per week was to be divided between companion; homemaker; and personal care services. It was not established, however, whether a need existed on an equal basis for each service category. Additionally, it was not clear how each service component contributed to the need for an additional seven hours per week.

33. Petitioner's overall health status is noted. To establish the need for additional hours, however, it is necessary to detail how those hours would be used and how those hours would satisfy an unmet need. That need must be medically necessary as defined by Fla. Admin. Code R. 59G-1.010.

34. A hearing officer must consider all evidence and draw permissible inferences from that evidence. After reviewing documentary evidence and testimony on a comprehensive basis, petitioner has not demonstrated an additional seven hours per week of personal care; homemaker; and companion services are medically necessary.

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;
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 Conclusions of Law:

- Appeal 16F-01220: Ultra-underwear is denied.
- Appeal 16F-03603: Seven additional hours per week of companion; homemaker; and personal care services 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 21 day of July, 2016,

in Tallahassee, Florida.

*Frank Houston*

---

Frank Houston  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
Office: 850-488-1429  
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Copies Furnished To:

CHRISTIA

 PETITIONER  
RHEA GRAY, AREA 11, AHCA FIELD OFFICE MANAGER  
N LAOS, UNITED HEALTHCARE

Aug 19, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 16F-01473

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES (DCF)  
CIRCUIT: 05 Sumter  
UNIT: 88999

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 9:30 a.m. on May 6, 2016. The hearing was reconvened at 9:35 a.m. on June 24, 2016.

**APPEARANCES**

For the Petitioner:

[REDACTED]

For the Respondent:  
Economic

Stan Jones, ACCESS  
Self-Sufficiency Specialist II

**STATEMENT OF ISSUE**

At issue is whether the respondent's action to deny the petitioner Institutional Care Program (ICP) Medicaid for August 2015, September 2015 and October 2015 is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

By notice dated January 29, 2016, the respondent (or the Department) notified the petitioner's AR that application, dated December 29, 2015 was denied; due to not receiving the information requested to determine eligibility. Petitioner's AR timely requested a hearing to challenge the denial.

Petitioner is deceased and was represented by her AR. [REDACTED] (not present) is another AR for the petitioner. The AR did not submit exhibits. Respondent submitted eight exhibits, entered as Respondent Exhibits "1" through "8". The record remained open until June 29, 2016, for the respondent to submit an additional exhibit. The exhibit was received timely and entered as Respondent Exhibit "9". The record was closed on June 29, 2016.

### **FINDINGS OF FACT**

1. Petitioner was a resident at [REDACTED] [REDACTED] from August 24, 2015 through October 30, 2015. Petitioner was admitted to the hospital on October 30, 2015, and passed away on November 8, 2015.
2. On December 29, 2015, the petitioner's AR submitted an ICP application requesting retroactive ICP Medicaid for August 2015, September 2015 and October 2015.
3. On January 11, 2016, the Department mailed the petitioner's AR a Notice of Case Action (NOCA) requesting income and asset verification for the retroactive months, by January 21, 2016. The NOCA in part states, "Application indicates client is separated, verification of husbands income and assets and identity including social security number."

4. The Department did not receive the requested information. And on January 29, 2016, the Department mailed the Nursing Home and the AR a NOCA; notifying that application dated December 29, 2015 was denied, "Reason: We did not receive all the information requested to determine eligibility."
5. Petitioner's AR agreed that the requested information was not provided to the Department. The AR asserts the Nursing Home made numerous attempts to retrieve the necessary income, asset, identity (including social security number) from the petitioner's husband and were unsuccessful. The AR asserts the husband refused to provide any financial information.
6. The AR asserts that the petitioner's husband was verbally and mentally abusive with the petitioner. And in accordance with the Department's policy 1640.0321 the petitioner is exempt from providing the requested information, because she is not liable if the information cannot be obtained from her husband.
7. The AR alleges that the petitioner's daughter stated her father is mentally not well, abusive and controlling. Therefore, the petitioner is exempt from providing the requested information, due to hardship.
8. To support her allegation, the AR provided the Department with an unsigned "Confidential Investigative Summary" report, dated June 15, 2015, from DCF Adult Protective Services (APS). The "Summary/Findings Implications" section of the report in part states, "Case is being closed with No Substantiated findings." The Confidential Investigative Summary report was closed on June 28, 2015.
9. Respondent's representative stated that APS received a report that the petitioner was in a dangerous position. APS completed an investigation and concluded that the

report was “unfounded”. Which is the reason the Confidential Investigative Summary report was not signed. Therefore, the report cannot be used as hardship.

10. In April 2016, the Department searched the [REDACTED] website and located an address for the petitioner’s husband. And on May 9, 2016, the Department mailed the petitioner’s husband a NOCA requesting the required documentation to determine the petitioner’s eligibility; due by May 19, 2016.

11. Petitioner’s husband did not provide the Department with the requested information. However, the petitioner’s husband contacted the Department’s representative on May 13, 2016.

12. The Department’s Running Record Comments, dated May 13, 2016, in part state:

[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 § 409.285, Fla. Stat. 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, “SSI-Related Medicaid Coverage Groups” defines the ICP Medicaid program and states in part:

(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.

16. Fla. Admin. Code R. 65A-1.712, "SSI-Related Medicaid Resource Eligibility Criteria"

explains how resources are counted in ICP for a couple. And states in part:

(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...

(4) Spousal Impoverishment. The Department follows policy in accordance with 42 U.S.C. § 1396r-5 for resource allocation and income attribution and protection when an institutionalized individual, including a hospice recipient residing in a nursing facility, has a community spouse...

(a) **When an institutionalized applicant has a community spouse all countable resources owned solely or jointly by the husband and wife are considered in determining eligibility...** (emphasis added)

(g) **The institutionalized spouse shall not be determined ineligible based on a community spouse's resources if all of the following conditions are found to exist:** (emphasis added)

1. The institutionalized individual is not eligible for Medicaid Institutional Care Program because of the community spouse's resources and the community spouse refuses to use the resources for the institutionalized spouse; and
2. The institutional spouse assigns to the State any rights to support from the community spouse by submitting the Assignment of Rights to Support, Form CF-ES 2504, PDF 10/2005 (incorporated by reference), signed by the institutionalized spouse or their representative; and
3. The institutionalized spouse would be eligible if only those resources to which they have access were counted; and
4. The institutionalized spouse has no other means to pay for the nursing home care.

17. In accordance with the above authority "When an institutionalized applicant has a community spouse all countable resources owned solely or jointly by the husband and wife are considered in determining eligibility."

18. The authority explains “The institutionalized spouse shall not be determined ineligible based on a community spouse’s resources” if all four mentioned conditions exist.

19. The evidence submitted establishes that at least two of the four mentioned conditions listed in the authority did not exist.

20. Petitioner’s husband did not meet condition one, “The institutionalized individual is not eligible for Medicaid Institutional Care Program because of the community spouse’s resources and the community spouse refuses to use the resources for the institutionalized spouse.”

21. The evidence submitted establishes that the petitioner’s husband did not refuse to use the resources for the petitioner. He did not disclose his resources.

22. Condition two also did not exist. There was no evidence submitted indicating that the petitioner completed the Assignment of Rights to Support form.

23. Petitioner’s AR argued that in accordance with the Department’s policy 1640.0321, the petitioner is exempt from providing the requested information. Because the petitioner is not liable if the information cannot be obtained from her husband.

24. The Department’s Program Policy Manual (Policy Manual), CFOP 165-22, passage 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.

25. The above policy explains that “The individual must present convincing evidence to prove the asset is unavailable to him due to circumstances beyond his control.”

26. The evidence submitted does NOT establish that the petitioner’s husband’s assets are unavailable. The assets/resources are unknown.

27. Petitioner’s AR argued that the petitioner’s husband was verbally and mentally abusive with the petitioner. And therefore, due to hardship, the petitioner is exempt from providing the requested information. To support her argument, the AR provided the Department with an unsigned “Confidential Investigative Summary” report, dated June 15, 2015, from APS.

28. The “Summary/Findings Implications” section of the Confidential Investigative Summary report in part states, “Case is being closed with No Substantiated findings.” The Confidential Investigative Summary was closed on June 28, 2015.

29. In careful review of the testimony, evidence, policy and authorities, the undersigned concludes the petitioner’s AR did not meet her burden of proof. The undersigned agrees with the Department’s action to deny the petitioner ICP 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   August  , 2016,

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

Office of Economic Self Sufficiency

Jul 11, 2016

Office of Appeal Hearings  
Dept. of Children and FamiliesSTATE OF FLORIDA  
DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-01701

PETITIONER,

Vs.

CASE FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 07 Volusia  
UNIT: 88778RESPONDENT.  

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**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 31, 2016 at 1:40 p.m.

**APPEARANCES**For the Petitioner: .

For the Respondent: Matthew Lynn, Economic Self-Sufficiency Specialist II for the Department of Children and Families (DCF).

**ISSUE**

The petitioner is appealing the Department's action on April 6, 2016 to approve the petitioner's application for Institutional Care Program (ICP) Medicaid with a patient responsibility in the amount of \$208.95.

The petitioner held the burden of proof by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

The hearing was originally scheduled for April 20, 2016 at 9:00 a.m. On April 4, 2016, the petitioner contacted the undersigned to request for the hearing to be rescheduled to allow additional time for her to prepare for the hearing. Her request was granted and the hearing was rescheduled to May 5, 2016 at 1:30 p.m.

On April 27, 2016, the petitioner contacted the undersigned to request for the hearing to be rescheduled to allow additional time to receive and review evidence. Her request was granted and the hearing was rescheduled to May 31, 2016 at 1:30 p.m.

Appearing as a witness for the petitioner was [REDACTED], Long Term Care Case Manager.

Evidence was received and entered as the Petitioner's Exhibit 1 and the Respondent's Exhibits 1 through 2.

The record was closed on May 31, 2016.

### **FINDINGS OF FACT**

1. The petitioner (age 90) is residing in a nursing facility. The petitioner's spouse (community spouse) lives in her own home in the community.

2. On March 16, 2016, the petitioner's spouse applied for ICP Medicaid on the petitioner's behalf. The petitioner was approved for ICP Medicaid with a patient responsibility in the amount of \$208.95.

3. In determining eligibility for the ICP program, the respondent takes into consideration the income of the institutionalized spouse.

4. The Department calculated the petitioner's income at \$2786.28, which included his Social Security income in the amount of \$1413 and his MetLife retirement pension at \$1373.28. The community spouse has \$0 income.

5. The petitioner's wife is 61 years old. The Department's Institutional Budget Sheet included the petitioner's wife's income of \$0. The Department determines the community spouse income allowance by a budgeting procedure that considers shelter and utility expenses as well as the community spouse's income. The community spouse reported monthly rent in the amount of \$650 and monthly homeowner's insurance in the amount of \$83.33. The Department included in its calculations the Food Assistance Program's (FAP) standard utility allowance (SUA) in the amount of \$345. The total shelter costs allowed was \$1078.33.

6. To determine how much of petitioner's income the community spouse can keep, a calculation is performed using a spousal impoverishment Minimum Monthly Maintenance Income Allowance (MMMIA) of \$1991 (Respondent Exhibit 2). The MMMIA was multiplied by 30% to result in \$597 in excess shelter standard. The excess shelter standard was subtracted from the total shelter costs to result in \$481.33 excess shelter costs. The excess shelter cost was added to the MMMIA (\$1991) to result in a subtotal of \$2472.33 for the Community Spouse Allowance. The Community Spouse Allowance was subtracted by the community spouse's gross income in the amount of \$0 (Respondent Exhibit 2) to result in a total Community Spouse Income Allowance in the amount of \$2472.33.

7. The petitioner's wife does not dispute the income and deductions included in the Department's calculations. The petitioner's wife argues that she was never asked to provide verification of her husband's pension from [REDACTED] and was not aware of the pension. The petitioner's wife contends that she contacted [REDACTED] to get verification of the pension but the Department had already approved the petitioner's case with a patient responsibility of \$208.95. The petitioner's wife does not understand how the Department approved the petitioner's ICP Medicaid before she provided the verification. The petitioner's wife argues that it took MetLife seven to eight days to send her verification of her husband's pension.

8. The petitioner's wife has complaints about her husband being mistreated by a nursing facility.

### **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 Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

11. Florida Admin. Code R. 65A-1.701 defines patient responsibility as, "(t)hat portion of an individual's monthly income which the department determines must be considered as available to pay for the individual's institutional care..."

12. Florida Admin. Code R. 65A-1.7141, SSI-Related Medicaid Post Eligibility

Treatment of Income, defines allowable deductions from income to determine patient responsibility and states:

After an individual is determined eligible for Hospice, Institutional Care Program (ICP), Program of All-Inclusive Care for the Elderly (PACE), Cystic Fibrosis waiver, Individual Budgeting (iBudget), or Statewide Medicaid Managed Care Long-Term Care (SMMC-LTC) Program, 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.

...

(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.

13. Florida Admin. Code R. 65A-1.716 Income and Resource Criteria states:

(5)(c) Spousal Impoverishment Standards.

1. State's Resource Allocation Standard. The amount of the couple's total countable resources which may be allocated to the community spouse is equal to the maximum allowed by 42 U.S.C. § 1396r-5.
2. State's Minimum Monthly Maintenance Income Allowance (MMMIA). The minimum monthly income allowance the department recognizes for a community spouse is equal to 150 percent of the federal poverty level for a family of two.
3. Excess Shelter Expense Standard. The community spouse's shelter expenses must exceed 30 percent of the MMMIA to be considered excess shelter expenses to be included in the maximum income allowance:  $MMIA \times 30\% = \text{Excess Shelter Expense Standard}$ . This standard changes July 1 of each year.
4. Food Assistance Program Standard Utility Allowance. The amount specified in Rule 65A-1.603, F.A.C.
5. Cap of Community Spouse Income Allowance. The MMMIA plus excess shelter allowance cannot exceed the maximum amount allowed under 42 U.S.C. § 1396r-5. This standard changes January 1 of each year.

14. Florida Admin. Code R. 65A-1.603 Food Assistance Program Income and Expenses lists the current standard Food Stamp utility allowance and states in relevant part:

...  
(2) Standard Utility Allowance. A standard utility allowance (SUA) of \$345 must be used by AGs who incur, or within the eligibility period expect to incur, heating or cooling expenses separate and apart from their rent or mortgage and by AGs who receive direct or indirect assistance authorized under the Low Income Home Energy Assistance Act of 1981. Actual utility expenses are not allowed. Any additional utility expenses, including the telephone standard, are not used.

15. Fla. Admin. Code R. 65A-1.712 "SSI-Related Medicaid Resource Eligibility Criteria" states in part:

(4) Spousal Impoverishment. The Department follows policy in accordance with 42 U.S.C. § 1396r-5 for resource allocation and income attribution and protection when an institutionalized individual, including a hospice recipient residing in a nursing facility, has a community spouse. Spousal impoverishment policies are not applied to individuals applying for, or receiving services under, HCBS Waiver Programs, except for individuals

in the Long-Term Care Community Diversion Program, the Assisted Living Facility Waiver or the Cystic Fibrosis Waiver.

(a) When an institutionalized applicant has a community spouse all countable resources owned solely or jointly by the husband and wife are considered in determining eligibility.

b) At the time of application only those countable resources which exceed the community spouse's resource allowance are considered available to the institutionalized spouse.

(c) The community spouse resource allowance is equal to the maximum resource allocation standard allowed under 42 U.S.C. § 1396r-5 or any court-ordered support, whichever is larger.

(d) After the institutionalized spouse is determined eligible, the Department allows deductions from the eligible spouse's income for the community spouse and other family members according to 42 U.S.C. § 1396r-5 and paragraph 65A-1.716(5)(c), F.A.C.

(e) If either spouse can verify that the community spouse resource allowance provides income that does not raise the community spouse's income to the state's minimum monthly maintenance income allowance (MMMIA), the resource allowance may be revised through the fair hearing process to an amount adequate to provide such additional income as determined by the hearing officer. Effective November 1, 2007 the hearing officers must consider all of the community spouse's income and all of the institutionalized spouse's income that could be made available to a community spouse. The hearing officers will base the revised community spouse resource allowance on the amount necessary to purchase a single premium lifetime annuity that would generate a monthly payment that would bring the spouse's income up to the MMMIA (adjusted to include any excess shelter costs). The community spouse does not have to actually purchase the annuity. The community spouse will have the opportunity to present convincing evidence to the hearing officer that a single premium lifetime annuity is not a viable method of protecting the necessary resources for the community spouse's income to be raised to the state's MMMIA. If the community spouse requests that the revised allowance not be based on the earnings of a single premium lifetime annuity, the community spouse must offer an alternative method for the hearing officer's consideration that will provide for protecting the minimum amount of assets required to raise the community spouse's income to the state's MMMIA during their lifetime

(f) Either spouse may appeal the post-eligibility amount of the income allowance through the fair hearing process and the allowance may be adjusted by the hearing officer if the couple presents proof that exceptional circumstances resulting in significant inadequacy of the allowance to meet their needs exist. Exceptional circumstances that result in extreme financial duress include circumstances other than those taken into account in establishing maintenance standards for spouses. An example is when a community spouse incurs unavoidable expenses for medical, remedial and other support services which impact the community spouse's ability to maintain herself *[sic]* in the community and in amounts that they could not be expected to be paid from amounts already recognized for maintenance and/or amounts held in resources. Effective November 1, 2007, the hearing officers must consider all of the community spouse's income and all of the institutionalized spouse's income that could be made available to a community spouse. If the expense causing exceptional circumstances is a temporary expense, the increased income allowance must be adjusted to remove the expenses when no longer needed.

16. The above controlling authority sets forth a provision for couples when one member is in a nursing facility and the other remains in the community to appeal the ICP income allowances determined by the Department. The hearing officer may adjust the allowances if proof is provided to show that exceptional circumstances have resulted in significant inadequacy of the community spouse's income allowance to meet her needs. In a situation where proof is provided to show that an exceptional circumstance has caused a significant inadequacy, the diversion amount to the community spouse can be increased, resulting in a lower patient responsibility amount and a greater amount paid by Medicaid to the nursing facility. In this case, the petitioner did not present any exceptional circumstances that has caused an extreme financial duress for the petitioner's wife. Therefore, in accordance with the above controlling authority, the undersigned concludes that the petitioner does not meet the requirements for an increase in the spousal diversion amount.

17. Based on these authorities, the undersigned concludes that the respondent's calculations in determining the community spouse income allowance in the amount of \$2472.33 and the petitioner's patient responsibility in the amount of \$208.95 beginning May 2016 is correct.

18. The petitioner's wife may contact the Agency for Health Care Administration at (888) 419-3456 with her complaints regarding the nursing facility's treatment of the petitioner.

### **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.

FINAL ORDER (Cont.)

16F-01701

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DONE and ORDERED this 11 day of July, 2016,

in Tallahassee, Florida.



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Paula Ali

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

Jul 07, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-02094

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 on May 2, 2016 at approximately 10:30 a.m.

**APPEARANCES**

For Petitioner:



For Respondent:

Cindy Henline  
Medical/Health Care Program Analyst  
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. Ellyn Theophilopolos, Physician Reviewer with eQHealth Solutions (“eQHealth”), appeared as a witness for Respondent, the Agency for Health Care Administration (“AHCA” or “Agency”). Petitioner’s mother gave oral testimony, but did not move any exhibits into evidence at the hearing. Respondent moved Exhibits 1 through 12 into evidence. The record was held open for Petitioner to submit additional evidence. Petitioner submitted evidence, entered as Exhibit 1.

Administrative notice was taken of the following:

- Section 409.815, Florida Statutes.
- Florida Administrative Code Rule 59G-1.010.
- The Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook, September 2013.

### **FINDINGS OF FACT**

1. Petitioner is a 6-year-old female.
2. Petitioner’s health conditions include:

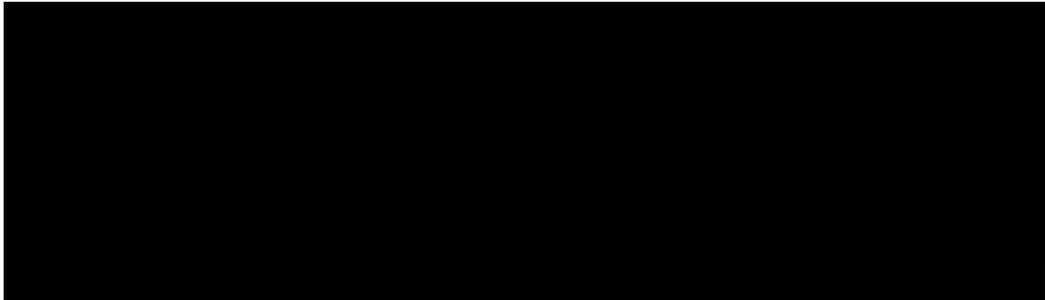


3. Petitioner attends a year-round school. She receives respiratory treatments twice a day and as needed. She receives Occupational Therapy (“OT”), Physical Therapy (“PT”), and Speech Therapy (“ST”) at school. She attends PPEC after school and on non-school days.
4. Petitioner had been receiving PPEC services prior to this request. Petitioner is continuing to receive PPEC services, pending the outcome of this appeal.

5. On March 14, 2016, eQHealth issued a Notice of Outcome – Denial Prescribed Pediatric Extended Care Services to Petitioner’s physician. (Respondent’s Exhibit

12). The reason given for the denial was:

Requested services are denied because the clinical information does not support the medical necessity.



6. Petitioner is underweight, weighing only 35.5 lbs. She previously underwent surgery to repair a hole in her heart. Her immune system is weak and she frequently gets sick. She sees a gastroenterologist. Even though she is able to eat by mouth, her physician wants her to take more of her nutrition via the G-tube because she is not eating enough. Administration of food and medicine via a G-tube requires skilled nursing care. Petitioner’s mother said she gave all of this information to her PPEC provider, and she thought they would forward it to AHCA for the re-certification.
7. Dr. Theophilopolos stated she had not seen any of the information sent to the PPEC provider, and if she had, this might have not have gone to hearing. She testified that from what she reviewed, Petitioner needed therapies and assistance with Activities of Daily Living (“ADLs”), but not skilled nursing care. A reconsideration of the decision was never requested.
8. Subsequent to the hearing, Petitioner’s physician wrote her a prescription for five (5) cans per day of PediaSure to be administered via the G-tube. (Petitioner’s Exhibit 1).

Petitioner also provided the documentation she gave the PPEC provider, including letters from her physician stating she needs closer supervision and to use the G-tube to administer feedings and medications when necessary.

9. It appears as though Petitioner qualifies as “medically complex” because she needs close supervision and has a chronic problem with her digestive system, which necessitates the use of the G-tube.

### **CONCLUSIONS OF LAW**

10. 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.
11. This hearing was held as a *de novo* proceeding, in accordance with Florida Administrative Code Rule 65-2.056.
12. This is a Final Order, pursuant to §§ 120.569 and 120.57, Fla. Stat.
13. 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, 7<sup>th</sup> Ed.).
14. 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.
15. The Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook, September 2013 (“PPEC Handbook”) is promulgated into law by Chapter 59G of the Florida Administrative Code.

16. 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.

17. 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.

18. 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....”

19. 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.

20. 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. Section 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.

21. 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 may present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)) (emphasis added).

22. 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.

23. In the instant matter, the testimony and documentary evidence indicates that

Petitioner's medically complex condition currently requires her nutrition to be administered via the G-tube. Her physician wrote a prescription for five (5) cans per day of PediaSure via the G-tube.

24. Of particular note is Dr. Theophilopolos's statement that if she had seen the

documentation provided to the PPEC provider (which was subsequently submitted in Petitioner's Exhibit 1), this might not have gone to hearing. Petitioner's mother testified as to the contents of the documents, they just had not been reviewed.

25. The burden of proof is on the Agency to show it was proper to terminate Petitioner's

PPEC services. The undersigned concludes the Agency has not met its burden of proof.

### **DECISION**

Based upon the foregoing, Petitioner's appeal is GRANTED. The Agency is directed to continue providing Petitioner with her PPEC services, consistent with her 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.

FINAL ORDER (Cont.)  
16F-02094  
PAGE - 9

DONE and ORDERED this 07 day of July, 2016,  
in Tallahassee, Florida.

*Rick Zimmer*

---

Rick Zimmer  
Hearing Officer  
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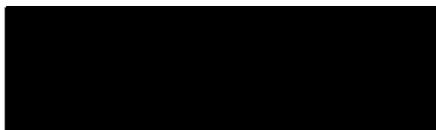
Copies Furnished [REDACTED], Petitioner  
Judy Jacobs, Area 7, AHCA Field Office

**FILED**

Jul 08, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-02211

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.



**FINAL ORDER**

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on May 17, 2016, at 12:40 p.m.

**APPEARANCES**

For the Petitioner:



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 direct member reimbursement ("DMR") for multiple refills of the prescription drugs [redacted] [redacted] and [redacted] [redacted]?

**PRELIMINARY STATEMENT**

[REDACTED] ("petitioner"), the petitioner, appeared on her own behalf.

Stephanie Lang, 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. At the request of the Agency and Staywell, Staywell was added as a party to this proceeding. The following individuals from Staywell appeared as witnesses on behalf of the Agency and Staywell: Alexandria Hicks, Regulatory Research Coordinator; Lauren Barnes, Pharm. D., Manager of Pharmacy Operations; Erika Hatchman, Pharm. D., Manager of Pharmacy Operations; and Lisa Hogan, Pharm. D., Director of Pharmacy Operations.

The respondent introduced Composite Exhibit "1", inclusive, at the hearing, which was accepted into evidence and marked accordingly. At the respondent's request, the hearing officer took administrative notice of the following: Sections 409.910, 409.962, 409.963, 409.964, 409.965, 409.973, 409.912, and 409.91195, F.S.; Chapters 59G-1.001, 59G-1.010, and 59G-4.250, F.A.C.; and the Florida Medicaid Prescribed Drug Services Coverage, Limitations, and Reimbursement Handbook.

The hearing record in this matter was left open until the close of business on May 18, 2016 for the respondent to provide additional information. Once the information was received, it was accepted into evidence and marked as respondent'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:

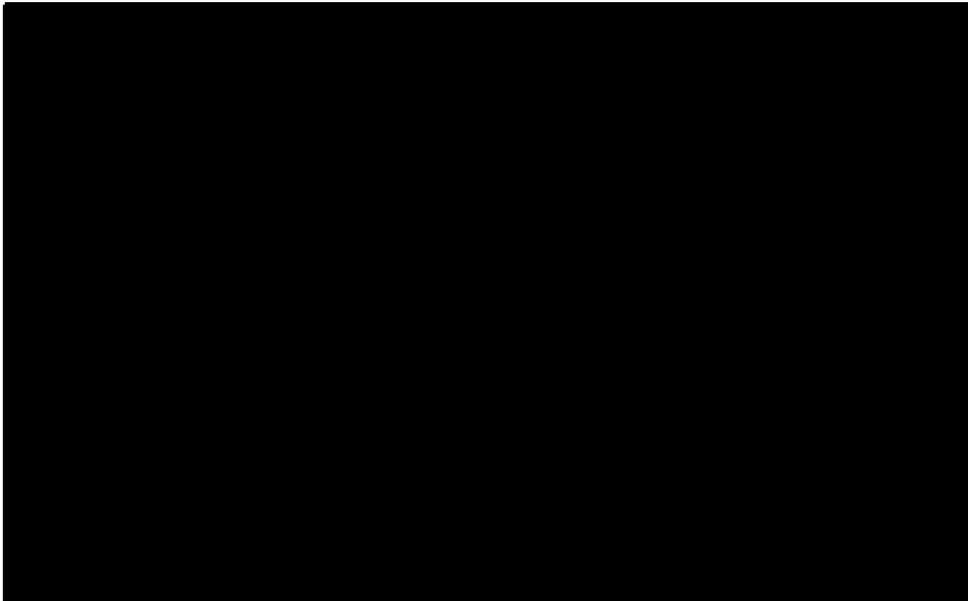
1. The petitioner is an adult female. Her date of birth is [REDACTED]

2. Petitioner was eligible to receive Medicaid services at all times relevant to this proceeding. There has been no erroneous denial or termination of her Florida Medicaid eligibility.

3. The 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. The petitioner's effective date of enrollment with Staywell is January 1, 2012. The petitioner transitioned to the Staywell Managed Medical Assistance ("MMA") Program at Staywell on June 1, 2014.

5. On February 24, 2016, the Plan received a direct member reimbursement request from the petitioner for the following medications:



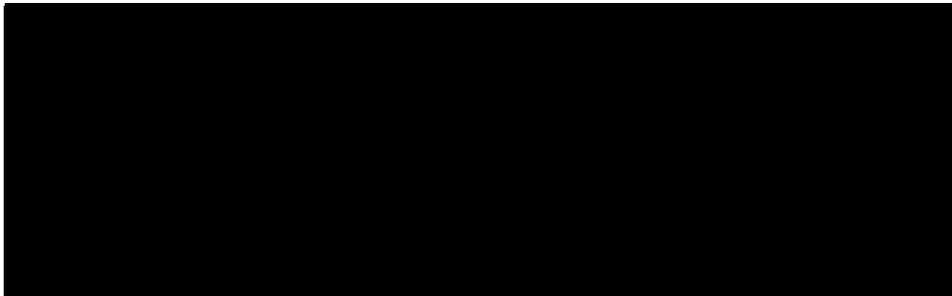
6. Staywell mailed a Notice of Action to the petitioner on or about February 25, 2016 advising the petitioner of its decision to deny her request for direct member reimbursement of the following medications:



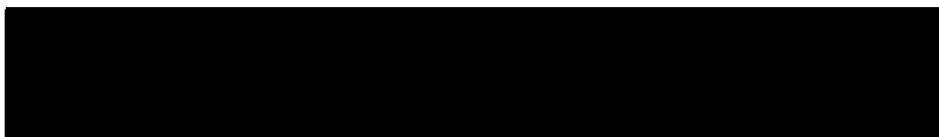
7. Staywell mailed a Notice of Action to the petitioner on or about February 26, 2016 advising the petitioner of its decision to deny her request for direct member reimbursement of the following medications:



8. On or about February 29, 2016, the petitioner submitted appeal requests to Staywell asking it to reconsider its decision to deny direct member reimbursement of the following medications:



9. Staywell mailed a Notice of Action to the petitioner on or about March 3, 2016 advising the petitioner of its decision to deny her request for direct member reimbursement of the following medications:



10. In response to the petitioner's requests for an internal reconsideration of the Plan's decision to deny direct member reimbursement for the prescriptions listed in Paragraph 8 above, Staywell completed a review of its denials on March 14, 2016.

11. Staywell reviewed the following information in order to conduct its internal reconsideration of the denials: prescription refill claims, Food and Drug Administration ("FDA") recommendations and/or industry guidelines; the Staywell Preferred Drug List ("PDL") and Plan formulary; prior authorization and utilization management criteria; and all other documents pertaining to the appeal.

12. [REDACTED] are compounded medications.

13. Compounded medications are personalized medications made by a licensed pharmacist or physician based on a patient's prescription. The pharmacist or physician mixes the individual ingredients together in the exact strength and dosage required by the patient.

14. The Agency for Health Care Administration has certain guidelines for the approval of compound drugs.

15. Staywell has adopted the Agency for Health Care Administration's criteria for the approval of compound drugs.

16. The petitioner's Hydromorphone 9 mg/ginger and Methadone 11 mg were made using bulk powder products.

17. Legend drugs are drugs that have been approved by the FDA.

18. Bulk powders are non-FDA approved products.

19. Bulk powders are not covered under the petitioner's Plan benefits.

20. On or about March 14, 2016, Staywell upheld its denial of the medications listed in Paragraph 8 above and sent correspondence to the petitioner advising her of its decision.

21. Staywell upheld its denial of the medications listed in Paragraph 8 above on the basis that bulk powder products are not covered under the petitioner's Plan.

22. The pharmaceuticals used in compounding petitioner's [REDACTED] mg/ginger and Methadone 11 mg are not reimbursable legend drugs.

23. The petitioner did not provide medical documentation to the respondent or the hearing officer establishing the specific conditions the finished products were being prepared to treat.

24. [REDACTED] and [REDACTED] mg do not appear on the Agency's or Staywell's Preferred Drug Lists.

25. Drugs not appearing on the Agency's Preferred Drug List require prior authorization.

26. The petitioner's pharmacy provider did not obtain prior authorization for the Hydromorphone 9 mg/ginger and Methadone 11 mg prior to filling the prescriptions.

#### **CONCLUSIONS OF LAW**

27. 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.

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

29. This hearing was held as a de novo proceeding pursuant to Fla. Admin.

Code R. 65-2.056.

30. In the present case, the petitioner 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, 7<sup>th</sup> Ed.).

32. The Florida Medicaid program is authorized by Chapter 409, Fla. Stat. and Chapter 59G, Fla. Admin. Code. The Medicaid program is administered by respondent.

33. 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 patient'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.

34. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Rule 59G-5.020. 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. Page 1-22 of the Florida Medicaid Provider General Handbook provides a list of Medicaid covered services. These services include prescribed drug services.

36. Page 1-28 of the Florida Medicaid Provider General Handbook provides a list of HMO covered services. These services include prescribed drug 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. 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.

39. The Florida Medicaid Prescribed Drug Services Coverage, Limitations, and Reimbursement Handbook discusses compound drugs on Page 2-20. It states:

Medicaid may reimburse for a compound drug if it is a combination of two or more pharmaceuticals and satisfied all of the following criteria:

1. At least one pharmaceutical is a reimbursable legend drug;
2. The finished product is not otherwise commercially available in strength and formulation; and
3. The finished product is being prepared to treat a specific recipient's condition.
4. Compounding may not be used in place of commercially available formulation (i.e., compounded inhalation products).

All sterile compounded products must be made in compliance with USP standards and in accordance with Chapter 465, F.S.

40. 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....

41. The Florida Medicaid Prescribed Drug Services Coverage, Limitations, and Reimbursement Handbook discusses Drug Prior Authorization on Page 2-11. It explains:

**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](http://www.ahca.myflorida.com/Medicaid/Prescribed_Drug).

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.

42. The Staywell Member Handbook on Page 41 explains that certain drugs require prior authorization.

43. In the present case, Staywell policy regarding compound drugs and prior authorization for non-PDL drugs is not more restrictive than that of the Agency.

44. In the present case, the petitioner's pharmacy provider did not seek or obtain prior authorization prior to filling the prescriptions as required by the Florida Medicaid Prescribed Drug Services Coverage, Limitations, and Reimbursement Handbook. Therefore, the respondent correctly denied the petitioner's direct reimbursement requests for [REDACTED] and [REDACTED]

45. Pursuant to the above, the petitioner has not met her burden of proof to demonstrate the Agency incorrectly denied her direct reimbursement requests for the listed medications.

### **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.

FINAL ORDER (Cont.)  
16F-02211  
PAGE - 11

DONE and ORDERED this 08 day of July, 2016,

in Tallahassee, Florida.

*Peter J. Tsamis*

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Peter J. Tsamis  
Hearing Officer  
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1317 Winewood Boulevard  
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Copies Furnished To:

  
Don Fuller, Area 5, AHCA Field Office Manager  
Stephanie Shupe

Aug 16, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-02212

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND  
AGENCY FOR HEALTH CARE ADMINISTRATION  
CIRCUIT: 17 Broward

CO-RESPONDENTS.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on July 19, 2016 at 8:30 a.m.

**APPEARANCES**

For Petitioner: 

For Respondent: Linda Latson, Registered Nurse Specialist,  
Agency for Health Care Administration

**STATEMENT OF ISSUE**

Whether it was appropriate for the Respondent to deny Petitioner's request for eight additional hours of personal care services (PCS) per week. Because the matter at issue is a request for an increase in services, the Petitioner carries the burden of proof.

### **PRELIMINARY STATEMENT**

Appearing as witnesses from Respondent Amerigroup, Petitioner's Long-Term Care (LTC) plan, were Lisa Williams, Quality Management Nurse and Dr. Mary Colburn, Medical Director. Appearing as observers from Amerigroup were: Carlene Brock, Quality Operations Nurse; Brian Hawkins, Manager II Healthcare; Jane Tates, Manager; Melinda Combast, Manager for Long-Term Care; and Carline Silus, Case Manager.

Petitioner's caregiver, [REDACTED], appeared as a witness on her behalf.

Petitioner submitted a 168-page document which was entered into evidence and marked Petitioner Exhibit 1. Respondent's 71-page document was entered into evidence and marked Respondent 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 is a 32 year-old Medicaid recipient and a member of Amerigroup's Long-Term care plan. In 2009, Petitioner was in a car accident that left her a

[REDACTED].

2. Petitioner is also a Medicare recipient. Medicare provides Petitioner 1 hour of licensed practical nurse (LPN) services 4 times per week and 1 hour of certified nurse aide (CNA) 3 times per week.

3. Petitioner was living with her mother but has moved to her own apartment, which she shares with a roommate. The roommate has medical limitations that prevent him

from providing care to the Petitioner. However, he does prepare the evening meal and puts her to bed. Her 30 hours of care services begin at 9:00 am in the morning and end at 4:30 p.m., Monday through Friday.

4. After Petitioner moved from her mother's residence, the natural support services the mother provided in the morning were assumed by Petitioner's personal care provider. Petitioner explained that the following tasks, previously done by her mother, take 1 ½ hours to complete each morning:

- Transfer from her bed in a timely manner [preventing pressure sores, and urine backup in catheter bag, resulting in hospitalization because of urinary tract infection];
- Change bed liner and her dressing;
- Prepare wheelchair and transfer from bed to wheelchair using Hoyer lift;
- Prepare toothbrush, put on her wheelchair gloves and contact lenses;
- Prepare breakfast and cleanup;
- Provide prescribed medicines and supplements.

She explained these tasks are now performed by her personal care provider.

5. Petitioner is currently approved for a total of 30 hours per week of services 20 hours of personal care services, 5 hours of adult companion care and 5 hours of homemaker services. The services are provided Monday through Friday. Petitioner receives natural supports from family and friends on Saturday and Sunday. Petitioner is requesting an additional 8 hours of personal care services per week.

6. Respondent did not rebut the services were provided by the mother nor the 1 ½ hours it took to provide them. The medical director suggested changing 5 hours of adult companion care to 5 hours of personal care services would meet Petitioner's medical needs. The medical director opined that Petitioner's request for 8 additional hours of personal care services was not medically necessary.

7. Petitioner reiterated that her caregiver has assumed the morning tasks her mother used to perform. She stated the caregiver should be compensated for performing these additional tasks. She observed that changing the adult companion services to personal care services did not result in an increase in approved service hours.

8. Petitioner is in the Participant Directed Option program which allows her to select her provider. The provider for her personal care, adult companion, and homemaker services is her sister. The sister submits her reimbursement requests by the number of hours allocated by service, not necessarily how they are provided. No time logs of tasks performed during the day/week are maintained by either the Petitioner or Respondent.

9. Respondent explained that based on the natural supports provided to Petitioner on the weekends and the services provided by Medicare, Petitioner does not need 8 additional hours of personal care services per week.

### **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. § 120.80. The Office of Appeal Hearings provided the parties with adequate notice of the administrative hearing.

11. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Program is administered by the Agency for Health Care Administration.

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

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

14. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Fla. Admin. Code R. 65-2.060(1).

15. The Florida Medicaid Home Health Services Coverage and Limitations Handbook (Medicaid Handbook), October 2014, has been promulgated by reference in the Florida Administrative Code at 59G-4.130(2). In order to receive services, the Handbook on page 2-2 states:

Medicaid reimburses services that are determined medically necessary and do not duplicate another provider's service. Chapter 59G-1.010 (166), Florida Administrative Code defines medically necessary 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. Petitioner needs assistance with her activities of daily living and maintaining her health and well-being. She received a total of 30 hours of services per week (personal care, adult companion, and homemaker services) while living with her mother and continues to receive 30 hours per week after moving from her mother's to her own apartment. Petitioner asserts her mother was providing natural supports in the morning for approximately 1 and ½ hours. Petitioner is requesting that her personal care provider be compensated for the 1 ½ hour tasks she has assumed since Petitioner moved into her apartment.

17. Respondent does not dispute the services provided by Petitioner's mother. Respondent suggests the companion care hours can be changed to personal care hours. Considering the intermittent natural supports Petitioner receives on the weekends and services covered by Medicare, Respondent opines the recommended change will be sufficient to meet Petitioner's needs. Respondent determines an additional 8 hours of personal care services is not medically necessary.

18. No evidence was offered indicating that the nursing services provided by Medicare included assisting the Petitioner in the morning hours. Petitioner asserted her caregiver performed necessary morning tasks for her. Nor was there any testimony that the natural supports provided by the family and friends on the weekends were available during the week.

19. Petitioner did testify that her mother provided for her morning needs until she moved to her own apartment and this was not disputed by the Respondent. Additionally, Petitioner stated her caregiver now performs these tasks that take 1 ½ hours each morning to perform. This was not rebutted by the Respondent.

20. The caregiver has assumed the morning functions Petitioner's mother used to perform. There is no dispute that it takes 1 ½ hours to perform these tasks. Simply changing the companion hours to personal care hours does not address the increase in the caregiver's duties. Petitioner has met her burden of proof. The undersigned concludes the additional services provided by the caregiver in the morning are medically necessary.

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

DONE and ORDERED this 16 day of August, 2016,  
in Tallahassee, Florida.



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Warren Hunter  
Hearing Officer  
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Copies Furnished To: [REDACTED], Petitioner  
AHCA, Medicaid Fair Hearings Unit  
Amerigroup Hearings Unit

Aug 15, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-02316

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 June 28, 2016 at 3:00 p.m.

**APPEARANCES**

For the Petitioner:



For the Respondent:

Fathima Leyva, 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.

Appearing as witnesses for the respondent were Dr. Susan Hudson, Dental Consultant, and Jackeline Salcedo, Grievance Specialist, from DentaQuest, which is the Petitioner's dental services review organization. Also present as witnesses for the respondent were Dr. Merlin Osorio, Medical Director, and Diana Anda, Grievance/Appeals Manager, for Simply Healthcare Plans, which is the petitioner's managed health care plan.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Exhibits: Exhibit 1 – Statement of Matters and Authorization Request; Exhibit 2 – Denial Notice; and Exhibit 3 – Dental Consultant Review Form.

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

### **FINDINGS OF FACT**

1. The petitioner is a forty-nine (49) 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, which utilizes DentaQuest for review and approval of dental services.
2. On or about March 14, 2016, the petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from Simply Healthcare and/or

DentaQuest to perform dental services, including surgical tooth extractions of 17 teeth, alveoplasty in 4 quadrants, and sedation/anesthesia related to those procedures.

Simply Healthcare partially denied this request on March 16, 2016. The sedation, alveoplasty in 3 quadrants, and surgical removal of 5 teeth were approved, but the alveoplasty in the upper right quadrant and the surgical removal of the other 12 teeth were denied.

3. Simply Healthcare's denial notice to the petitioner advised her that the surgical extractions of the other 12 teeth were denied because a less severe method of extraction could be utilized and surgical extraction was not necessary. The alveoplasty in the upper right quadrant was denied because less than 4 teeth in that quadrant were being extracted, and therefore a different procedure code was required.

4. The petitioner stated she needs all her teeth removed due to a medical condition, and she has already lost some of her teeth.

5. The respondent's expert witness, Dr. Hudson, testified that the removal of some of the petitioner's teeth could be accomplished by a simple extraction and a surgical extraction is not appropriate. Some of the teeth were approved for surgical extraction since those required removal of tissue or bone. Alveoplasty was denied in one quadrant since there were less than 4 teeth to be removed in that quadrant of the mouth.

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), Florida Administrative Code. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7<sup>th</sup> 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 Handbooks are incorporated by reference in Chapter 59G-4, Florida Administrative Code.

12. Florida Statute § 409.912 requires that the 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. The Florida Medicaid Program provides limited dental services for adults. The

Dental Handbook describes the covered services for adults as follows:

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. Managed care plans, such as Simply Healthcare, may provide more generous benefits but cannot be more restrictive than the Medicaid guidelines contained in the Dental Handbook.

16. The petitioner stated she needs all her teeth removed due to her medical conditions.

17. The respondent's position is that the 12 extractions at issue should be performed as simple extractions rather than surgical extractions and the alveoplasty requires a different procedure code since less than 4 teeth in that quadrant are to be extracted.

18. After considering the evidence and testimony presented, the undersigned concludes the petitioner has not demonstrated that the respondent should have approved the requested services. The petitioner should consult with her provider concerning re-submitting the request using more appropriate procedure codes.

### **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 indigence 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.

FINAL ORDER (Cont.)

16F-02316

PAGE - 7

DONE and ORDERED this 15 day of August, 2016,

in Tallahassee, Florida.



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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  
AHCA, MEDICAID FAIR HEARINGS UNIT

Aug 26, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-02380  
16F-03726

PETITIONER,

Vs.

CASE NO



FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 11 Dade  
UNIT: 88682

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on August 11, 2016 at 1:00 p.m. All parties appeared telephonically from different locations.

**APPEARANCES**

For the Petitioner:



For the Respondent:

Kenesha Hanley,  
Operations Management Consultant I

**STATEMENT OF ISSUE**

At issue is the department's action to deny the petitioner's request for Food Assistance Program (FAP) benefits and Medicare Supplemental Program (MSP)

benefits at application. The burden of proof was assigned to the petitioner by a preponderance of evidence.

### **PRELIMINARY STATEMENT**

A hearing was scheduled and conducted on May 13, 2016. Adaobi Ike-Chinye, Operations Management Consultant I, represented the department. It was determined that the department representative was not prepared to represent at the hearing based on the petitioner's issue. The hearing was rescheduled.

Several hearing continuances were granted for various reasons.

The petitioner's issue concerning the approval of the FAP benefits was resolved prior to going on record. All benefits were issued to the petitioner from the original date of application. Subsequently, the FAP appeal was dismissed as moot.

The petitioner provided no evidence. The respondent submitted 101 pages of evidence, which included information from the petitioner, were marked and entered as Respondent's Composite Exhibit "1".

The record was left open through August 11, 2016 for additional information including the Notice of Case Action detailing approval of benefits. The above mentioned information was provided on August 8, 2016. Additional evidence provided was the Individual Eligibility History was included. All evidence was marked and entered as Respondent's Composite Exhibit 2. The record was closed on August 11, 2016.

**FINDINGS OF FACT**

1. On January 4, 2016 the petitioner submitted a paper application requesting Food Assistance Program (FAP) benefits and Medicaid, including the Medicare Savings Plan (MSP).
2. The petitioner is the only member of her household.
3. The petitioner has been determined disabled by the Social Security Administration (SSA) and receives \$1,205 in Social Security Disability Income (SSDI) monthly.
4. The petitioner incurs no household expenses.
5. On January 11, 2016 the respondent mailed a Notice of Case Action (NOCA) to the petitioner requesting the petitioner come into the office for identity authentication. It states:



The following is information about your eligibility.

---

Once you receive your case number you can go to [www.myflorida.com/accessflorida](http://www.myflorida.com/accessflorida) to activate your My ACCESS Account. You will be able to get case status information. You will also be able to print a temporary Medicaid card if you are eligible for Medicaid.

We need to have a phone interview with you to determine your eligibility or to continue your benefits. Please call (305) 428 - 1407 on or before January 19, 2016 between the hours of 9:00 A.M and 12:00 P.M for your phone interview.

To finish your application we need the following information no later than ten days from the date of your interview.

\*Proof of your identification (example: driver's license)  
Other - please see comments below

PLEASE GO TO YOUR NEAREST DCF OFFICE FOR FACE TO FACE AUTHENTICATION WITH A PHOTO IDENTIFICATION NO LATER THAN 1/19/2016. YOU MUST ALSO COMPLETE AN INTERVIEW BY PHONE.

6. On February 4, 2016, the respondent mailed a NOCA to the petitioner informing her she was ineligible for FAP benefits citing, "Reason: You failed to complete an interview necessary for us to determine your eligibility for this program". The application for Medicaid was not addressed.

7. On March 3, 2016, the petitioner submitted a paper additional application for FAP benefits and Medicaid.
8. According to the running record comments (CLRC), the petitioner's application was approved on March 15, 2016 for FAP and Medicaid, including Medically Needy (MN) and MSP.
9. The petitioner's MN and MSP were approved with an eligibility date beginning March 1, 2016. The petitioner's FAP benefits were approved and she was provided retroactive FAP benefits beginning January 4, 2016.
10. The petitioner asserts she is entitled to MSP benefits from January 2016 due to the department being "dishonest" in not processing her original application of January 4, 2016.
11. On August 5, 2016 the respondent mailed a NOCA to the petitioner informing her eligibility for the MSP had been approved effective January 2016, February 2016, and March 2016. All other benefits remained the same.
12. The petitioner argues that she is due a reimbursement from the Medicaid department as money was taken from her check to pay her Medicare premium that she applied to have paid by the state timely to avoid the deduction through MSP coverage.

#### **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 Section 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under Section 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. 65-2.060, Evidence, states in relevant part:

(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.** (*emphasis added*) The party having the burden shall establish his/her position, by a preponderance of evidence, to the satisfaction of the hearing officer.

16. The above cited authority explains that the party asserting the affirmative holds the burden of proof. The burden of proof is upon the petitioner when the respondent takes action to deny benefits applied for by the petitioner.

17. Fla. Admin. Code R. 65-1.203 Administrative Definitions (4) states: "Date of Application: The date the Department receives an application. If a web or facsimile application is received after business hours, the next business day following receipt is the date of application. Applications may be submitted in person, by the postal system, facsimile or electronically."

18. In accordance with the above cited authority, the date the department receives an application is considered the date of application for an application. The petitioner submitted her application requesting FAP and Medicaid benefits on January 4, 2016.

19. Fla. Admin. Code R. 65-1.205 Eligibility Determination Process (1)(a) states in pertinent part: "The Department must determine an applicant's eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter."

20. The above cited authority explains that the department must determine an applicant's eligibility at application. The respondent did not determine eligibility for the petitioner for MSP based on her January 4, 2016 application.

21. Fla. Admin. Code R. 65-1.702 Special Provisions states in the pertinent part:

(1) Rules 65A-1.701 through 65A-1.716, F.A.C., implement Medicaid coverage provisions and options available to states under Titles XVI and XIX of the Social Security Act.

(2) Date of Eligibility. The date eligibility for Medicaid begins. This was formerly called the date of entitlement... Eligibility for Medicaid begins the first day of a month if an individual was eligible any time during the month...

(7) (e) If a case is re-opened and the department discovers that an error was made in the eligibility determination, benefits must be provided retroactively as follows:

1. If an application was denied, benefits will be awarded back to the date of eligibility provided all other eligibility requirements are satisfied.

22. The above cited authority explains the date of eligibility for Medicaid begins on the first day of the month of application. The authority further explains if a case is re-opened and it is determined a mistake has been made, the benefits will be awarded back to the original date of eligibility.

23. The petitioner's request for MSP benefits was updated on August 5, 2016 by the department with an eligibility date of January 1, 2016 going forward. In accordance with the cited authority, the respondent provided eligibility for the petitioner beginning with the original application dated January 4, 2016.

24. The petitioner is requesting reimbursement of her Medicare premiums paid prior to approval for benefits. For any further concerns on reimbursement, the petitioner may want to seek guidance from the Social Security Administration.

**DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeals are denied as corrective action has been made and all benefits received. All issues have been resolved concerning her eligibility.

**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 26 day of August, 2016,

in Tallahassee, Florida.

*Pamela B. Vance*

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Pamela B. Vance  
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

Jul 01, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-02474

PETITIONER,

Vs.

CASE NO.

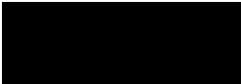


FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 11 DADE  
UNIT: 88674

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on June 10<sup>th</sup>, 2016 at 8:30 a.m. in 

**APPEARANCES**

For the Petitioner:



For the Respondent: Heather Brooks, Program Administrator for the Economic Self-Sufficiency program.

**STATEMENT OF ISSUE**

The petitioner is appealing the respondent's action to terminate her disability-related Medicaid. On the record, the burden of proof was originally assigned to the petitioner based on the contention that the petitioner's application was denied. However, upon evidence developed on the record indicated that the petitioner's Medicaid was terminated; therefore, the burden of proof must be assigned to the respondent. The standard of proof at a fair hearing is a preponderance of the evidence.

**PRELIMINARY STATEMENT**

1. The hearing was originally scheduled to be conducted telephonically on May 27<sup>th</sup>, 2016. The hearing was rescheduled upon the petitioner's request for an in-person hearing.

2. Appearing as an observer was Kimberly Vargo of the Office of Appeal Hearings.

3. Petitioner's Exhibits 1 and 2 were submitted into evidence.

4. Respondent's Exhibits 1 through 12 were submitted into evidence.

5. By way of a Notice of Case Action dated March 2<sup>nd</sup>, 2016, the respondent informed the petitioner that her application for Medicaid dated February 19<sup>th</sup>, 2016 was approved for the months of January 2016, February 2016, March 2016, and ongoing. (See Petitioner's Exhibit 1.)

6. By way of a Notice of Case Action dated March 2<sup>nd</sup>, 2016, the respondent informed the petitioner that her application for Medicaid dated February 19<sup>th</sup>, 2016 was approved effective January 2016, February 2016, and March 2016 and ongoing.

7. By way of a Notice of Case Action dated May 11<sup>th</sup>, 2016, the respondent informed the petitioner that her application for Medicaid dated February 19<sup>th</sup>, 2016 was denied effective April 2016, May 2016, June 2016 and ongoing. The reason listed on the notice is "You or a member(s) of your household do not meet the disability requirement." (See Respondent's Exhibit 2, page 7 of the exhibits.) On April 1<sup>st</sup>, 2016 the petitioner filed a timely appeal to challenge the respondent's action.

**FINDINGS OF FACT**

8. The petitioner, 53 years of age, applied for Medicaid on February 19<sup>th</sup>, 2016.

9. The petitioner is a single-person household. As she is not yet 65 years of age and has no minor children in her custody, the petitioner must meet the disability-related criteria in order to be considered for Medicaid.

10. On the above-mentioned application, the petitioner reported that she was not disabled (see Respondent's Exhibit 1, page 4 of the exhibits.) Therefore, a disability review was not initiated.

11. On March 2<sup>nd</sup>, 2016, the respondent issued a Notice of Case Action informing the petitioner of her eligibility for Medicaid as described above; however, how respondent made this determination was not clear.

12. On March 25<sup>th</sup>, 2016, the respondent completed an interview with the petitioner and completed a disability package documenting the conditions alleged by the petitioner. The package was then forwarded to the Division of Disability Determinations (DDD) for review and disposition.

13. On April 25<sup>th</sup>, 2016, DDD responded, via a Disability Determination Transmittal (Respondent's Exhibit 12) that the petitioner did not meet the disability criteria, and denied her application using code N31, which signifies "Non-pay – Capacity for substantial gainful activity – customary past work, no visual impairment."

14. The respondent subsequently discovered, through its Data Exchange Alert system (the system used to collect data from various sources, to be used to determine

an individual's eligibility for benefits), that the petitioner had applied for disability-related SSI (Supplemental Security Income) and SSI-related Medicaid through the Social Security Administration on January 8<sup>th</sup>, 2016. This application was denied on April 25<sup>th</sup>, 2016 with reason code N31 (see above). In addition to the denial, the alert indicates that the petitioner filed an appeal to challenge SSA's denial on May 16<sup>th</sup>, 2016. The petitioner confirmed this at the hearing, and stated that as of the date of the instant hearing, she has received no reply on the SSA appeal.

### **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 Section 120.80 of the Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285 of the Florida Statutes.

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

17. The Code of Federal Regulations at 42 C.F.R. § 435.541, Determinations of disability 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 Sec. 435.911 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 Sec. 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....

18. According to the regulations above, the Department is bound by the federal agency's (in this case, SSA) decision unless there is evidence of a new disabling condition not reviewed by SSA. The petitioner did not submit any such evidence at the hearing.

19. The above authorities also explain that if SSA has denied disability within the past year, or if the denial is under appeal, the SSA decision is to be adopted. The findings show that on April 25<sup>th</sup>, 2016, SSA took action to deny the petitioner's Medicaid effective January 2016. The findings show that the petitioner filed an appeal to challenge SSA's action on May 16<sup>th</sup>, 2016, and that this appeal is still pending.

20. Therefore, the hearing officer concludes that the petitioner must complete the appeal process with SSA, and that the respondent is bound by SSA's decision unless an exception described above is met.

**DECISION**

Based on the foregoing Findings of Fact and 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.

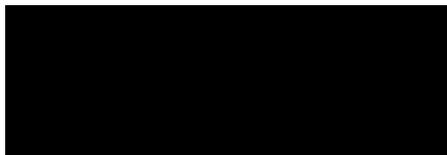
DONE and ORDERED this 01 day of July, 2016,  
in Tallahassee, Florida.



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](mailto:Appeal.hearings@myFLfamilies.com)

Copies Furnished To [REDACTED] Petitioner  
Office of Economic Self Sufficiency

Jul 28, 2016

Office of Appeal Hearings  
Dept. of Children and FamiliesSTATE OF FLORIDA  
DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-02601

PETITIONER,

Vs.

CASE NO. FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 20 Lee  
UNIT: 88287RESPONDENT.  

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**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 29<sup>th</sup>, 2016, at 8:30 a.m., and reconvened the hearing on July 13<sup>th</sup>, 2016, at 8:30 a.m.

**APPEARANCES**At both hearingsFor the Petitioner: 

For the Respondent: Mary Dahmer, Senior Worker for the Economic Self-Sufficiency Program.

**STATEMENT OF ISSUE**

The petitioner is appealing the department's action to deny his application for the Medicare Savings Program (MSP) and SSI-Related Medicaid coverage. The petitioner carries the burden of proving his position by a preponderance of the evidence in this appeal.

**PRELIMINARY STATEMENT**

The hearing was originally scheduled for May 26<sup>th</sup>, 2016, at 9:00 a.m., but was rescheduled at the petitioner's request. The hearing was rescheduled for June 14<sup>th</sup>, 2016 and June 29<sup>th</sup>, 2016, both times at the petitioner's request. The respondent then requested a continuance, as it was not previously made aware of the MSP issue, and additional time was needed to prepare. The continuance was granted for July 13<sup>th</sup>, 2016.

Appearing as a witness for the petitioner at both proceedings was his friend,



Appearing as an observer at the first hearing was Nicole Nuriddin, Economic Self-Sufficiency Specialist II, of the Department of Children and Families.

The petitioner did not provide any documents for the hearing officer's consideration.

Respondent's exhibits 1 through 8 were admitted into evidence.

By way of a Notice of Case Action dated March 30<sup>th</sup>, 2016, the respondent informed the petitioner that his application for Qualifying Individual 1 (QI1) dated March 24<sup>th</sup>, 2016, was denied because his household's income is too high. The Notice of Case Action also informed the petitioner that he was enrolled in the Medically Needy (MN) program with a Share of Cost (SOC) of \$1,088.00 per month. On April 5<sup>th</sup>, 2016, the petitioner filed a timely request to challenge the respondent's action.

**FINDINGS OF FACT**

1. The petitioner applied for MSP and SSI-Related Medicaid on March 24<sup>th</sup>, 2016. 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 all sources of income and allowable expenses.

2. The petitioner is a single-person household, aged 63.

3. The petitioner is disabled and receives Social Security Disability Insurance (SSDI) of \$1,393.00 before deductions. However, the petitioner claims he receives \$1,039.00. The respondent considered \$1,393.00 in disability payments.

4. The respondent calculated the petitioner's countable income for the MSP program as follows:

\$1,393.00	Total unearned income
- \$ 20.00	<u>Unearned income disregard</u>
\$1,373.00	Countable unearned income

The respondent determined the petitioner was ineligible for QI1 benefits as his income of \$1,373.00 was over the income limit of \$1,325.00.

5. The petitioner has been receiving Medicare benefits of Parts A and B since May 2011. The Part B premiums are \$104.90. The respondent considered this amount as a medical expense for the MN program.

6. The respondent calculated the petitioner's countable income for the MN program as follows:

\$1,393.00	Total unearned income
- \$ 20.00	<u>Unearned income disregard</u>
\$1,373.00	Countable unearned income

Total countable income:	\$1,393.00
-Medically Needy Income Limit (MNIL)	\$ 180.00
-Medical Insurance Premium	\$ 104.90
Remaining SOC	\$1,088.00

7. The petitioner asserts that he pays approximately \$249.60 per month in court ordered child support, approximately \$150.00 per month in out of pocket medical expenses, and approximately \$103.00 per month in prescriptions. However, the petitioner was unable to provide evidence of the exact amounts.

8. The respondent completed bill tracking and approved Medicaid effective March 31<sup>st</sup>, 2016, and April 16<sup>th</sup>, 2016 through April 30<sup>th</sup>, 2016. The respondent also completed bill tracking for the months of May 2016 and June 2016, but the SOC was not met and Medicaid was not approved.

### **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 120.80, Fla. Stat. 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-1.701, 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.

12. The above controlling authority explains that the full coverage Medicaid coverage group (MEDS-AD Demonstration Waiver) in the SSI-related Programs is for individuals whose income is below the federal poverty level and are not receiving Medicare, or if receiving Medicare are eligible for Medicaid covered institutional care services (ICP), hospice services, or community based services. The findings show that the petitioner is receiving Medicare but is not receiving ICP, hospice, or community based services. Therefore, the undersigned concludes that the respondent was correct in its action to deny full Medicaid.

13. Federal Regulations at 20 C.F.R. 416.1123 define how unearned income is counted for SSI-Related Medicaid programs and in part states:

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 §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** *[emphasis added]*, and the amount of the debt reduction is also part of your unearned income...

(2) We also include more than you actually receive if amounts are withheld from unearned income **because of a garnishment, or to pay a debt or other legal obligation, or to make any other payment such as payment of your Medicare premiums** *[emphasis added]*.

14. Federal Regulations at 20 C.F.R. 416.1124 defines unearned income that is not counted and in part states:

(a) General. While we must know the source and amount of all of your unearned income for SSI, we do not count all of it to determine your eligibility and benefit amount. We first exclude income as authorized by other Federal laws (see paragraph (b) of this section). Then we apply the

other exclusions in the order listed in paragraph (c) of this section to the rest of your unearned income in the month. We never reduce your unearned income below zero or apply any unused unearned income exclusion to earned income except for the \$20 general exclusion described in paragraph (c)(12) of this section.

(b) Other Federal laws. Some Federal laws other than the Social Security Act provide that we cannot count some of your unearned income for SSI purposes. We list the laws and the exclusions in the appendix to this subpart which we update periodically.

(c) Other unearned income we do not count. We do not count as unearned income—

(1) Any public agency's refund of taxes on real property or food;

(2) Assistance based on need which is wholly funded by a State or one of its political subdivisions...

(3) Any portion of a grant, scholarship, fellowship, or gift used or set aside for paying tuition, fees, or other necessary educational expenses.

However, we do count any portion set aside or actually used for food or shelter;

(4) Food which you or your spouse raise if it is consumed by you or your household;

(5) Assistance received under the Disaster Relief and Emergency Assistance Act and assistance provided under any Federal statute because of a catastrophe which the President of the United States declares to be a major disaster...

(6) The first \$60 of unearned income received in a calendar quarter if you receive it infrequently or irregularly...

(7) Alaska Longevity Bonus payments ...

(8) Payments for providing foster care...

(9) Any interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement which are left to accumulate and become a part of the separate burial fund...

(10) Certain support and maintenance assistance as described in §416.1157;

(11) One-third of support payments made to or for you by an absent parent if you are a child;

(12) The first \$20 of any unearned income in a month...

(13) Any unearned income you receive and use to fulfill an approved plan to achieve self-support if you are blind or disabled and under age 65 or blind or disabled and received SSI...

(14) The value of any assistance paid with respect to a dwelling unit under—

(i) The United States Housing Act of 1937;

(ii) The National Housing Act;

(iii) Section 101 of the Housing and Urban Development Act of 1965;

(iv) Title V of the Housing Act of 1949; or

- (v) Section 202(h) of the Housing Act of 1959;
- (15) Any interest accrued on and left to accumulate as part of the value of an excluded burial space purchase agreement...
- (16) The value of any commercial transportation ticket, for travel by you or your spouse among the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands, which is received as a gift by you or your spouse and is not converted to cash. If such a ticket is converted to cash, the cash you receive is income in the month you receive the cash;
- (17) Payments received by you from a fund established by a State to aid victims of crime;
- (18) Relocation assistance provided you by a State or local...
- (19) Special pay received from one of the uniformed services pursuant to 37 U.S.C. 310;
- (20) Interest or other earnings on a dedicated account which is excluded from resources. (See §416.1247);
- (21) Gifts from an organization as described in section 501(c)(3) of the Internal Revenue Code of 1986 ...
- (22) Interest and dividend income from a countable resource or from a resource excluded under a Federal statute other than section 1613(a) of the Social Security Act; and
- (23) AmeriCorps State and National and AmeriCorps National Civilian Community Corps cash or in-kind payments to AmeriCorps participants or on AmeriCorps participants' behalf. These include, but are not limited to: Food and shelter, and clothing allowances;
- (24) Any annuity paid by a State to a person (or his or her spouse) based on the State's determination that the person is:
  - (i) A veteran (as defined in 38 U.S.C. 101); and
  - (ii) Blind, disabled, or aged.

15. In accordance with the above federal regulations, garnished child support is not listed as an income exclusion in the Medicaid program or MSP. Therefore, the respondent correctly determined the petitioner's gross income; which includes the garnishment of the child support obligation. The above controlling authority establishes a \$20 unearned income disregard. The respondent correctly deducted \$20 from the petitioner's \$1,393.00 SSDI to arrive at \$1,373.00 countable income for the MSP.

16. Fla. Admin. Code R. 65A-1.702 Special Provisions explains the Buy-In

Programs 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.)...

16. Fla. Admin. Code R.65A-1.713 "SSI-Related Medicaid Income Eligibility Criteria," 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 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.

17. The MSP standards for income appear in Appendix A-9 of the Policy Manual.

Effective July 2015, the QI1 income limit was \$1,325.00. As noted in the Findings of

Fact, the petitioner's countable income is \$1,373.00 which is over the QI1 income limit.

Therefore, the respondent was correct to deny the petitioner's application for MSP.

18. Federal Regulations at 20 C.F.R. 435.831, Income Eligibility, states in part:

(e) *Determination of deductible incurred expenses: Required deductions based on kinds of services.* Subject to the provisions of paragraph (g), in determining

incurred medical expenses to be deducted from income, the agency must include the following:

- (1) Expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges, including enrollment fees, copayments, or deductibles imposed under §447.51 or §447.53 of this subchapter;
- (2) Expenses incurred by the individual or family or financially responsible relatives for necessary medical and remedial services that are recognized under State law but not included in the plan;
- (3) Expenses incurred by the individual or family or by financially responsible relatives for necessary medical and remedial services that are included in the plan, including those that exceed agency limitations on amount, duration, or scope of services.

(f) *Determination of deductible incurred expenses: Required deductions based on the age of bills.* Subject to the provisions of paragraph (g), in determining incurred medical expenses to be deducted from income, the agency must include the following:

- (1) For the first budget period or periods that include only months before the month of application for medical assistance, expenses incurred during such period or periods, whether paid or unpaid, to the extent that the expenses have not been deducted previously in establishing eligibility;
- (2) For the first prospective budget period that also includes any of the 3 months before the month of application for medical assistance, expenses incurred during such budget period, whether paid or unpaid, to the extent that the expenses have not been deducted previously in establishing eligibility;
- (3) For the first prospective budget period that includes none of the months preceding the month of application, expenses incurred during such budget period and any of the 3 preceding months, whether paid or unpaid, to the extent that the expenses have not been deducted previously in establishing eligibility;
- (4) For any of the 3 months preceding the month of application that are not includable under paragraph (f)(2) of this section, expenses incurred in the 3-month period that were a current liability of the individual in any such month for which a spenddown calculation is made and that had not been previously deducted from income in establishing eligibility for medical assistance;
- (5) Current payments (that is, payments made in the current budget period) on other expenses incurred before the current budget period and not previously deducted from income in any budget period in establishing eligibility for such period; and
- (6) If the individual's eligibility for medical assistance was established in each such preceding period, expenses incurred before the current budget period but not previously deducted from income in establishing eligibility, to the extent that such expenses are unpaid and are:
  - (i) Described in paragraphs (e)(1) through (e)(3) of this section; and
  - (ii) Carried over from the preceding budget period or periods because the individual had a spenddown liability in each such preceding period that was met without deducting all such incurred, unpaid expenses.

19. Following the above controlling authorities, the petitioner's medical and prescription expenses cannot be used to both lower his SOC and meet his SOC. The respondent was correct to exclude the medical expenses from the MN budget since the petitioner has submitted or is planning to submit the expenses for bill tracking to meet his SOC.

### **DECISION**

Based upon 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 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 28 day of July, 2016,

in Tallahassee, Florida.



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Kimberly Vargo  
Hearing Officer  
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FINAL ORDER (Cont.)

16F-02601

PAGE-11

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

Jul 01, 2016

Office of Appeal Hearings  
Dept. of Children and FamiliesSTATE OF FLORIDA  
DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGS

[REDACTED]

APPEAL NO. 16F-02624

PETITIONER,

Vs.

CASE [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 13 Hillsborough  
UNIT: 883DTRESPONDENT.  

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**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing by phone in the above-referenced matter on June 3, 2016 at 10:06 a.m.

**APPEARANCES**

For Petitioner: [REDACTED]

For Respondent: Ed Poutre, Economic Self Sufficiency Specialist II

**STATEMENT OF ISSUE**

At issue is whether the respondent's action to enroll the petitioner's nineteen year old daughter in the Medically Needy (MN) Program with a share of cost (SOC) effective May 2016 and ongoing is correct. Respondent carries the burden of proof by a preponderance of the evidence.

**PRELIMINARY STATEMENT**

Petitioner was present and testified. Petitioner submitted no exhibits at the hearing. Respondent was represented by Ed Poutre with the Department of Children

and Families (hereafter “DCF”, “Respondent” or “Agency”). Respondent submitted eight exhibits, which were accepted into evidence and marked as Respondent’s Exhibits “1” through “8”. [REDACTED], from [REDACTED], translated the proceedings.

The record was left until June 6, 2016 to allow the respondent to submit additional information. On June 6, 2016, the respondent the submitted the additional information which was accepted into evidence and marked as Respondent’s Exhibits “9” through “10”. The record closed on June 6, 2016.

### **FINDINGS OF FACT**

1. Petitioner’s current Medicaid certification period is from October 2015 through September 2016. Petitioner’s daughter received six months of continuous Medicaid from October 2015 through March 2016.
2. On March 10, 2016, the petitioner completed a recertification application for Food Assistance (FA) and Family-Related Medicaid benefits. FA benefits are not an issue under appeal. The application listed petitioner and her two children as the only household members; petitioner’s earned income as the only income for the household; and the petitioner filing taxes this year and claiming her two children as tax dependents. Petitioner’s daughter turned nineteen years old in March 2016.
3. On March 16, 2016, the respondent requested the petitioner submit proof of her last four weeks of income by March 28, 2016.
4. On March 30, 2016, the petitioner submitted two paystubs dated February 19, 2016 and February 26, 2016. The gross income for the February 19, 2016 paystub was \$385.96 and the gross income for the February 26, 2016 paystub was \$424.40.

Respondent calculated her monthly earned income by considering the two pays of February 19, 2016 and February 26, 2016 as representative.

5. Respondent determined the petitioner's monthly gross income as \$1,620.72 or  $\$385.96 + \$424.40 = \$810.36$  divided by 2 =  $\$405.18 \times 4 = \$1,620.72$ .

6. Initially, the respondent determined the petitioner's Family-Related MN SOC amount as \$1,134 per month for May 2016 and ongoing as follows:

<u>\$1620.72</u>	<u>petitioner's earned income</u>
\$1620.72	total countable net income
<u>-\$ 486.00</u>	<u>MNIL for a household of three</u>
\$1134.00	share of cost

7. On May 9, 2016, the respondent reviewed the nineteen year old's Family-Related Medicaid benefits a second time to ensure her benefits were correct. Respondent determined the petitioner was required to submit the last four paystubs to correctly determine the nineteen year old's eligibility for Family-Related Medicaid benefits.

8. On May 10, 2016, the respondent mailed petitioner a Notice of Case Action requesting the petitioner submit proof of her last four weeks of earned income and contact the respondent by May 20, 2016.

9. On May 17, 2016, the petitioner submitted her last four paystubs dated April 15, 2016, April 22, 2016, April 29, 2016, and May 6, 2016. Petitioner is paid weekly. Respondent determined the petitioner's paystub of April 22, 2016 was non-representative as it included bonus pay. The gross income for the April 15, 2016 paystub was \$426.40, the gross income for the April 22, 2016 paystub was \$468.83; the gross income for the April 29, 2016 paystub was \$426.40; and the gross income for the May 6, 2016 paystub was \$213.20.



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

17. The Fla. Admin. Code R. 65A-1.703(1)(a), Family-Related Medicaid General Eligibility Criteria 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.

(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.

18. Pursuant to the above authority, since the petitioner's eldest daughter is under the age of twenty-one and lives in same household as her mother, she is eligible for Medicaid benefits under the Family-Related Medicaid Program.

19. Federal Medicaid Regulations 42 C.F.R. § 435.603, Application of modified adjusted gross income states, in part:

(a) Basis, scope, and implementation...

(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...

(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...

(f) Household—

(2) Basic rule for individuals claimed as a tax dependent. In the case of an individual who expects to be claimed as a tax dependent by another taxpayer for the taxable year in which an initial determination or renewal of eligibility is being made, the household is the household of the taxpayer claiming such individual as a tax dependent...

20. Pursuant to the above authority, petitioner and her two children are considered the petitioner's household. Furthermore, the petitioner's earned income is considered in her eldest daughter's Family-Related Medicaid budget.

21. Federal Medicaid Regulations 42 C.F.R. § 435.603, Application of modified adjusted gross income states, in part:

(h) Budget period—

(2) Current beneficiaries. For individuals who have been determined financially-eligible for Medicaid using the MAGI-based methods set forth in this section, a State may elect in its State plan to base financial eligibility either on current monthly household income and family size or income based on projected annual household income and family size for the remainder of the current calendar year.

(3) In determining current monthly or projected annual household income and family size under paragraphs (h)(1) or (h)(2) of this section, the agency may adopt a reasonable method to include a prorated portion of reasonably predictable future income, to account for a reasonably predictable increase or decrease in future income, or both, as evidenced by a signed contract for employment, a clear history of predictable fluctuations in income, or other clear indicia of such future changes in income. Such future increase or decrease in income or family size must be verified in the same manner as other income and eligibility factors, in accordance with the income and eligibility verification requirements at § 435.940 through § 435.965, including by self-attestation if reasonably compatible with other electronic data obtained by the agency in accordance with such sections...

22. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 2430.0509 Income More Often than Monthly (MFAM) states, in part:

The following procedure to calculate the average of earned or unearned income received in varying amounts more frequently than monthly is the same for all programs:

1. Add the gross income amounts for the past four weeks to get the total.
2. If income is received weekly, add four pay periods and divide by four to get the weekly average.
3. If income is received biweekly, add two pay periods and divide by two to get the biweekly average.
4. If income is received semimonthly, add two pay periods and divide by two to get the semimonthly average.
5. If income is received monthly, use the most recent month if representative.

23. Pursuant to the above authorities, the respondent utilizes monthly gross income amounts to determine eligibility for Family-Related Medicaid benefits. To convert weekly income to monthly income, the respondent first adds the past four weeks of earned income, then divides the sum by four, and then multiplies the sum by four. Respondent correctly calculated the petitioner's monthly earned income as \$1,421.32.

24. Federal Medicaid Regulations 42 C.F.R. § 435.218 Individuals with MAGI-based income above 133 percent FPL (Federal Poverty Level) states, in part:

- (a) Basis. This section implements section 1902(a)(10)(A)(ii)(XX) of the Act.
- (b) Eligibility—(1) Criteria. The agency may provide Medicaid to individuals who:
  - (i) Are under age 65;
  - (ii) Are not eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part;
  - (iii) Are not otherwise eligible for and enrolled for optional coverage under a State's Medicaid State plan in accordance with section 1902(a)(10)(A)(ii)(I) through (XIX) of the Act and subpart C of this part, based on information available to the State from the application filed by or on behalf of the individual; and
  - (iv) Have household income that exceeds 133 percent FPL but is at or below the income standard elected by the agency and approved in its Medicaid State plan, for the applicable family size.
- (2) Limitations. (i) A State may not, except as permitted under an approved phase-in plan adopted in accordance with paragraph (b)(3) of

this section, provide Medicaid to higher income individuals described in paragraph (b)(1) of this section without providing Medicaid to lower income individuals described in such paragraph.

(ii) The limitation on eligibility of parents and other caretaker relatives specified in § 435.119(c) of this section also applies to eligibility under this section.

25. The Policy Manual, CFOP 165-22, passage 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.

26. The Policy Manual, Appendix A-7, lists the Family-Related Medicaid Income

Limits for Children 19 & 20 in a household size of three as follows: the Income

Standard is \$303 and the Standard Disregard \$183. The Medically Needy Income Limit

(MNIL) for a family of three is \$486. The MAGI Disregard is \$84.

27. Pursuant to the above authorities, the respondent determined the petitioner's

total countable income by the aforementioned income limits, formula, and disregards.

The household's countable income of \$1,421.32 exceeds the income limit of \$303 for the petitioner's daughter to receive full Family-Related Medicaid benefits; therefore, she is correctly enrolled in the Medically Needy Program with a share of cost.

28. In careful review of the cited authorities and evidence, the undersigned concludes the respondent met its burden of proof in establishing the petitioner's nineteen year old daughter is correctly enrolled in the Family-Related Medically Needy Program with a monthly share of cost amount.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's 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 01 day of Julv, 2016,

in Tallahassee, Florida.

*Mary Jane Stafford*

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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

Aug 19, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-02659

PETITIONER,

Vs.

CASE NO.



FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 18 Brevard  
UNIT: 88585

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 8:17 a.m. on June 17, 2016.

**APPEARANCES**

For the Petitioner:



For the Respondent:

Susan Martin, ACCESS  
Operations Management Consultant

**STATEMENT OF ISSUE**

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

### **PRELIMINARY STATEMENT**

By notice dated May 13, 2016, the respondent (or the Department) notified the petitioner her Medicaid application was denied. The petitioner timely requested a hearing to challenge the Medicaid denial.

Petitioner did not submit exhibits. Respondent submitted six exhibits, entered as Respondent Exhibits "1" through "6". The record was closed on June 17, 2016.

### **FINDINGS OF FACT**

1. On April 28, 2016, the petitioner, age 54, submitted a Food Assistance and SSI-Related Medicaid disability application for herself. Medicaid is the only issue.
2. To be eligible for SSI-Related Medicaid petitioner must be over age 65 or considered disabled by the Social Security Administration (SSA) or the Division of Disability Determination (DDD). DDD is responsible for making disability determinations on behalf of the Department.
3. Petitioner applied for disability through the SSA in March 2015. SSA denied petitioner in June 2015. Petitioner is appealing the SSA denial decision through an attorney.
4. Petitioner described her disabilities as medical problems with her knee, lower back, neck, shoulder, right hand and hip. Petitioner said she is in need of physical therapy and pain management.
5. On May 4, 2016, the Department forwarded petitioner's disability documents to DDD for a disability eligibility review. DDD reviewed petitioner's disability documents and denied her Medicaid disability on May 9, 2016; due to adopting the SSA denial decision.

6. On May 13, 2016, the Department mailed the petitioner a Notice of Case Action, denying Medicaid; due to not meeting the disability requirements.
7. Petitioner said that she does not have new medical conditions that SSA did not consider.

### **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. The Code of Federal Regulations at 42 C.F.R. § 435.541, Determinations 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...

11. In accordance with the above authority, the respondent denied petitioner's April 28, 2016, Medicaid application; due to adopting the SSA June 2015 denial decision.

12. 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". Petitioner does not have new or worsening medical conditions not considered by the SSA.

13. In careful review of the cited authority and evidence, the undersigned concludes that the petitioner did not meet her burden of proof. And agrees the Department's action to deny petitioner Medicaid; due to adopting the SSA disability is proper.

### **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 August, 2016,

in Tallahassee, Florida.



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Priscilla Peterson  
Hearing Officer  
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Copies Furnished To [REDACTED] Petitioner  
Office of Economic Self Sufficiency

Jul 19, 2016

Office of Appeal Hearings  
Dept. of Children and FamiliesSTATE OF FLORIDA  
DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-02684

PETITIONER,

Vs.

CASE NO. FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 15 PALM BEACH  
UNIT: 88071RESPONDENT.  

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**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on June 22, 2016 at 2:34 p.m., in West Palm Beach, Florida.

**APPEARANCES**For the Petitioner: 

For the Respondent: Marjorie Desporte, attorney for the respondent

**STATEMENT OF ISSUE**

The petitioner is appealing the respondent's action to deny her application for Medicaid benefits. The petitioner carries the burden of proof by preponderance of evidence.

**PRELIMINARY STATEMENT**

The petitioner submitted 20 exhibits which were entered into evidence and marked as Petitioner's Exhibit 1 through 20. The respondent presented one exhibit which was entered into evidence and marked as Respondent's Composite Exhibit 1.

Present as witnesses for the petitioner were [REDACTED] medical coordinator, [REDACTED] housing supervisor, [REDACTED]

Present as witness for the Department was Roderika Mack, supervisor

**FINDINGS OF FACT**

1. The petitioner was born in Honduras and entered the United States of America (USA) in July 2014. She is an undocumented immigrant (no legal right to be or remain in the United States) and resides in Florida. She was born on [REDACTED] She was awarded to the state of Florida on January 20, 2016, as a foster child.
2. On January 22, 2016, the petitioner submitted an application for Medicaid benefits.
3. The respondent denied the petitioner's application for Medicaid benefits, as she did not have an Immigration and Naturalization Service (INS) status.
4. On April 7, 2016, the petitioner requested a hearing to appeal the respondent's action.
5. On May 31, 2016, the respondent sent a Medicaid and /or Title IV-E/Non IV-E Adoption Subsidy Notice of Case Action informing of the Medicaid denial.

6. At the hearing, the Department explained the petitioner did not meet the technical eligibility requirements for Medicaid benefits. The respondent argues the petitioner must have an INS status and provide proof.
7. The petitioner's representative argues that although the petitioner is not eligible for Title IV, it does not mean she does not qualify for Medicaid. The petitioner's representative also argues that it is difficult to schedule medical appointments for the petitioner without Medicaid.
8. The respondent explained the petitioner is only eligible for Emergency Medicaid for Aliens (EMA) and not ongoing regular Medicaid.

#### **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 Section 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under section 409.285, Fla. Stat.
10. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
11. The Department's Program Policy Manual CFOP-165-22, (Policy Manual) at passage, 1450.0100, addresses Citizenship/Noncitizen status (CIC) as follows:

The eligibility specialist must evaluate the citizenship/noncitizen status for each individual as a condition of eligibility for public assistance. Citizenship information on those family members who are not applying for benefits is not required. Non-receiving members are to be asked only if they are citizens or noncitizens, not their BCIS status. Citizenship/noncitizen requirements must be met in order to establish eligibility.

12. The Policy Manual, at passage, 1450.0004 addresses Technical Factors (CIC) states:

For Title IV-E Foster Care, the technical factors that may be considered are:

1. citizenship/noncitizen status,
2. Social Security number,
3. residency,
4. age,
5. deprivation,
6. living in the home of a specified relative,
7. receipt of other benefits,
8. cooperation with child support, and
9. assignment of support rights for third party

13. The above lists citizenship/Non citizenship as a technical factor to be considered when determining Medicaid benefits.

14. Policy Manual, at passage, 1430.0116, addresses Assistance for Ineligible Noncitizens (MFAM) and states: "Any noncitizen who does not have an eligible qualified noncitizen status is not eligible for Medicaid on the factor of citizenship. These noncitizens may be eligible for Medicaid through Emergency Medical Assistance for Aliens (EMA), if they meet all other eligibility criteria."

15. The Policy Manual at passage, 2050.0506, Non-Title IV-E Foster Care Medicaid (CIC) states, "Medicaid may be provided under this coverage group for children in foster care who do not meet Title IV-E requirements. **Medicaid coverage is available to children who meet the technical and financial requirements.**"

16. The above states that foster care children may be provided Medicaid if the children meet technical requirements for Medicaid such as citizenship or qualified non-citizen. The petitioner has not provided evidence that she met the technical requirement of citizenship or qualified non-citizen status.

■

17. The U.S. Code at 8 U.S. Code § 1612, Limited eligibility of qualified aliens for certain Federal programs, sets forth:

(a) Limited eligibility for specified Federal programs

(1) In general

Notwithstanding any other provision of law and except as provided in paragraph (2), an alien who is a qualified alien (as defined in section 1641 of this title) is not eligible for any specified Federal program (as defined in paragraph (3)).

(2) Exceptions

(A) Time-limited exception for refugees and asylees

With respect to the specified Federal programs described in paragraph (3), paragraph (1) shall not apply to an alien until 7 years after the date—

(i) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act [8 U.S.C. 1157];

(ii) an alien is granted asylum under section 208 of such Act [8 U.S.C. 1158];

(iii) an alien's deportation is withheld under section 243(h) of such Act [8 U.S.C. 1253] (as in effect immediately before the effective date of section 307 of division C of Public Law 104–208) or section 241(b)(3) of such Act [8 U.S.C. 1231(b)(3)] (as amended by section 305(a) of division C of Public Law 104–208);

(iv) an alien is granted status as a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980); or

(v) an alien is admitted to the United States as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 (as contained in section 101(e) of Public Law 100–202 and amended by the 9th proviso under migration and refugee assistance in title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1989, Public Law 100–461, as amended).

18. Fla. Admin. Code R. 65A-1.301 addresses Citizenship requirements as follows:

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...

19. 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...

20. According to the above, the individual must provide satisfactory documentary evidence of citizenship or qualified alien status to be eligible for Medicaid benefits. The petitioner confirmed she is not a US citizen nor does she have any qualified alien status; therefore, she has not met the technical requirements stated in the above authority to be eligible for Medicaid benefits.

21. The undersigned concludes the respondent correctly denied the petitioner's request for Medicaid benefits based on the above authority and on her statement that she is not a citizen nor has a qualified status. She is ineligible for Medicaid benefits based on the technical factor of citizenship or non-citizen criteria.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the Department's 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

FINAL ORDER (Cont.)

16F-02684

PAGE -7

petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

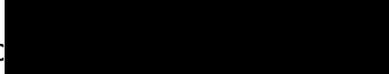
DONE and ORDERED this 19 day of July, 2016,

in Tallahassee, Florida.



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Christiana Gopaul-Narine  
Hearing Officer  
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Tallahassee, FL 32399-0700  
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Copies Furnished To  Petitioner  
Office of Economic Self Sufficiency  
Marjorie Desporte, Esq.

Aug 25, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-02744

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 July 12, 2016 at 8:30 a.m.

**APPEARANCES**

For the 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 action to partially deny Occupational Therapy (OT) service hours that were requested for the petitioner for the certification period January 19, 2016 through May 30, 2016, was correct. The respondent bears the burden of proof in this matter by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

The petitioner did not submit any documents as evidence for the hearing.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Composite Exhibit 1: Statement of Matters, Clinical History Notes, Denial Notices, and Supporting Documentation (therapy reports and records).

Appearing as a witness for the respondent was Rakesh Mittal, M.D., Physician-Consultant with eQHealth Solutions, Inc.

### **FINDINGS OF FACT**

1. The petitioner's OT service provider, Integrative Methods (hereafter referred to as "the provider"), requested the following OT service hours for the certification period at issue: 4 units (1 hour), three times per week – a total of 3 hours weekly.
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 eQ Health Solutions.

4. The medical information submitted by the provider contained, in part, the following information in regard to the petitioner:

- 7 years old
- Diagnosis includes [REDACTED]

5. The petitioner is also currently receiving speech therapy services through the Medicaid Program. He is not receiving physical therapy services.

6. The petitioner was previously approved for 3 hours weekly of occupational therapy in the prior certification period.

7. 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 OT provider.

The duties include, in part, instruction/therapy in the following areas:

- ADLs (activities of daily living)
- Perceptual-Motor Tasks
- Handwriting and Typing
- Motor Strengthening
- Reflex Integration Exercises
- Motor Planning Activities
- Sensory Processing Activities
- Memory Retrieval Activities
- Parent and Teacher Education/Training

8. A physician at eQHealth Solutions, who is board-certified in pediatrics, reviewed the submitted information and partially denied the requested OT services (approving two hours weekly rather than three hours weekly). The rationale for the decision was: "The request is excessive based on the severity of the delay, goals submitted and the progress made." A notice of this determination was sent to all parties on January 22, 2016.

9. 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 and a reconsideration determination letter was sent to all parties on February 4, 2016 which upheld the initial decision to approve 2 hours weekly.

10. The petitioner thereafter requested a fair hearing and this proceeding followed. Administrative approval for 3 hours weekly of services pending the outcome of the hearing was not granted by the respondent, so the petitioner is currently receiving 2 hours weekly.

11. The petitioner's mother stated her son was improving until about a year ago when he began to develop hearing problems, which will require ear tubes. He has now regressed in some areas and cannot perform some tasks which he was previously able to perform.

12. The respondent's witness, Dr. Mittal, stated that the decision was made to reduce the services from 3 hours to 2 hours weekly since the petitioner had been receiving services at 3 hours weekly since 2012 and had made good progress in his therapy goals. He also stated, after hearing the mother's testimony, it would be appropriate to approve 3 hours weekly of services for the current certification period pending the outcome of hearing tests and review of medical information from an ENT (ear, nose, and throat) specialist.

13. OT service for children (individuals under age 21) 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**

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 Fla. Stat. § 120.80.

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

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

17. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof for any reduction in services was assigned to the respondent since the petitioner had been previously approved for 3 hours weekly of OT service and the respondent is seeking to reduce the services to 2 hours 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, 7<sup>th</sup> Ed.).

18. 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.

19. The petitioner has requested OT 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.

20. 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.

21. 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<sup>1</sup> 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.*

22. The service the petitioner has requested (OT services) is one of the services provided by the state to treat or ameliorate an individual's conditions under the State

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<sup>1</sup> "You" in this manual context refers to the state Medicaid agency.

plan. Chapter 409.905, Fla. Stat., states, in part:

*Any service under this section shall be provided only when medically necessary ...*

23. 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.*

24. 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.*

25. Based upon the information submitted by the petitioner's provider, eQHealth Solutions completed a prior authorization review to determine medical necessity for the requested OT services.

26. In the petitioner's case, the respondent has determined that some occupational therapy service is medically necessary, but its initial determination was that 2 hours weekly are medically necessary rather than the 3 hours weekly requested by the petitioner's provider.

27. 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 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.*

28. 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.

29. OT services are described on page 1-3 of the Therapy Handbook as follows:

*Occupational therapy is the provision of services that address the developmental or functional needs of a child related to the performance of self-help skills; adaptive behavior; and sensory, motor and postural development.*

*Occupational therapy services include evaluation and treatment to prevent or correct physical and emotional deficits, minimize the disabling effect of these deficits, maintain a level of function, acquire a skill set or restore a skill set. Examples are perceptual motor activities, exercises to enhance functional performance, kinetic movement activities, guidance in the use of adaptive equipment and other techniques related to improving motor development*

30. The Therapy Handbook on page 2-2 sets forth the requirements for OT services, as follows:

*Medicaid reimburses for services that are determined medically necessary and do not duplicate another provider's service.*

31. The petitioner's physician ordered an OT 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.

32. The respondent's witness stated that although the initial decision was to reduce services since the petitioner has been receiving 3 hours weekly for the past several years and has made good progress, it would be appropriate for the petitioner to continue receiving 3 hours weekly pending the outcome of his hearing tests.

33. The petitioner's mother stated that services should be provided for 3 hours weekly since her son has regressed in some skills due to his hearing problems.

34. After considering all the documentary evidence and witness testimony presented, the undersigned concludes that the petitioner's OT services should remain at the level of 3 hours weekly until his hearing problems are evaluated, diagnosed, and/or treated. The certification period at issue already expired prior to the fair hearing in this matter and the petitioner was only receiving 2 hours weekly of services for most of the certification period. Accordingly, he should receive 3 hours weekly of OT services for the next certification period.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is GRANTED and the petitioner shall receive three (3) hours weekly of OT 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 indigence 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 August, 2016,

in Tallahassee, Florida.



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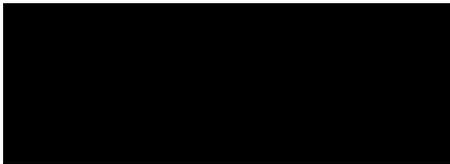
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Copies Furnished To: [REDACTED] PETITIONER  
AHCA, MEDICAID FAIR HEARINGS UNIT

Jul 11, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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

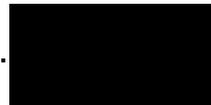


APPEAL NO. 16F-02765

PETITIONER,

Vs.

CASE NO.



FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 05 Hernando  
UNIT: 66292

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 10:55 a.m. on June 24, 2016.

**APPEARANCES**

For the Petitioner:



For the Respondent:

Susan Martin, ACCESS  
Operations Management Consultant I

**STATEMENT OF ISSUE**

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

### **PRELIMINARY STATEMENT**

By notice dated April 5, 2016, the respondent (or the Department) notified the petitioner his Medicaid application was denied. The petitioner timely requested a hearing to challenge the Medicaid denial.

[REDACTED] (MB) petitioner's friend/girlfriend, appeared as a witness for the petitioner. Petitioner did not submit exhibits. Respondent submitted six exhibits, entered as Respondent Exhibits "1" through "6". The record remained open until June 27, 2016, for the respondent to submit an additional exhibit. The exhibit was received timely and entered as Respondent Exhibit "7". The record was closed on June 27, 2016.

### **FINDINGS OF FACT**

1. On March 2, 2016, MB submitted an application for Food Assistance, Family Medicaid and SSI-Related Medicaid disability; Medicaid for the petitioner is the only issue. The application lists household members as MB, petitioner (age 31) and MB's 20 year old son.
2. Petitioner does not have children, he moved from Washington to Florida in October 2014; he received Medicaid in Washington.
3. To be eligible for Family Medicaid, petitioner must have minor children. To be eligible for SSI-Related Medicaid, petitioner must be age 65 or older or considered blind or disabled by the Social Security Administration (SSA) or the Division of Disability Determination (DDD). DDD determines Medicaid disability for the Department.
4. Petitioner does not have minor children, is not age 65 or older and has not been considered blind or disabled by the SSA or DDD.

5. On March 4, 2016, the Department incorrectly mailed MB a Notice of Case Action (NOCA) requesting a disability interview. The disability interview NOCA should have been sent to the petitioner; as he is the one applying for Medicaid disability.

6. Petitioner was unaware that he required a disability interview. Therefore, he did not contact the Department for the required disability interview.

7. On April 5, 2016, the Department mailed the petitioner a NOCA notifying he was denied Medicaid; due to not completing an interview to determine Medicaid eligibility.

8. On May 12, 2016, the Department's representative completed a pre-hearing conference with the petitioner and determined a disability determination and an interview had not been completed with the petitioner. During the call the Department determined petitioner applied for disability through the SSA on February 13, 2015; SSA denied petitioner disability on May 6, 2015. Petitioner reported that his brain medical condition had worsened.

9. Also on May 12, 2016, the Department's representative sent DDD the petitioner's medical documents for a disability review; which included his worsened medical condition.

10. Petitioner described his disabilities as [REDACTED]

11. Petitioner was again denied by the SSA in September 2015. He is in the process of appealing the SSA denial through an attorney. Petitioner's attorney and the SSA are aware of the petitioner's medical conditions, including his worsened brain medical condition.

12. On May 16, 2016, the DDD denied petitioner Medical disability; due to adopting the SSA disability denial.

13. On June 27, 2016 the Department mailed the petitioner a NOCA, denying Medicaid.

### **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 § 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.

16. 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 as SSI-Related Medicaid) for disabled adults and adults 65 or older.

17. Fla. Admin. 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...

18. Petitioner does not have children. Therefore, petitioner is not eligible for Family-Related Medicaid.

19. The Code of Federal Regulations at 42 C.F.R. § 435.541, Determinations 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...

20. The above authority explains the SSA determination is binding on the Department.

21. In accordance with the above authority, the Department denied petitioner's March 2, 2016 Medicaid application; due to adopting the SSA September 2015 denial decision.

22. The above authority also states that 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", "Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations".

23. Petitioner argued that his [REDACTED] condition has worsened since he applied for disability through the SSA in 2015.

24. Petitioner is appealing the September 2015 SSA denial decision. He has also notified the SSA and his attorney of his worsened [REDACTED] condition.

25. In careful review of the cited authority and evidence, the undersigned agrees with the Department's action to deny 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   11   day of   July  , 2016,

in Tallahassee, Florida.



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Priscilla Peterson  
Hearing Officer  
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Copies Furnished To: [REDACTED] Petitioner  
Office of Economic Self Sufficiency

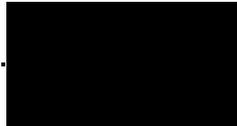
Jul 18, 2016

Office of Appeal Hearings  
Dept. of Children and FamiliesSTATE OF FLORIDA  
DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-02780

PETITIONER,

Vs.

CASE NO. FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 13 Hillsborough  
UNIT: 883CFRESPONDENT.  

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**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing by phone in the above-referenced matter on June 16, 2016 at 1:31 p.m. One continuance was granted for the respondent.

**APPEARANCES**For Petitioner: 

For Respondent: Ed Poutre, Economic Self Sufficiency Specialist II

**STATEMENT OF ISSUE**

At issue is whether respondent's action to deny petitioner's request for SSI-Related Medicaid benefits for the month of October 2013 is correct. The burden of proof is assigned to the petitioner by a preponderance of the evidence.

**PRELIMINARY STATEMENT**

Petitioner was not present but was represented by [REDACTED] financial assistance caseworker, with [REDACTED] [REDACTED] testified. Respondent was represented by Ed Poutre with the Department of Children and Families (hereafter "DCF", "Respondent" or "Agency"). Mr. Poutre testified.

Petitioner submitted no exhibits at the hearing. Respondent submitted nine exhibits, which were entered and marked as Respondent's Exhibits "1" through "9". The record was left open until June 23, 2016 to allow the respondent to submit additional information. On June 23, 2016, the respondent submitted the additional information, which was entered and marked as Respondent's Exhibits "10" through "16". The record closed on June 23, 2016.

Petitioner is appealing the respondent's Medicaid denial action from February 26, 2015. Petitioner did not request an appeal until March 17, 2016, which exceeds the time limit to request a hearing. However, the unsigned will address the merits of the appeal as the respondent did not send a Notice of Case Action to the petitioner or her representative relating to the February 26, 2015 denial.

**FINDINGS OF FACT**

1. On April 18, 2013, the petitioner applied for Supplemental Security Income (SSI) benefits from the Social Security Administration (SSA). On July 19, 2013, SSA denied the petitioner's SSI application using the code N37. N37 means "Non-pay-Failure or refusal to submit to consultative examination". Petitioner never appealed the denial of her April 18, 2013 SSI application.

2. Petitioner was hospitalized from October 17, 2013 through October 19, 2013.

Petitioner's medical conditions that resulted in her hospitalization were also the cause of her death.

3. Petitioner reapplied for SSA benefits on or about October 18, 2013 and SSA denied her reapplication for benefits on or about January 10, 2014. Petitioner did not submit evidence of the denial code utilized by SSA when it denied petitioner's SSI application.

4. Petitioner is only requesting Medicaid benefits for the month of October 2013.

5. On October 18, 2013, the petitioner submitted an application for Family-Related and SSI-Related Medicaid benefits. The application listed petitioner as the only individual in the household; petitioner as forty-four years old; petitioner as disabled; and petitioner as requesting past medical bills to be paid.

6. On October 21, 2013, the petitioner submitted another application for Family-Related Medicaid benefits.

7. On October 22, 2013, the respondent mailed petitioner a Notice of Case Action indicating petitioner's Medicaid application dated October 21, 2013 was denied as "You or a member (s) of your household do not meet the disability requirement. No household members are eligible for this program".

8. On November 26, 2013, the respondent submitted the Disability Determination and Transmittal form and a packet of medical information to DDD to determine if petitioner met the criteria to be considered disabled.

9. On December 19, 2013, the respondent updated the Florida computer system so DDD could input its information.

10. On January 7, 2014, the respondent resubmitted the Disability Determination and Transmittal form (Respondent's Exhibit 14) and a packet of medical information to DDD to determine if petitioner met the criteria to be considered disabled.

11. On January 10, 2014, DDD determined petitioner not disabled using the denial code N37. The Disability Determination and Transmittal form had "Hankerson N37 7/13" handwritten on it. The document also listed petitioner's primary diagnosis as [REDACTED]. The SSI-Related Medicaid date of application utilized for this DDD denial was October 21, 2013.

12. On January 14, 2014, the respondent denied petitioner's application for SSI-Related Medicaid benefits as DDD determined petitioner not disabled. DDD denied the petitioner's SSI-Related Medicaid application using the denial code N37.

13. On January 15, 2014, the respondent mailed petitioner a Notice of Case Action indicating petitioner's Medicaid application dated October 21, 2013 was denied as "You or a member (s) of your household do not meet the disability requirement. No household members are eligible for this program".

14. Petitioner passed away on January 25, 2014.

15. On January 27, 2014, the petitioner's representative submitted an application for Family-Related Medicaid benefits. The application listed petitioner as the only individual in the household; petitioner as forty-four years old; petitioner as disabled; petitioner as applying for SSA benefits on October 18, 2013; and petitioner as requesting past medical bills to be paid.

16. On January 29, 2014, the respondent denied petitioner's January 27, 2014 Medicaid application as on January 10, 2014, DDD determined petitioner not to be

disabled. DDD denied the petitioner's SSI-Related Medicaid application using the denial code N37.

17. On January 30, 2014, the respondent mailed petitioner a Notice of Case Action indicating petitioner's Medicaid application dated January 27, 2014 was denied as "You or a member (s) of your household do not meet the disability requirement. No household members are eligible for this program".

18. On February 17, 2015, the petitioner's representative submitted an application for Family-Related and SSI-Related Medicaid benefits. The application listed petitioner as deceased; and as petitioner requesting retroactive posthumous Medicaid for the month of October 2013.

19. On February 20, 2015, the respondent resubmitted the Disability Determination and Transmittal form and a packet of medical information to DDD to determine if petitioner met the criteria to be considered disabled.

20. On February 26, 2015, DDD determined petitioner's onset date of disability as January 11, 2014 because petitioner passed away on January 25, 2014. Petitioner's Medicaid benefits began January 11, 2014. DDD determined petitioner not disabled in October 2013 as she was not eligible for Medicaid benefits prior to January 2014 because SSA denied her reapplication for benefits on or about January 10, 2014.

21. On March 3, 2015, the respondent approved petitioner's Medicaid benefits for January 2014.

22. Respondent did not submit a Notice of Case Action regarding the approval of petitioner's Medicaid benefits for January 2014 and denial of her Medicaid benefits for the month of October 2013.

23. On March 17, 2016, the petitioner appealed the respondent's February 26, 2015 action to deny Medicaid benefits for petitioner for the month of October 2013.

**CONCLUSIONS OF LAW**

24. 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.

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

26. Prior to addressing the merits of the appeal, the undersigned has to determine if petitioner timely requested her appeal. The Fla. Admin. Code R. 65-2.046, Time Limits in Which to Request a Hearing, states in 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:

...

(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

27. The Department's Program Policy Manual, CFOP 165-22, passage 0440.0603

Time Limits to Request Hearing (MSSI, SFP) 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.

28. Pursuant to the above authorities, an individual must file a request for an appeal within 90 calendar days of the date of the written notification of an action other than an application decision or a decision to reduce or terminate program benefits. Petitioner is appealing the respondent's denial of her request for Medicaid benefits for the month of October 2013. On February 26, 2015, DDD determined petitioner disabled effective January 2014. DDD also determined petitioner not disabled for the month of October 2013 as her disability onset date was January 11, 2014. Respondent approved petitioner's Medicaid benefits effective January 2014 on March 3, 2015.

29. Respondent did not send a Notice of Case Action to the petitioner or her representative regarding its denial of petitioner's request for Medicaid benefits for the month of October 2013. Since the respondent did not provide proper notification, petitioner meets an exception to the ninety day rule; therefore, the undersigned will address the merits of the appeal regarding the respondent's denial of petitioner's Medicaid benefits for October 2013.

30. 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...

31. 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. Since petitioner does not have a minor child under age 18 living in the household, she does not meet the technical requirement to be eligible for Family-Related Medicaid benefits.

32. 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 Medicaid 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. 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 (see § 416.960(b)) or any other substantial gainful work that exists in the national economy.

33. Pursuant to the above authority, to be eligible for SSI-Related Medicaid benefits, petitioner must be determined disabled as she is under the age of 65 and has not been deemed disabled by SSA.

34. 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.

....

(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—

(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...

35. Petitioner first applied for SSI benefits on April 18, 2013 and was denied SSI benefits on July 19, 2013 pursuant to code N37. Petitioner never appealed this SSI denial with SSA. On or about October 18, 2013, the petitioner reapplied for SSI and SSA denied her reapplication for SSI benefits on or about January 10, 2014.

36. On February 26, 2015, DDD determined petitioner disabled for only the month of January 2014. DDD determined petitioner not disabled for October 2013 by adopting SSA's January 10, 2014 (approximate date) denial of petitioner's October 18, 2013 (approximate date) SSI application. DDD determined petitioner's disability onset date as January 11, 2014 because she passed away on January 25, 2014.

37. Pursuant to the above authority, an independent disability determination must be made by a State Agency if petitioner's condition has changed (she passed away on

January 25, 2014) less than twelve months after her most recent SSI denial (on or about January 10, 2014). Petitioner needs just to allege and not prove (1) her medical condition has changed since the last SSI denial; and (2) the date of the last SSI denial.

38. Furthermore, petitioner must allege a new period of disability, which meets the disability durational requirements as found in Sec. 1614(a)(1)(3)(A) of the Social Security Act (42 U.S.C. § 1382c). Petitioner's new medical condition must either result in her death or last more than twelve months. Petitioner's medical condition resulted in her January 25, 2014 death. Again, petitioner needs just to allege and not prove.

39. Lastly, SSA will not reconsider or reopen petitioner's disability decision as she has passed away.

40. Therefore, the respondent was incorrect to adopt SSA's denial decision for the requested retroactive Medicaid month of October 2013 as DDD must complete an independent disability determination on petitioner for the aforementioned month.

41. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner has met her burden of proof to indicate the respondent incorrectly denied her request for retroactive SSI-Related Medicaid benefits for the month of October 2013.

42. Therefore, the undersigned remands the case to the respondent for further development. Respondent is hereby ordered to complete an independent disability review on petitioner for October 2013 in accordance with the controlling legal authorities. Respondent is to issue a Notice of Case Action 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 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 18 day of July, 2016,

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

Jul 11, 2016

Office of Appeal Hearings  
Dept. of Children and FamiliesSTATE OF FLORIDA  
DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-02792

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION  
CIRCUIT: 09 OSCEOLA  
UNIT: AHCARESPONDENT.  

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**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 26, 2016 at 1:00 p.m.

**APPEARANCES**

For the Petitioner:



For the Respondent:

Cindy Henline, Medical Health Care Program Analyst  
Agency for Health Care Administration (AHCA)**STATEMENT OF ISSUE**

At issue is whether the respondent's denial of the petitioner's request for bilateral radio frequency ablation was correct. The petitioner bears 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.

Appearing as a witness for the petitioner was [REDACTED], a medical assistant at her physician's office.

Appearing as witnesses for the respondent were Carlene Brock, Quality Operations Nurse, and Dr. Mary Jones, Medical Director, from Amerigroup, which is the petitioner's managed health care plan.

Respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Composite Exhibit 1: authorization request, medical records, notices of action, and medical review criteria.

### **FINDINGS OF FACT**

1. The petitioner is a forty-two (42) 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 Amerigroup.
2. On or about March 9, 2016, the petitioner's treating physician (hereafter referred to as "the provider"), requested prior authorization from Amerigroup for [REDACTED]. On March 15, 2016, Amerigroup requested additional information from the provider concerning the intended procedure. Amerigroup then denied the requested procedure on March 25, 2016 due to lack of information.
3. The petitioner initiated an internal grievance/appeal with Amerigroup concerning the denial. Amerigroup denied the internal grievance/appeal on March 31, 2016. That denial notice contained the following reason for the denial:



4. The petitioner stated she suffers from [REDACTED] and she believes the requested procedure will allow her to have a better quality of life.

5. The petitioner's witness stated that the requested procedure would relieve the petitioner's [REDACTED] for 6-12 months.

6. The respondent's witness, Dr. Jones, testified that the requested procedure was denied because it would be performed on the [REDACTED] [REDACTED] [REDACTED], and this is not a covered benefit. She stated the procedure would be covered if it was for the neck area of the spine or the lower spine.

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.

**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, 7<sup>th</sup> 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 referred to above is incorporated by reference in Fla. Admin. Code R. 59G-4.001.

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. Although the denial notice from Amerigroup indicated that the procedure was denied due to medical necessity considerations, the testimony from the Amerigroup representatives at the hearing indicated that this procedure is not a covered benefit for the thoracic area of the spine. The procedure would be covered if it was to be performed on the lumbar or cervical area of the spine. Although this was not fully explained at the hearing, the medical review criteria included in the respondent's evidence packet contains references to this procedure being considered investigational and not medically necessary for the thoracic spine.

16. The petitioner has not established by a preponderance of the evidence that the requested procedure should have been approved by Amerigroup. The testimony at the hearing established that this procedure is not a covered benefit under the Amerigroup health plan provisions. Accordingly, the hearing officer cannot make a determination that this procedure must be approved by the health 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

FINAL ORDER (Cont.)

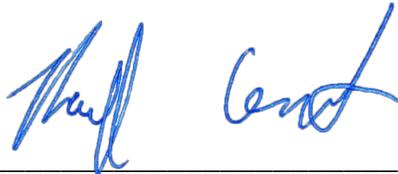
16F-02792

PAGE - 6

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 July, 2016,

in Tallahassee, Florida.



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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

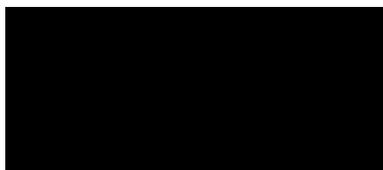
Copies Furnished To: [REDACTED] PETITIONER  
AGENCY FOR HEALTH CARE ADMINISTRATION, MEDICAID  
FAIR HEARINGS UNIT

**FILED**

Aug 09, 2016

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

Office of Appeal Hearings  
Dept. of Children and Families



APPEAL NO. 16F-02793

PETITIONER,

Vs.

AGENCY FOR HEALTH  
CARE ADMINISTRATION  
CIRCUIT: 07 Volusia  
UNIT: AHCA

And

UNITED HEALTHCARE

RESPONDENTS.

---

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on August 8, 2016 at 1:18 p.m.

**APPEARANCES**

For the Petitioner: 

For the Respondent: Dr. Sloan Karver, Long Term Care Program medical director

**STATEMENT OF ISSUE**

At issue is the respondent's decision partially denying the petitioner's request for additional home health services through Medicaid.

### **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 or respondent) is the contracted health care organization in the instant case.

By notice dated March 7, 2016, United informed the petitioner that his request for additional home health hours through Medicaid was partially denied.

The petitioner requested a hearing on April 12, 2016 to challenge the partial denial decision.

██████████, petitioner's wife, was present as a witness on his behalf.

Present as a respondent witness from United: Susan Frishman, senior compliance analyst. Present as an observer from AHCA: Sheila Broderick, registered nurse specialist.

### **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. At the time of the hearing request in March 2016, the petitioner was a Florida Medicaid recipient. The petitioner was enrolled with United's Long Term Care Program (LTCP). The LTCP provides home health services to individuals who would otherwise require nursing home placement.

2. In March 2016, the petitioner requested that the level of home health hours be increased from approximately 40 hours weekly to 124 hours weekly. The respondent increased the number of hours to 54 weekly.

3. The petitioner requested a hearing on April 12, 2016, seeking 124 hours weekly.

4. The petitioner's Medicaid coverage was terminated by the Department of Children and Families (also known as DCF, the government agency that determines eligibility for participation in the Medicaid Program) in May 2016, the month after he filed the hearing request. DCF determined that the petitioner was no longer eligible for full coverage Medicaid due to income in excess of program limits and enrolled him in the Medically Needy Program with a share of cost. Individuals enrolled in the Medically Needy Program are not eligible for Medicaid until they meet their share of cost (deductible) each month.

5. The petitioner was dis-enrolled from United LTCP and his home health services terminated because he is no longer Medicaid eligible. United argues that the issue under appeal is now moot because the petitioner is no longer a program participant.

6. The petitioner is communicating with DCF in the hopes that his full coverage Medicaid (and LTCP enrollment with United) will be reinstated. However, as of the date of the hearing, he was still enrolled in the Medically Needy Program with a share of cost.

### **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 Section 120.80, Florida Statutes.

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

9. Fla. Admin. Code § 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. **The program does not cover...long-term care services.** (emphasis added)

10. The above authority explains that the Medically Needy Program is for individuals or couples who do not qualify for full Medicaid due to the level of their income or resources. In addition, the authority explains the long term service care services are not covered by the Medically Needy Program.

11. The respondent partially denied the petitioner's request to increase the home health hours he received through Medicaid's LTCP in March 2016. The petitioner lost Medicaid and LTCP coverage in May 2016 due the level of his income; as a result, his home health care services were terminated. The petitioner is now enrolled in the Medically Needy Program which does not cover long term care services.

12. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the issue under appeal, the level of home health care the petitioner is eligible to receive through Medicaid's LTCP, is now moot because he is no longer a program participant.

**DECISION**

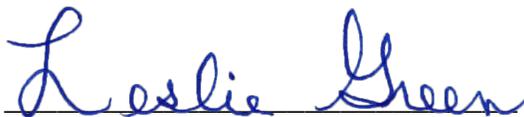
The appeal is dismissed as moot.

**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 August, 2016,

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  
AHCA, Medicaid Fair Hearings Unit

Jul 13, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 16F-02809

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 07 Volusia  
UNIT: 88328

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 26, 2016 at 1:34 p.m.

**APPEARANCES**

For the Petitioner: [REDACTED].

For the Respondent: Matthew Lynn, Economic Self-Sufficiency Specialist II with the Department of Children and Families (DCF).

**ISSUE**

At issue is the Department's action to not approve the petitioner for Institutional Care Program (ICP) for the month of March 2016.

The petitioner holds the burden of proof by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

Evidence was received and entered as the Petitioner's Exhibit 1 and the Respondent's Exhibits 1 through 2.

The record was held open until 5:00 p.m. on May 31, 2016 to allow the respondent to submit additional evidence. Evidence was received and entered as the Respondent's Exhibit 3 through 4.

The record was closed as of 5:00 p.m. on May 31, 2016.

### **FINDINGS OF FACT**

1. The petitioner (age 76) is currently residing in the [REDACTED]. The petitioner's daughter submitted an application for ICP Medicaid on January 17, 2016. On January 29, 2016, the petitioner's daughter contends that she received a Notice of Case Action requesting the financial release and power of attorney documents.

2. The Department's evidence does not include copy of the Notice of Case Action that was sent to the petitioner's daughter to request verifications. The Respondent's Exhibit 2 includes the Running Record Comments (CLRC) dated January 28, 2016. The CLRC includes a list of the additional verifications needed in the petitioner's case and states:

Additional Comments: Level of Care. Proof (Not Bank Statements) of Gross Monthly Income (SSA, Private Pensions, Interest, VA, Civil Svc., Railroad, Annuities, etc) before deductions. Current bank statement and investment accounts with all pages (checking, savings, stocks, bonds, cds, interest earned, etc.) owned alone or with someone else. Documentation of all real estate, trusts, funeral/burial, vehicles, cemetery

lots, personal care contracts, etc, you own in whole or in part. Copies of all life insurance policies you own. Provide proof of face and actual cash value of policy (ies). Signed Form 2613-Financial Information Release.

3. The petitioner's daughter contends that she was notified on February 22, 2016 that petitioner's application for ICP Medicaid was denied but the Medically Needy program was approved.

4. The petitioner's daughter contends that she contacted DCF on March 2, 2016 to inquire as to the reason for the denial of ICP Medicaid and was informed that she needed to provide three months' worth of bank statements. The petitioner's daughter was under the impression that she only needed three months' worth of bank statements if she were asking for retroactive Medicaid coverage. The Respondent's Exhibit 2, page 43, includes CLRC dated February 8, 2016, which states "BS-only turned in 1 mth worth, we need 3 mths."

5. The petitioner's daughter contends that she submitted the petitioner's bank statements on March 3, 2016 and March 7, 2016. The petitioner's daughter argues that she did not get a response from DCF regarding the status of the verifications submitted. The petitioner's daughter contends that she contacted DCF on March 30, 2016 and was informed that her verifications were not processed. The petitioner's daughter explained that the DCF case worker processed the verifications on March 30, 2016. The petitioner's daughter contends that the DCF caseworker contacted her at 4:00 p.m. on March 30, 2016 and informed her that the petitioner's bank account balance was over the asset limit.

6. The petitioner's daughter contends that she contacted the bank on March 31, 2016 and liquidated the investment bank account on Saturday, April 2, 2016 in the form of a cashier's check. The petitioner's daughter contends that the account had a balance of almost \$10000. The petitioner's daughter contends that she took the cashier's check to the nursing home on April 4, 2016 to pay on the petitioner's \$25000 balance owed to the facility. The petitioner's daughter contends that she faxed the verification on Tuesday, April 5, 2016 to inform DCF that the balance of the account was \$0.

7. The petitioner's daughter believes the Department should grant the petitioner a hardship because it delayed in informing her that the bank account balance was over the asset limit. The petitioner's daughter believes that the petitioner would have been eligible for the month of March 2016 if the Department had not delayed in reviewing the bank statements after she submitted the statements; it only took her a few days to liquidate the account after being informed that her mother was over the asset limit.

8. The Department contends that the petitioner's application for ICP Medicaid that was submitted in January 2016 was denied for failure to provide bank statements, not for exceeding the asset limit. The Department contends that it is the responsibility of the designated representative for being knowledgeable of the financial institutions owned by the person for whom he or she is applying for benefits. The Department may assist in obtaining verifications but the designated representative is ultimately responsible for obtaining verifications. The Department explained that the DCF case worker is not allowed to inform an applicant as to how to spend down assets to become eligible for its programs.

9. The petitioner's daughter contends that she was not asking for guidance as to how to spend down the bank account but believes she should have been informed earlier that the petitioner's bank account caused the petitioner to be ineligible for ICP Medicaid. The petitioner's daughter does not understand why the petitioner was approved for the MN program but not ICP Medicaid when she had this bank account at that time.

10. The Department believes the petitioner's application for the Medically Needy (MN) program was approved with the bank account in question because the asset limit is higher for that program and provided no other explanation. The Department explained that the asset limit is \$2000; however, individuals whose income is under the MEDS-AD income limit of \$872 would qualify for the higher asset limit of \$5000. The Department explained that the petitioner would be eligible for the higher asset limit since her income is under the MEDS-AD income limit. The Department explained that the petitioner is eligible for ICP Medicaid beginning April 1, 2016 because the bank account that put her over the asset limit was not spent down until April 2, 2016. The Department explained that the balance on the investment account would still exceed the \$5000 asset limit if it were to include the \$2500 burial exclusion.

#### **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 Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

13. Federal Regulations at 20 CFR §416.1201 Resources; general states:

(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).

...

(b) *Liquid resources.* Liquid resources are cash or other property which can be converted to cash within 20 days, excluding certain nonwork days as explained in §416.120(d). Examples of resources that are ordinarily liquid are stocks, bonds, mutual fund shares, promissory notes, mortgages, life insurance policies, financial institution accounts (including savings, checking, and time deposits, also known as certificates of deposit) and similar items...

14. The Fla. Admin. Code R. 65A-1.712, SSI-Related Medicaid Resource Eligibility Criteria, states: “

(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...”

(2) Exclusions...

(d) The individual, and their spouse, may designate up to \$2,500 each of their resources for burial funds for any month, including the three months prior to the month of application. The designated funds may be excluded regardless of whether the exclusion is needed to allow eligibility. The \$2,500 is not reduced by the value of excluded life insurance policies or irrevocable burial contracts. The funds may be commingled in the retroactive period.

15. 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.

16. The Department’s Program Policy Manual (Policy Manual), CFOP 165-22, passage 1640.0205 Asset Limits (MSSI, SFP) states in relevant part:

Total countable assets for an individual or a couple must not exceed the following limits:

1. For MEDS-AD and Medically Needy, the asset limit is \$5,000 for an individual and \$6,000 for a couple.

...

3. For ICP, PACE, all HCBS Waivers and Hospice, the asset limit is \$2,000 for an individual (\$3,000 for eligible couple) or \$5,000 if the individual’s income is within the MEDS-AD limit (\$6,000 for eligible couple).

17. The Policy Manual, Appendix A-9, effective April 2016, lists the MEDS-AD income limit for an individual as \$872.

18. The above authorities explain that an asset is cash, a liquid asset, real, or personal property owned by an individual that can be converted to cash. An example of a liquid asset is property that can be converted to cash within 20 days, such as a financial institution account.

19. The asset limit is \$5000 for individuals whose income is under the MEDS-AD income limit. The findings show that the petitioner owned an investment account with a financial institution and her income is under the MEDS-AD income limit. Therefore, the undersigned concludes that the Department was correct to include as a liquid asset, the petitioner’s investment account with a financial institution. The undersigned concludes that the petitioner qualifies for the \$5000 asset limit.

20. The asset limit is the same for the MN and ICP programs according to the above authorities. The petitioner's daughter questioned how the petitioner was approved for the MN program but not the ICP Medicaid in February 2016 since the investment account was available at that time. The Department was unable to explain the reason for approval of the MN program in the month of February 2016. The undersigned concludes that the investment account exceeded the asset limit for the MN program for the month at issue. Therefore, the undersigned is unable to find a more favorable outcome for the petitioner in this case.

21. The findings show that the petitioner had an investment account with a financial institution with a balance of \$9899.57, which was not spent down to under the asset limit for an individual until April 2, 2016. The petitioner's daughter argues that the petitioner should be granted a hardship due to the Department's delay in informing her that the investment account was over the asset limit. The petitioner's daughter's arguments and situation is recognized; however, the petitioner's investment account was over the asset limit for the month of March 2016. Therefore, the undersigned concludes the Department was correct to deem petitioner ineligible for ICP Medicaid for March 2016. Even with the \$2500 burial fund exclusion, petitioner would still exceed her \$5000 asset limit for ICP Medicaid during the time period at issue.

### **DECISION**

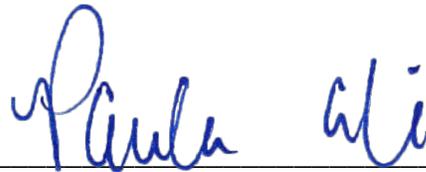
Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is denied.

**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 13 day of July, 2016,

in Tallahassee, Florida.



Paula Ali  
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

**FILED**

Jul 27, 2016

Office of Appeal Hearings  
Dept. of Children and Families



APPEAL NO. 16F-02829

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 05 Hernando  
UNIT: 883DT

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 10:40 a.m. on May 25, 2016.

**APPEARANCES**

For the Petitioner:



For the Respondent:

Sylma Dekony, ACCESS  
Economic Self-Sufficiency Specialist II

**STATEMENT OF ISSUE**

At issue is whether the respondent's action to terminate petitioner's full Medicaid and instead approve Medicaid Medically Needy (MN) with a Share of Cost (SOC) is proper. The respondent carries the burden of proof by a preponderance of the evidence.

**PRELIMINARY STATEMENT**

By notice dated February 5, 2016, the respondent (or the Department) notified the petitioner Medicaid benefits would end on February 29, 2016. Also by notice, dated

March 28, 2016, the Department notified the petitioner her March 10, 2016 application was approved for MN with a \$2,282 SOC, effective March 2016. Petitioner timely requested a hearing to challenge the termination of Medicaid and approval of MN with a SOC.

Petitioner did not submit exhibits. Respondent submitted seven exhibits, entered as Respondent Exhibits "1" through "7". The record was closed on May 25, 2016.

### **FINDINGS OF FACT**

1. Prior to the action under appeal, petitioner received full Medicaid through the Social Security Administration (SSA), due to receiving Supplemental Security Income (SSI).
2. In 2014, the SSA changed the petitioner's SSI to \$693 Social Security Disability Income (SSDI). As a result, the petitioner's full Medicaid through the SSA ended. The Department was unaware that the petitioner's husband received income from the SSA. Therefore, the Department authorized petitioner full Medicaid (MMS) in February 2015.
3. On December 23, 2015, the Department mailed petitioner a Notice of Eligibility Review, which states in part: "To continue your current benefits, you must complete a review to find out if you are still eligible. One option is for you or your representative to complete and return the enclosed form to the above address by January 4, 2016. Another option to find out if you are still eligible is to complete your review on our web site..."
4. On March 10, 2016, the petitioner, age 63, submitted an Interim Contact application for Medicaid for herself. The application lists income from Social Security for petitioner and her husband; \$693 for petitioner and \$1,929 for her husband.

5. For petitioner to be eligible for full Medicaid, her income cannot exceed the \$1,175 SSI-Related Medicaid income limit for a couple. Petitioner's \$2,622 household income (her and her husband) exceeds \$1,175. The next available Medicaid is MN with a SOC.

6. The Department calculated petitioner's SOC as follows:

\$1,929.00	petitioner's husband's SSDI
+\$ 693.00	petitioner's SSDI
<hr/>	
\$2,622.00	total household income
-\$ 20.00	unearned income disregard
-\$ 241.00	MN income level (MNIL) for a household size of two
-\$ 78.20	husband's Medicare premium (cents dropped)
<hr/>	
\$2,282.00	SOC

7. On March 28, 2016, the Department mailed the petitioner a Notice of Case Action, notifying her March 10, 2016 application was approved for MN with a \$2,282 SOC, effective March 2016.

8. Petitioner disagrees that the Department did not include her other medical expenses in the SOC determination.

9. Respondent's representative explained petitioner's other medical expenses are only deductible in the Food Assistance determination.

10. Petitioner also disagrees that the Department has her listed in Hernando County, because she resides in ██████ County.

11. Respondent's representative explained that the County petitioner resides in does not affect her Medicaid eligibility.

#### **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

§ 409.285, Fla. Stat. 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 Fla. Admin. Code R. 65-2.056.

14. Fla. Admin. Code R. 65A-1.701, Definitions, in part 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...

15. The Department's Program Policy Manual, CFOP 165-22, Appendix A-9, sets forth 88 percent of the federal poverty level (FPL) for a household size of two at \$1,175.

16. In accordance with the above authority, petitioner's income cannot exceed \$1,175 (88% of the FPL). Petitioner's \$2,622 household income exceeds \$1,175. Therefore, petitioner is not eligible for full Medicaid.

17. 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:

...

(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.

18. The above authority explains MN provides coverage for individuals who do not qualify for full Medicaid due to income.

19. Federal Regulation at 20 C.F.R. § 416.1124 explains 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...”

20. The Fla. Admin. Code R. 65A-1.716 sets forth the MNIL at \$241 for a family size of two.

21. Federal Regulation at 42 C.F.R. § 436.831 explains allowable deductions in the Medically Needy Program and in part states:

(d) Deduction of incurred medical expenses. If countable income exceeds the income standard, the agency must deduct from income medical expenses incurred by the individual or family or financially responsible relatives that are not subject to payment by a third party. An expense is incurred on the date liability for the expense arises. The agency must determine deductible incurred expenses in accordance with paragraphs (e), (f) and (g) of this section and deduct those expenses in accordance with paragraph (h) of this section.

(e) Determination of deductible incurred expenses: Required deductions based on kinds of services. Subject to the provisions of paragraph (g) of this section, in determining incurred medical expenses to be deducted from income, the agency must include the following:

(1) Expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges, including enrollment fees, copayments, or deductibles imposed under §447.52, §447.53, or §447.54 of this chapter;

(2) Expenses incurred by the individual or family or financially responsible relatives for necessary medical and remedial services that are recognized under State law but not included in the plan;

(3) Expenses incurred by the individual or family or by financially responsible relatives for necessary medical and remedial services that are included in the plan, including those that exceed agency limitations on amount, duration or scope of services...

(g) Determination of deductible incurred medical expenses: Optional deductions. In determining incurred medical expenses to be deducted from income, the agency—

(1) May include medical institutional expenses (other than expenses in acute care facilities) projected to the end of the budget period at the Medicaid reimbursement rate;

(2) May, to the extent determined by the agency and specified in its approved plan, include expenses incurred earlier than the third month before the month of application; and

(3) May set reasonable limits on the amount to be deducted for expenses specified in paragraphs (e)(1), (e)(2), and (g)(2) of this section.

22. Petitioner argued that her other medical expenses (doctor visits, medical prescriptions and eyeglasses) were not included in the SOC determination.

23. In accordance with the above Federal Regulation, petitioner's doctor visits (every three or four months), medical prescriptions and eyeglasses are not acceptable medical deductions in determining the MN SOC amount. Petitioner's husband's Medicare premium is the only expense allowable.

24. In accordance Fla. Admin. Code R. 65A-1.713 (#17), petitioner's doctor visits, medical prescriptions and eye glasses, may be considered in petitioner's monthly SOC eligibility determination.

25. In accordance with the above authorities, the Department deducted \$20 unearned income (#19), \$241 MNIL (#20) and petitioner's husband's \$78 Medicare premium (#21) from petitioner's \$2,622 household income to arrive at a \$2,282 SOC.

26. In careful review of the cited authorities and evidence, the undersigned concludes the respondent met its burden of proof. The Department's action to approve petitioner in the MN Program with a \$2,282 SOC is proper.

**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 27 day of July, 2016,

in Tallahassee, Florida.



---

Priscilla Peterson  
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

Jul 12, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-02895

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION  
CIRCUIT: 18 Brevard  
UNIT: AHCA

AND

MAGELLAN COMPLETE CARE,

RESPONDENTS.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on June 9, 2016 at approximately 10:30 a.m.

**APPEARANCES**

For Petitioner:



For Respondent:

Cindy Henline  
Medical/Health Care Program Analyst  
Agency for Health Care Administration

**STATEMENT OF ISSUE**

At issue is the Co-Respondents' denial of Petitioner's request for the extraction of all four (4) wisdom teeth, along with I.V. sedation. The burden of proof is assigned to Petitioner.

### **PRELIMINARY STATEMENT**

Petitioner's mother represented her at the hearing. She gave oral testimony, but did not move any exhibits into evidence.

The following individuals were present as witnesses for Respondent:

- Michelle Riegler, Compliance Officer, Magellan Complete Care
- Dr. Susan Hudson, Dental Consultant, DentaQuest
- Jackelyn Salcedo, Complaints & Grievances Specialist, DentaQuest
- Omeshia Smith, Complaints & Grievances Specialist, DentaQuest

Respondent moved Exhibits 1 - 5 into evidence at the hearing.

### **FINDINGS OF FACT**

1. Petitioner is a 16-year-old female. Petitioner is enrolled with Magellan Complete Care ("Magellan") as her Managed Medical Assistance (MMA) plan. DentaQuest is Magellan's dental vendor.
2. On March 25, 2016, Petitioner's dentist submitted a request for extraction of all four (4) of her wisdom teeth and deep anesthesia.
3. On March 29, 2016, Magellan issued a Notice of Action ("Notice") denying the request. The Notice gives the same facts used to make the decision for each tooth, stating: "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." (Respondent's Exhibit 4). The anesthesia was automatically denied because the extractions were denied.
4. Petitioner's mother gave credible testimony throughout the hearing, stating that her daughter is unable to eat meat because of the pain caused by chewing. She said

her daughter is only able to eat soft foods, such as smoothies, scrambled eggs, protein shakes, and yogurt.

5. In the Wisdom Teeth Consult Note, Petitioner stated her chief complaint was “My teeth has been causing me pain for 3 months and the pain gets worse when I eat anything chewy.” (Respondent’s Exhibit 3). Her mother said the pain is not chronic, but primarily occurs when she eats. She said her daughter has lost four (4) pounds because she hasn’t been able to eat properly due to the pain.
6. The “History of Present Illness” section of the consult notes indicate Petitioner has pain in all of her wisdom teeth. The “Physical Examination” section states the pain is only present in her lower wisdom teeth (#’s 17 and 32), caused by the roots encroaching on the inferior alveolar nerve, which results in shooting pain bilaterally. The notes also say that all four (4) wisdom teeth have [REDACTED], which can potentially cause [REDACTED] and that it would be negligent not to remove them.
7. Dr. Hudson said there is normally discomfort when the wisdom teeth are forming and erupting into the mouth. She testified the X-ray provided does not show any pathology or infection.
8. DentaQuest’s Criteria for Dental Extractions, Respondent’s Exhibit 5, provides for when extractions may be approved in the event of pain with no pathology, stating:

On a per tooth basis, provider must furnish a narrative that describes pain that is more than normal eruption pain – for example: a description of duration, intensity, medications, or other factors that are more than normal eruption pain – the description of such factors is necessary to demonstrate need.
9. The Criteria states that extraction will likely be denied if:

b. Probable Denial

- i. Impaction or Symptomology =
  1. Impaction with no other pathology
  2. Pain or discomfort with unknown pathology
- ii. Other 3<sup>rd</sup> molars have pathology (if one, two, or three teeth show pathology, DQ will not automatically approved the extraction of the remaining non-pathologic teeth)

10. Dr. Hudson said another requirement for extraction is that the teeth must have at least half of their roots fully-formed. She said that Petitioner's upper wisdom teeth do not have any root formation and have ample room to enter the mouth. She said the lower teeth are a little tighter, but there appears to be a path for them to erupt because as the roots develop the teeth will rotate slightly. The roots of the lower teeth are a slightly less than one-third (1/3) developed.
11. Petitioner takes Advil or Tylenol for the pain. Her mother does not want her taking a narcotic due to fear of potential addiction. She is also concerned that taking Tylenol frequently could cause damage to her liver.
12. Petitioner's mother said during the hearing that the testimony given makes it sound like her daughter only needs her lower wisdom teeth removed at this time. She inquired if she would have to go through the process again in the event the upper teeth need to be extracted at a later date. Dr. Hudson said the treating dentist would have to provide a tooth-by-tooth narrative of the need for extraction, per DentaQuest's criteria.
13. Ms. Riegler said it sounds like there was insufficient information from Petitioner's dentist to assess the medical necessity of the extractions. She said Petitioner's dentist can also have a peer-to-peer discussion with DentaQuest. Ms. Riegler

provided Petitioner's mother with her phone number in order to assist her with care coordination and getting the needed information.

### **CONCLUSIONS OF LAW**

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 § 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, 7<sup>th</sup> 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. The Florida Medicaid Dental Services Coverage Policy, May 2016 ("Dental Handbook"), is promulgated into law by Chapter 59G of the Florida Administrative Code.
20. Page 4 of the Dental Handbook provides:  
  
**Surgical Procedures and Extractions**  
Florida Medicaid reimburses for surgical procedures and extraction services for recipients under the age of 21 years.

....

**Early and Periodic Screening, Diagnosis, and Treatment**

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's authorization requirements policy

21. The Dental Handbook therefore provides coverage for wisdom teeth extractions for children under age 21. The Dental Handbook requires that all procedures be medically necessary.

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 (EPSDT) requirements. Section 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. Under the above statute, the Agency offers dental services as an EPSDT service to Medicaid-eligible recipients less than 21 years of age.

25. 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 may present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)) (emphasis added).

26. 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.

27. In the instant-matter, Dr. Hudson testified, based upon the records available to her, that she did not see any evidence that the wisdom teeth need to be removed. She said discomfort due to eruption of the teeth is normal and that the teeth appear to be coming in straight. She also saw no evidence of pathology.

28. It is clear Petitioner is experiencing pain, primarily when she chews tough food. Absent pathology, DentaQuest requires a narrative explaining the cause of the pain

on a tooth-by-tooth basis, and the pain must be severe enough to exceed normal eruption.

29. In the Physical Examination section of the Wisdom Teeth Consult Note, Petitioner's dentist stated with specificity the cause of the pain in the lower wisdom teeth, and that there is shooting pain. The undersigned concludes this is a sufficient narrative showing the reason for the pain, and that it is shooting pain, rather than normal pain associated with eruption. Removal of the lower wisdom teeth (#'s 17 and 32) is medically necessary.

30. Regarding the upper wisdom teeth, removal appears to be prophylactic in nature.

The narrative indicates there is a risk of [REDACTED] or [REDACTED]. However, there is no indication that either of these conditions exist, or that the risk of problems is even high. There is no evidence any pain associated with the upper wisdom teeth is greater than what would be expected from normal eruption. Petitioner has failed meet her burden of proof to show the removal of the upper wisdom teeth is medically necessary at this time.

31. Petitioner and her mother are encouraged to work with Magellan care coordination going forward, and to closely monitor the status of her upper wisdom teeth. In the event removing them becomes medically necessary in the future, Petitioner can put in another request at that time.

### **DECISION**

Based upon the foregoing, Petitioner's appeal is PARTIALLY GRANTED and PARTIALLY DENIED. Co-Respondents are directed to provide Petitioner with extraction of her lower wisdom teeth (#'s 17 and 32), along with the deep sedation,

consistent with her request. Co-Respondents are not required to provide extraction of Petitioner's upper wisdom teeth.

**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 12 day of July, 2016,

in Tallahassee, Florida.



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Rick Zimmer  
Hearing Officer  
Building 5, Room 255  
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Tallahassee, FL 32399-0700  
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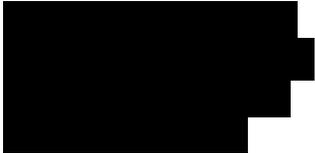
Copies Furnished [REDACTED], Petitioner  
Agency For Health Care Administration, Medicaid Fair Hearings Unit

Michelle Riegler

Jul 11, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-02910

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 May 20, 2016 at 10:00 a.m. in 

**APPEARANCES**

For the 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 action to partially deny Occupational Therapy (OT) service hours that were requested for the petitioner for the certification period March 28, 2016 through August 7, 2016, was correct. The respondent bears the burden of proof by a preponderance of the evidence regarding a decrease in service

hours and the petitioner bears the proof by a preponderance of the evidence regarding an increase in service hours.

### **PRELIMINARY STATEMENT**

The petitioner was present for the hearing and was represented by her mother. The petitioner did not submit any documents as evidence for the hearing.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Composite Exhibit 1: Statement of Matters, Clinical History Notes, Denial Notices; and Supporting Documentation (therapy reports and records).

Appearing as a witness for the respondent was Rakesh Mittal, M.D., Physician-Consultant with eQHealth Solutions, Inc.

### **FINDINGS OF FACT**

1. The petitioner's OT service provider, Orrett and Associates (hereafter referred to as "the provider"), requested the following OT service hours for the certification period at issue: 4 units (1 hour), three times per week – a total of 3 hours weekly.
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; her functional limitations; and other pertinent information related to the household.

3. eQHealth Solutions' personnel had no direct contact with the petitioner, her family, or her physicians. All pertinent information was submitted by the provider directly to eQ Health Solutions.

4. The medical information submitted by the provider contained, in part, the following information in regard to the petitioner:

- 20 years old
- Diagnosis includes [REDACTED]

5. The petitioner is also currently receiving speech therapy and physical therapy services through the Medicaid Program.

6. The petitioner was previously approved for 2 hours weekly of occupational therapy in the prior certification period.

7. 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 OT provider.

The duties include, in part, instruction/therapy in the following areas:

- ADLs (activities of daily living) and Self-Care
- Perceptual Activities
- Fine Motor and Gross Motor Activities
- Range of Motion
- Sensory Activities
- Motor Planning Activities
- Strengthening Exercises
- Sitting/Standing Balance
- Family Education

8. A physician at eQHealth Solutions, who is board-certified in pediatrics, reviewed the submitted information and partially denied the requested OT services (approving one hour weekly rather than three hours weekly). The rationale for the decision was:

“The patient has been in therapy since 2012, with modest progress, and will be transitioning out of therapy when 21 y.o.” A notice of this determination was sent to all parties on April 7, 2016.

9. 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 not requested in this case.

10. The petitioner thereafter requested a fair hearing and this proceeding followed.

11. The petitioner’s mother stated her daughter has been making progress in her therapy and she feels the therapy services should be increased to 3 hours weekly.

12. The respondent’s witness, Dr. Mittal, testified that the petitioner has been making progress while receiving therapy for 2 hours weekly, and, therefore, there was no justification for increasing services at this time. Dr. Mittal also stated it would be appropriate to approve 2 hours weekly, rather than 1 hour as stated in the eQ notice, since the petitioner was receiving 2 hours weekly in the prior certification period.

13. OT service for children (individuals under age 21) 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**

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 Fla. Stat. § 120.80.

15. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.
16. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
17. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof for any reduction in services was assigned to the respondent since the petitioner had been previously approved for 2 hours weekly of OT service and the initial notice indicated a reduction to 1 hour weekly. The burden of proof for any increase in services 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, 7<sup>th</sup> Ed.).
18. 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.
19. The petitioner has requested OT 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.
20. 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.
21. 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<sup>1</sup> 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.*

22. The service the petitioner has requested (OT 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:

*Any service under this section shall be provided only when medically necessary ...*

23. 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*

---

<sup>1</sup> "You" in this manual context refers to the state Medicaid agency.

*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.*

24. 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.*

25. Based upon the information submitted by the petitioner's provider, eQHealth Solutions completed a prior authorization review to determine medical necessity for the requested OT services.

26. In the petitioner's case, the respondent has determined that some occupational therapy service is medically necessary, but its initial determination was that 1 hour weekly is medically necessary rather than the 3 hours weekly requested by the petitioner's provider.

27. 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 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.*

28. 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.

29. OT services are described on page 1-3 of the Therapy Handbook as follows:

*Occupational therapy is the provision of services that address the developmental or functional needs of a child related to the performance of self-help skills; adaptive behavior; and sensory, motor and postural development.*

*Occupational therapy services include evaluation and treatment to prevent or correct physical and emotional deficits, minimize the disabling effect of these deficits, maintain a level of function, acquire a skill set or restore a skill set. Examples are perceptual motor activities, exercises to enhance functional performance, kinetic movement activities, guidance in the use of adaptive equipment and other techniques related to improving motor development*

30. The Therapy Handbook on page 2-2 sets forth the requirements for OT services, as follows:

*Medicaid reimburses for services that are determined medically necessary and do not duplicate another provider's service.*

31. The petitioner's physician ordered an OT 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.

32. The respondent's witness stated he believes services should be maintained at the current level of 2 hours weekly since the petitioner has been making progress in her therapy.

33. The petitioner's mother also stated her daughter has been progress in her therapy, but she believes the services should be increased to 3 hours weekly.

34. After considering all the documentary evidence and witness testimony presented, the undersigned concludes that the petitioner's OT services should remain at the current level of 2 hours weekly since she has been making progress at this level of service. The respondent has not demonstrated that the service should be reduced at this time, and the petitioner has not demonstrated that the services should be increased at this time.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is GRANTED, in part, and the petitioner shall receive two (2) hours weekly of OT services for the certification period at issue.

### **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 indigence 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.

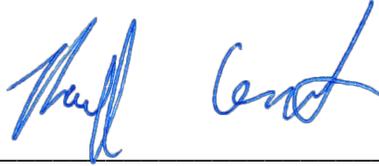
DONE and ORDERED this 11 day of July, 2016,

FINAL ORDER (Cont.)

16F-02910

PAGE - 11

in Tallahassee, Florida.

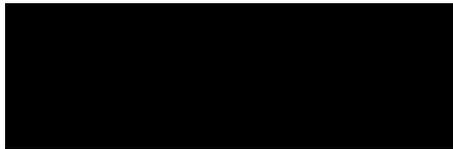


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Hearing Officer  
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Copies Furnished To: [REDACTED], PETITIONER  
AGENCY FOR HEALTH CARE ADMINISTRATION, MEDICAID  
FAIR HEARINGS UNIT

Aug 26, 2016

Office of Appeal Hearings  
Dept. of Children and FamiliesSTATE OF FLORIDA  
DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-02941

PETITIONER,

Vs.

CASE NO. FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 17 Broward  
UNIT: 88071RESPONDENT.  

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**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on May 12, 2016 at approximately 11:42 a.m. CDT. The hearing was reconvened on June 10, 2016 at approximately 8:32 a.m. CDT.

**APPEARANCES**For the Petitioner: 

For the Respondent: Belinda Lindsey, economic self-sufficiency specialist supervisor

**STATEMENT OF ISSUE**

Petitioner is appealing the respondent's action of May 5, 2016 denying Family-Related Medicaid benefits for her son and enrolling him in the Medically Needy Program (MN) with a Share of Cost (SOC). As this action is the result of processing a change, the respondent carries the burden of proof by the preponderance of evidence.

### **PRELIMINARY STATEMENT**

The same parties mentioned above appeared at both hearings.

The petitioner submitted documents into evidence, which were marked as Petitioner's Exhibits "1" through "7".

The respondent submitted documents that were admitted into evidence and marked as Respondent's Exhibits "1" through "16".

### **FINDINGS OF FACT**

1. Petitioner's son, born February 15, 2009, was terminated from Supplemental Security Income effective August 2015.
2. The respondent was notified of this change by an automated data match on May 13, 2015 and again on May 29, 2015. This data match, "data exchange," was reviewed by the respondent on October 14, 2015; however there was no action taken.
3. After the respondent received the request for this Administrative Hearing, the case was reopened and eligibility reviewed. The result of this review, which is identified as an *ex parte* (a redetermination made after the termination of Medicaid eligibility), was to enroll him in the MN program with a SOC of \$4,285 effective September 2015 through February 2016. The petitioner was informed of this by a Notice of Case Action (NOCA) dated May 5, 2016.
4. The petitioner is seeking Medicaid benefits for the months of September 2015 through February 2016. Effective March 2016, the child is determined eligible for a Medicaid Waiver.

### 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 Section 409.285, Florida Statutes.
6. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.
7. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.
8. The Fla. Admin. Code R. 65A-1.702 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. [emphasis added]
9. The above policies show that an individual who loses his/her full Medicaid eligibility, must have an *Ex Parte* determination to determine if the individual is eligible for Medicaid in another coverage group. It also states that Medicaid eligibility should continue until the *Ex Parte* process is completed.
10. In this instant case, the Medicaid eligibility of the child was terminated effective

August 2015. The related *Ex Parte* did not take place until May 2016. According to the above authority, the child's Medicaid eligibility should have continued from September 2015 until the redetermination, *Ex Parte* process, was completed.

11. The undersigned concludes that Medicaid eligibility for the child in question was terminated in error as it should have continued from September 2015 until the *Ex Parte* process was completed.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted and the case is remanded back to the respondent to have Medicaid eligibility established for the child in question for the months of September 2015 through February 2016, inclusive.

### **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.

FINAL ORDER (Cont.)  
16F-02941  
PAGE -5

DONE and ORDERED this 26 day of August, 2016,  
in Tallahassee, Florida.



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Gregory Watson  
Hearing Officer  
Building 5, Room 255  
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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

**FILED**

Aug 31, 2016

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

Office of Appeal Hearings  
Dept. of Children and Families



APPEAL NO. 16F-03019

PETITIONER,

Vs.

CASE NO.



FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 01 Escambia  
UNIT: 88630

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on July 18, 2016 at 9:34 a.m.

**APPEARANCES**

For the Petitioner:



For the Respondent:

Sonya Greene, ACCESS Supervisor

**STATEMENT OF ISSUE**

Petitioner is appealing the Department's action of April 6, 2016 enrolling him in Adult-Related Medically Needy and denying Adult-Related Medicaid for his wife. The petitioner carries the burden of proof by the preponderance of evidence.

**PRELIMINARY STATEMENT**

The petitioner did not appear for the hearing scheduled for June 22, 2016. The petitioner called to have the hearing rescheduled. Hearing was set for July 18, 2016 and convened that date.

The Department submitted evidence on June 2, 2016. This was entered as Respondent's Exhibit 1. The record was held open through July 22, 2016 for additional information from the Department. The Department submitted additional information on July 19, 2016.

The record closed on July 22, 2016.

### **FINDINGS OF FACT**

1. The petitioner filed an application for Medicaid for himself (age 59) and his wife (age 61) on April 4, 2016.

2. The petitioner is established as disabled by Social Security. He receives Social Security Disability in the amount of \$1,016 per month. This is the only income received in the household. He also receives Medicare.

3. The petitioner's wife is not established as disabled by Social Security.

4. The Department explained a person must be age 65 or disabled to qualify for Medicaid under the Adult-Related Medicaid program.

5. The petitioner's wife was denied disability by Social Security on January 6, 2016. The petitioner confirmed the decision has been appealed. They are awaiting a court date at this time.

6. The Department adopted the Social Security decision made within the last 12 months. The Department reported the denial by Social Security was for reason N31 "Non-pay= Capacity for substantial gainful activity – customary past work, no visual impairment."

7. The Department explained for an individual to receive full Medicaid, the income must be under \$872. The Department did not approve the petitioner to receive

full Medicaid as his income of \$1,016 less the \$20 unearned income disregard (\$1,016 - \$20 = \$996) exceeds the income limit.

8. The Department calculated the petitioner's eligibility for Medically Needy Share of Cost by counting the petitioner's gross income of \$1,016 less the \$20 unearned income disregard and \$180 Medically Needy Income Level (\$1,016 - \$20 - \$241 = \$755). The Department enrolled the petitioner in Medically Needy Share of Cost in the amount of \$755.

9. The Department issued a Notice of Case Action on April 6, 2016 enrolling the petitioner in Medically Needy with a Share of Cost of \$755 and denying the petitioner's wife Medicaid due to not meeting the disability requirement.

10. The petitioner explained his wife has end stage liver disease and the next step for her is a transplant. She also has [REDACTED] and [REDACTED]

11. The petitioner notified Social Security of all conditions. He reports no new conditions for his wife.

12. The petitioner explained they lack sufficient income. Her medical bills and prescription costs are exceeding what they are able to afford on their own.

#### **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 Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

15. The findings show the petitioner is 59 years old and his wife is 61 years old. They have no minor children in the home. Fla. Admin. Code R. 65A-1.705, Family-Related Medicaid General Eligibility Criteria, sets forth the rules to be eligible under the Family-Related Medicaid groups. The undersigned concludes the petitioner wife does not meet the criteria to be eligible for Medicaid under the Family-Related Medicaid Program. The undersigned further concludes the Department correctly began to review the petitioner's case for potential eligibility under the Adult-Related Medicaid Program rules.

16. The definition of MEDS-AD Demonstration Waiver is found in Fla. Admin. Code R. 65A-1.701 "Definitions":

(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.  
(emphasis added)

17. Fla. Admin. Code R. 65A-1.711 "SSI-Related Medicaid Non-Financial Eligibility Criteria" states in relevant part:

To qualify for Medicaid an individual must meet the general and categorical requirements in 42 C.F.R. Part 435, subparts E and F (2007) (incorporated by reference), with the exception that individuals who are neither aged nor disabled may qualify for breast and cervical cancer treatment, and the following program specific requirements as appropriate. Individuals who are in Florida temporarily may be considered residents of the state on a case-by-case basis, if they indicate an intent to reside in Florida and can verify that they are residing in Florida.

(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 (2007) (incorporated by reference).

18. 20 C.F.R. § 416.905 “Basic definition of disability for adults” states in relevant 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.

19. Federal Medicaid Regulations 42 C.F.R. § 435.541 “Determinations of disability” states in relevant 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 §435.912 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—

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

...

(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.

20. Federal Regulations at 20 C.F.R. § 416.1121 “Types of unearned income” states in relevant part: “(a) Annuities, pensions, and other periodic payments. This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veterans benefits, worker’s compensation, railroad retirement annuities and unemployment insurance benefits.”

21. 20 C.F.R. § 416.1124 “Unearned income we do not count” states in relevant part:

(c) Other unearned income we do not count. We do not count as unearned income—

...

(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.

22. Fla. Admin. Code R. 65A-1.713 “SSI-Related Medicaid Income Eligibility Criteria” states in relevant part:

(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.

23. Fla. Admin. Code R. 65A-1.716 "Income and Resource Criteria" states in relevant part:

(2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows:  
Family Size of 1 has a Monthly Income Level of \$180. Family size of 2 has a Monthly Income Level of \$241.

Petitioner's Determination for Medically Needy

24. The findings show Social Security established the petitioner as disabled. The undersigned concludes the petitioner meets the technical requirement for Adult-Related Medicaid eligibility determination.

25. The findings show the petitioner receives Medicare. Under the above controlling authority, the undersigned concludes, as he has Medicare, the petitioner does not qualify for the MEDS-AD or Adult-Related Medicaid program as he has

Medicare. The undersigned further concludes the Department correctly proceeded to determine the petitioner's eligibility for Medically Needy Share of Cost program.

26. The findings show the petitioner has Social Security Disability income of \$1,016. The above controlling authorities show that a \$20 unearned income disregard is allowed. The authorities also allow the Medically Needy Income Level for a two-person household of \$241 to be deducted in determining the petitioner's Medically Needy Share of Cost. The undersigned concludes the petitioner's share of cost is \$755 ( $\$1,016 - \$20 - \$241 = \$755$ ). The undersigned further concludes the Department correctly determined the petitioner's share of cost during this certification process.

Petitioner's wife Determination for Medicaid

27. The findings show the petitioner's wife is under age 65 and has not been established by Social Security as disabled as of the time of the application. The undersigned concludes the Department correctly determined a disability determination is required prior to establishing the petitioner's wife as meeting the technical requirement for Adult-Related Medicaid.

28. The findings show Social Security Administration (SSA) denied petitioner's wife disability in January 2016 on appeal. According to the above controlling authorities, the undersigned concludes a decision made by SSA within 12 months of the Medicaid application is controlling and binding on the state agency **unless** the applicant alleges a disabling condition different from, or in addition to, those considered by SSA in making its determination.

29. The findings show the petitioner's wife has reported all conditions to SSA. The findings further show the SSA decision is under appeal and awaiting a court date.

The undersigned concludes as the petitioner's SSA decision is under appeal, the above controlling authority of 42 C.F.R. § 435.541 (4)(iii) applies to this case. The authority requires if it has been less than 12 months since an SSA decision **and** the decision is under appeal **and** SSA has refused to consider the new allegation the state agency make a disability determination. In this instant case, the petitioner has not proven that SSA refused to consider any condition of the petitioner's wife in making the disability determination. The undersigned concludes the SSA decision remains binding upon the Department. The undersigned further concludes the Department correctly adopted the SSA decision of January 5, 2016 and denied the petitioner's wife Adult-Related 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.

FINAL ORDER (Cont.)

16F-03019

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DONE and ORDERED this 31 day of August, 2016,  
in Tallahassee, Florida.



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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  
Office of Economic Self Sufficiency

Jul 18, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-03038

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION  
CIRCUIT: 13 Hillsborough  
UNIT: AHCA

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on June 13, 2016, at 3:25 p.m.

**APPEARANCES**

For the 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 Agency for Health Care Administration incorrectly denied her request for four dental crowns?



1. Petitioner is a 58-year-old female. She resides in [REDACTED]
2. Petitioner was eligible to receive Medicaid services at all times relevant to this proceeding.
3. Petitioner is an enrolled member of Amerigroup. Amerigroup is a health maintenance organization 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 Amerigroup was June 1, 2014.
5. Amerigroup provides certain dental benefits to its members.
6. Amerigroup has contracted DentaQuest to be its dental vendor. In its capacity as vendor, DentaQuest completes prior authorization reviews of requests for dental services submitted to it by Amerigroup members.
7. On or about April 7, 2016, the petitioner's dental provider submitted a prior authorization request (*Resp. Exhibit 2*) to DentaQuest for the following services:
  1. D3330 – Endodontic therapy, molar – excluding final restoration; Tooth 18;
  2. D3330 – Endodontic therapy, molar – excluding final restoration; Tooth 19;
  3. D2950 – Core buildup, including any pins when required; Tooth 14;
  4. D2950 – Core buildup, including any pins when required; Tooth 18;
  5. D2950 – Core buildup, including any pins when required; Tooth 19;
  6. D2950 – Core buildup, including any pins when required; Tooth 31;
  7. D2751 – Crown – porcelain fused to predominantly base metal; Tooth 14;
  8. D2751 – Crown – porcelain fused to predominantly base metal; Tooth 18;
  9. D2751 – Crown – porcelain fused to predominantly base metal; Tooth 19;
  10. D2751 – Crown – porcelain fused to predominantly base metal; Tooth 31;
  11. D2392 – Resin based composite – two surfaces posterior; Tooth 4;
  12. D2392 – Resin based composite – two surfaces posterior; Tooth 20;
  13. D2335 – Resin based composite – four or more surfaces involving incisal angle (anterior); Tooth 9;
  14. D2332 – Resin based composite – three surfaces posterior, Tooth 8

8. In an Authorization Determination dated April 8, 2016 (*Resp. Exhibit 4*), addressed to the petitioner's dental provider, DentaQuest denied all of the requested services with the exception of the four listed below:

1. D2392 – Resin based composite – two surfaces posterior; Tooth 4;
2. D2392 – Resin based composite – two surfaces posterior; Tooth 20;
3. D2335 – Resin based composite – four or more surfaces involving incisal angle (anterior); Tooth 9; and
4. D2332 – Resin based composite – three surfaces posterior, Tooth 8.

9. There is a notation in the Authorization Determination next to each of the four services listed in the previous paragraph indicating "Authorization Not Required".

10. DentaQuest mailed a Notice of Action dated April 8, 2016 (*Resp. Exhibit 5*) to the petitioner advising it was denying her request for services on the grounds that "The requested **service is not a covered benefit.**"

#### **CONCLUSIONS OF LAW**

11. 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.

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. 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.

15. 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, 7<sup>th</sup> Ed.).

16. The Florida Medicaid program is authorized by Chapter 409, Fla. Stat. and Chapter 59G, Fla. Admin. Code. The Medicaid program is administered by respondent.

17. 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...

18. 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.

19. 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.

20. Section (1)(d) highlights 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.

21. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Chapter 59G-5.020. 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.

22. 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....”

23. 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.”

24. The Florida Medicaid Dental Services Coverage Policy (November 2011) is a handbook promulgated into rule by Chapter 59G of the Florida Administrative Code.

25. 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.

26. Page 2-33 of the Dental Handbook regarding Restorative Service states: “Restorations may be reimbursed for eligible recipients under age 21....”

27. The plain language of the Dental Handbook excludes reimbursement for restorative services, including crowns, for individuals over age 21.

28. The services requested by the petitioner are not covered services under the Medicaid State Plan.

29. The services requested by the petitioner do not appear on the list of dental services for adults covered by Amerigroup (*Resp. Exhibit 6*). They are non-covered services.

30. Since restorative services, including crowns, are not available to recipients over age 21 under the Medicaid State Plan, Amerigroup's policy is not more restrictive than that of the Medicaid State Plan.

31. As the services requested by the petitioner are non-covered services by both Amerigroup and the Medicaid State Plan, Amerigroup correctly denied petitioner's request for these services.

32. Pursuant to the above, the petitioner has not shown by a preponderance of the evidence that the respondent incorrectly denied her request.

### **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.

/////

FINAL ORDER (Cont.)

16F-03038

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DONE and ORDERED this 18 day of July, 2016,

in Tallahassee, Florida.



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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:

██████████, Petitioner  
AHCA, Medicaid Fair Hearings Unit

Aug 19, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-03040

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION  
CIRCUIT: 11 DADE  
UNIT: AHCA,

And

MOLINA HEALTHCARE,

RESPONDENTS.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on July 12, 2016 at 3:00 p.m.

**APPEARANCES**

For the Petitioner:



For the Respondent:

Stephanie Lang, Registered Nurse Specialist  
Agency for Health Care Administration (AHCA)

**STATEMENT OF ISSUE**

At issue is whether the respondent's denial of the petitioner's request for a referral to an out-of-network provider (neurologist) 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.

Appearing as witnesses for the respondent were Carlos Galvez, Government Contracts Specialist; Bonnie Blitz, Nursing Director; Elvis Leyva, Health Services Manager, and Dr. Teresa Blanco, Medical Director, from Molina Healthcare, which is the petitioner's managed health care plan. Molina Healthcare was included as an additional party to this proceeding pursuant to its request to be added as a party.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent composite Exhibit 1: Fair Hearing Summary, Authorization Request (with medical records), and Denial Notice.

### **FINDINGS OF FACT**

1. The petitioner is a six (6) 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 Molina Healthcare. She became covered by Molina on November 1, 2015.
2. The petitioner suffers from [REDACTED]. The petitioner is seeking authorization from her health plan for an office visit to an out-of-network provider, a pediatric neurologist in Boston, Massachusetts. She previously saw this physician for an office visit in 2015, which was paid for out-of-pocket by her parents. She was referred to this physician by the [REDACTED] Foundation.

3. The petitioner submitted an authorization request to Molina for the office visit with the out-of-network provider on April 6, 2016. Molina denied the request on April 8, 2016. The denial notice stated the following reason for the denial:

The asked for non-participating provider is not approved. Using standard and accepted rules a Molina Healthcare doctor has looked at this request. There are participating providers within the Molina Network that can treat your condition. Please call member services if you need the names of participating providers in your area. Please talk to your provider about your healthcare options.

4. The petitioner's mother stated her daughter needs to see the neurologist in Boston because he is the only doctor who was able to stop her seizures. This doctor prescribed a special diet to control the seizures, and the diet needs to be modified since the petitioner is now older. The mother also described her difficulties in making arrangements to see a neurologist in Florida, and she stated that no doctor in Florida is familiar with the special diet for [REDACTED] patients.

5. The respondent's witness, Dr. Blanco, stated the health plan will only approve an out-of-network provider if there is no in-network provider available to treat the patient. She also stated there are two university hospitals in Florida that can provide treatment to [REDACTED] patients ([REDACTED] and [REDACTED]) and the health plan has pediatric neurologists available to treat the petitioner.

### **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 Section 120.80, Fla. Stat.

7. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.
8. This hearing was held as 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 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, 7<sup>th</sup> Ed.).
10. 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, AHCA.
11. 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.

12. After considering the evidence and testimony presented, the undersigned concludes that the petitioner has not demonstrated that Molina should have approved the referral to the out-of-network provider. The preponderance of the evidence establishes that Molina can provide in-network providers and/or physicians to treat the petitioner's medical conditions.

### **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 indigence 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 19 day of August, 2016,

in Tallahassee, Florida.



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Rafael Centurion  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700

FINAL ORDER (Cont.)

16F-03040

PAGE - 6

Office: 850-488-1429

Fax: 850-487-0662

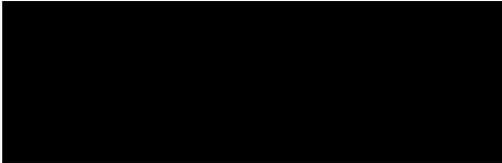
Email: [Appeal.Hearings@myflfamilies.com](mailto:Appeal.Hearings@myflfamilies.com)

Copies Furnished To: [REDACTED], PETITIONER  
AHCA, MEDICAID FAIR HEARINGS UNIT  
MOLINA HEARINGS UNIT

Jul 20, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-03066

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION  
CIRCUIT: 09 Orange  
UNIT: AHCA

AND

AMERIGROUP FLORIDA,

RESPONDENTS.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on July 6, 2016, at approximately 10:00 a.m.

**APPEARANCES**

For Petitioner:



For Amerigroup:

Lisa Williams  
Quality Analyst Nurse

**STATEMENT OF ISSUE**

At issue is whether or not Respondents' denial of Petitioner's request for adult diapers was correct. The burden of proof is assigned to Petitioner.

### **PRELIMINARY STATEMENT**

Petitioner's daughter represented him at the hearing. Lisa Sanchez, Medical/Health Care Program Analyst with the Agency for Health Care Administration ("AHCA" or "Agency") observed the hearing. The following individuals were present for Amerigroup:

- Lisa Williams – Quality Management Nurse - Amerigroup
- Dr. Amy Zitiello – Medical Director - Amerigroup
- Brian Hawkins – Manager, Healthcare Management Services - Amerigroup

Petitioner's daughter gave oral testimony, but did not move any exhibits into evidence. Ms. Williams was the lead presenter for Amerigroup. Amerigroup moved Exhibits 1 – 5 into evidence. A Spanish language interpreter was present.

### **FINDINGS OF FACT**

1. Petitioner is a 92-year-old male. Petitioner is enrolled with Amerigroup as his Managed Medical Assistance (MMA) plan.
2. Petitioner suffers from [REDACTED]. Petitioner's physician submitted a Precertification Request to Amerigroup for adult diapers.
3. On April 6, 2016, Amerigroup issued a Notice of Action, Respondent's Exhibit 3, denying the request as not a covered benefit. The Notice states, in pertinent part:

[REDACTED]

4. Petitioner requested an internal appeal from Amerigroup. On April 12, 2016, Amerigroup issued a letter upholding the denial on the basis that diapers are only covered for children ages four (4) to 21-years-old. (Respondent's Exhibit 4).

5. Dr. Zitiello testified the request for the diapers was not reviewed for medical necessity because they are not a covered benefit.

6. Dr. Zitiello said Petitioner receives Medicare, but that Medicare also does not cover adult diapers. She suggested that Petitioner look into becoming enrolled in a Long-Term Care plan. She said Amerigroup can have a case manager contact Petitioner's daughter regarding enrolling in a Long-Term Care plan. She also said that Petitioner is eligible to remain in his MMA plan during the time period he would spend on a waiting list for enrollment into a Long-Term Care plan.

#### **CONCLUSIONS OF LAW**

7. 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 to conduct this hearing pursuant to § 120.80, Fla. Stat.

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

9. This is a Final Order, pursuant to Sections 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, 7<sup>th</sup> Ed.).

11. 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, is the single state agency that administers the Medicaid Program.

12. The July 2010 Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook ("DME Handbook") is promulgated into law by Chapter 59G of the Florida Administrative Code.

13. Page 2-48 of the DME Handbook states:

Disposable incontinence briefs, diapers, protective underwear, pull-ons, liners, shields, guards, pads, and undergarments are covered for recipients four (4), when a child would normally be expected to achieve continence, through twenty (20) years of age.

14. Page 2-97 of the DME Handbook also explicitly lists "Diapers and incontinence briefs of any kind for recipients 21 years and older" as non-covered items.

15. The plain language of the DME Handbook shows the diapers are a non-covered item, therefore no medical necessity analysis is required. Petitioner has failed to meet his burden of proof to show that it was improper to deny his request for the diapers.

16. Petitioner is encouraged to follow Dr. Zitiello's recommendation to try to enroll in a Long-Term Care plan, where the incontinence supplies would be covered.

### **DECISION**

Based upon the foregoing, Petitioner's appeal is DENIED and the Respondents' 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

FINAL ORDER (Cont.)

16F-03066

PAGE - 5

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 July, 2016,

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  
AHCA, Medicaid Fair Hearings Unit

**FILED**

Aug 05, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-03070

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION  
CIRCUIT: 11 DADE  
UNIT: AHCA.

And

UNITED HEALTHCARE,

RESPONDENTS.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, a telephonic administrative hearing in the above-referenced matter was convened by Hearing Officer Frank Houston on June 9, 2016, at 1:00 p.m.

**APPEARANCES**

For the Petitioner:



For the Respondent: Lisa Sanchez, Medical Program Analyst, AHCA

**STATEMENT OF ISSUE**

At issue is the Agency action denying the petitioner's request for additional home health services (overnight respite care) under the Long Term Care (LTC) Program.

The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

Appearing as witnesses for the petitioner were her daughter and three staff members from the ██████ Center, which is her adult day care facility – ██████, Director of Nursing, ██████, LPN, and ██████, Social Worker.

The petitioner submitted an article concerning life expectancy as evidence for the hearing, which was marked as Petitioner Exhibit 1.

Appearing as witnesses for the respondent were Dr. Marc Kaprow, Medical Director, and Christian Laos, Senior Compliance Analyst, from United Healthcare, which is the petitioner's managed health care plan. United Healthcare was included as an additional party to this proceeding pursuant to its request to be added as a party.

The respondent submitted documents as evidence for the hearing consisting of the following which were marked as Respondent Composite Exhibit 1: Denial Notice, Case Notes, and an article concerning night-time monitoring of dementia patients.

At the conclusion of the hearing, the record was held open for the parties to file additional documents or written comments as evidence. The Petitioner submitted an article concerning falls in nursing homes as well as a series of written comments, which were marked Petitioner Exhibits 2 through 12. The respondent submitted a medical assessment form, which was marked Respondent Exhibit 2.

The hearing in this matter was held before Hearing Officer Frank Houston. The petitioner thereafter requested that Hearing Officer Houston recuse himself from this case. The matter was subsequently re-assigned to the undersigned hearing officer, who is issuing this Final Order based on the audio recording of the hearing held on June 9, 2016 and the documentary evidence submitted.

### **FINDINGS OF FACT**

1. The petitioner is eighty-three (83) years of age and lives by herself in an apartment. The petitioner's medical conditions include [REDACTED]. She is legally blind. She also suffers from [REDACTED] and [REDACTED] which is now under control with medication. Her daughter, who is her primary caregiver, lives in another apartment in the same building complex.

2. The petitioner is a Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Long Term Care (LTC) Plan. She receives services under the plan from United Healthcare.

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 United Healthcare provide services to Medicaid recipients pursuant to a contract with AHCA.

4. The petitioner currently attends an adult day care facility (the [REDACTED] Center) from approximately 9:00 a.m. to 4:00 p.m., Monday to Friday. In addition, she is

approved for home care services such as personal care assistance, homemaker services, and companion care. She has also been previously approved for respite care services in the home on days when the [REDACTED] Center has been closed.

5. On or about March 11, 2016, the petitioner made a request to United Healthcare for overnight respite care hours in her home – from 10:00 p.m. on March 22, 2016 through 9:00 a.m. on March 23, 2016. On March 21, 2016, United sent a letter to the petitioner denying her request for the overnight respite care services in the home as not being medically necessary. The notice stated the following:

You asked for respite at home. This includes overnight care. Overnight respite care can be provided in a facility. This is safer than overnight respite at home. The health plan will cover overnight respite care in a facility. The health plan will approve the overnight respite in a facility. The plan will not approve overnight respite care at home.

6. The petitioner's daughter stated she is requesting overnight respite care in the home rather than in a facility because her mother would become agitated if she has to leave her home at night to go to the overnight facility. Due to her [REDACTED], her mother would become angry, combative, and violent if she is placed in an unfamiliar environment. When the petitioner began attending her adult day care facility (the [REDACTED] Center), it took her approximately 8 weeks to become acclimated to the facility and, during that time, she was combative and aggressive both with the facility staff and with her daughter.

7. The petitioner's daughter also described what happened when she once tried to move her mother's bed to her apartment so she could stay there overnight. Her

mother became angry and attacked her with scissors and/or knives and the police were called to the home.

8. The witnesses from the [REDACTED] Center, Ms. [REDACTED] and Ms. [REDACTED] supported the statements of the daughter in regard to the petitioner becoming angry or agitated with others when her daily routine is changed or when she is unfamiliar with her surroundings. Ms. [REDACTED] also stated that long-term care facilities generally have a 25 to 2 ratio of staff to patients, the [REDACTED] Center has a 5 to 1 ratio, and the petitioner would have a 1 to 1 ratio if she were to receive respite care in the home.

9. The respondent's witness, Dr. Kaprow, stated that the overnight respite care should be provided in a facility rather than in the home because a facility would be safer for a [REDACTED] patient. He also stated that day visits to the facility could be arranged to acclimate the petitioner to the facility before beginning the overnight stay. He also expressed a concern that if something were to happen to the daughter during the overnight respite care, the petitioner could remain safe in the facility rather than being potentially left alone at 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, 7<sup>th</sup> 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 she believes her services under the Program should be increased to include overnight respite care hours.

16. Fla. Stat. § 409.98 lists the services which must be covered by Long-Term Care plans. Respite care services are among the services available from Long-Term Care plans and are addressed in the AHCA contract.

17. The issue in this proceeding is respite care services, which are defined in the contract 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.

18. 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.”

19. 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.”

20. 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.

21. The need for overnight respite care was acknowledged by United Healthcare since it indicated it would approve the respite care in a facility, but not in the home. The petitioner's daughter provides care to her mother during the overnight hours and is in need of occasional respite care services to provide a break from caring for her mother. The issue is whether the respite care should be provided in the petitioner's home or in a facility.

22. After considering the evidence and testimony presented, the hearing officer concludes that the petitioner has demonstrated by a preponderance of the evidence that the respite care services should be provided in the home rather than in a facility. The hearing officer has taken into account Dr. Kaprow's testimony that overnight respite care should be provided in a facility since it is safer for a dementia patient. While this may be true in general, the testimony of the petitioner's daughter and the staff at the ██████ Center establish that it would not be safer in the petitioner's case since she would become combative and agitated when faced with unfamiliar surroundings. It should also be noted that the petitioner has in the past been receiving occasional daytime

respite care in the home without any reported incidents. She has also been receiving other home care services in the early evening hours without any apparent problems.

23. Although the petitioner could perhaps be acclimated to attend the new overnight facility through day visits to that facility, it seems unreasonable to do so when that process would most likely cause her to endure anxiety and stress. In addition, it seems unnecessary to undergo this acclimatization process when the request is only for intermittent or occasional overnight respite care, not for a continuous period of time. According to the contract provision concerning respite care, this service can be provided in the home or place of residence and is not required to be provided in a facility.

24. The undersigned notes that the requested services and denial concerned overnight respite care for March 22, 2016 and that time period has passed. However, the issue is whether the respite care should be provided in the home or in a facility and that issue is addressed in this final order. The frequency of the service was not at issue so the undersigned has not addressed how often the overnight respite care must be provided to the petitioner.

### **DECISION**

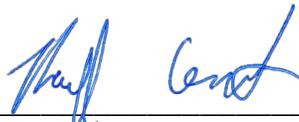
Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is GRANTED, and the overnight respite care to the petitioner should be provided in the home rather than in a facility.

**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 05 day of August, 2016,

in Tallahassee, Florida.



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Rafael Centurion  
Hearing Officer  
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Copies Furnished To: [REDACTED] PETITIONER  
AHCA, MEDICAID FAIR HEARINGS UNIT  
UHC MEDICAID FAIR HEARING

Aug 22, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 16F-03112

PETITIONER,

Vs.

CASE [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 09 Orange  
UNIT: 55207

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on June 30, 2016 at 1:00 p.m. at [REDACTED]

[REDACTED]

**APPEARANCES**

For the petitioner: [REDACTED]

For the respondent: Jennie Rivera, ACCESS Economic Self-Sufficiency

Specialist II

**STATEMENT OF ISSUE**

The petitioner is appealing the respondent's action to open her son's Medically Needy (MN) Program with a share of cost (SOC) untimely for May 2016. The petitioner carries the burden of proof by a preponderance of the evidence.

The petitioner is also appealing no Medicaid coverage for her son in the MN Program with a SOC for 2013. The petitioner carries the burden of proof by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

By notice dated May 4, 2016, the respondent notified the petitioner that her son's MN Program coverage was opened beginning May 2, 2016 through May 31, 2016.

Petitioner did not submit any exhibits. Respondent submitted eight exhibits, entered as Respondent's Exhibits "1" through "8". The record was held open until close of business on July 15, 2016 for submission of additional evidence from the respondent. On July 13, 2016, the respondent contacted the undersigned and petitioner through e-mail and requested an extension to provide the additional evidence. The undersigned granted the respondent's request and the record remained open until close of business on July 25, 2016. No additional evidence was received by the due date from the respondent; therefore, the record closed on July 25, 2016.

### **FINDINGS OF FACT**

1. Prior to the action under appeal, the petitioner's son was enrolled in the MN Program with a \$3,361.00 SOC. Petitioner's son has recurring medical bills with Walgreens and PSA Health-Care. Medicaid benefits for the petitioner's son is the only issue.
2. The petitioner's son's recurring medical and prescription bills are submitted to the respondent each month for bill tracking.
3. On March 10, 2016, the respondent activated Medicaid benefits for the petitioner's son effective March 8, 2016 through March 31, 2016. On April 7, 2016, the respondent

activated Medicaid benefits for the petitioner's son effective April 5, 2016 through April 30, 2016.

4. On April 22, 2016, the petitioner contacted the Department and requested a hearing to appeal the respondent's delay in activating her son's Medicaid benefits and not approving these benefits from the first of each month.

5. On May 3, 2016, the respondent activated Medicaid benefits for the petitioner's son effective May 2, 2016 through May 31, 2016.

6. During a supervisory review, the respondent determined there were errors made on the case. Petitioner's son was declared disabled; therefore, only a portion (deemed income) of the petitioner's income should have been counted to determine her son's Medicaid eligibility. The respondent recalculated the income and determined the SOC amount decreased from \$3,361.00 to \$898.00 beginning May 2016. The respondent recalculated the income for each month and decreased the SOC beginning February 2014.

7. Petitioner is not disputing the new SOC amount. Petitioner explained her child has recurring homecare services, therapy and medications. Petitioner asserted there is a delay in receiving therapy services and filling prescriptions due to the respondent not taking timely action to activate her son's Medicaid benefits beginning the first of each month. Petitioner submits the PSA Health-Care services bills every month. Petitioner recently found out she has an outstanding balance with PSA Health-Care services since 2013; therefore, the organization is refusing to continue services. Petitioner is requesting the respondent evaluate Medicaid coverage for her son beginning 2013.

8. The respondent explained bill tracking is processed when the petitioner's son's recurring pharmacy and medical bills are received. The petitioner's son becomes eligible for Medicaid on the date he meets his SOC according to the date of service for the medical bills submitted each month.
9. The respondent reevaluated the petitioner's son's Medicaid coverage using the corrected \$898.00 SOC amount and determined he was eligible for Medicaid benefits from the first day of each month beginning February 1, 2014.
10. On June 22, 2016, the respondent manually submitted claim requests for Medicaid coverage for the petitioner's son beginning February 2014 to the Agency for Health Care Administration (AHCA). AHCA is responsible for administering Florida's Medicaid Program. AHCA contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.

#### **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 Section 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.
12. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
13. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 3230.0407.01, Billing Authorization (MFAM) states:

In Medically Needy cases, expenses incurred on the day the Share of Cost is met and are used in full to meet the Share of Cost are not eligible to be paid by Medicaid. Any bills incurred on the date the Share of Cost is

met that are not used in full to meet the SOC are eligible for reimbursement by Medicaid.

The eligibility specialist must complete a Billing Authorization Form for each provider who provided services on the day the SOC was met and whose bill was not used in full to meet the Share of Cost and send the form to the applicable provider(s).

14. The Policy Manual, CFOP 165-22, passage 3230.0407.02, Medicaid Claims

Payment (MFAM), continues and states:

Medicaid pays claims for covered services within prescribed program limits. A provider who chooses to participate in the Medicaid Program must submit the claim. A Medicaid provider does not have to bill Medicaid; however, if he chooses to bill Medicaid, he must accept the Medicaid payment as payment in full.

Providers must submit clean claims to Medicaid within 365 days of the date of service. A clean claim is an original, correctly completed claim that is ready to process. Medicaid claims over 365 days old may be paid if an eligibility or technical (systems) error was made on the case by DCF.

15. Fla. Admin. Code R. 65A-1.702 addresses Medicaid coverage provisions, as

follows:

...

**(2) Date of Eligibility...**

**(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 by federal funds, equal their share of cost, provided that all other conditions of eligibility are met.**

[emphasis added] Any bill used in full to meet the individual's share of cost (SOC) shall not be paid by Medicaid.

...

(7) Re-evaluating Medicaid Adverse Actions. The department shall re-evaluate any adverse Medicaid determination upon a showing of good cause by the individual that the previous determination was incorrect and that the individual did not request a hearing within the time prescribed in Chapter 65-2, Part IV, F.A.C. This provision applies only when benefits were terminated or denied erroneously or a share of cost or patient responsibility was determined erroneously.

(a) Good cause exists if evidence is presented which shows any of the following:

1. Mathematical Error – The department made a mechanical, computer or human error in its mathematical computations of resources, income, or spend down requirements for Medicaid eligibility.

...

(c) A re-evaluation must be requested before the expiration of 12 months from the effective date of the notice of adverse action.

(d) The public assistance specialist (PAS) is responsible for the initial determination of good cause. All initial decisions must be reviewed by the PAS's supervisor. If both the PAS and the supervisor determine that good cause does not exist the operational program administrator must review the good cause determination in consultation with the District Program Office. The operational program administrator's decision is final. If a final determination is made that good cause does not exist, the individual will be notified of the decision and of the right to request a hearing...

16. Fla. Admin. Code R. 65A-1.713 sets forth when bills are deducted to meet the SOC as follows:

...

(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...

17. The above authorities and policies explain that individuals enrolled in the MN Program become eligible for Medicaid on the date the incurred allowable medical expenses (excluding payments by all third party sources) equal their SOC. The SOC

represents the amount of recognized medical expenses that a MN enrolled individual or family must incur each month before becoming eligible to receive Medicaid benefits.

18. On May 3, 2016, the respondent reviewed the medical and prescription bills it had received for the petitioner's son, determined he met his SOC on May 2, 2016 and activated his Medicaid benefits from May 2, 2016 through May 31, 2016. On May 4, 2016, the respondent mailed the petitioner a notice informing her that her son was eligible for Medicaid from May 2, 2016 to May 31, 2016.

19. During a supervisory review, the respondent realized the petitioner's son is disabled and should have received Medicaid benefits under the SSI-Related Medicaid Program. The respondent made the necessary corrections and enrolled the petitioner's son in the SSI-Related Medically Needy Program, which caused the petitioner's son's SOC to decrease from \$3,361.00 to \$898.00 beginning May 1, 2016. The respondent also corrected the SOC amount from February 1, 2014 through April 1, 2016. Once the SOC amount was corrected, the respondent determined the petitioner's son was eligible for Medicaid benefits from the first day of each month beginning February 1, 2014.

20. An individual's right to a fair hearing is set forth in the Code of Federal Regulations at 42 C.F.R. § 431.220 which states in part:

(a) The State agency must grant an opportunity for a hearing to the following:

(1) Any applicant who requests it because his claim for services is denied or is not acted upon with reasonable promptness.

(2) Any beneficiary who requests it because he or she believes the agency has taken an action erroneously.

21. 42 C.F.R. § 431.201 defines action as "a termination, suspension, or reduction of Medicaid eligibility or covered services."

22. 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:

(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.

23. According to the above authority, an 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. The petitioner is also seeking Medicaid coverage for her son for 2013. The undersigned does not have jurisdiction to address any action that occurred three years ago pursuant to Fla. Admin. Code R. 65-2.046.

24. In careful review of the evidence and cited authorities, the undersigned concludes that the respondent followed rule in bill tracking the petitioner's son's medical bills submitted in May 2016. Furthermore, the respondent corrected the petitioner's son's SOC and determined he was eligible for Medicaid benefits from the first of each month effective February 2014. There is no better outcome the undersigned can provide to the petitioner. In regards to medical bills tracked in 2013, the undersigned does not have jurisdiction to address that matter.

25. AHCA has not denied or approved the petitioner's son's medical bills from February 2014 through May 2016, which were manually submitted for processing on June 22, 2016. Once AHCA makes a determination on those claims, the petitioner may file an appeal to address any action taken by AHCA if she disagrees with such action. The providers may address payment matters through the managed care plan, the Agency's Provider Relations Office and/or the Statewide Provider and Health Plan Claim Dispute Resolution Program, since the petitioner's child already received the services at issue.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal concerning the respondent's delay in processing the petitioner's son's bill tracking for May 2016 is dismissed as MOOT. And the appeal concerning the petitioner's son's Medicaid coverage for 2013 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 22 day of August, 2016,

in Tallahassee, Florida.



Cassandra Perez  
Hearing Officer  
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Copies Furnished To: [REDACTED]  
Office of Economic Self Sufficiency

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

**FILED**

Jul 27, 2016

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-03135

PETITIONER,

Vs.

AGENCY FOR HEALTH  
CARE ADMINISTRATION  
CIRCUIT: 07 Volusia  
UNIT: AHCA

And

UNITED HEALTHCARE

RESPONDENTS.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 10, 2016 at 3:09 p.m.

**APPEARANCES**

For the Petitioner: [REDACTED], pro se

For the Respondent: Sheila Broderick, registered nurse specialist with AHCA

**STATEMENT OF ISSUE**

Whether it is medically necessary for the petitioner to receive [REDACTED] surgery from an out-of-state/out-of-network provider. The petitioner holds the burden of proof by a preponderance of the evidence.

**PRELIMINARY STATEMENT**

The Agency for Health Care Administration (Agency or AHCA or respondent) administers the Florida Medicaid Program. The Agency contracts with numerous health care organizations to provide medical services to Medicaid enrollees. United Healthcare (United) is the contracted HMO in the instant case.

By notice dated April 8, 2016, United informed the petitioner that her request to undergo [REDACTED] surgery in the state of Illinois was denied.

The petitioner timely requested a hearing to challenge the denial decision.

Present as witnesses for the petitioner: Dr. Pamela Carbiener, the petitioner's obstetrician/gynecologist and Matthew Hall, petitioner's husband. The petitioner did not submit documentary evidence.

Present as witnesses for the respondent from United: Susan Frishman, senior compliance analyst and Dr. Eina Fishman, chief medical officer. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

The record was held open until close of business on June 17, 2016 for the submission of additional evidence. Evidence was timely received from the respondent and admitted as Respondent's Composite Exhibit 2. The petitioner did not submit additional evidence.

**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 34) is a Florida Medicaid recipient. She is enrolled with United HMO.

2. The petitioner has an [REDACTED] which makes it impossible for her to carry a baby to full term. She has suffered seven miscarriages over the past 15 years.

3. The petitioner has undergone multiple [REDACTED] to prevent miscarriage. During a [REDACTED], stitches are placed in the cervix after conception to hold it close to prevent miscarriage. The petitioner's procedures were not successful. The petitioner miscarried during the second trimester of her pregnancies.

4. The petitioner's treating OB/GYN, [REDACTED], is board certified and has been practicing medicine for more than 25 years. [REDACTED] opined that the petitioner requires a more aggressive surgical procedure, an [REDACTED]. Dr. [REDACTED] opined that the petitioner will not be able to carry a baby to full term without [REDACTED] surgery. Dr. [REDACTED] performed the petitioner's most recent [REDACTED] in December 2015; the petitioner miscarried a short time after the surgery. Dr. [REDACTED] does not perform [REDACTED]. The petitioner must see another physician in order to receive this procedure.

5. [REDACTED] are performed before the patient conceives. Placement of the [REDACTED] before conception reinforces the cervix and helps the patient carry a baby to full term. [REDACTED] is a complex procedure performed by only a few surgeons in the United States. Dr. [REDACTED] testified that there are no physicians in the state of Florida who perform [REDACTED] surgery; she referred the

petitioner Dr. [REDACTED] of Chicago, Illinois. Dr. [REDACTED] is an expert in [REDACTED] [REDACTED]. He has successfully treated a number of Dr. [REDACTED]'s other patients. Dr. [REDACTED] performs over 300 [REDACTED] procedures a year and has a 99% surgical success rate.

6. Dr. [REDACTED] submitted a request to United in early 2016 to perform an [REDACTED] on the petitioner in his home state of Illinois. The request form reads in pertinent part:

[REDACTED]

7. United denied the petitioner's request in a notice dated April 8, 2016. The notice reads in pertinent part:

[REDACTED] After our review, this service has been denied...The requested service is not a covered benefit.

The facts that we used to make our decision are: Your doctor asked for this procedure for you. This doctor is not part of your health plan. Based on health plan guidelines, non-emergency care must be sought with providers in the health plan. The request to get services from a non-plan provider is not covered. Services may be sought in the health plan. Thus,

the request for services out of health plan is not approved. The health plan has a list of providers who work with your health plan.

8. Respondent witnesses, Susan Frishman and Dr. Eina Fishman, testified the petitioner's request was denied because United's contract with AHCA/Medicaid does not include a provision for enrollees to receive out-of-state services for non-emergency procedures and because Dr. [REDACTED] is not a United HMO provider.

9. The record was held open for the respondent to provide portions of United's contract with AHCA/Medicaid and any other applicable policy citations. The respondent did not provide copies of the contract. Instead, Susan Frishman, United senior compliance analyst, sent the undersigned an electronic communication (e-mail) on June 14, 2016 that reads in pertinent part:

During this hearing on 6/10/16, you had requested information indicating that Medicaid Managed Medical Assistance (MMA) members do not have benefits out of the state. We have researched and there are, in fact, times when Medicaid recipients can receive non-emergency services out of state:

- 1) Providers within 50 miles of Florida border, who are currently licensed in their state (GA or AL) and have not been excluded. This exception does not apply in this case, as the services are to be provided in Illinois.
- 2) Situations where covered medically necessary services are not available in Florida. Prior authorization is normally required in these cases, to determine whether medical necessity criteria...has been met. In this case, United Healthcare Community Plan is still reviewing the documentation. At this time, the requested services remain denied by United.

10. United also contended that the surgery procedure code [REDACTED] used by Dr. [REDACTED] on the authorization form, was not included in the Medicaid Practitioner Fee Schedule and therefore was not a covered service. Sheila Broderick, AHCA

representative, testified that United was mistaken; code [REDACTED] is included in the Medicaid Practitioner Fee Schedule as a covered service. Dr. [REDACTED] explained that Dr. [REDACTED] used the more generic code [REDACTED] because the only procedure code in the Fee Schedule that specifically uses the word [REDACTED] addresses surgery after conception. [REDACTED] is performed prior to conception. [REDACTED] is a generic code which is used for rare and non-specified surgical procedures which are explained in detail in the clinical documentation submitted with the authorization request form and/or during physician peer-to-peer consultations.

#### **CONCLUSIONS OF LAW**

11. 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 Section 120.80, Florida Statutes.

12. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.

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

14. In accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof was 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. 65-2.060(1)). The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7<sup>th</sup> Ed.).

16. The Florida Medicaid Program is authorized by Chapter 409 Florida Statutes and Fla. Admin. Code Chapter 59G.

17. 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:

“Medical 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 patient’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. . .

18. Page 2-35 of the Medicaid Provider General Handbook addresses non-emergency out-of-state services:

Florida Medicaid reimburses for non-emergency services when the recipient receives the services at an out of state location, if those services cannot be obtained in Florida and if Medicaid prior authorizes the service. Services received by a recipient in an out of state location cannot be post authorized.

Note: See Out-Of-State Enrollments in Chapter 2 of this handbook for information on other types of out-of-state claims that do not require prior authorization.

A Florida Medicaid enrolled primary care or specialist physician may refer a Medicaid recipient for out-of-state care to obtain medically-necessary

services that cannot be provided in Florida. The physician must request and obtain prior authorization before the recipient receives out-of-state services.

19. The respondent denied the petitioner's request for out-of-state [REDACTED] surgery as a non-covered benefit. The authority cited above states that out-of-state non-emergency services are covered if the services cannot be obtained in Florida and if the services are medically necessary.

20. Dr. [REDACTED], the only expert witness to appear at the hearing, testified that no physician in the state of Florida performs abdominal cerclage surgery. The respondent provided no evidence which contradicts Dr. [REDACTED]'s expert testimony. The undersigned concludes that the petitioner's meets an out-of-state medical services exception because no physician in Florida performs the request medical procedure.

21. Dr. [REDACTED] opined that the requested surgery is medically necessary to ameliorate the petitioner's medical condition, [REDACTED]. All other viable medical options have been exhausted. The respondent provided no evidence which contradicts Dr. [REDACTED]'s expert opinion.

22. The undersigned carefully reviewed the medical necessity criteria and reached the following conclusions: The petitioner has a significant illness, an [REDACTED]. Petitioner meets step one of the medical necessity criteria. The requested surgical procedure is the only way to ameliorate the petitioner's condition. The procedure is not experimental. The doctor who requested the service performs 300 procedures each year and has a 99% success rate. There is no more conservative or less costly treatment available. The service is not being requested for the

convenience of the petitioner. Petitioner meets steps two through five of the medical necessity criteria.

23. The undersigned also took into consideration Fla. Admin. Code R. 59G-4.030 which addresses covered reproductive services and states that Medicaid does not cover infertility treatments. The evidence proves that the petitioner is not infertile. She has conceived a child seven times in the past 15 years. The petitioner has a medical condition, an [REDACTED], which can only be ameliorated with an [REDACTED]. Dr. [REDACTED], the requesting physician, notes that this procedure does not affect fertility.

24. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the respondent's decision in this matter was incorrect. The petitioner proved by a preponderance of the evidence that the requested abdominal cerclage surgery is a covered benefit because no physician in Florida performs the procedure. The petitioner also proved that the procedure is medically necessary.

### **DECISION**

The appeal is GRANTED. The respondent is hereby ordered to authorize the requested out-of-state abdominal cerclage surgery.

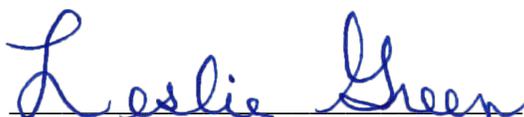
### **NOTICE OF RIGHT TO APPEAL**

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 27 day of July, 2016,

in Tallahassee, Florida.



Leslie Green  
Hearing Officer  
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Copies Furnished To: [REDACTED], Petitioner  
AHCA, Medicaid Fair Hearings Unit  
Christian Laos, United Healthcare

Aug 01, 2016

Office of Appeal Hearings  
Dept. of Children and FamiliesSTATE OF FLORIDA  
DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-03136

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION  
CIRCUIT: 09 Osceola  
UNIT: AHCA

AND

STAYWELL HEALTH PLAN

RESPONDENTS.  

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**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on July 11, 2016 at approximately 3:30 p.m.

**APPEARANCES**

Petitioner:



For Respondent:

Stephanie Shupe  
Regulatory Research Coordinator  
Staywell**STATEMENT OF ISSUE**

At issue is Staywell's denial of Petitioner's request for two (2) fillings. The appeal previously included an appeal of a denial of a lower partial denture, but the denial has subsequently been overturned. The appeal also included the denial of an upper fixed

bridge, however, Petitioner stated she wants an upper partial denture, not a fixed bridge. The burden of proof is assigned to Petitioner.

### **PRELIMINARY STATEMENT**

The undersigned granted Staywell's outstanding Motion to be Added as a Party on the record. Lisa Sanchez, Medical/Health Care Program Analyst with the Agency for Health Care Administration ("AHCA" or "Agency") observed the hearing. Stephanie Shupe was the lead representative for Staywell. The following individuals were present as witnesses:

- Altagracia Recio – National Account Coordinator – Staywell
- Kelly Carr – Vendor Account Manager – Staywell
- Dr. Andrea Spurr – Dental Consultant – Liberty Dental
- Dr. Richard Hague – Dental Director – Liberty Dental

Petitioner gave oral testimony, but did not move any exhibits into evidence. Staywell moved Exhibits 1 and 2 into evidence at the hearing. The record was held open until July 18, 2016 in order for Staywell to submit additional evidence. Staywell submitted additional evidence, entered as Exhibit 3.

### **FINDINGS OF FACT**

1. Petitioner is a 56-year-old female. Petitioner is enrolled with Staywell as her Managed Medical Assistance ("MMA") plan. Petitioner is enrolled with United Healthcare ("United") as her Long-Term Care ("LTC") plan.
2. Liberty Dental ("Liberty") is Staywell's vendor for dental prior authorization reviews.
3. Petitioner's dentist submitted a request for a lower partial denture, two (2) fillings, and an upper fixed bridge. Petitioner said she wants an upper partial denture, not a

bridge, however, Dr. Hague testified the request that came from Petitioner's dentist was for a bridge, not an upper partial denture. Since an upper partial denture was never formally requested, and Petitioner does not want a bridge, the undersigned with not address those in this Order.

4. Liberty initially denied the lower partial denture. However, on March 18, 2016, the denial was overturned. Petitioner testified she has received the lower partial denture, but she still wants the two (2) fillings and the upper partial denture, which, as stated above, will not be reviewed since it was not requested.

5. Dr. Hague testified fillings are not covered benefits for adults age 21 and older. He said the procedure codes for fillings start with "23," and those codes do not appear on the Adult Benefit Schedule because they are not covered. (Respondent's Exhibit 1).

#### **CONCLUSIONS OF LAW**

6. 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.

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

8. This is a Final Order, pursuant to Sections 120.569 and 120.57, Fla. Stat.

9. 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, 7<sup>th</sup> Ed.).

10. 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.

11. The May 2016 Florida Medicaid Dental Services Coverage Policy (“Dental Handbook”) is promulgated into law by Chapter 59G of the Florida Administrative Code.

12. The Dental General Fee Schedule (“Fee Schedule”) is incorporated by reference into the Dental Handbook by R.59G-4.002, Fla. Admin. Code. The Fee Schedule lists a maximum age of 20 years old for fillings (codes beginning with “23”).

13. Page 5 of the Dental Handbook states that Medicaid does not reimburse for services that are not listed on the Fee Schedule.

14. Since Petitioner is over 20 years of age, the plain language of the Dental Handbook and Fee Schedule show the fillings are not covered services under Petitioner’s MMA plan.

15. Petitioner is encouraged to work with her LTC plan regarding any dental services she may require.

### **DECISION**

Based upon the foregoing, Petitioner’s appeal is DENIED and Respondents’ 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

FINAL ORDER (Cont.)

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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 August, 2016,

in Tallahassee, Florida.



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Rick Zimmer  
Hearing Officer  
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Copies Furnished To: [REDACTED], Petitioner  
AHCA, Medicaid Fair Hearings Unit

Ray Walker

Jul 21, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-03142

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION  
CIRCUIT: 11 DADE  
UNIT: AHCA.

And

UNITED HEALTHCARE,

RESPONDENTS.

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**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 31, 2016, at 10:00 a.m.

**APPEARANCES**

For the Petitioner:



For the Respondent: Dianna Chirino, Senior Program Specialist

**STATEMENT OF ISSUE**

At issue is the Agency action partially denying the petitioner's request for additional home health services (homemaker services, companion services, and personal care services) under the Long Term Care (LTC) Program. The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

The petitioner submitted medical records as evidence for the hearing, which were marked as Petitioner Composite Exhibit 1.

Appearing as witnesses for the respondent were Dr. Sloan Karver, Medical Director, and Christian Laos, Senior Compliance Analyst, from United Healthcare, which is the petitioner's managed health care plan. United Healthcare was included as an additional party to this proceeding pursuant to its request to be added as a party.

The respondent submitted documents as evidence for the hearing consisting of the following which were marked as Respondent Composite Exhibit 1: Statement of Matters, Denial Notice, Member Notes Reports, and Medical Assessment Form.

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

### **FINDINGS OF FACT**

1. The petitioner is ninety (90) years of age and lives with her daughter, who is 69 years old, and her grandson. The petitioner's medical conditions include [REDACTED]

[REDACTED]  
surgeries and is bed-bound.

2. The petitioner is a Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Long Term Care (LTC) Plan. She receives services under the plan from United Healthcare.

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 United Healthcare provide services to Medicaid recipients pursuant to a contract with AHCA.

4. The petitioner currently receives a total of thirty-three (33) hours weekly of home health services through United, which is allocated as follows: fourteen (14) hours weekly of personal care assistance, seven (7) hours weekly of homemaker services, and twelve (12) hours weekly of companion services. The petitioner is currently receiving the home health services from 12:00 p.m. to 5:00 p.m. daily. She also receives periodic nursing services for wound care.

5. On or about March 20, 2016, the petitioner made a request to United Healthcare for a total of 56 hours weekly of home health services. At that time, she was receiving 19 hours weekly of home health services. On March 24, 2016, United sent a letter to the petitioner partially denying her request for the additional home health services as not being medically necessary. United advised her it had approved 14 additional hours weekly of home health services, but it had denied the balance of the requested hours. The 14 additional hours combined with the previously approved 19 hours weekly resulted in the current approval of 33 hours weekly.

6. The petitioner's daughter stated her mother should be approved for the additional hours because she needs total assistance throughout the day with all her activities of daily living and she is bed-bound. The daughter also stated she has her own health problems such as [REDACTED] and cannot lift any weight. Her mother needs to be turned over in her bed every 2 hours to prevent bed

sores. Her mother never leaves the bed and performs her toileting functions and bathing in the bed. The daughter also stated that she herself is on the waiting list to receive Long-Term Care services. The petitioner's grandson suffers from [REDACTED] and cannot provide assistance according to his mother.

7. The Respondent's witness, Dr. Karver, stated that the petitioner met the criteria for 33 hours weekly of home health services. She also stated that, based on the daughter's testimony, it appears the petitioner's needs are not being met in her home. However, Dr. Karver stated the health plan can only provide total care in a facility such as a nursing home where she could be turned in her bed every 2 hours. Hospice care could also be another alternative to provide additional care.

8. The petitioner's daughter stated she did not want to pursue a nursing home placement for her mother because it was her experience that [REDACTED] patients do not survive long in a nursing home.

#### **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. 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, 7<sup>th</sup> Ed.).

12. 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).

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

14. The petitioner requested a fair hearing because she believes her services under the Program should be increased.

15. Fla. Stat. § 409.98 lists the services which must be covered by Long-Term Care plans. Companion services, personal care assistance, and homemaker services are among the services available from Long-Term Care plans and are addressed in the AHCA contract.

16. 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.

17. 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.

18. The petitioner also currently receives Companion care services, which are defined in the contract 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.

19. 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."

20. 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."

21. 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.

22. After considering the evidence and testimony presented, the hearing officer concludes that the petitioner has not demonstrated that her home health services should be increased under the LTC Program. The petitioner clearly needs assistance with all her activities of daily living (ADLs). However, she is currently approved for 33 hours weekly of home health services to assist her with bathing and other activities. The petitioner may benefit from arranging the approved hours to be provided two or more separate times per day rather than a continuous 5 hour block of time, in order to provide more assistance to her daughter in turning her in the bed.

23. In addition, the petitioner's family should consider other available services such as nursing home placement or hospice care if they are unable to completely meet her needs at home.

**DECISION**

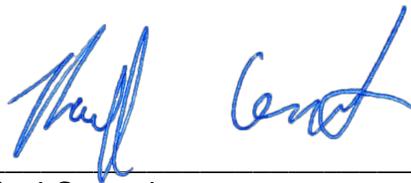
Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED.

**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 21 day of July, 2016,

in Tallahassee, Florida.



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Rafael Centurion  
Hearing Officer  
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FINAL ORDER (Cont.)

16F-03142

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Copies Furnished To: [REDACTED] PETITIONER  
AHCA, MEDICAID FAIR HEARINGS UNIT  
UNITED HEALTHCARE – MEDICAID FAIR HEARINGS

Jul 22, 2016

Office of Appeal Hearings  
Dept. of Children and FamiliesSTATE OF FLORIDA  
DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-03150

PETITIONER,

Vs.

CASE NO. FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 18 Seminole  
UNIT: 55207RESPONDENT.  

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**FINAL ORDER**

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 12:47 p.m. on June 3, 2016.

**APPEARANCES**

For the Petitioner:

For the Respondent:  
EconomicSylma Dekony, ACCESS  
Self-Sufficiency Specialist II**STATEMENT OF ISSUE**

At issue is whether the respondent's action to terminate the petitioner's full Medicaid and instead approve Medicaid Medically Needy (MN) with a Share of Cost (SOC) is proper. The respondent carries the burden of proof by a preponderance of the evidence.

**PRELIMINARY STATEMENT**

By notice dated January 12, 2016, the respondent (or the Department) notified the petitioner she was approved MN with a \$431 SOC, effective January 2016. Also by

notice dated February 4, 2016, the Department notified the petitioner her SOC increased from \$431 to \$452 effective March 2016. Petitioner timely requested a hearing to challenge the termination of full Medicaid and approval of MN with a SOC.

Petitioner did not submit exhibits. Respondent submitted five exhibits, entered as Respondent Exhibits "1" through "5". The record was closed on June 3, 2016.

### **FINDINGS OF FACT**

1. The petitioner and the respondent agreed that prior to the action under appeal, the petitioner received full Medicaid.
2. On January 4, 2016, the petitioner submitted a Food Assistance and Medicaid benefits redetermination application for her and her two minor children. The application lists petitioner's employment at [REDACTED] Medicaid for the petitioner is the only issue.
3. The Department first determined the petitioner's MN SOC amount with income it previously had in file. And on January 12, 2016, the Department mailed the petitioner a Notice of Case Action (NOCA) notifying her January 4, 2016 application was approved "with an estimated" \$431 SOC, effective January 2016.
4. On January 26, 2016, the petitioner submitted a completed and signed employment verification form from Aue Staffing listing the following income:

<u>Date</u>	<u>Amount</u>
12/18/15	\$237.45
12/24/15	\$227.65
01/15/16	\$236.75
01/22/16	\$236.75
Total	\$938.60

5. The following is the Department's recalculation of the petitioner's SOC, using her verified income:

\$938.60	petitioner's	income
<u>-\$486.00</u>	<u>MN income limit (MNIL) for household size of three</u>	
\$452.00	SOC	

6. On February 4, 2016, the Department mailed petitioner another NOCA, notifying her SOC increased from \$431 to \$452, effective March 1, 2016.

7. Petitioner said that she is employed for the school board through a temporary job agency. And she does not get paid in the month of December or during spring and summer.

8. Respondent's representative recommended that the petitioner submit a change report with verification that she is not currently employed and the Department will re-determine her Medicaid eligibility.

### **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 § 409.285, Fla. Stat. 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-1.707 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...

12. In accordance with the above authority, the Department determined petitioner's Medicaid eligibility using her employment (earned) income.

13. 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
3	\$303

14. The above authority explains, for petitioner to be eligible for full Medicaid, the income for a household size of three, cannot exceed \$303 monthly. Petitioner's \$938.60 income exceeds \$303; therefore, petitioner is not eligible for full Medicaid. The next available Program is MN with a SOC.

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

(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...

16. The above authority explains the SOC is determined by subtracting the income level (MNIL) from the gross income.

17. The Department's Program Policy Manual, at Appendix A-7 sets forth the MNIL at \$486 for a household size of three.

18. In accordance with the above authorities, the Department calculated petitioner's SOC by deducting \$486 (MNIL) from \$938.60 (petitioner's income) to arrive at \$452 SOC.

19. Petitioner argued that she is currently not employed, due to school being out for summer break.

20. Respondent's representative recommended that petitioner submit a change report with verification that she is not employed and the Department will reconsider her Medicaid eligibility.

21. In careful review of the cited authorities and evidence, the undersigned concludes the Department met its burden of proof. The Department is correct in authorizing petitioner MN with a \$452 SOC.

### **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   22   day of   July  , 2016,

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

Jul 21, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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

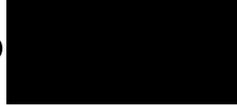


APPEAL NO. 16F-03151

PETITIONER,

Vs.

CASE NO



FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 03 Columbia  
UNIT: 88781

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on June 14, 2016 at 11:59 a.m.

**APPEARANCES**

For the Petitioner:



For the Respondent: Viola Dickinson, Economic Self-Sufficiency Specialist II

**STATEMENT OF ISSUE**

Petitioner is appealing the Department's action of January 11, 2016 ending his Qualifying Individual 1 as his income was too high for this program. The respondent carries the burden of proof by the preponderance of evidence.

**PRELIMINARY STATEMENT**

The petitioner submitted evidence on May 11, 2016, which was entered as Petitioner's Exhibit 1. The respondent submitted evidence on June 7, 2016, which was entered as Respondent's Exhibit 1. The petitioner did not receive the Department

evidence prior to hearing. The Department confirmed a new evidence packet would be sent to the petitioner via certified mail on the day of the hearing. The record remained open through June 29, 2016 to allow the petitioner to receive the Department's exhibit and to submit a rebuttal statement to that exhibit if he so chose. The petitioner resubmitted the documents received on May 11, 2016 on June 14, 2016. The petitioner did not submit a rebuttal statement. The record closed on June 29, 2016.

### **FINDINGS OF FACT**

1. The petitioner submitted an application for recertification on December 17, 2015. The petitioner receives Medicare Part A and B.

2. The petitioner receives Social Security income in the gross amount of \$1,388. The petitioner's Medicare Part B premium is \$104.90.

3. The Department discovered during this certification process that the petitioner's Social Security income was listed as \$1,282 during the previous certification process.

4. The Department took action to correct the petitioner's case with the correct gross Social Security income of \$1,388. The Department then issued the petitioner a Notice of Case Action on January 11, 2016 informing the petitioner his Qualifying Individual 1 (QI1) benefit would end on January 31, 2016, as his income was too high to qualify for this program.

5. The Department explained the budget calculation for the QI1 program. Policy requires the Department to use the gross income of \$1,388. The Department deducted a \$20 unearned income disregard leaving the countable unearned income of \$1,368. The Department compared the countable unearned income of \$1,368 to the

income standard for a one-person household for this program of \$1,325. The Department determined the petitioner is over the income limit to receive the QI1 assistance.

6. The petitioner explained he is dependent on this program so that he has some income to afford his copays at the doctors or even gas to get to his seven doctors each month.

7. The petitioner believes he is entitled to receive this benefit. He has worked his entire life and now his body broke down so he needs the help.

#### **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 Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

10. Fla. Admin. Code R. 65A-1.702 "Special Provisions" states in part: "(12)(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.)"

11. 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:

...

(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.

12. Federal Regulations at 20 C.F.R. § 416.1121 "Types of unearned income" states in relevant part: "(a) Annuities, pensions, and other periodic payments. This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veterans benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits."

13. 20 C.F.R. § 416.1124 "Unearned income we do not count" states in relevant part:

(c) Other unearned income we do not count. We do not count as unearned income—

...

(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.

14. The Department's Program Policy Manual, CFOP 165-22, Appendix A-9 effective July 1, 2015 lists the income limit for an individual to receive QI1 as \$1,325. Appendix A-9 effective April 1, 2016 lists the income limit for an individual to receive QI1 as \$1,337.

15. The findings show the petitioner's income is Social Security income. The above controlling authorities identify this income type as unearned income. The findings show the petitioner's gross Social Security income is \$1,388. The above

controlling authority allows \$20 of this income to be excluded. The undersigned concludes the petitioner's countable income is \$1,368 ( $\$1,388 - \$20 = \$1,368$ ). The undersigned further concludes the petitioner's countable income of \$1,368 exceeds the income limit to receive QI1 under the standards in effect as of July 1, 2015 and April 1, 2016.

16. The undersigned reviewed all applicable rules and regulations and found no other allowable deduction for the QI1 eligibility determination. Therefore, the undersigned concludes the Department's action to terminate the petitioner's QI 1 benefit is correct as the QI1 program has the highest limit of the three Medicare Savings Plan programs.

### **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 21 day of July, 2016,  
in Tallahassee, Florida.



---

Melissa Roedel  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
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Copies Furnished To  Petitioner  
Office of Economic Self Sufficiency

Jul 20, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-03169

PETITIONER,

Vs.

CASE NO



FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 02 Leon  
UNIT: 886DD

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on June 14, 2016 at 10:37 a.m.

**APPEARANCES**

For the Petitioner:



For the Respondent:

Marixsa Griffith, ACCESS Supervisor

Interpreter Services:



**STATEMENT OF ISSUE**

Petitioner is appealing the Department's action of April 28, 2016 approving him for Medically Needy effective May 2016. The petitioner believes he is eligible to receive full Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

### **PRELIMINARY STATEMENT**

The petitioner submitted evidence on June 7, 2016. This was entered as Petitioner's Exhibit 1. The Department submitted evidence on June 7, 2016. This was entered as Respondent's Exhibit 1. The record remained open through June 14, 2016 for the paystubs utilized in the April recertification. The Department provided this post hearing. The paystubs were entered as Respondent's Exhibit 2. The record closed on June 14, 2016.

### **FINDINGS OF FACT**

1. The petitioner submitted an application for recertification of his Adult-Related Medicaid benefits on March 28, 2016.
2. The petitioner's household consists of himself, age 59, and his wife, age 54).
3. The petitioner's wife is employed with [REDACTED]. Her paystubs for March 24, 2016 and April 7, 2016 were provided. The March 24, 2016 paystub reflects a total of 72.35 hours worked as regular earnings, 1.84 hours worked at overtime rate, and 2.12 hours of "Sunday premium". Total gross pay on this paystub was \$1,235.47. The April 7, 2016 paystub reflects a total of 72.12 hours of regular earnings, 0.52 hours of overtime earnings and 3.97 hours of "Sunday Premium". The total gross pay on this paystub was \$1,201.09.
4. The paystubs for the petitioner's wife were provided for May 19, 2016 and June 2, 2016. The petitioner maintained these stubs were not reflective of her normal pay as she received the quarterly bonus, which is not guaranteed, in one check and paid time off in the other check.

5. The Department did not have the May 19, 2016 or June 2, 2016 paystubs when completing the eligibility determination effective May 2016.

6. The Department totaled the earned income of the petitioner's wife from March 24, 2016 (\$1,235.47) and April 7, 2016 (\$1,201.09) to reach the total gross earned income of \$2,436.56. The Department deducted \$20 remaining unearned income disregard and \$65 earned income disregard leaving \$2,351.56 ( $\$2,436.56 - \$20 - \$65 = \$2,351.56$ ) in income. The Department then disregarded one-half of the remaining income leaving \$1,175.78 as countable earned income ( $\$2,351.56 / 2 = \$1,175.78$ ). As the petitioner's countable earned income exceeded the Income Standard of \$1,175, the Department determined the petitioner's eligibility under the Medically Needy (Share of Cost) program.

7. The Department explained that if an individual exceeds the income standard for full Medicaid even by one penny, they exceed the income standard and do not qualify for full Medicaid.

8. The Department calculated the share of cost by using the countable earned income of \$1,175.78 and subtracting the Medically Needy Income Level of \$241 and the medical insurance premium of \$121.69 to reach a share of cost of \$813 ( $\$1,175.78 - \$241 - \$121.69 = \$813$ ).

9. The petitioner explained he needs full Medicaid due to his multiple health issues including prescription costs, which exceed \$2,000 per month.

10. The petitioner believed he was approved for Medicaid through 2019.

11. The Department explained that the Division of Disability Determinations (DDD) established the petitioner as disabled in 2012. The disability was approved

through 2019. The disability is a factor of eligibility in Adult-Related Medicaid or Medically Needy programs.

### **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 Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

14. Fla. Admin. Code R. 65A-1.701 "Definitions" states in relevant 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.

...

(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.

15. Fla. Admin. Code R. 65A-1.710 "SSI-Related Medicaid Coverage Groups" states in relevant 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.

16. Fla. Admin. Code R. 65A-1.713 "SSI-Related Medicaid Income Eligibility

Criteria" states in relevant 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 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.

...

(3) When Income Is Considered Available for Budgeting. The department counts income when it is received, when it is credited to the individual's account, or when it is set aside for their use, whichever is earlier.

...

(4) Income Budgeting Methodologies. To determine eligibility SSI budgeting methodologies are applied except where expressly prohibited by 42 U.S.C. § 1396 (2000 Ed., Sup. IV) (incorporated by reference), or another less restrictive option is elected by the state under 42 U.S.C. § 1396a(r)(2) (2000 Ed., Sup. IV) (incorporated by reference). When averaging income, all income from the most recent consecutive four weeks shall be used if it is representative of future earnings. A longer period of past time may be used if necessary to provide a more accurate indication of anticipated fluctuations in future income.

(a) For MEDS-AD Demonstration Waiver, Protected Medicaid, Medically Needy, Qualified Working Disabled Individual, QMB, SLMB, QI1, and to compute the community spouse income allocation for spouses of ICP individuals, the following less restrictive methodology for determining gross monthly income is followed:

1. When income is received monthly or more often than once per month the monthly income from that source shall be computed by first determining the weekly income amount and then multiplying that amount by 4. A five-week month shall not be treated any differently than a four-week month.

...

3. When earned income is received less often than monthly, the department counts the total amount in the month received and does not prorate.

...

(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.

17. 20 C.F.R. § 416.1112 "Earned income we do not count" states in relevant

part:

(c) Other earned income we do not count. We do not count as earned income—

...

4) Any portion of the \$20 monthly exclusion in §416.1124(c)(10) which has not been excluded from your unearned income in that same month;

(5) \$65 of earned income in a month;

...

(7) One-half of remaining earned income in a month;

18. The Department's Program Policy Manual, CFOP 165-22, Appendix A-9, Eligibility Standards for SSI-Related Program effective April 1, 2016, lists the income limit for the MEDS-AD program for a couple as \$1,175.

19. Fla. Admin. Code R. 65A-1.716 "Income and Resource Criteria" (2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows: Family Size 2; Monthly Income Level \$241.

20. The findings show the petitioner's wife is employed and the gross pay received March 24, 2016 (\$1,235.47) and April 7, 2016 (\$1,201.09) totaled \$2,436.56. These paystubs did not reflect any bonus or holiday pay received. The undersigned concludes the Department correctly calculated the income to be considered in this case.

21. The undersigned reviewed the calculations to determine if the petitioner is eligible to receive full Adult Related Medicaid. The total earned income of \$2,436.56 less the \$20 monthly exclusion and \$65 of earned income leaves \$2,351.56. The one-half disregard applied to \$2,351.56 leaves countable income of \$1,175.78. The undersigned concludes the petitioner's income exceeds the income standard of \$1,175.

22. According to the above authorities, the Medically Needy Program is for aged, blind or disabled individuals who do not qualify for categorical assistance due to their level of income or resources. Therefore, the undersigned concludes the Department correctly determined petitioner did not qualify for full coverage Medicaid and enrolled him in the Medically Needy Program.

23. In accordance with the above controlling authorities, the Medically Needy share of cost (SOC) begins with the countable income of \$1,175.78. Deductions from the countable income of the Medically Needy Income Level of \$241 and medical

insurance premiums of \$121.69 are given to reach the SOC of \$813 (\$1,175.78 - \$241 - \$121.69 = \$813).

**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 July, 2016,

in Tallahassee, Florida.



---

Melissa Roedel  
Hearing Officer  
Building 5, Room 255  
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Tallahassee, FL 32399-0700  
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Copies Furnished To [REDACTED] Petitioner  
Office of Economic Self Sufficiency

Jul 25, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-03213

PETITIONER,

Vs.

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

And

HUMANA, INC.

RESPONDENTS.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, a telephonic administrative hearing was convened in this matter before the undersigned hearing officer on June 20, 2016 at 10:25 a.m.

**APPEARANCES**

For the Petitioner: , Mother

For the Respondent: Fatima Leyva,  
Senior Human Services Program Specialist,  
Agency for Health Care Administration

**STATEMENT OF ISSUE**

The Petitioner is appealing the Respondents' decision, through DentaQuest, to deny the Petitioner's request for dental procedure D8080-comprehensive orthodontic treatment (braces) and D8670-periodic orthodontic treatment (monthly visits for the

braces). Because the issue under appeal involves requests for services, Petitioner bears the burden of proof.

### **PRELIMINARY STATEMENT**

Mindy Aikman, Grievance and Appeals Specialist, appeared as Respondent's witness from the Petitioner's managed care plan, Humana. Dr. Susan Hudson, Dental Consultant, and Yvie Labady, Complaints and Grievance Specialist, appeared as Respondent's witnesses from DentaQuest. Karina, interpreter from Propio Languages, provided Spanish translation for the mother.

Respondent's exhibit 1 was entered into evidence.

Human's request to be added as a party to this appeal was granted by the undersigned on the record.

### **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 an eleven year-old Medicaid recipient enrolled with Humana, a Florida Health Managed Care provider.
2. Humana requires prior authorization for services related to dental care and has subcontracted with DentaQuest to review prior authorization requests.
3. The Petitioner's dentist sent a prior authorization request for dental procedure D8660: pre-orthodontic treatment examination to monitor growth and development; D8080: comprehensive orthodontic treatment of the adolescent dentition (braces); and D8670: periodic orthodontic treatment (24) visits.

4. DentaQuest made its determination on April 20, 2016 approving procedure D8660 and denying procedures D8080 and D8670. Notice was sent to the provider providing the denial reason:

[A] score of 26 points must be reached in order to qualify for orthodontic treatment [braces].

5. DentaQuest sent a Notice of Action to Petitioner on April 21, 2016 providing the following explanation for the denial:

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):

- ✓ Must be needed to protect life, prevent significant illness or disability, or alleviate severe pain.
- ✓ Must be individualized, specific, 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.

6. Petitioner filed a timely fair hearing request on April 26, 2016.

7. Petitioner's mother explained that her daughter has significant pain in her jaw, especially in the morning. She advised the Petitioner's dentist told them her jaw was misplaced. Petitioner was seen by a second orthodontist who told them if she did not get braces she would need to undergo jaw surgery in the future, which would be more painful. Petitioner provided no supporting medical documentation.

8. Respondent's Dental Consultant explained that proof of medical necessity was necessary in order to qualify for braces. Medical necessity for orthodontic work (braces) could be met by any one of several conditions – a cleft palate or the top front teeth biting behind the lower front teeth, or a score of 26 points on a score card (Medicaid's

Initial Assessment Form (IAF)). The score represents the severity of a member's malocclusion.

9. Petitioner does not meet the first two criteria for braces and her IAF score was less than 26 points. The provider's score on the IAF was 16 points with 8 points for overjet, 4 points for overbite and 4 points for Labio-Lingual spread. The dental consultant for DentaQuest who reviewed the request scored 2 points for overjet and 1 point for Labio-Lingual spread for a total IAF score of 3.

10. The Respondent's Dental Consultant further explained that pain associated with temporomandibular joint disorder (TMD) is not a qualifying condition.

11. The Respondent's Dental Consultant noted that the Petitioner's pain in the jaw could be caused by teeth bite, grinding of teeth, or some other reason. Having braces does not always address the joint pain.

### **CONCLUSIONS OF LAW**

12. 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.

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

14. 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).

15. 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.

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

17. 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.

18. 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.

19. Because the Petitioner is under twenty-one-years-old, a broader definition of medical necessity applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPDST) requirements. Florida Statute § 409.905, Mandatory Medicaid services, provides that Medicaid services for children must 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 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 may present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)).

21. Consistent with these requirements, the state is obligated to provide services to recipients under twenty-one 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.

22. Florida Medicaid’s Dental Services Coverage and Limitations Handbook (Handbook), incorporated by reference into Chapter 59G-4.060, Fla. Admin. Code, effective May 3, 2012 provides a description of “Orthodontic Services” on page 2-15:

Prior authorization is required for all orthodontic services. Orthodontic services are limited to those recipients with the most handicapping malocclusion (emphasis added). 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.

23. On page 2-17, the Handbook explains the use of the Medicaid Orthodontic Initial Assessment Form (IAF):

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.

....

The conditions listed in the IAF index should be considered in the context of whether they contribute to a disabling malocclusion. The provider scores each applicable condition and totals the recipient's index score. Special or mitigating circumstances, such as deep bites with palatal trauma or occlusion related temporomandibular joint dysfunction (TMD) must be described in detail. Include description of limited mobility history (locking open or closed) and other severe symptoms of TMD.

24. On page 2-18 of the Handbook, the required index score on the IAF is explained:

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 (emphasis added).

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 (emphasis added).

25. Petitioner has pain in her jaw and is seeking to have braces to relieve the pain.

No medical documentation was provided to support the Petitioner's assumption that the

pain will be relieved by having braces. Respondent's dental consultant stated the source of pain could be from other sources such as grinding teeth or teeth bite. The consultant asserted braces do not always address joint pain.

26. Petitioner needs to score at least 26 points on the Medicaid Orthodontic Initial Assessment Form (IAF) to qualify for braces.

27. Petitioner's dentist scored 17 on the IAF for the Petitioner.

28. Petitioner has failed to meet her burden of proof in establishing the medical necessity for braces. The low IAF score indicates a malocclusion not severe enough to qualify for braces. No medical documentation was provided that identified the source(s) of Petitioner's jaw pain. Petitioner's mother is encouraged to discuss with Petitioner's dentist alternative approaches to addressing the pain her daughter is experiencing.

### **DECISION**

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

FINAL ORDER (Cont.)

16F-03213

PAGE - 10

DONE and ORDERED this 25 day of July, 2016,

in Tallahassee, Florida.



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Warren Hunter  
Hearing Officer  
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Copies Furnished To: [REDACTED], Petitioner  
AHCA, Medicaid Fair Hearings Unit  
Mindy Aikman  
Humana Hearings Unit

Jul 21, 2016

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

Office of Appeal Hearings  
Dept. of Children and Families



APPEAL NO. 16F-03214

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 June 3, 2016 at 11:30 a.m.

**APPEARANCES**

For the Petitioner: , 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 denial of the petitioner's request for dental/orthodontic services (braces) was correct. The petitioner has the burden of proving her case by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

The petitioner submitted documents as evidence for the hearing which were marked as Petitioner Exhibit 1.

Appearing as witnesses for the respondent were Dr. Daniel Dorrego, Dental Consultant, and Jackeline Salcedo, Complaint and Grievance Specialist, from DentaQuest, which is the petitioner's dental services organization. Also present as a witness for the respondent was Carlene Brock, Quality Operations Nurse from Amerigroup, which is the petitioner's managed health care plan.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent composite Exhibit 1: case summary, authorization request, orthodontic evaluation form, dental records, denial notices, and criteria.

### **FINDINGS OF FACT**

1. The petitioner is a nine (9) 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 Amerigroup, which utilizes DentaQuest for review and approval of dental services.
2. On or about February 23, 2016, the petitioner's treating dentist or orthodontist (hereafter referred to as "the provider"), requested prior authorization for orthodontic treatment (braces). DentaQuest, on behalf of Amerigroup, denied this request on February 24, 2016. Amerigroup had previously approved an orthodontic evaluation visit to determine the need for braces.

3. The denial notice stated the request for braces was denied since it was not medically necessary. This denial notice also stated the following regarding the reason for the denial:

To qualify for braces you need to get 26 points on a test. The test gives points for crowded, missing, and rotated teeth as well as spacing. Our Dental Director scored your teeth. You do not qualify for braces. We have told your dentist. Please talk to your dentist. You reached a score of: 14 points.

4. The petitioner's mother stated her daughter needs braces because she has impacted teeth (4 canine teeth) and there is no space for the teeth to grow out. She also stated the braces will create more space to allow those teeth to come out.

5. The respondent's expert witness, Dr. Dorrego, testified that the denial of the petitioner's request for the braces was appropriate because an individual must have a score of 26 or higher on the evaluation form which is used to assess the need for braces, and the petitioner's score on that form was 14 based on DentaQuest's review. The petitioner's dentist reached a score of 10 on the evaluation form. Dr. Dorrego also stated that impacted canine teeth are not considered to be a qualifier for braces. He also stated the petitioner may qualify for braces when she is older after a new assessment is completed.

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, 7<sup>th</sup> 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. Braces are a covered service for individuals under age twenty-one (21) in the Florida Medicaid Program. The Dental Handbook, on page 2-15, states the following in reference to orthodontic services:

Orthodontic procedures may be reimbursed for Medicaid recipients under age 21.

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.

14. The Dental Handbook also describes an evaluation form used to assess the need for orthodontic treatment. This form is referred to as "The Medicaid Orthodontic Initial Assessment Form (IAF)" and the form calculates a numerical score based on the individual patient's conditions. The Dental Handbook, on page 2-18, describes the scores as follows:

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.

When the IAF score is less than 26, but the strategical positioning of the malocclusion constitutes a serious impediment or threat to normal growth, development and function of the jaws or dentition, the provider must submit a completed prior authorization, IAF, diagnostic photographs, panoramic x-ray and study models to the Medicaid orthodontic consultant for determination of medical necessity.

15. The petitioner's mother believes the braces should be approved since the braces will create space in her mouth to allow impacted teeth to grow out.

16. The respondent's witness stated that the braces were denied since the petitioner's score on the evaluation form was less than 26 (her score was 14).

17. After considering the evidence presented and relevant authorities set forth above, the undersigned concludes the petitioner has not demonstrated that the denial of the request for the braces was incorrect. The petitioner has not established that the request for this service is medically necessary as defined by Fla. Admin. Code R. 59G-1.010(166). Although the petitioner's orthodontist requested the braces, this does not establish it is medically necessary. The respondent's witness testimony and the Handbook provisions addressing orthodontic treatment support the denial of the requested service. The petitioner should explore other treatment options with her provider.

**DECISION**

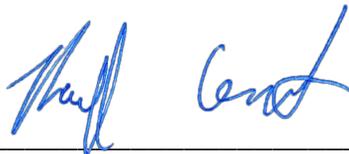
Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is DENIED.

**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 21 day of July, 2016,

in Tallahassee, Florida.



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Rafael Centurion  
Hearing Officer  
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Copies Furnished To: [REDACTED], PETITIONER  
AHCA, MEDICAID FAIR HEARINGS UNIT

Aug 16, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 16F-03215

PETITIONER,

Vs.

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 June 20, 2016 at 1:30 p.m. in [REDACTED] Florida and reconvened on July 12, 2016 at 2:10 p.m. in [REDACTED], Florida.

**APPEARANCES**

For the Petitioner: [REDACTED]

For the Respondent: Linda Latson, Registered Nurse Specialist,  
Agency for Health Care Administration (AHCA).

**STATEMENT OF ISSUE**

At issue is the Agency's action in partially denying Petitioner's request for ten hours of Speech Therapy per week, for the certification period February 4, 2016 to May 8, 2016. Because the matter at issue involves an initial request for services, Petitioner carries the burden of proof.

**PRELIMINARY STATEMENT**

Dr. Rakesh Mittal, physician consultant for eQHealth Solutions, appeared as witness for the Respondent.

Petitioner's Speech Language Pathologist, [REDACTED], and Waiver Support Coordinator, [REDACTED], appeared as witnesses on his behalf.

Respondent submitted a 96-page document which was entered into evidence and marked Respondent Exhibit 1. Petitioner submitted a 60-page document which was entered into evidence and marked Petitioner Exhibit 1.

Petitioner has been approved for two hours of Speech Therapy per week. He continues to receive five hours per week from his provider, although only two hours have been approved and authorized by Medicaid.

### **FINDINGS OF FACT**

1. Petitioner is a nine year-old recipient of the Medicaid program and is covered under Medicaid fee-for-service.
2. Petitioner is diagnosed with [REDACTED]  
[REDACTED]
3. EQHealth Solutions has been authorized to make Prior Authorization decisions for the Agency. Petitioner's provider submitted an initial request on February 1, 2016 to receive eight units (two hours) of Speech Therapy five times a week for a total of ten hours of Speech Therapy per week for the certification period. (Each unit of service is fifteen minutes.) An exception to Medicaid's maximum of 14 units of therapy per week is also required in order to approve the Petitioner's request.

4. EQHealth made its initial determination and sent a Notice of Outcome-Partial Denial to the Petitioner on February 8, 2016 approving 1 hour (4 units) per week of Speech Therapy. It stated the basis for the partial denial is that the services are not medically necessary as defined in 59G-1.010, Florida Administrative Code (F.A.C.).

5. Notice of the partial denial was also sent to the Petitioner's provider and provided the principle reason for the decision as:

Submitted information does not support the medical necessity for requested frequency and/or duration. Therapy services are approved for partial length of service requested, based on the documentation provided.

It also provided the clinical rationale for the decision as:

The patient is an 8 year old with [REDACTED] who may benefit from continued speech therapy addressing expressive language and articulation skills. The request is excessive based on the severity of the delay, goals submitted and the progress made. Four units one time per week 2/4/16 thru 5/8/16 is sufficient therapy to address the goals submitted.

6. Request for reconsideration was received by eQHealth on February 8, 2016 and eQHealth sent A Notice of Reconsideration Determination to the Petitioner on February 19, 2016 which approved 8 units (2 hours) once a week.

7. The Petitioner submitted a timely request for a fair hearing on April 26, 2016.

8. Petitioner was diagnosed with autism at 1 ½ years of age and at that time he began receiving five (5) hours of speech therapy except in the summer when he received ten (10) hours of speech therapy. Petitioner's mother stated her son only made progress in his speech when he received the ten (10) hours of speech therapy per week.

9. Petitioner's Speech Language Pathologist (SLP) wrote a Letter of Medical Necessity on February 8, 2016 (See Respondent Exhibit 1, page 45) which states in relevant part:

... [Petitioner] has had many years of therapy because of his support from his family, doctors, therapists, and teachers. [Petitioner] is an 8 year old boy with [REDACTED]. He is unable to function in his daily life because he has difficulty communicating his wants and needs, as stated in his speech and language evaluation. He has made significant progress using his words but [Petitioner] still needs a model to request, comment, and protest. His articulation skills are at a 3 year old level with articulation. His language skills cannot be scored because they are too low to be scored on all formal tests presented, as stated in his evaluation. These deficits are profound for an 8 year old. He is performing significantly below his chronological age and struggles in all areas of communication at home and in the community.

10. The SLP explained that she sets Petitioner's goals so he can master them within a six month period. She increases the goals in complexity as he progresses in his mastery of speech and language skills. However, the mother also explained that if Petitioner does not have regular weekly speech therapy sessions he regresses in his speech and language skills.

11. Respondent's physician consultant reviewed the SLP's November 11, 2015 evaluation of Petitioner. He noted Petitioner mastered six of his eleven short term goals and met 70% of two other short term goals. He referenced her comments in the Summary section:

He has shown amazing success producing final consonants and consonant blends which has increased his overall intelligibility in words and phrases.

12. Because the Petitioner has received intensive speech therapy services from an early age and the SLP shows he has made progress for the last six months, the

physician consultant agreed with the decision to approve two hours (8 units) of speech therapy services per week. He concluded Petitioner continues to need speech therapy services but not at the intensive level. He also explained that approval of intensive speech therapy above the maximum of 14 units per week is for a few months, based on clinical need, and not a full certification period.

13. The SLP explained that the Petitioner met his short term goals because of the intensity of the sessions and also because she wants him to master his speech and language skills incrementally. As he progresses, the goals will become more complex. Her goal is for the Petitioner to communicate closer to his chronological age.

### **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 Chapter 120.80 Fla. Stat.

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

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

17. 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).

18. 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.

19. Fla. Admin. Code 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.

(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...(Emphasis added.)**

20. Because the Petitioner is under twenty-one-years-old, the requirements of Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT) must be considered. Florida Statute § 409.905, Mandatory Medicaid services, provides that Medicaid services for children must 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.

21. In reviewing the appeal for compliance with EPSDT requirements, speech therapy services are part of Florida's Medicaid state plan of services. The agency is providing these services to the Petitioner for the certification period under appeal, and is therefore, in compliance with this EPSDT requirement. The remaining matter to consider is compliance with the EPSDT definition of medical necessity, which includes the amount and duration of the services.

22. The Therapy Services Coverage and Limitations Handbook- August 2013 (Handbook), has been promulgated by reference in the Florida Administrative Code at 59G-4.320. Page 1-2, provides the following purpose of the therapy services program:

The purpose of the therapy services program is to provide medically necessary physical therapy (PT), occupational therapy (OT), respiratory therapy (RT) and speech-language pathology (SLP) services to recipients under the age of 21. The therapy services program also provides 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.

23. The Handbook, on page 1-4, sets forth a description of the speech-language pathology services:

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.

24. Page 2-18 of the Handbook describes reimbursement limitations:

Medicaid reimbursement for therapy services is based on units-of-service. Each unit-of-service consists of a minimum of 15 minutes of face-to-face therapy treatment between the therapist or therapy assistant and the recipient.

The units-of-service may be combined into one treatment visit or provided as individual treatment visits. Up to four units-of-service, per type of therapy, may be provided on a single date of service. Daily treatments may not exceed four units-of-service. **No more than 14 units-of-service, per therapy, will be reimbursed per calendar week from Sunday to Saturday.** (Emphasis added.)

Only one type of therapy will be reimbursed for a given 15-minute session. Multiple providers, be it the school district or a community provider, cannot be reimbursed for the same procedure provided to a recipient on the same day.

... Speech therapy may be rendered to a group of children as described in the Group Therapy Treatment Visits for Speech Therapy.

Physical therapy, occupational therapy, and **speech-language therapy services in excess of limitations described in Chapter 3, Appendix A shall be prior authorized by the Medicaid QIO based on a plan of care submitted by the provider.** (Emphasis added.)

25. Chapter 3, Appendix A of the Handbook provides the procedure codes, fee schedule, and maximum units of service allowed. Speech therapy visits are limited to 4 visits per day or 14 visits per week (equal to 3 ½ hours per week).

26. Petitioner argues that he needs intense speech therapy of ten hours per week in order to continue to make progress in his language skills and ability to communicate.

27. Because of the Petitioner's success in meeting his short term goals for the past certification period and his history of intense speech therapy, Respondent agrees Petitioner continues to need speech therapy at two hours per week. Respondent opined that intense speech therapy at five hours per week is not medically necessary.

28. After considering the evidence, EPSDT requirements, and all of the appropriate authorities set forth above, the hearing officer concludes that Petitioner has not met his burden of proof.

29. Petitioner has received intense speech therapy for almost seven years. Petitioner's request for continued intensive speech therapy at ten hours per week exceeds the maximum number of speech therapy hours normally allowed by Medicaid. Respondent's physician consultant explained that approval beyond the maximum can be done on an exception basis if found clinically necessary. Respondent's consultant determined that five hours of speech therapy per week are not medically necessary.

### **DECISION**

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

DONE and ORDERED this 16 day of August, 2016,

in Tallahassee, Florida.



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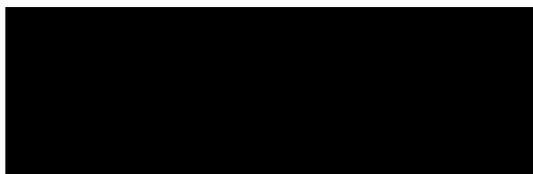
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Copies Furnished To: [REDACTED], Petitioner  
AHCA, Medicaid Fair Hearings Unit

Jul 26, 2016

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

Office of Appeal Hearings  
Dept. of Children and Families



PETITIONER,

APPEAL NO. 16F-03222

vs.

MANAGED HEALTH CARE ORGANIZATION,  
AND AGENCY FOR HEALTH CARE ADMINISTRATION  
CIRCUIT: 10 Hardee  
UNIT: AHCA

CO-RESPONDENTS.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 8, 2016, at approximately 11:06 a.m. All parties and witnesses appeared via teleconference.

**APPEARANCES**

For Petitioner:



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

**STATEMENT OF ISSUE**

At issue is a decision by Respondents, the Agency for Health Care Administration (AHCA or "the Agency") and its contracted health plan, Staywell/WellCare ("Staywell"), to deny Petitioner's request for a dental crown. Petitioner's dental provider submitted to Staywell a request for two types of crown for

the same tooth. Petitioner bears the burden of proving, by a preponderance of the evidence, that the plan's denial was improper.

### **PRELIMINARY STATEMENT**

This matter was originally assigned to and scheduled by Hearing Officer Danielle Murray, but was transferred to the undersigned hearing officer prior to final hearing. At hearing, Respondent, AHCA, was represented by, Stephanie Lang, RN Specialist. Respondent, Staywell, was represented by Stephanie Schupe, Regulatory Research Coordinator, and Jamira Dixon, National Ancillary Coordinator. Respondents also presented testimony from Richard Hague, DMD, Dental Director of Staywell's contracted review agency, Liberty Dental.

Respondent's Exhibits 1 through 11, inclusive, were accepted into evidence. Administrative Notice was taken of all pertinent legal authority. This Final Order follows.

### **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, who is under 21 years of age. He receives his Medicaid-based medical care through Staywell, a managed care organization/health maintenance organization (MCO/HMO), contracted by AHCA to provide medically necessary items and services to its enrollees.
2. On or about April 15 2016, Petitioner's dentist submitted to Molina a prior authorization request, asking that Petitioner be authorized to receive dental items/procedures coded D2740 (crown porcelain/ceramic substrate) and D2750 (crown, porcelain fused to high noble metal, both on tooth number 9.

3. Staywell forwarded this request, along with Petitioner's supportive documentation and x-rays, to Liberty Dental ("Liberty"). Liberty is the dental service review agency contracted with Staywell to determine whether dental services requested by Staywell enrollees are covered and/or medically necessary.

4. Via Notice of Action dated April 19, 2016, Staywell notified Petitioner of the plan's determination. Said Notice stated, in pertinent part:

... After our review, this service has been: DENIED as of 04/19/2016

We made our decision because:...

#1 DG-42 Denied – This patient's oral condition does not meet benefit criteria.

#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.

5. At hearing, Dr. Hague, the reviewing dentist from Liberty, explained that although he believed the denial of Petitioner's request was proper, Staywell's Notice cited incorrect reason(s) for said denial. Liberty testified that the request was actually denied based upon a benefit exclusion, as the use of a crown is limited to cases in which the patient's tooth requires a root canal. Liberty also conducted a second review of Petitioner's request, in preparation for final hearing. In his own review of Petitioner's x-rays, along with the dental records submitted to Liberty, Dr. Hague noted there was no reference to durational pain, sensitivity, or discoloration when trauma/pressure was applied to the area surrounding the tooth. As such, Dr. Hague had no indication that a root canal and/or crown was the proper course of medical treatment.

6. Petitioner's mother provided relevant history regarding the request, stating that Petitioner chipped his number 9 tooth, and had same filled two or 3 times at a clinic;

however, when Petitioner subsequently bit down on the filling, it failed to hold and the tooth chipped again. Petitioner was informed that because this tooth keeps on breaking, he requires a crown. Petitioner's mother asked that the provider request the cheapest type of crown appropriate to meet Petitioner's needs.

7. To support his determination, Dr. Hague referenced the November, 2011 version of Medicaid's Dental Services Coverage and Limitations Handbook ("2011 Dental Handbook"), which permits the provision of porcelain fused or porcelain/ceramic substrate crowns "when the tooth has been endodontically treated and cannot be adequately restored with a resin restoration." Dr. Hague explained that "endodontic" treatment, in this capacity, refers to root canal procedures. He further noted that this limitation is incorporated into Staywell's Child Medicaid Plan Benefit Schedule (entered into evidence), under the entries for procedure codes D2740 and D2750.

8. Dr. Hague stated that it appeared as though Petitioner's dentist submitted a request for both types of crowns to see if Staywell would cover either; however, it was Dr. Hague's opinion that, absent documentation to prove otherwise, a pin and resin amalgam might suffice to repair the subject tooth. Although he did consider the requirements of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Dr. Hague felt that a dental crown was in excess of Petitioner's medical needs, at this time.

9. Review of Staywell's AHCA contract reflects that Staywell must cover "full dental services for all enrollees age 20 and below." Staywell must also comply with pertinent provisions of the Medicaid Dental services Coverage and Limitations Handbook, and cannot impose limitations or exclusions which are more restrictive than those imposed under fee-for-service Medicaid.

10. Both Medicaid's fee-for-service fee schedule and Staywell's own fee schedule include codes D2740 and D2750; however, the 2011 Dental Handbook also notes the requirement for endodontic treatment prior to coverage for certain types of crowns.<sup>1</sup>

11. Petitioner's mother contends that the Petitioner needs dental services, and that the family requires Staywell's assistance in obtaining same. To this end, Staywell agreed to assign to Petitioner a case manager, who will work directly with Petitioner and his mother, so as to find new/additional providers, schedule additional evaluations, and/or submit a new request for services, at any time.

12. Petitioner's mother accepted this offer for case management, but requested a Final Order and ruling on the instant appeal.

#### **CONCLUSIONS OF LAW**

13. 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.

14. 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.

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, in accordance with Fla. Admin. Code R. 65-2.056.

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<sup>1</sup> This provision does not appear in the updated/May, 2016 version of the Dental Handbook. The effect of this change is discussed, below.

17. The burden of proof in the instant case is assigned to Petitioner, who has requested approval for a specific item/service.

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

19. Fla. Stat. § 409.905 addresses mandatory Medicaid services under the State Medicaid Plan, noting, in pertinent parts:

(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.

...

(6)(a)The agency shall pay for preventive, diagnostic, therapeutic, or palliative care and other services provided to a recipient in the outpatient portion of a hospital licensed under part I of chapter 395, and provided under the direction of a licensed physician or licensed dentist, except that payment for such care and services is limited to \$1,500 per state fiscal year per recipient, unless an exception has been made by the agency, and with the exception of a Medicaid recipient under age 21, in which case the only limitation is medical necessity. (underlined emphasis added)

20. Although dental services are not explicitly included in the above-referenced list of mandatory MCO services, AHCA does provide dental services for children under its fee-for-service Medicaid model. The MCO is not permitted to be more restrictive than fee-for-service Medicaid, in this regard. Further, Fla. Stat. § 409.912 provides 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, and Staywell has

agreed to contract, on a prepaid or fixed-sum basis, with appropriately licensed prepaid dental health plans to furnish medically necessary dental care.

21. Consistent with these requirements, the July 2012 Florida Medicaid Provider General Handbook (incorporated by reference into Fla. Admin. Code R. 59G-5), 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.  
(emphasis added)

22. Echoing Staywell's contract with AHCA, Page 1-30 of this Handbook notes: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service," but also states that the HMO can require prior authorization for any services it covers.

23. At the time Staywell rendered its decision in the instant matter, Medicaid fee-for-service dental services were governed, in part, by the 2011 Dental Handbook, as (then) promulgated by Fla. Admin. Code R. 59G-4.060(2). The 2011 Dental Handbook limited provision of certain types of crowns, noting on page 2-34:

- Porcelain fused to predominantly base metal crowns for permanent posterior or anterior teeth when the tooth has been endodontically treated and cannot be adequately restored with a stainless steel crown, amalgam or resin restoration; and

- Porcelain/ceramic substrate crowns for permanent and anterior teeth when the tooth has been treated endodontically and cannot be adequately restored with a resin restoration.

24. As previously noted, this language is consistent with the restrictions contained within Staywell's own Dental Benefits Table. Although the 2016 version of AHCA's fee-for-service Dental Fee Schedule does not include such language, or note the need for prior authorization of dental services for children under 21, all pertinent legal authority must be reviewed collectively.

25. As of May 3, 2016, a new version of the Dental Handbook has been promulgated into rule (Fla. Admin. Code R. 59G-4.060(2)(2016)). This updated Dental Handbook provides little guidance for the provision of dental services, but notes on page 4:

#### **4.2.8 Restorative Services**

Florida Medicaid reimburses for all-inclusive restorative services for recipients under the age of 21 years as follows:

- Restorations
- Crowns

...

#### **4.3 Early and Periodic Screening, Diagnosis, and Treatment**

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's authorization requirements policy. (underlined emphasis added)

26. Per Fla. Admin. Code. R. 59G-1.010(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)

27. Again, because 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 (cited, above) have been considered in the development of this Order.

28. 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.

29. 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 may present its own evidence of medical necessity in disputes between the state and Medicaid patients (citations omitted).

30. In the instant case, a dental crown is requested to treat and ameliorate Petitioner's chipped tooth; however, because it is not clear that Petitioner requires a root canal, nor clear that Petitioner's tooth is best restored using one of the types of crowns requested by his provider (or any crown, at all), the request is not consistent with generally accepted medical standards, may be in excess of Petitioner's needs, and is not a service for which no equally effective and less-costly treatment is available. (Fla. Admin. Code R. 59G-1.010(166)(2,3,4).) Indeed, as Dr. Hague opined, because restoration by resin or amalgam may be appropriate, there are less costly but potentially effective treatment options available, which have yet to be explored/ruled out.

31. 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 Petitioner has not met his burden of proof to show that AHCA's denial was improper.

32. Petitioner's mother is strongly encouraged to communicate with Staywell, and to avail herself of Petitioner's newly assigned case management service, so as to pursue dental treatment appropriate to meet petitioner's needs. Staywell is encouraged to contact Petitioner's mother to discuss Petitioner's options, and to assist in locating resources within her community and Medicaid coverage area.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner's appeal is DENIED, and 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 26 day of July, 2016,

in Tallahassee, Florida.



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Patricia C. Antonucci  
Hearing Officer  
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Copies Furnished To:

██████████, Petitioner  
AHCA, Medicaid Fair Hearings Unit  
Ray Walker, Staywell/WellCare

Aug 18, 2016

Office of Appeal Hearings  
Dept. of Children and FamiliesSTATE OF FLORIDA  
DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-03278

Vs. PETITIONER,

CASE NO

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 09 Orange  
UNIT: 55207RESPONDENT.  

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**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 9, 2016 at 1:00 p.m.

**APPEARANCES**For the petitioner: 

For the respondent: Sylma Dekony, Economic Self-Sufficiency Specialist II

**STATEMENT OF ISSUE**

At issue is the respondent's action to deny the petitioner's application for SSI-Related Medicaid benefits on the basis that he did not meet the disability Program requirement. Petitioner carries the burden of proof by a preponderance of the evidence.

**PRELIMINARY STATEMENT**

By notice dated April 20, 2016, the respondent notified the petitioner his Medicaid application was denied because he did not meet the disability requirement. Petitioner timely requested a hearing to challenge the respondent's action.

Petitioner did not submit any exhibits at the hearing. Respondent submitted five exhibits, entered as Respondent's Exhibits "1" through "5". The record was held open until close of business on June 23, 2016 for submission of additional evidence from the parties. On June 9, 2016, additional evidence was received from the respondent and entered as Respondent's Exhibit "6". On June 21, 2016 and June 22, 2016, evidence was received from the petitioner, which was combined and entered as Petitioner's Exhibit "1". The record closed on June 23, 2016.

### **FINDINGS OF FACT**

1. Petitioner (45) applied for SSI-Related Medicaid on January 4, 2016 for himself. Petitioner reported on his application that he is disabled. Petitioner is not aged 65 or older and does not have any minor children.

2. Petitioner has the following disabling conditions: [REDACTED]

[REDACTED]

benefits with Social Security Administration (SSA) on February 2015. Petitioner reported all of these conditions to (SSA).

3. On April 24, 2015, SSA denied the petitioner's disability application. SSA denied the petitioner with reason code N-35. The code N-35 means the denial was based on "Impairment is severe at time of adjudication but not expected to last 12 months, no visual impairment". Petitioner is unsure if an appeal was filed on this SSA decision.

4. On April 22, 2015, the petitioner slipped and fell causing injury to his [REDACTED]. Petitioner had surgery on April 22, 2015 due to this new injury which has required extensive medical follow-up. Petitioner alleges a new condition [REDACTED].

[REDACTED]

5. On August 11, 2015, the petitioner reapplied for SSA disability alleging this new condition. The August 11, 2015 application for SSA disability remains pending.
6. The Division of Disability Determination (DDD) is responsible for making a State disability determination on behalf of the respondent when an applicant applies for Medicaid on the basis of disability. Petitioner's application was referred to DDD on April 11, 2016. It is unknown why the petitioner's application was referred to DDD over the time standard.
7. On April 13, 2016, DDD determined the petitioner was not disabled because it adopted the SSA denial reason code N-35. On April 20, 2016, the respondent mailed the petitioner a Notice of Case Action denying his Medicaid application based on DDD's decision.
8. The conditions listed on the Disability Determination Transmittal by DDD were [REDACTED], on the transmittal remarks DDD wrote "same allegations, hearing pending". It is unknown why DDD wrote on the transmittal remarks "hearing pending".
9. The record was held open for the respondent to provide evidence if the petitioner's new disabling condition was considered by DDD in its determination. The respondent presented an email from DDD Program Operations Administrator explaining she was unable to provide any additional information.
10. The record was held open for the petitioner to provide evidence of the conditions reported to SSA. The petitioner submitted a SSA Notice of Disapproved Claim, dated April 24, 2015, which shows SSA based its decision on the petitioner's medical records from March 31, 2015 through April 21, 2015. The medical records for the petitioner's new condition (April 22, 2015) were not included in the evidence SSA used when it

denied the petitioner's disability claim. The respondent could not confirm if DDD included the new condition as part of its determination.

11. The respondent provided a State of Florida SSA State On-Line Query that indicates the petitioner reapplied for SSA disability on August 11, 2015 and SSA has not yet made a decision on that application. The query did not indicate if the petitioner appealed his April 24, 2015 SSA denial.

### **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 § 409.285, Fla. Stat. 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 Fla. Admin. Code R. 65-2.056.

14. Adults who are not elderly and who do not have minor children and apply for medical assistance must have their eligibility based on the same disability standards as those used by SSA. Fla. Admin. Code R. 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 less than 65 years of age to receive Medicaid benefits, he must meet the disability criteria of Title XVI of the Social Security Act appearing in the Code of Federal Regulations 20 C.F.R. § 416.905, "Basic definition of disability for adults".

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...

15. 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 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:** (emphasis added)

(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...** (emphasis added)

(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** (emphasis added)

(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—** (emphasis added)

(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.

(d) Basis for determinations. The agency must make a determination of disability as provided in paragraph (c) of this section—

(1) On the basis of the evidence required under paragraph (e) of this section; and

(2) In accordance with the requirements for evaluating that evidence under the SSI program specified in 20 CFR 416.901 through 416.998.

(e) Medical and nonmedical evidence. The agency must obtain a medical report and other nonmedical evidence for individuals applying for Medicaid on the basis of disability. The medical report and nonmedical evidence must include diagnosis and other information in accordance with the requirements for evidence applicable to disability determinations under the SSI program specified in 20 CFR part 416, subpart I.

(f) Disability review teams—(1) Function. A review team must review the medical report and other evidence required under paragraph (e) of this section and determine on behalf of the agency whether the individual's condition meets the definition of disability.

16. According to the above controlling authority, a decision made by SSA within 12 months of the Medicaid application is binding on the state agency **unless** the applicant alleges a disabling condition different from, or in addition to, those considered by SSA in making its determination. In this case, SSA denied the petitioner's disability claim on April 24, 2015 based on the petitioner's medical records from March 31, 2015 through April 21, 2015. On April 7, 2016, the respondent forwarded the case to DDD to determine if the petitioner was disabled. DDD determined petitioner was not disabled

by adopting SSA's April 24, 2015 denial; however, the evidence does not indicate that DDD considered the petitioner's new medical condition when it determined he was not disabled. No DDD witness appeared to provide testimony regarding its determination that the petitioner is not disabled.

17. The above federal regulation also explains that the respondent must make a determination of disability if the individual applies both to SSA and to the State Medicaid agency for Medicaid and SSA has not made a disability determination within 90 days from the date of the individual's application for Medicaid. On August 11, 2015, the petitioner reapplied for SSA disability alleging his new condition which began on April 22, 2015. As of the date of the hearing, SSA had not made a disability determination within 90 days from the date of the petitioner's August 11, 2015 application. Therefore, the respondent should have completed an independent disability determination.

18. DDD was incorrect in adopting SSA's April 24, 2015 denial and in not completing an independent disability review. DDD is to complete an independent disability determination based on the petitioner's new disabling condition.

19. After considering the evidence, testimony and appropriate authorities, the undersigned concludes the respondent erred in denying the petitioner's SSI-Related Medicaid application without completing an independent disability determination. Therefore, the undersigned remands this matter to the Department for DDD to complete an independent disability determination. The respondent is to preserve and honor the petitioner's application dated January 4, 2016. Once an eligibility determination is made, the respondent is to issue a written Notice of Case Action to the petitioner as soon as possible, including his appeal rights.

**DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted and remanded to the Department 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 18 day of August, 2016,

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

Jul 15, 2016

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

Office of Appeal Hearings  
Dept. of Children and Families



APPEAL NO. 16F-03282

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 11 Dade  
UNIT: 66703

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on June 6, 2016 at 11:12 a.m. All parties appeared telephonically from different locations.

**APPEARANCES**

For the Petitioner:



For the Respondent:

Lesbia Gutierrez,  
Operations Management Consultant I

**STATEMENT OF ISSUE**

At issue is the respondent's action to deny the petitioner's request for full Medicaid and enroll her in the Medically Needy (MN) program with an \$855 Share of Cost (SOC). The burden of proof was assigned to the petitioner by a preponderance of evidence.

**PRELIMINARY STATEMENT**

██████████, operator identification number ██████████, of Language Line Solutions, provided interpreter services for the hearing.

The petitioner submitted no exhibits. The respondent submitted 29 pages of evidence, which were marked and entered as Respondent's Composite Exhibit "1".

**FINDINGS OF FACT**

1. On April 1, 2016, the petitioner submitted an application for recertification of her Food Assistance Program benefits and requested the additional benefit of Medicaid.
2. The petitioner is the only household member.
3. The petitioner has been determined disabled by the Social Security Administration (SSA) and receives \$1,055 in Social Security Disability Income (SSDI) each month.
4. The petitioner is not eligible for Medicare Part A or B at this time.
5. For the petitioner to be eligible for full Medicaid, her income cannot exceed the income limit of \$872. The petitioner's \$1,055 SSDI exceeds the income limit. The next available program is MN with a SOC.
6. The department calculated the petitioner's SOC as follows:

\$1055	SSDI
- 20	unearned income disregard
- 180	<u>MNIL (medically needy income limit) for a household of one</u>
\$ 855	SOC

7. On April 19, 2016 the respondent sent the petitioner a Notice of Case Action (NOCA) informing her she has been enrolled in the Medically Needy (MN) program with an \$855 Share of Cost (SOC).
8. The petitioner timely requested the hearing.

9. The petitioner is requesting full Medicaid just for a few months as it would make her life easier. She also states she is having trouble finding providers that will take the MN coverage.

10. The respondent asserts that the petitioner is over the income limit for full Medicaid.

11. The respondent has also referred the petitioner to the Department of Elder Affairs for additional assistance.

### **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 Section 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

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

### **Full Medicaid will be addressed first:**

14. 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. The petitioner was evaluated under the SSI-Related Medicaid coverage group.

15. Fla. Admin. Code R. 65A-1.713 defines the income limits for SSI – Related Medicaid programs. 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:

(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.

16. The Department's Policy Manual (The Policy Manual), CFOP 165-22 at Appendix A-9, sets forth 88 % of the federal poverty level (FPL) for a household size of one at \$872, effective April 2016.

17. In accordance with the above authority and The Policy Manual, the petitioner's income cannot exceed 88% of the FPL and she cannot be receiving Medicare unless she is receiving institutional services, hospice services, or home and community based services.

18. The petitioner's \$1,055 SSDI exceeds the \$872 FPL for a household size of one. Therefore the petitioner is not eligible for full Medicaid.

19. After careful review of all cited authorities, the undersigned concludes the petitioner is ineligible for full Medicaid. The next program available is the Medically Needy (MN) program.

**Enrollment in Medically Needy and Share of Cost amount will now be addressed:**

20. 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.

21. The above authority explains MN provides coverage for individuals who do not qualify for full Medicaid due to income.

22. Fla. Admin. Code R. 65A-1.701 (30) states, "Share of Cost (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."

23. The Fla. Admin. Code R. 65A-1.713, SSI-Related Medicaid Income Eligibility Criteria, states in part:

(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.

24. The Federal Regulations at 20 C.F.R. § 416.1124 explains unearned income not counted and states, "(c) Other unearned income we do not count...(12) The first \$20.00 of any unearned income in a month..."

25. The Fla. Admin. Code R. 65A-1.716 sets forth the MNIL at \$180 for a family size of one.

26. In accordance with the above cited authorities, the respondent deducted \$20 unearned income and \$180 MNIL from the petitioner's \$1,055 SSDI to arrive at \$855 SOC.

27. The undersigned reviewed the respondent's budget calculations and the petitioner's reported income using the rules cited above and did not find a more favorable outcome than the SOC assigned by the respondent.

**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 15 day of July, 2016,

in Tallahassee, Florida.



\_\_\_\_\_  
Pamela B. Vance  
Hearing Officer  
Building 5, Room 255  
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Tallahassee, FL 32399-0700  
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Copies Furnished To:   
Office of Economic Self Sufficiency

**FILED**

Jul 14, 2016

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

Office of Appeal Hearings  
Dept. of Children and Families



APPEAL NO. 16F-03286

PETITIONER,

Vs.

AGENCY FOR HEALTH  
CARE ADMINISTRATION  
CIRCUIT: 04 Duval  
UNIT: AHCA

and

SUNSHINE STATE HEALTH PLAN, INC.

RESPONDENTS.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on July 8, 2016 at 10:28 a.m. at the Department of Children and Families program office in Jacksonville, Florida.

**APPEARANCES**

For the Petitioner:



For the Respondent: Paula Daily, grievance and appeals coordinator

**STATEMENT OF ISSUE**

At issue is the quality of service the petitioner received from her Medicaid HMO.

**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. Sunshine State Health Plan (Sunshine) is the contracted health care organization in the instant case.

There were no additional witnesses for the petitioner. The petitioner submitted documentary evidence which was admitted into the record as Petitioner's Composite Exhibit 1.

In addition to Paula Daily, the respondent presented two witnesses from Sunshine: Dr. Davis Gilchrist, medical director; Kizzy Alleyne, paralegal; Joerosa Davis, manager of appeals and grievances; Tammi Swan, director of Long Term Care; and Deadra McKinney, Long Term Care case manager. The Sunshine witnesses appeared telephonically. Present as an AHCA witness: Bonnie Taylor, program administrator. Present as observer from AHCA: Selwyn Gossett, medical healthcare analyst. 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 is a Florida Medicaid recipient. The petitioner is enrolled with Sunshine HMO.

2. The petitioner filed a request with Sunshine for a hospital bed repair evaluation on February 9, 2016 because she believed her bed had malfunctioned. Sunshine denied the petitioner's request on February 10, 2016 because Medicare is the petitioner's primary insurance coverage and there was no evidence that Medicare had denied this service request. The petitioner requested reconsideration. Sunshine upheld the original denial decision on April 21, 2016.

3. The petitioner filed request with Sunshine for a semi electric hospital bed on February 17, 2016. Sunshine denied the request on February 24, 2016 because Medicare is the petitioner's primary insurance coverage and there was no evidence that Medicare had denied this service request.

4. The petitioner requested a hearing to address both denial decisions on April 28, 2016.

5. Sunshine reversed its denial decision and provided the petitioner with a semi electric hospital bed on May 13, 2106.

6. Sunshine argues that the issues under appeal are now moot.

7. The petitioner confirmed receipt of the semi electric hospital bed on May 13, 2016. However, she is seeking a resolution for what she argued was poor provider relations and quality of care from Sunshine HMO. She wants to ensure that this never happens to her again or to any other Sunshine enrollee.

### **CONCLUSIONS OF LAW**

8. 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 Section 120.80, Florida Statutes.

9. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.

10. Federal Medicaid Regulations at 42 C.F.R. § 431.220 states in relevant part, “(a) The State agency must grant an opportunity for a hearing to the following: (1) Any applicant who requests it because his claim for services is denied or is not acted upon with reasonable promptness (2) Any recipient who requests it because he or she believes the agency has taken an action erroneously...”

11. The Centers for Medicare & Medicaid Services’ State Medicaid Manual, publication #45, states in part:

#### **2900 FAIR HEARINGS AND APPEALS**

Section 1902(a)(3) of the Social Security Act requires that States ‘provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness.’ Regulations implementing this section of law are found at 42 CFR 431 Subpart E. In addition, certain court decisions further amplify and modify the law and regulations governing the provision of notices and hearings to Medicaid applicants and recipients. Where appropriate, those decisions are cited . 2900.1 Basic Responsibility (42 CFR 431.200 and 431.205).--Establish policies and procedures for assuring a system of fair hearings that meet all the requirements of the regulations and instructions.

Notify and make available to the applicant or recipient the hearing procedures required by regulations and these instructions, if any of the following events occur:

- o denial of eligibility,

- o the claim is not acted upon with reasonable promptness,
- o termination of eligibility or covered services,
- o suspension of eligibility or covered services, or
- o reduction of eligibility or covered service

12. The above federal authority explains that an opportunity for a hearing must be granted when a Medicaid claim for service has been denied or when a recipient believes the agency has taken an action erroneously. The State Medicaid Manual further explains the recipient's right to a hearing when either Medicaid eligibility or a claim for a service under Medicaid is denied, terminated, reduced or delayed.

13. The respondent reversed its original denial decision and provided the petitioner with a semi electric hospital bed on May 13, 2016. Provision of the hospital bed renders the issues under appeal moot. The petitioner has received the equipment she requested. Accordingly, a bed repair evaluation is no longer necessary for her old hospital bed.

14. The petitioner's remaining issue involves the quality of customer service she received from Sunshine. The Office of Appeal Hearings does not have jurisdiction over HMO customer relations or quality of care issues. The petitioner may address her concerns about Sunshine HMO by calling AHCA's Consumer Complaint Office at 1-877-254-1055.

### **DECISION**

The appeal is dismissed as moot in regards to the service issues and non-jurisdictional in regards to the HMO customer relations issue.

**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 July, 2016,

in Tallahassee, Florida.



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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  
AHCA, Medicaid Fair Hearings Unit

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

**FILED**

Jul 27, 2016

Office of Appeal Hearings  
Dept. of Children and Families



APPEAL NO. 16F-03288

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION  
CIRCUIT: 18 Seminole  
UNIT: AHCA

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-styled matter on June 20, 2016 at approximately 3:00 p.m. in .

**APPEARANCES**

For Petitioner:



For Respondent:

Lissette Knott  
Program Administrator  
Agency for Health Care Administration

**STATEMENT OF ISSUE**

At issue is Respondent's partial reduction of Petitioner's request for physical therapy. Petitioner was previously receiving two (2) 45-minute sessions per week, and she was only approved for one (1) 45-minute session per week for the next certification period. The burden of proof is assigned to Respondent.

**PRELIMINARY STATEMENT**

Petitioner was physically present at the hearing, but was represented by her mother. Lissette Knott, Program Administrator, represented and appeared as a witness for Respondent, the Agency for Health Care Administration (“AHCA” or “Agency”). The Agency presented one (1) witness, Dr. Darlene Calhoun, Physician Reviewer with eQHealth Solutions (“eQHeath”).

Petitioner moved Exhibits 1 – 3 into evidence. AHCA moved Exhibits 1 – 14 into evidence. Administrative notice was taken of the Florida Medicaid Therapy Services Coverage and Limitations Handbook, August 2013.

**FINDINGS OF FACT**

1. Petitioner is a 19-year-old female. She was 18-years-old at the time of the request.
2. Petitioner’s diagnoses include:

- [REDACTED]

3. Petitioner is wheelchair-dependent. She recently had a shunt put in her neck. Dr. Calhoun said she was surprised the shunt has not been in place her entire life.

4. Petitioner has been receiving physical therapy (“PT”) twice per week for 18 years. Her mother has performed PT activities for her daughter for years as part of a home plan. She said the physical therapists do a better job, and that she avoids her daughter’s neck because of the shunt.

5. Petitioner’s physical therapy provider requested PT twice per week for 45 minutes per session. Petitioner’s mother stated the frequency of the PT sessions are more important to her than the duration. She said she would rather have two (2) 30-minute sessions instead of one (1) 45-minute session because she wants the professional physical therapists to see her daughter more often.

6. eQHealth is the Quality Improvement Organization (“QIO”) contracted with AHCA to review PT requests. On April 25, 2016, eQHealth issued a Notice of Outcome – Partial Denial Physical, Occupational, or Speech Therapy Services. (Resp. Exh. 4).

The Notice stated:

The rationale for our decision is as follows:

PR Principal Reason – Denial:

Submitted information does not support the medical necessity for requested frequency and/or duration. Therapy services are approved for partial length of service requested, based on documentation provided.

Clinical Rationale for Decision: 18 yo with [REDACTED]  
Therapy is needed to improve passive ROM of lower extremities, ROM of head/neck, neutral alignment of the pelvis on lumbar spine, no rotation of rib cage on the spine.

Deny requested units. Based on the patient’s deficits and needs, 3 units 1x/wk is sufficient therapy.

7. A reconsideration of the decision by a different physician was requested. On April 27, 2016, eQHealth issued a Notice of Reconsideration Determination –

Physical Therapy, Occupational Therapy and Speech Therapy, upholding the denial

(Resp. Exh. 5). The Notice stated:

The medical basis for the reconsideration decision is as follows:

PR Recon Determination: The patient is an 18 year old with [REDACTED] who may benefit from continued PT. After reconsidering the submitted information, the original decision has to be upheld based on the severity of delay, goals submitted and the progress made over many years. Three units one time per week is sufficient PT for ROM, positioning, and to establish a HEP.

8. Petitioner’s Physical Therapy Evaluation & Plan of Care, Respondent’s Exhibit 9,

lists the following Long Term Goals (“LTG”) and Short Term Goals (“STG”):

LTG: 1	Current	[Petitioner] will display passive ROM of the lower extremities within functional limits, as demonstrated by goniometric measurement.
STG: A	Current	[Petitioner] will maintain range of motion of the ankles to WNL, bilaterally.
	Progress	Range of motion of the ankles has been restored to WNL. We will continue this goal.
STG : B	Current	[Petitioner] will maintain knee extension (with hip at 0’), to R -5’ and L -10’, as measured goniometrically.
	Progress	<b>Range has been improved to R -10’ and L -15’. This is progress from her last evaluation.</b> We will continue this goal to restore her previous range. (emphasis added).

LTG: 2	Current	[Petitioner] will demonstrate increased
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		range of motion of the head and neck.
STG: A	Current	[Petitioner] will demonstrate passive lateral flexion of the neck to +5 to the right.
	Progress	Passive lateral flexion is possible to neutral. *There has been some concern from the neurologist and pediatric physiatrist that there may be scar tissue binding her shunt tubing and that increased range may not be possible without surgery to correct this.* <b>We will therefore discontinue this goal.</b> (emphasis added).
STG: B	New	[Petitioner] will demonstrate passive rotation of the head/neck to +20' to the left.
	Progress	Passive rotation is possible to +5'. <b>Goal will be discontinued to reason listed above.</b> (emphasis added).

LTG: 2	New	[Petitioner] will demonstrate neutral alignment of the pelvis on the lumbar spine (no retraction) and no rotation of her rib cage on the spine.
STG: A	New	[Petitioner] will demonstrate reduction of retraction of pelvis on left side to 5'.
STG: B	New	[Petitioner] will demonstrate reduction of her rib cage rotation (rib

		hump) to .5cm on the right side when prone.
--	--	---

9. Dr. Calhoun gave credible testimony that the goals can be achieved by Petitioner's mother at home, and that the PT sessions once per week will primarily be to monitor Petitioner's condition. She said the goals are small. She said there have to be short and long-term goals and documented progress to approve continued PT. She said she can't guarantee that staying at two (2) sessions per week will yield any progress, and she can't guarantee that dropping to one (1) session per week will not cause some regression.

10. Petitioner's mother said she thinks the goals were poorly written and the lack of documentation is the problem because the provider was likely not detailed enough since she has been receiving the service for 18 years and the recertification is routine.

### **CONCLUSIONS OF LAW**

11. 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.

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

13. This is a Final Order, pursuant to Sections 120.569 and 120.57, Fla. Stat.

14. 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, 7<sup>th</sup> Ed.).

15. 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.

16. The Florida Medicaid Therapy Services Coverage and Limitations Handbook, August 2013 (“Therapy Handbook”), is promulgated into law by Chapter 59G, Florida Administrative Code.

17. Page 1-3 of the Therapy Handbook defines physical therapy:

Physical therapy is a specifically prescribed program to develop, maintain, improve or restore neuro-muscular or sensory-motor function, relieve pain, acquire a skill set, restore a skill set, or control postural deviations to attain maximum performance.

Physical therapy services include evaluation and treatment of range-of-motion, muscle strength, functional abilities and the use of adaptive and therapeutic equipment. Examples are rehabilitation through exercise, massage, the use of equipment and habilitation through therapeutic activities.

18. Page 2-2 of the Therapy Handbook requires that all services be medically necessary.

19. The definition of “medically necessary” is found in 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.

20. Since 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:

**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.

21. Under the above statute, the Agency must provide physical therapy that would correct or ameliorate Petitioner's condition.

22. 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 may present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)).

23. 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.

24. In the instant-matter, there is no compelling reason to continue Petitioner's PT services at two (2) sessions per week, 45 minutes per session. The goals are small and could potentially be performed by Petitioner's mother at home.

25. At the same time, there is no compelling reason to reduce Petitioner's PT services down to one (1) 45-minute session per week. The Plan of Care adds a new long-term goal and two (2) new short-term goals, and discontinues a long-term goal and two (2) short-term goals. Petitioner has also shown some improvement in one of her short-term goals. In addition, Petitioner's mother stated she is uncomfortable touching her daughter's neck now that the shunt is in place.

26. Dr. Calhoun candidly and credibly said she could not say for certain whether continuing with two (2) sessions per week would lead to improvement in Petitioner's condition, or that dropping to one (1) session would worsen her condition.

27. Since there is no compelling reason to change the status quo, the undersigned concludes the Agency has failed to meet its burden of proof to show the reduction of PT services was correct.

### **DECISION**

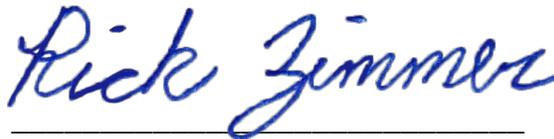
Based upon the foregoing, Petitioner's appeal is GRANTED. The Agency is directed to provide Petitioner with two (2) 45-minute sessions per week of physical therapy, consistent with her request.

**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 27 day of July, 2016,

in Tallahassee, Florida.



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Rick Zimmer  
Hearing Officer  
Building 5, Room 255  
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Fax: 850-487-0662  
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Copies Furnished To: [REDACTED], Petitioner  
AHCA, Medicaid Fair Hearings Unit

Aug 01, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-03324

PETITIONER,

Vs.

CASE NO



FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 19 ST. LUCIE  
UNIT: 88085

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on July 8, 2016 at 3:07 p.m., in



**APPEARANCES**

For the Petitioner:



For the Respondent:

Patricia Roy, supervisor

**STATEMENT OF ISSUE**

The petitioner is appealing the Department's action to deny her application for Medicaid benefits as she did not meet the disability requirement. The petitioner carries the burden of proof by the preponderance of evidence.

**PRELIMINARY STATEMENT**

The petitioner presented one exhibit which was accepted into evidence and marked as Petitioner's Composite Exhibit 1. The respondent submitted two exhibits,

which were accepted into evidence and marked as Respondent's Composite Exhibits 1 and 2.

The petitioner's request for hearing was scheduled to convene telephonically on June 21, 2016. On June 16, 2016, she requested an in-person hearing. Her request for continuance was granted and the hearing rescheduled for an in-person hearing on July 8, 2016. The record was closed on July 8, 2016.

### **FINDINGS OF FACT**

1. The petitioner submitted an online application on November 16, 2015 for SSI-Related Medicaid benefits. She has no minor children. She indicated on the application that she was disabled. At the time of the application, the petitioner was 51 years old. Her date of birth is [REDACTED]
2. The petitioner filed a disability application with the Social Security Administration (SSA) on December 8, 2015. SSA denied the petitioner's disability claim on December 30, 2015.
3. On April 25, 2016, the petitioner filed an appeal of the SSA denial. That appeal is currently pending.
4. On January 11, 2016, the respondent forwarded the petitioner's November 16, 2015 application to the Division of Disability Determination (DDD) which conducts disability determinations for the Department.
5. DDD did not conduct an independent review but instead, it denied the petitioner's disability claim by adopting the SSA denial.
6. On January 19, 2016, DDD informed the Department of its decision by way of the Disability Determination and Transmittal form, which stated that the petitioner was not

disabled as they adopted the SSA denial decision with reason code N31 and same allegations. The form also noted that the primary diagnosis was [REDACTED] and that the secondary diagnosis was [REDACTED]

7. On January 20, 2016, the respondent notified the petitioner that she was denied Medicaid.

8. On April 21, 2016, the petitioner submitted a second online application for SSI - Related Medicaid. She indicated on the application that she was disabled. The Department denied the second application without sending it to DDD for a disability decision.

9. The petitioner describes her disabling condition as [REDACTED]

[REDACTED] All these conditions have left her very ill and unable to work. She alleges that she cannot sit or stand for more than 2 hours and she cannot walk for more than 100 feet. She is in constant pain.

10. The Department's disability determination screen (AIDD) indicates DDD denied the petitioner's SSI Related Medicaid with reason code N31, no visual impairment. The petitioner appealed the SSA denial and it is currently pending. The petitioner alleged her condition worsened at the beginning of January 2016 and continues to deteriorate. She also indicated on her Medicaid application that her condition changed since her denial. The petitioner has not provided proof that her condition has worsened since her January 2016 denial.

### 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 Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

13. Florida Admin Code, R. 65A-1.710, 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...

14. 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 § 435.911 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 following circumstances exist... [emphasis added]**

(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 [emphasis added]

(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;** [emphasis added] 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**

15. The Department's Program Policy Manual, CFOP 165-22 (The Policy Manual) at

1440.1205 addresses Exceptions to State Determination of Disability (MSSI, SFP) as

follows:

The state does not make a disability determination under the following conditions:

1. When an individual only applies to SSA (no application is filed with DCF and no SSI denial or ex parte is involved).

2. When an individual receives Title II disability or SSI benefits based on their own disability (not dependent or early retirement benefits).
3. When an earlier favorable federal or state determination of blindness/disability is still in effect and no unfavorable decision has been rendered by SSA.
4. When an individual is no longer eligible for SSI solely due to institutionalization.
5. When the applicant is appealing an earlier decision from SSA and claims no new disabling condition (condition not previously considered by SSA).
- 6. When the individual files an application within 12 months after the last unfavorable disability determination by SSA, and the individual alleges no new disabling condition or claims a deterioration of an existing condition previously considered by SSA. Refer the individual to SSA for disability reconsideration or appeal. [emphasis added]**

16. The above explains that when an individual files an application within 12 months after the last unfavorable decision and claims a deterioration of an existing condition previously considered by SSA the Department should refer the individual to SSA for appeal or reconsideration. The petitioner was denied disability by SSA within the past 12 months, alleges worsening conditions, but did not allege any new conditions. The petitioner currently has an appeal pending with SSA.

17. In accordance with the above controlling authority, the undersigned concludes the Department correctly adopted the SSA disability decision to denied the petitioner SSI Related Medicaid rather than make an independent decision on petitioner's disability request.

### **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   01   day of   August  , 2016,

in Tallahassee, Florida.



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Christiana Gopaul-Narine  
Hearing Officer  
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Copies Furnished To: [REDACTED] Petitioner  
Office of Economic Self Sufficiency

Jul 20, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-03333

PETITIONER,

Vs.

CASE NO



FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 01 Okaloosa  
UNIT: 88630

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter in Fort Walton Beach, Florida on June 17, 2016 at 11:52 a.m.

**APPEARANCES**

For the Petitioner:



For the Respondent:

Steve Kent, ACCESS Supervisor

**STATEMENT OF ISSUE**

Petitioner is appealing the Department's action of January 29, 2016 terminating her Qualifying Individuals 1 (QI 1) benefit. The respondent carries the burden of proof by the preponderance of evidence.

**PRELIMINARY STATEMENT**

This hearing was originally scheduled by telephone for June 22, 2016. The petitioner requested a face-to-face hearing, which was held on June 17, 2016 in Fort Walton Beach.

Michael Dupe, ACCESS Supervisor, appeared as an observer to these proceedings with no objection from the petitioner.

The Department submitted information prior to the hearing, which was entered as Respondent's Exhibit 1. The petitioner submitted information at hearing, which was entered as Petitioner's Exhibit 1.

The record closed on June 17, 2016.

### **FINDINGS OF FACT**

1. The petitioner filed an application for recertification of the petitioner's Qualifying Individuals 1 (QI 1) on January 19, 2016.
2. The petitioner's income is from Social Security disability. Her gross income is \$1,677 per month. The petitioner receives Medicare. The petitioner's Medicare Part B premium is \$104.90.
3. The Department explained there is a \$20 unearned income disregard that is given when determining the countable income in the Medicare Savings Programs, which pay the Medicare premium for recipients. In this instant case, the petitioner's gross income of \$1,677 less the \$20 unearned income disregard leaves the petitioner a countable income of \$1,657.
4. The Department explained the petitioner's countable income of \$1,657 exceeds the income standard of \$1,325 to receive QI 1 benefit. QI 1 is the program with the highest income limit.
5. The Department issued a Notice of Case Action on January 29, 2016 informing the petitioner that her application for QI 1 was denied as her income was too high to qualify for the program.

6. The petitioner stated her Medicare premium was paid for her for about three months and then she lost the overage. She would like to have the program again.

7. The petitioner explained she is in a catastrophic financial situation. She also stopped receiving the “Extra Help” that was assisting with her prescriptions, which are in excess of \$2,000 per month.

8. The petitioner stated she has been trying request a “court date” since February 3, 2016.

9. The petitioner’s evidence shows documents where she wanted to request a reconsideration of the Extra Help termination benefits.

10. The Department explained the Extra Help benefit was determined by Social Security.

### **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 Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

13. Fla. Admin. Code R. 65A-1.702 “Special Provisions” states in part: “(12)(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.)”

14. 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:

...

(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.

15. Federal Regulations at 20 C.F.R. § 416.1121 “Types of unearned income”

states in relevant part: “(a) Annuities, pensions, and other periodic payments. This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veterans benefits, worker’s compensation, railroad retirement annuities and unemployment insurance benefits.”

16. 20 C.F.R. § 416.1124 “Unearned income we do not count” states in

relevant part:

(c) Other unearned income we do not count. We do not count as unearned income—

...

(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.

17. The Department’s Program Policy Manual, CFOP 165-22, Appendix A-9

effective July 1, 2015 lists the income limit for an individual to receive QI 1 as \$1,325.

Appendix A-9 effective April 1, 2016 lists the income limit for an individual to receive QI 1 as \$1,337.

18. The findings show the petitioner's income is Social Security income. The above controlling authorities identify this income type as unearned income. The findings show the petitioner's gross Social Security income is \$1,677. The above controlling authority allows \$20 of this income to be excluded. The undersigned concludes the petitioner's countable income is \$1,657 ( $\$1,677 - \$20 = \$1,657$ ). The undersigned further concludes the petitioner's countable income of \$1,657 exceeds the income limit to receive QI 1 under the standards in effect as of July 1, 2015 and April 1, 2016.

19. The undersigned reviewed all applicable rules and regulations and found no other allowable deduction for the QI 1 eligibility determination. Therefore, the undersigned concludes the Department's action to deny the petitioner's QI 1 benefit is correct as the QI 1 program has the highest limit of the three Medicare Savings Plan programs.

### **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.

FINAL ORDER (Cont.)

16F-03333

PAGE - 6

DONE and ORDERED this 20 day of July, 2016,

in Tallahassee, Florida.



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Melissa Roedel  
Hearing Officer  
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Copies Furnished To [REDACTED] Petitioner  
Office of Economic Self Sufficiency

Jul 14, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-03348

PETITIONER,

Vs.

AGENCY FOR HEALTH  
CARE ADMINISTRATION  
CIRCUIT: 07 Flagler  
UNIT: AHCA

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on July 8, 2016 at 3:08 p.m.

**APPEARANCES**

For the Petitioner: 

For the Respondent: Dr. Brittany Vo, dental consultant

**STATEMENT OF ISSUE**

1. At issue is the denial of the petitioner's request for a second lower denture through Medicaid.
2. Also at issue is the quality of care and customer service the petitioner received from a Medicaid dental provider.

### **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.

There were no additional witnesses for the petitioner. The petitioner submitted documentary evidence which was admitted into the record as Petitioner's Exhibit 1.

In addition to Dr. Vo, the respondent presented two witnesses from United: Christian Laos, senior compliance analyst and Lori Eubanks, account manager. Selwyn Gossett, medical healthcare analyst with AHCA was present as an observer. 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 is a Florida Medicaid recipient. The petitioner is enrolled with United HMO.

2. In early 2016, the petitioner's treating dentist, [REDACTED], requested authorization to extract several teeth and fit him with upper and lower false teeth/dentures.

3. The request was approved.

4. [REDACTED] removed the petitioner's lower teeth and later provided him with a lower denture. The lower denture did not fit his mouth and the teeth were not properly aligned. The petitioner was dissatisfied with the quality of care and customer service he received from [REDACTED] office. The petitioner switched to a different dental provider, Economy Dentures, in mid-2016.

5. Economy Dentures filed a request with United to remove the petitioner's upper teeth and to fit him with upper and lower false teeth/dentures.

6. United denied the request for lower false teeth/dentures citing service limitation issues and approved the remaining services.

7. Economy dentures removed the petitioner's top teeth and fitted him with upper false teeth/dentures in June 2016.

8. The petitioner's remaining issue is his dissatisfaction with fit and appearance of the lower dentures. He does not wish to return to [REDACTED]'s office for an adjustment or further consultation because of past treatment and concerns about quality of care. He would like for Medicaid to provide a second lower denture through his new dental provider, Economy Dentures.

9. United argued the Medicaid rules provides for one lower denture per recipient, per life time. The petitioner has received the maximum service limit. United encouraged the petitioner to file a provider grievance with its Customer Service Department and allow United to seek a resolution with the provider.

### **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 Section 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 Fla. Admin. Code R. 65-2.056.

13. 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, 7<sup>th</sup> Ed.).

15. The Florida Medicaid Program is authorized by Chapter 409 Florida Statutes and Fla. Admin. Code Chapter 59G.

### **DENIAL OF REQUEST FOR A SECOND LOWER DENTURE WILL BE ADDRESSED**

#### **FIRST**

16. The Dental Services Coverage Handbook defines coverage limitations for receipt of dentures on page 4:

#### **Prosthodontic Services**

Florida Medicaid reimburses for prosthodontic services to diagnose, plan, rehabilitate, fabricate, and maintain dentures as follows:

- One upper, lower, or complete set of full or removable partial dentures per recipient
- One relines, per denture, per 366 days, per recipient
- One all-acrylic interim partial (flipper) for the anterior teeth, per recipient under the age of 21 years

17. The cited authority explains that Medicaid will reimburse for one lower denture per recipient. There are no noted exceptions to this coverage limitation.

18. The petitioner received a lower denture in mid-2016, through [REDACTED], his former dental provider. He would like another lower denture, through Economy Dentures, his new dental provider. United denied the request due to service limitations.

19. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the respondent's decision in this matter was correct. Medicaid rule provides for one lower denture per recipient. The petitioner has received the maximum coverage limit for this service.

#### **DISSATISFACTION WITH DENTAL PROVIDER ISSUE WILL NOW BE ADDRESSED**

20. Federal Medicaid Regulations at 42 C.F.R. § 431.220 states in relevant part, "(a) The State agency must grant an opportunity for a hearing to the following: (1) Any applicant who requests it because his claim for services is denied or is not acted upon with reasonable promptness (2) Any recipient who requests it because he or she believes the agency has taken an action erroneously..."

21. The Centers for Medicare & Medicaid Services' State Medicaid Manual, publication #45, states in part:

#### **2900 FAIR HEARINGS AND APPEALS**

Section 1902(a)(3) of the Social Security Act requires that States 'provide for granting an opportunity for a fair hearing before the State agency to

any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness.' Regulations implementing this section of law are found at 42 CFR 431 Subpart E. In addition, certain court decisions further amplify and modify the law and regulations governing the provision of notices and hearings to Medicaid applicants and recipients. Where appropriate, those decisions are cited . 2900.1 Basic Responsibility (42 CFR 431.200 and 431.205).--Establish policies and procedures for assuring a system of fair hearings that meet all the requirements of the regulations and instructions.

Notify and make available to the applicant or recipient the hearing procedures required by regulations and these instructions, if any of the following events occur:

- o denial of eligibility,
- o the claim is not acted upon with reasonable promptness,
- o termination of eligibility or covered services,
- o suspension of eligibility or covered services, or
- o reduction of eligibility or covered service

22. The above federal authority explains that an opportunity for a hearing must be granted when a Medicaid claim for service has been denied or when a recipient believes the agency has taken an action erroneously. The State Medicaid Manual further explains the recipient's right to a hearing when either Medicaid eligibility or a claim for a service under Medicaid is denied, terminated, reduced or delayed.

23. The petitioner's issue involves the quality of care and customer service he received from a Medicaid dental provider. The Office of Appeal Hearings does not have jurisdiction over provider relations or quality of care issues. The petitioner issues may be addressed by contacting AHCA's Consumer Complaint Office at 1-877-254-1055.

### **DECISION**

The appeal is denied in regards to the petitioner's request for a second lower denture. The provider relations issue is dismissed as non-jurisdictional.

**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 July, 2016,

in Tallahassee, Florida.



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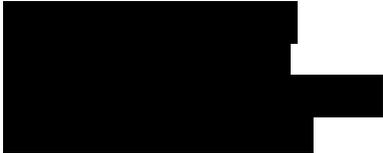
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Aug 02, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-03399

PETITIONER,

Vs.

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

And

MAGELLAN COMPLETE CARE

RESPONDENTS.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, a telephonic administrative hearing was convened in this matter before the undersigned hearing officer on June 22, 2016 at 3:05 p.m.

**APPEARANCES**

For the Petitioner:



For the Respondent:

Fatima Leyva,  
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) decision, through DentaQuest, to deny the Petitioner's requests for dental procedures D2750-Crown porcelain fused to high noble metal (crown) for tooth 27 and D3310-

Endodontic therapy, anterior tooth (root canal) for tooth 22 and tooth 27. Because the issue under appeal involves requests for services, Petitioner bears the burden of proof.

### **PRELIMINARY STATEMENT**

Michelle Riegler, Compliance Officer, appeared as Respondent's witness from the Petitioner's managed care plan Magellan Complete Care (Magellan). Omisha Smith and Jackelyn Salcedo, Complaints and Grievance Specialists from DentaQuest, appeared as Respondents' witnesses. Magellan requested to be added as a party to this appeal; the request was granted.

DentaQuest approved dental procedures D5110-complete upper denture and D5214-partial lower denture. The dental procedures under appeal are in regards to tooth 22 and 27, which are to be used as anchor teeth for the lower partial denture. Petitioner has no other lower teeth.

Respondent submitted a 168-page document, which was entered into evidence and marked 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. The Petitioner is a 25 year-old male Medicaid recipient enrolled with Magellan, a Florida Health Managed Care provider.
2. Magellan requires prior authorization for services related to dental care and has subcontracted with DentaQuest to perform prior authorization requests.

3. The Petitioner's dentist sent a prior authorization for dental procedure: D2750-Crown porcelain fused to high noble metal (crown) for tooth 27 and D3310-Endodontic therapy, anterior tooth (root canal) for tooth 22 and tooth 27. DentaQuest received the prior authorization request on October 23, 2015.

4. DentaQuest sent a Notice of Action to the Petitioner on April 25, 2016. The notice advised the requested services are denied because they are not covered services.

5. The Petitioner filed a timely request for a fair hearing on May 4, 2016.

6. Petitioner's aunt explained that tooth 22 and 27 are to anchor the lower partial denture. She feels the crown and root canal procedures are necessary so the teeth can anchor the lower partial denture. She further explained that the upper full denture could not be done without the lower partial denture being done. She felt the crown and root canals were part of preparing the mouth for dentures.

7. Respondent explained that procedure D2750-Crown porcelain fused to high noble metal (crown) and D3310-Endodontic therapy, anterior tooth (root canal) are not covered services for recipients over 21 years of age.

8. Petitioner's aunt felt exceptions could be made.

9. Respondent stated no exceptions are permitted for the coverage limitations.

#### **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. Dental services are one of the mandatory services that must be provided.

14. Section 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) 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.

17. The Florida Medicaid Dental Services Coverage and Limitations Handbook- November 2011 (Handbook)<sup>1</sup>, which is 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 program:

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.

18. On page 2-8 of the Handbook, Endodontic services is described:

Endodontic services include pulp capping, therapeutic pulpotomies, root canal therapy, apexification, and apicoectomies.

....

Endodontic services are only reimbursed for Medicaid eligible recipients **under age 21**[emphasis added].

19. On page 2-33 of the Handbook, Restorative Services are described below  
Crowns are described as restorative services on page 2-34.

Restorations may be reimbursed for eligible recipients **under age 21** to eliminate carious or post-traumatic lesions from teeth and to restore the anatomic shape, function and aesthetics of teeth [emphasis added].

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<sup>1</sup> The Florida Medicaid Dental Services Coverage Policy Handbook- May 2016 took effect on May 3, 2016 via Rule 59G-4.060. Like the prior handbook, Endodontic and Restorative Services remain reimbursable for Medicaid recipients under 21 years old.

20. The Petitioner has been approved for a full upper denture and a lower partial denture. Petitioner's aunt argues that tooth 22 and 27 are needed to anchor the lower partial denture. In order for the teeth to anchor the lower partial denture, the aunt argues the crown and root canal procedures for tooth 22 and 27 are medically necessary.

21. Respondent explained that the crown and root canal procedures are not covered for recipients over 21 years of age.

22. Petitioner's aunt feels an exception to the coverage limitations can be made in order for the Petitioner to get his dentures. Respondent explained no exceptions can be made to the service limitations.

23. Florida Medicaid provides limited preventive dental care coverage as noted in paragraphs 17, 18, and 19 above. The Dental Handbook makes it clear that crown and root canal procedures are not covered services for the Petitioner. Petitioner has failed to meet his burden of proof that Respondent erred in denying Petitioner's request for crown and root canal services.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED and the Agency 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

FINAL ORDER (Cont.)

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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 02 day of August, 2016,

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  
Magellan Complete Care

Jul 25, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 16F-03451

PETITIONER,

Vs.

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

And

HUMANA, INC.

RESPONDENTS.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 27, 2016 at 8:38 a.m.

**APPEARANCES**

For Petitioner: [REDACTED]

For Respondent: Linda Latson, Registered Nurse Specialist,  
Agency for Health Care Administration

**STATEMENT OF ISSUE**

Whether it was appropriate for the Respondents to deny Petitioner's request to use approved Adult Companion Care service hours other than for weekly doctor appointments.

**PRELIMINARY STATEMENT**

Petitioner has been approved for five (5) hours of Adult Companion Care (Companion) services per week for doctor appointments. Petitioner has requested that any Companion service hours not used during the week for doctor appointments be used for visits to the mall or family members. Respondent has denied the use of Companion service hours for any purpose other than doctor appointments.

Dr. Pablo Calzada, Medical Director for Long-Term Care, and Stacey Larsen, Clinical Guidance Analyst, from Petitioner's managed care plan, Humana American Eldercare, appeared as witnesses for the Respondent. Respondent's 63-page exhibit was entered into evidence and marked Respondent Exhibit 1.

Petitioner's 7-page exhibit was entered into evidence and marked 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. The Petitioner is an 87 year-old female who is a dual-eligible Medicaid and Medicare recipient. She is diagnosed with [REDACTED]

2. In addition to the five (5) hours per week of Companion Care for medical appointments, Petitioner also receives fourteen hours (14) per week of Personal Care services, and ten (10) hours per week of Respite. She also is provided a Personal Emergency Response System (PERS).

3. Petitioner and her son live together. As primary caregiver, the son cooks for Petitioner and ensures she takes her medications as prescribed. Her medications

include: [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED],

[REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED],

[REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED].

4. Petitioner's son submitted a request for twenty (20) hours of Adult Companion Care per month on February 29, 2016. The request was for taking his mother to medical appointments and a few social visits. Medical appointments were scheduled once per week and two bi-monthly visits to family, friends, and the mall.

5. On April 4, 2016, Respondent sent a Notice of Action to Petitioner denying the request for twenty (20) hours of Adult Companion Care because:

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)

Must be furnished in a manner not primarily intended for convenience of the recipient, caretaker, or provider.

6. Petitioner filed a timely fair hearing request on May 4, 2016.

7. Petitioner has been approved for twenty (20) hours per month of Companion Care to assist her while attending medical appointments. She is transported to the medical appointments by family, but she is at risk of falling during transfers/toileting. Petitioner's request is to modify the use of the Companion Care hours to accommodate visits to family, friends and the mall.

8. Petitioner's son explained his mother is suffering from [REDACTED]

[REDACTED] Petitioner is asking for flexibility in using the approved Companion Care hours for

visits to family, friends and the mall. These visits are important for Petitioner's mental health.

9. Petitioner's primary care physician wrote a prescription on April 18, 2016 stating:

She needs more social activity outside of the home for her memory and mental health.

10. An April 11, 2016 prescription from her neurologist advises she increase her outside and social interaction to address her functional decline.

11. Respondent's doctor recommended Petitioner use Adult Day Care (ADC) services to address her socialization needs. Respondent stated Petitioner going to the mall was a safety concern. ADC would be a safe environment in which planned activities and supervision would be provided by trained caregivers.

12. Petitioner's son explained that his mother is energized and enjoys sharing memories with family and friends of the same culture and age. She would be disconnected with those at an ADC. Because of her physical and mental limitations, she is not able to engage in the activities an ADC would provide. He explained that visits at the mall would be after medical appointments that are at the mall.

### **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. § 120.80. The Office of Appeal Hearings provided the parties with adequate notice of the administrative hearing.

14. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Program is administered by the Agency for Health Care Administration.

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

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

17. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Fla. Admin. Code R. 65-2.060(1).

18. Section 409.979, Fla. Stat. sets forth eligibility requirements for the Long-Term Care Program and states:

(1) PREREQUISITE CRITERIA FOR ELIGIBILITY. 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).

19. Humana's Member Handbook, on page 14, describes Adult Companion care (see Petitioner's exhibit 1, page 6):

Companions can perform tasks such as meal assistance, laundry, go with you on an appointment and shopping, while also providing socialization for the member. This does not include hands-on nursing care or bathing assistance.

20. Chapter 59G-1.010 (166), Florida Administrative Code defines medically necessary 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 and Respondent agree to her need for socialization activities to delay her functional decline and to address her depression. What is at dispute is the context in which that socialization is provided. Petitioner is requesting the use of Companion Care hours to visit friends, family and the mall. Respondent recommends she use Adult Day Care where her activities and supervision can be provided in a safe environment by trained care givers.

22. Because of her physical and mental limitations she is not able to engage in the planned ADC activities. Additionally, she is energized and enjoys her visits with family and friends with the same cultural background.

23. Petitioner visits the mall after attending her doctor appointments at the mall.

24. After considering all the evidence and relevant authorities, the undersigned finds the Petitioner has met her burden of proof. The issue becomes where she should receive socialization activities to delay her decline in function and to address her [REDACTED]. While Respondent argued the clinical benefits of Adult Day Care services, Petitioner explained that she would be disconnected in an ADC. Because of her mental and physical limitations, she could not participate in an ADC's planned activities.

25. The undersigned finds it a more compelling argument for Petitioner, who suffers from dementia, to visit friends and family to share memories which help her maintain her sense of identity and sense of connection with her culture. These visits are authorized under the plan's definition of Adult Companion Care services for socialization purposes.

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

FINAL ORDER (Cont.)  
16F-03451  
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DONE and ORDERED this 25 day of July, 2016,  
in Tallahassee, Florida.



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Warren Hunter  
Hearing Officer  
Building 5, Room 255  
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Copies Furnished To: [REDACTED], Petitioner  
Agency for Health Care Administration, Medicaid Fair Hearings Unit  
Humana Hearings Unit

Jul 21, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-03460

PETITIONER,

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 July 18, 2016 at 10:10 a.m.

**APPEARANCES**

For the Petitioner: 

For the Respondent: Sheila Broderick, registered nurse specialist with AHCA

**STATEMENT OF ISSUE**

Whether it is medically necessary for the petitioner to receive Prescribed Pediatric Extended Care (PPEC) services. The petitioner holds the burden of proof by a preponderance of the evidence.

**PRELIMINARY STATEMENT**

The Agency for Health Care Administration (Agency or AHCA or respondent) administers the Florida Medicaid Program. The Agency contracts with eQ Health Solutions (eQ) to perform prior services authorizations for certain Medicaid services, including PPEC services.

By notice dated April 23, 2016, eQ informed the petitioner that his request to receive PPEC services for six months (April 2016 – October 2016) was denied in-part. eQ approved three months of PPEC services to evaluate petitioner's medical condition and to educate and train natural supports. Ongoing PPEC services were denied.

The petitioner requested reconsideration.

By notice dated May 31, 2016, eQ informed the petitioner that the original decision was upheld.

The petitioner timely requested a hearing to challenge the partial denial decision.

Present as witnesses for the petitioner from Tender Care Medical services (the PPEC provider): Maribel Villegas, director of nursing and Janine Duffy, assistant director of nursing. The petitioner submitted documentary evidence which was admitted into the record as Petitioner's Exhibit 1.

Present as a witness for the respondent from eQ: Dr. Darlene Calhoun, physician consultant. 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 6 months) is a Florida Medicaid recipient.
2. The petitioner was born with [REDACTED]. The [REDACTED]

[REDACTED] There is no cure for the petitioner's condition, he will require hormone supplements all of his life. The petitioner feeds by mouth. He takes medication by mouth and injection. The petitioner does not require mechanical devices (G-tube, ventilator, IVs, etc.) to maintain his life; however, his blood pressure and temperature must be closely monitored and medications administered when needed to regulate his levels.

3. The petitioner's treating physician submitted a request for PPEC services (specialized medical daycare for children with complex medical needs) to eQ (AHCA's contracted review agent) on April 13, 2016. The petitioner's request form reads as follows:

Patient is medically stable to attend Prescribed Pediatric Extended care facility (PPEC).

Patient is medically stable to attend full time 5-7 days per week for a certification period of 180 days.

Patient is medically stable to be transported to and from PPEC via Medicaid non-emergency transportation services.

Physical therapy evaluation and treatment.

Occupational therapy evaluation and treatment.

Speech therapy evaluation and treatment.

List of diagnoses: [REDACTED].

4. All Medicaid services must be medically necessary as determined through a prior service authorization process. eQ reviews the authorization request form and all supporting documentation during the review process. eQ has no direct contact with the child or child's family.

5. In the instant case, eQ reviewed the request form and petitioner's Plan of Care (a document which defines the patient's need for Medicaid services and service goals) to make the eligibility decision.

6. The Plan of Care described the petitioner as a child with a serious medical condition, who needs monitoring and supervision due to his parents' work and school schedules.

7. The petitioner lives in the family home with his parents and one sibling (age 3). None of the family members are disabled, but all have medical issues. All three family members suffer from [REDACTED]. The father has been diagnosed with [REDACTED] [REDACTED]y. The mother suffers from [REDACTED], not otherwise specified. Both parents work outside the home 3 to 4 days a week. In addition, the mother attends school two days per week. The mother is the only source of natural support. The mother is a licensed practical nurse (LPN); she is trained and skilled in the petitioner's care. The father's mental health issues prevent him from being able to participate in the petitioner's care. The maternal grandparents helped care for the

petitioner in the past (grandmother is also an LPN), but can no longer do so due to recent health issues.

8. The petitioner requested six months of PPEC services. eQ approved three months of PPEC services in order to assess the petitioner's medical condition and for PPEC nursing staff to train the petitioner's caregivers. At the end of the three month assessment period, eQ concluded that the petitioner's medical condition was serious, but he did not require continuous skilled nursing care. The clinical rationale section of eQ's evaluation explains the decision:

[REDACTED]

[REDACTED]

[REDACTED]

The additional services are not approved.

9. Dr. Darlene Calhoun, physician reviewer with eQ, explained that after the three month assessment period, eQ determined that the petitioner's needs can be met by a capable and responsible adult. eQ concluded that the petitioner's care needs do not require the services of skilled nurse staff because he does not require mechanical devices (such as G-tube feedings, ventilator, or IV medications) to maintain life. In addition, the petitioner has not required emergency medical attention or hospitalization since the single hospitalization shortly after birth. Dr. Calhoun opined that it is not medically necessary that the petitioner receive PPEC services.

10. The petitioner's mother asserted that his needs cannot be met at a standard day care center because changes in his blood pressure or blood sugar levels require the administration of medications; standard day care centers do not administer medications.

11. The petitioner's mother also noted that she must work to supplement the family's income. In addition, she has to attend to the needs of her other child (age 3), who has been waitlisted for daycare services.

12. Maribel Villegas, director of nursing at the petitioner's PPEC, attested to his need for PPEC services for monitoring and supervision of blood pressure and blood sugar levels and administration of medications. PPEC also monitors the petitioner's temperature. Ms. Villegas also noted that the petitioner would benefit from PPEC physical therapy in the future because children with [REDACTED] frequently suffer from developmental delays.

13. On rebuttal, Dr. Calhoun explained that the petitioner can receive physical therapy in an outpatient setting, if this service is needed at some future date. Dr. Calhoun asserted that trained caregivers should seek appropriate medical services when/if a situation should arise which requires administration of medication. Regarding the mother's need to work outside the home, Dr. Calhoun explained that Medicaid services are based on the medical needs of the patient, not the financial needs of the patient's family.

#### **CONCLUSIONS OF LAW**

14. 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 Section 120.80, Florida Statutes.

15. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.

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

17. In accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof was assigned to the petitioner.

18. 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, 7<sup>th</sup> Ed.).

19. The Florida Medicaid Program is authorized by Chapter 409 Florida Statutes and Fla. Admin. Code Chapter 59G.

20. 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:

“Medical 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 patient’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.

21. As the petitioner is under 21, a broader definition of medically necessary applies to include the EPSDT requirements. Section 409.905, Florida Statutes, 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.

22. The above citation explains that the respondent must provide treatment and services to Medicaid recipients under 21 years of age, but only to the extent such services are medically necessary. The state is authorized to establish the amount, duration, and scope of such services.

23. 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.”

24. On page 2-1 thru 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.

25. 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.

26. The respondent, through its agent eQ, denied the petitioner's request for ongoing PPEC services. The respondent determined that the services were not medically necessary because the petitioner did not meet the eligibility requirements.

27. The evidence proves that the petitioner has a serious medical condition, [REDACTED] which requires monitoring and supervision. However, the evidence does not prove that the petitioner requires continuous therapeutic interventions or skilled nursing care. The petitioner does not require G-tube feedings; he is not ventilator dependent nor does he require a medical apparatus to maintain life.

28. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the petitioner did not meet his burden of proof in this matter. The petitioner did not prove by a preponderance of the evidence that it is medically necessary that he receive ongoing PPEC services.

### **DECISION**

The appeal is denied. The respondent's decision in this matter is upheld.

### **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

FINAL ORDER (Cont.)

16F-03460

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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 July, 2016,

in Tallahassee, Florida.



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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  
AHCA, Medicaid Fair Hearings Unit

Jul 01, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-03463

PETITIONER,

Vs.

CASE NO



FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 14 Bay  
UNIT: 55143

RESPONDENT.

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**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on June 30, 2016 at 11:07 a.m.

**APPEARANCES**

For the Petitioner:



For the Respondent:

Anne Marie Sport, ACCESS Supervisor

**STATEMENT OF ISSUE**

Petitioner is appealing the Department's action of denying her application for Adult Related Medicaid on February 29, 2016. The petitioner carries the burden of proof by the preponderance of evidence.

**PRELIMINARY STATEMENT**

Lauren Coe, Program Operations Administrator, Division of Disability Determinations, Department of Health, appeared as a witness for the Department.

The Department submitted evidence prior to the hearing. It was not entered as an exhibit during the hearing. All findings are taken from testimony given by the parties.

The record was closed on June 30, 2016.

### **FINDINGS OF FACT**

1. The petitioner applied for Medical Assistance for herself on January 11, 2016. The Social Security Administration has not established the petitioner as disabled.
2. The petitioner believes she meets the disability requirements due to her diagnosis of [REDACTED] and [REDACTED], which cause tremendous pain and inability to work. She further stated the diseases make it hard for her to complete her activities of daily living sometimes.
3. The Department submitted the case to the Division of Disability Determinations (DDD) on January 21, 2016.
4. The Department provided DDD with the petitioner's living address rather than her mailing address on the disability transmittal.
5. DDD issued two letters to the petitioner. Both letters were mailed to the petitioner's living address.
6. DDD attempted to call the petitioner, but noted they were unable to leave a voicemail.
7. DDD returned the disability to the Department as denied due to insufficient evidence to determine if the petitioner was disabled or not.
8. The Department issued a Notice of Case Action on February 29, 2016 denying the petitioner's application for Medicaid effective January 2016, as she did not meet the disability requirement.

9. The petitioner reported she has no mail receptacle at her living address.

The petitioner confirmed all of her mail goes to her PO Box.

10. The petitioner does receive a pension, but it is below the poverty level.

The petitioner reports she cannot afford insurance.

### **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 Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

13. Fla. Admin. Code R. 65A-1.205 "Eligibility Determination Process" states in relevant part:

(1)(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.

...

(d) In accordance with 42 C.F.R. § 435.911, unusual circumstances that might affect the timely processing of Medicaid applications include applicant delay, physician delay and emergency delay as defined below. Unusual circumstances are non-agency processing delays, and the

calendar time passing during such delay(s) does not count as part of the 90-day time standard for determining the timeliness of Medicaid eligibility decisions based on disability.

14. Fla. Admin. Code R. 65A-1.711 “SSI-Related Medicaid Non-Financial

Eligibility Criteria” states in relevant part:

To qualify for Medicaid an individual must meet the general and categorical requirements in 42 C.F.R. Part 435, subparts E and F (2007) (incorporated by reference), with the exception that individuals who are neither aged nor disabled may qualify for breast and cervical cancer treatment, and the following program specific requirements as appropriate. Individuals who are in Florida temporarily may be considered residents of the state on a case-by-case basis, if they indicate an intent to reside in Florida and can verify that they are residing in Florida.

(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 (2007) (incorporated by reference).

15. 20 C.F.R. § 416.905 “Basic definition of disability for adults” states in

relevant 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. If your severe impairment(s) does not meet or medically equal a listing in appendix 1 to subpart P of part 404 of this chapter, we will assess your residual functional capacity as provided in §§416.920(e) and 416.945. (See §416.920(g)(2) and 416.962 for an exception to this rule.) We will use this residual functional capacity assessment to determine if you can do your past relevant work. If we find that you cannot do your past relevant work, we will use the same residual functional capacity assessment and your vocational factors of age, education, and work experience to determine if you can do other work. (See §416.920(h) for an exception to this rule.)

16. The findings show Social Security Administration has not established the petitioner as disabled. In accordance with the above controlling authorities, the

undersigned concludes the Department correctly referred the petitioner to DDD for a disability determination. However, in the process of the referral, the Department failed to notify DDD of the petitioner's correct mailing address. This error caused DDD to deny the petitioner's disability due to insufficient evidence to support disability. The undersigned remands the case to the Department for submission of the disability packet to DDD with the correct mailing address.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted. The Department is to resubmit the petitioner's disability to the Division of Disability Determinations. The Department is to issue new notices, 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.

FINAL ORDER (Cont.)

16F-03463

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DONE and ORDERED this 01 day of July, 2016,  
in Tallahassee, Florida.



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Melissa Roedel  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
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Email: Appeal.Hearings@myflfamilies.com

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

Jul 22, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 16F-03501

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 June 13, 2016 at 1:30 p.m.

**APPEARANCES**

For the Petitioner:

[REDACTED]

For the Respondent:

Dianna Chirino, 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 proving her case by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

The petitioner submitted medical records as evidence for the hearing, which were marked as Petitioner Exhibit 1. The petitioner also submitted a document entitled “fitness nutrition guidelines”, which was marked as Petitioner Exhibit 2.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Exhibits: Exhibit 1 - Statement of Matters and Authorization Request (with attached medical records); Exhibit 2 – Denial Notice; Exhibit 3 – Appeal Request; Exhibit 4 – Medical Determination/Resolution Letter; and Exhibit 5 – Additional Medical Records.

Appearing as witnesses for the respondent were Dr. Jeannette Rios, Medical Director, and Diana Anda, Grievance/Appeals Manager, from Simply Healthcare, which is the petitioner’s managed health care plan.

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 forty-five (45) 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 March 21, 2016, the petitioner’s treating physician (hereafter referred to as “the provider”), requested prior authorization from Simply Healthcare to perform

bariatric surgery. Simply Healthcare denied this request on or about March 25, 2016

based on medical necessity criteria. The denial notice stated the following:

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.

3. The petitioner has been diagnosed with [REDACTED]. She is seeking the bariatric surgery as a means of achieving weight loss.
4. The respondent's witness, Dr. Rios, 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. Rios also stated the medical records submitted by the petitioner's treating physician do not mention any specific diets and there were indications the petitioner was making improper food choices and not engaging in regular exercise.
5. The petitioner stated she believes the bariatric surgery should be approved because she is overweight and she has tried various diets and pills without any success. She also stated she completed an exercise program in April, 2016 but did not lose any weight. She also believes her medical records may not accurately reflect her attempts at weight loss because she has been doing exercise in a gym and she takes long walks. The petitioner underwent a gastric bypass procedure in Cuba in 2013, but failed to lose weight.

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, 7<sup>th</sup> 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-4.001.

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. Although the petitioner testified she has tried to lose weight through diets, pills, and exercise, she must also satisfy each of the remaining components of the rule's requirements concerning medical necessity. The respondent's medical expert testified that medical necessity guidelines require a documented trial and failure of a medically supervised weight loss program and this was not established in the petitioner's pre-authorization request. 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.

14. The petitioner has not established by a preponderance of the evidence that her requested gastric bypass procedure is medically necessary as defined by Fla. Admin. Code R. 59G-1.010(166). The submitted medical records do not contain sufficient documentation of a supervised weight loss program. Although the records contain some general references to various diet plans, there is no additional documentation

such as diet logs to show what foods were being consumed and why the diet failed to produce weight loss. After considering the evidence and relevant authorities set forth above, the undersigned concludes that the petitioner has not met her burden of proof in establishing that the respondent's action was 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 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 July, 2016,

in Tallahassee, Florida.



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Rafael Centurion  
Hearing Officer  
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1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
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FINAL ORDER (Cont.)

16F-03501

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Copies Furnished To: [REDACTED], PETITIONER  
AHCA, MEDICAID FAIR HEARINGS UNIT

**FILED**

Aug 04, 2016

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

Office of Appeal Hearings  
Dept. of Children and Families



APPEAL NO. 16F-03503

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 June 13, 2016 at 10:00 a.m.

**APPEARANCES**

For the Petitioner:



For the Respondent:

Diana Chirino, 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.

Appearing as witnesses for the respondent were Dr. Susan Hudson, Dental Consultant, and Jackeline Salcedo, Grievance Specialist, from DentaQuest, which is the Petitioner's dental services review organization. Also present as a witness for the respondent was Diana Anda, Grievance/Appeals Manager, for Simply Healthcare Plans, which is the petitioner's managed health care plan.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Exhibits: Exhibit 1 – Statement of Matters and Authorization Request; Exhibit 2 – Denial Notice; and Exhibit 3 – Dental Consultant Review Form.

Also present for the hearing was a [REDACTED]

[REDACTED]

**FINDINGS OF FACT**

1. The Petitioner is a sixty-three (63) 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, which utilizes DentaQuest for review and approval of dental services.
2. On or about May 3, 2016, the Petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from Simply Healthcare and/or DentaQuest to perform dental services, including surgical tooth extractions, alveoplasty, and for

medication related to those procedures. Simply Healthcare denied this request on May 5, 2016.

3. Simply Healthcare's denial notice to the petitioner advised her that the surgical extractions were denied because a less severe method of extraction could be utilized and surgical extraction was not necessary. The alveoplasty was denied because less than 4 teeth in each quadrant were being extracted, and therefore a different procedure code was required. The request for medication was denied as not being a covered service.

4. The petitioner stated she needs her teeth extracted in order to receive dental implants and because she has [REDACTED]. She is in pain due to the condition of her teeth and can only eat pureed foods.

5. The respondent's expert witness, Dr. Hudson, testified that the removal of the petitioner's teeth could be accomplished by a simple extraction and a surgical extraction is not appropriate.

6. The Simply Healthcare representative stated the requested services could be re-considered if the request is re-submitted using the proper procedure codes. However, the medication requested is a non-covered service.

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, 7<sup>th</sup> 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 the 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. The Florida Medicaid Program provides limited dental services for adults. The Dental Handbook describes the covered services for adults as follows:

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.

16. Managed care plans, such as Simply Healthcare, may provide more generous benefits but cannot be more restrictive than the Medicaid guidelines contained in the Dental Handbook.
17. The petitioner stated she needs her teeth removed in order to receive dental implants and because she is in pain.

18. The respondent's position is that the extractions should be performed as simple extractions rather than surgical extractions and the alveoplasty requires a different procedure code since less than 4 teeth per quadrant are to be extracted. Regarding the medications requested, that is a non-covered service under the dental health plan.

19. After considering the evidence and testimony presented, the undersigned concludes the petitioner has not demonstrated that the respondent should have approved the requested services. The petitioner should consult with her provider concerning re-submitting the request using more appropriate procedure codes.

**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 04 day of August, 2016,

in Tallahassee, Florida.



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Rafael Centurion

FINAL ORDER (Cont.)

16F-03503

PAGE - 7

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](mailto:Appeal.Hearings@myflfamilies.com)

Copies Furnished To: [REDACTED], PETITIONER  
AHCA, MEDICAID FAIR HEARINGS UNIT

Aug 03, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-03568

PETITIONER,

Vs.

CASE NO.



FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 18 Seminole  
UNIT: 88999

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 12:55 p.m. on June 17, 2016.

**APPEARANCES**

For the Petitioner:



For the Respondent:

Susan Martin, ACCESS  
Operations Management Consultant

**STATEMENT OF ISSUE**

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

**PRELIMINARY STATEMENT**

By notice dated April 27, 2016, the respondent (or the Department) notified the petitioner her Medicaid application was denied. The petitioner timely requested a hearing to challenge the Medicaid denial.

Petitioner did not submit exhibits. Respondent submitted six exhibits, entered as Respondent Exhibits "1" through "6". The record was closed on June 17, 2016.

**FINDINGS OF FACT**

1. On April 6, 2016, the petitioner, age 46 (at the time of application) submitted a SSI-Related Medicaid disability application for herself. Petitioner moved from Connecticut to Florida in December 2015; she received Medicaid in Connecticut.
2. To be eligible for SSI-Related Medicaid, petitioner must be over age 65 or older, or considered disabled by the Social Security Administration (SSA) or the Division of Disability Determination (DDD). DDD is responsible for making disability determinations on behalf of the Department.
3. Petitioner applied for disability through the SSA in February 2015. SSA denied petitioner in December 2015. Petitioner is appealing the SSA denial decision through an attorney; an appeal date has not been set.
4. Petitioner described her disabilities as [REDACTED]  
[REDACTED]
5. On April 22, 2016, the Department forwarded petitioner's disability documents to DDD for review. DDD reviewed petitioner's disability documents and denied her Medicaid disability on April 25, 2016; due to adopting the SSA denial decision.

6. On April 27, 2016, the Department mailed the petitioner a Notice of Case Action, denying her April 6, 2016 Medicaid application; due to not meeting the disability requirements.

7. Petitioner alleges [REDACTED] as new medical conditions since she applied with the SSA. Petitioner has notified both the SSA and her attorney of her new medical conditions.

### **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. The Code of Federal Regulations at 42 C.F.R. § 435.541, Determinations 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...

11. The above authority explains the SSA determination is binding on the Department.

12. In accordance with the above authority, the respondent denied petitioner's April 6, 2016 Medicaid application; due to adopting the SSA December 2015 denial decision.

13. The above authority states that 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" and "Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations".

14. Petitioner argued [REDACTED] as new medical conditions since she applied for disability through the SSA. Petitioner has notified both the SSA and her attorney of her new medical conditions.

15. Petitioner is currently appealing the SSA December 2015 denial decision; an appeal date has not been set. The SSA has not refused to consider petitioner's new medical conditions.

16. In careful review of the cited authority and evidence, the undersigned agrees with the Department's action to deny 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   03   day of   August  , 2016,

in Tallahassee, Florida.



---

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

**FILED**

Aug 04, 2016

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

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. [REDACTED]

PETITIONER,

Vs.

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

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER OF DISMISSAL**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 14, 2016 at 3:00 p.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 transportation services was correct. The petitioner has the burden of proving her case by a preponderance of the evidence.

**PRELIMINARY STATEMENT**

Neither party submitted any documents as evidence for the hearing.

### **FINDINGS OF FACT**

1. The petitioner requested a fair hearing on May 9, 2016 because she was denied transportation services by her health plan or provider.
2. The AHCA representative stated the petitioner's Medicaid coverage was canceled effective January 31, 2016 and, therefore, she was not entitled to any Medicaid services after that date.
3. The petitioner stated she never received any notice that her Medicaid coverage had been canceled and was not aware of that cancellation.

### **CONCLUSIONS OF LAW**

4. 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.
5. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.
6. This hearing was held as 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 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, 7<sup>th</sup> Ed.).
8. 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.

9. The undersigned concludes that there is no relief which can be afforded to the petitioner as part of the Medicaid fair hearing process since her Medicaid coverage was canceled effective January 31, 2016. The petitioner would be best served by re-applying for Medicaid eligibility or seeking information from the Department of Children and Families (which determines Medicaid eligibility issues) concerning why her coverage was previously canceled.

**DECISION**

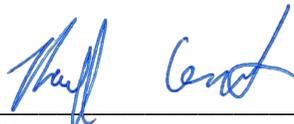
Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is DISMISSED.

**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 indigence 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 04 day of August, 2016,

in Tallahassee, Florida.



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Rafael Centurion  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700

FINAL ORDER (Cont.)

16F-03604

PAGE - 4

Office: 850-488-1429

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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED] PETITIONER  
AHCA, MEDICAID FAIR HEARINGS UNIT

Aug 15, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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

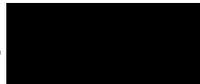


APPEAL NO. 16F-03624

PETITIONER,

Vs.

CASE NO.



FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 03 Columbia  
UNIT: 88264

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on July 20, 2016 at 11:34 a.m.

**APPEARANCES**

For the Petitioner:



For the Respondent: Diane Washington, Economic Self-Sufficiency Specialist II

**STATEMENT OF ISSUE**

Petitioner is appealing the Department's action of March 25, 2016 terminating her Family-Related Medicaid and denying her Adult-Related Medicaid (also known as SSI-Related Medicaid). The respondent carries the burden of proof by the preponderance of evidence.

### **PRELIMINARY STATEMENT**

Petitioner missed her first hearing scheduled for July 6, 2016. Petitioner called to request a rescheduled hearing. Hearing was rescheduled for July 20, 2016.

The Department submitted evidence on June 30, 2016 and July 20, 2016. Evidence received on June 30, 2016 was entered as Respondent's Exhibit 1. Evidence submitted on July 20, 2016 was entered as Respondent's Exhibit 2.

The record closed on July 20, 2016.

### **FINDINGS OF FACT**

1. The petitioner's household consists of herself, age 52, and her son, age 18. The petitioner's son turned 18 in February 2016.
2. The Department issued a Notice of Case Action on March 25, 2016 informing the petitioner that her Family-Related Medicaid would end April 30, 2016.
3. The petitioner filed an appeal on May 9, 2016.
4. The petitioner also claims disability. The Department completed an ex parte review of the petitioner's case to determine if the petitioner qualified for Adult-Related Medicaid.
5. The Department found the petitioner had a denial date by Social Security of March 15, 2015. The Department also found the petitioner had filed an appeal of the most recent Social Security decision July 30, 2015.
6. The Department adopted the Social Security denial decision as it is presently under appeal.

7. The Department included on the Notice of Case Action dated March 25, 2016 a denial of Adult-Related Medicaid citing “you or a member of your household do not meet the disability requirement”.

8. The petitioner cited her conditions as [REDACTED]

[REDACTED] The petitioner added she was diagnosed with [REDACTED] in April 2016.

9. The petitioner has an attorney who is assisting with her Social Security appeal. The attorney has notified Social Security of all conditions including the recent diagnosis.

10. The petitioner did not report a refusal by Social Security to consider a new condition.

11. The petitioner stated they are presently waiting a hearing date before the Administrative Law Judge.

### **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 Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

14. Fla. Admin. Code R. 65-1.705 “Family-Related Medicaid General Eligibility Criteria” states in relevant part:

(7) A standard filing unit (SFU) is determined based on the individual for whom assistance is requested. A fully deprived child is one who is not living with either birth parent due to reasons such as death, abandonment or incarceration. The following are illustrations of SFU determinations:

...

(c) 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.

15. The findings show the petitioner's son is now over the age of 18. The undersigned concludes the petitioner is no longer eligibility for Medicaid under the Family-Related Medicaid program.

16. Fla. Admin. Code R. 65-1.702 "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.

17. The findings show the Department reviewed the petitioner's potential eligibility for Adult-Related Medicaid prior to issuing the notice terminating the petitioner's Medicaid eligibility on March 25, 2016. The findings also show the petitioner

filed her appeal on May 9, 2016. This was more than 10 days following the notice date, there are no continuing benefits pending the outcome of the appeal. The undersigned concludes the Department correctly applied the above controlling authority to the instant case.

18. The definition of MEDS-AD Demonstration Waiver is found in Fla. Admin.

Code R. 65A-1.701 "Definitions":

(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.

19. Fla. Admin. Code R. 65A-1.711 "SSI-Related Medicaid Non-Financial

Eligibility Criteria" states in relevant part:

To qualify for Medicaid an individual must meet the general and categorical requirements in 42 C.F.R. Part 435, subparts E and F (2007) (incorporated by reference), with the exception that individuals who are neither aged nor disabled may qualify for breast and cervical cancer treatment, and the following program specific requirements as appropriate. Individuals who are in Florida temporarily may be considered residents of the state on a case-by-case basis, if they indicate an intent to reside in Florida and can verify that they are residing in Florida.

(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 (2007) (incorporated by reference).

20. 20 C.F.R. § 416.905 "Basic definition of disability for adults" states in relevant 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.

21. The findings show the petitioner is under age 65 and has not been established by Social Security as disabled as of the time of her application. The undersigned concludes the Department correctly determined a disability determination is required prior to establishing the petitioner as eligible for Adult-Related Medicaid.

22. Federal Medicaid Regulations 42 C.F.R. § 435.541 “Determinations of disability” states in relevant 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 §435.912 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—

- (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 findings show Social Security Administration (SSA) denied the petitioner disability in March 2015. The findings also show this decision was appealed in July 2015 and the appeal remains pending. According to the above controlling authorities, a decision made by SSA is controlling and binding on the state agency **until** changed by SSA.

24. The findings show the petitioner believes her attorney has notified the SSA of all her conditions and updated SSA with her newest diagnosis. The undersigned concludes as the SSA decision was made more than 12 months prior to the application or ex parte review for Medicaid, the above controlling authority of 42 C.F.R. § 435.541 (4)(ii) applies to this case. The authority requires if it has been more than 12 months since an SSA decision **and** her condition has not changed or deteriorated **and** alleges a new period of disability **and** she has not applied to SSA for a determination with respect to these allegations, then a new determination can be made. In this instant case, the petitioner has identified a new condition, but it has been reported to SSA and SSA has not refused to consider the new allegation. The

undersigned concludes the SSA decision remains binding upon the Department. The undersigned further concludes the Department correctly adopted the SSA decision of March 15, 2015.

**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  15  day of  August , 2016,

in Tallahassee, Florida.



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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  
Office of Economic Self Sufficiency

Aug 30, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 16F-03638

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND  
AGENCY FOR HEALTH CARE ADMINISTRATION  
CIRCUIT: 02 Leon  
UNIT: AHCA

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on July 13, 2016 at 2:09 p.m. in [REDACTED]

**APPEARANCES**

For the Petitioner: [REDACTED]

For the Respondent: Ephraim Livingston, Esq., Agency for Health Care Administration  
Kevin Dewar, Esq., Agency for Health Care Administration

**STATEMENT OF ISSUE**

Whether the denial of the petitioner's request for 20 additional hours of personal care services per week was proper. The petitioner carries the burden of proof by the preponderance of evidence.

**PRELIMINARY STATEMENT**

[REDACTED] mother of the petitioner; [REDACTED], Support Coordinator with [REDACTED] [REDACTED] Personal Support Provider; and [REDACTED], Area Director with [REDACTED]; appeared as witnesses for the petitioner.

Cindy Henline, Medical/Health Care Program Analyst with Agency for Health Care Administration and Dr. Ellyn Theophilopoulos, Physician Peer Reviewer with eQ Health Solutions, appeared as witnesses for the Respondent. Dr. Theophilopoulos was qualified as an expert witness.

The undersigned took Administrative Notice Florida Statutes sections 409.092, 409.905, 409.913 and 409.9131; Florida Administrative Code Rules 59G-4.130 and 59G-01010; and the Florida Medicaid Home Health Services Coverage and Limitations Handbook (October 2014).

On July 7, 2016, the petitioner filed 108 pages of evidence. The petitioner's evidence pages one through 66 were entered as Petitioner's Composite Exhibit 1. Pages 67 through 108 were included in documents of which Administrative Notice was taken.

On July 6, 2016, the respondent filed 206 pages of evidence. The respondent's pages one through eight were excluded as the notices from the Office of Appeal Hearings. Pages nine through 93 were entered as Respondent's Composite Exhibit 1. Pages 94 through 182 were excluded as items the undersigned took under Administrative Notice. Pages 183 through 206 were entered as Respondent's Composite Exhibit 2.

The parties submitted a Joint Prehearing Stipulation on July 8, 2016. The parties confirmed in the stipulation a possible settlement of the matter was discussed.

However, the parties could not settle and proceeded to hearing.

The record remained open through August 3, 2016 to allow both parties to submit Proposed Final Orders. Both parties submitted a Proposed Final Order on August 3, 2016.

The record closed on August 3, 2016.

### **FINDINGS OF FACT**

1. Agency for Health Care Administration (AHCA) is the single state agency responsible for administering Florida's Medicaid program and reimbursing enrolled health care providers for goods and services rendered to eligible Medicaid recipients.

2. AHCA has entered into contracts with eQ Health Solutions (eQ) to perform prior authorization of home health services (home health visits, private duty nursing, CDC+ Services, and personal care services), inpatient hospital services, therapy services, prescribed pediatric extended care (PPEC) services, durable medical equipment, dental services, physician services, hearing services, vision services, out-of-state services, advanced diagnostic imaging services, and special services.

3. The petitioner is a recipient of Florida Medicaid Services.

4. The petitioner was born on [REDACTED] and was 14 years old at the time of the appeal request and hearing.

5. The petitioner is non-verbal and has no formal means of communication. He has multiple diagnosis including, but not limited to, [REDACTED]

[REDACTED]

[REDACTED]

The petitioner is ambulatory, but requires assistance with all activities of daily living. Due to his frequent rumination and spills, the petitioner requires supervision.

6. The petitioner is an Agency for Persons with Disabilities client on the Home and Community Based Services Waiver Program. In this program, the petitioner is allowed to participate in the Consumer Directed Care Program (CDC+).

7. On March 17, 2016, the petitioner requested a modification to an existing authorization of personal care services. The existing authorization for personal care services was for six hours per day, five days per week. (30 hours per week) The modification was to request an increase to 10 hours per day, five days per week (50 hours per week) for six months. The modification was requested due to the petitioner's onset of puberty and subsequent behavior changes, which require more active monitoring of the petitioner's activities.

8. The request for modification included the Personal Care Services Plan of Care in which the petitioner's doctor prescribed 10 hours per day Monday through Friday.

9. On March 31, 2016, upon initial review of the request, eQ denied the request for additional hours. During this review, eQ also reduced the petitioner's personal care hours to two hours per day, four days per week for six months.

10. A reconsideration request and supplemental documentation was received by eQ on April 7, 2016.

11. A Notice of Reconsideration Determination was issued on April 13, 2016 by eQ Health Solutions. The reconsideration decision was to restore the petitioner to

six hours per day, five days per week through the certification period. The reconsideration continued to deny the petitioner's request for additional hours. A note on the reconsideration determination states:



12. The petitioner attends [REDACTED]. He is provided two full-time aides while he is at school.

13. The petitioner's father is a self-employed business owner. His working hours are documented in Respondent Composite Exhibit 1, page 51. According to the petitioner's mother, the father's work schedule does include some Saturday and Sunday office hours, for emergency patients, and seminars.

14. The petitioner's mother works for the family business five days per week. Her working hours are documented in Respondent Composite Exhibit 1, pages 52 and 53. The petitioner's mother works partially at the office and partially in the home. She explained she does so that she can be available to assist with personal care and activities that relate to the petitioner's activities of daily living (ADL).

15. The petitioner's mother described an increase in compulsive behaviors such as slamming doors, putting items into ears and rumination (regurgitation).

16. The petitioner requires assistance dressing, showering, toileting, medication administration, food preparation, handwashing, and brushing teeth.

17. The petitioner's increased compulsive behavior of putting items into his ears has caused many more doctor trips and several surgeries in the last six months to remove the items. In addition, he is starting to put items into his nose.

18. The petitioner's increased rumination behavior increases the amount of showering, dressing, handwashing and teeth brushing required. The petitioner's mother expressed concern that if the petitioner's teeth are not brushed promptly after rumination, the acid will wear down the petitioner's teeth causing additional dental issues.

19. The petitioner will "play" in areas where there are spills or his own rumination. The petitioner's mother expressed concern that if the area is not cleaned up he will take debris or his own regurgitation and "play" in the results or place the items in his ears. This activity has caused frequent ear flushes at home, as well as additional doctor appointments and surgeries.

20. The petitioner's mother and other witnesses expressed a concern that the family may not be able to continue to maintain the petitioner in the family home without additional assistance.

21. The staff from [REDACTED] are not assisting with Activities of Daily Living. Engage does require an adult be available to assist the petitioner with his ADL's during the behavioral therapy.

22. The petitioner's personal support provider, [REDACTED], has provided services since 2013. Her services prior to the petitioner's enrollment in the Medicaid program in May 2015 were paid for privately by the petitioner's parents. She assists with the petitioner's activities of daily living. She further assists with food preparation,

cleaning up rumination and other messes, medication administration, brushing teeth, prompting the petitioner to keep his clothes on when he is in public and transportation. She is currently providing personal care based on the hours covered by the petitioner's personal care hours.

23. Dr. Theophilopoulos explained the petitioner's request for additional personal care service hours was carefully reviewed by eQ Health Solutions. The initial review involved a nurse review and a Board Certified pediatric physician review. A separate Board Certified pediatric physician who is not involved in the initial review conducted the reconsideration review. The initial Board Certified pediatric physician review brought the decision of March 31, 2016 that additional hours were not needed, and in fact, the petitioner needed fewer hours. The reconsideration review found that six hours per day of personal care services is more than sufficient to meet the petitioner's personal needs.

24. Dr. Theophilopoulos reviewed all documentation provided by the petitioner. She also observed all testimony from the petitioner's mother and other witnesses. Dr. Theophilopoulos opined the petitioner's situation and request does not meet the requirements of medical necessity.

25. Dr. Theophilopoulos considered Early and Periodic Screening, Diagnosis and Treatment (EPSDT) in this matter. She did not find it applicable to the instant case. She believes the request was not necessary for treatment, correction or amelioration under EPSDT standards.

### **CONCLUSIONS OF LAW**

26. 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 Section 120.80, Florida Statutes.

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

28. 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, 7<sup>th</sup> Ed.).

29. 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....

(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.

...

(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.

(a) The agency shall require prior authorization of home health services based on diagnosis, utilization rates, and billing rates. The home health agency must submit the recipient's plan of care and documentation that supports the recipient's diagnosis to the agency when requesting prior authorization.

(b) The agency shall implement a comprehensive utilization management program 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 must 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; 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. When implemented, the private duty nursing utilization management program shall replace the current authorization program used by the agency and the Children's Medical Services program of the Department of Health. The agency may competitively bid a contract to select a qualified organization to provide utilization management of private duty nursing services. The agency may seek federal waivers to implement this initiative.

(c) The agency may not pay for home health services unless the services are medically necessary and:

1. The services are ordered by a physician.
2. The written prescription for the services is signed and dated by the recipient's physician before the development of a plan of care and before any request requiring prior authorization.
3. The physician ordering the services is not employed, under contract with, or otherwise affiliated with the home health agency rendering the services. However, this subparagraph does not apply to a home health agency affiliated with a retirement community, of which the parent corporation or a related legal entity owns a rural health clinic certified under 42 C.F.R. part 491, subpart A, ss. 1-11, a nursing home licensed under part II of chapter 400, or an apartment or single-family home for independent living. For purposes of this subparagraph, the agency may, on a case-by-case basis, provide an exception for medically fragile children who are younger than 21 years of age.
4. The physician ordering the services has examined the recipient within the 30 days preceding the initial request for the services and biannually thereafter.

5. The written prescription for the services includes the recipient's acute or chronic medical condition or diagnosis, the home health service required, and, for skilled nursing services, the frequency and duration of the services.

6. The national provider identifier, Medicaid identification number, or medical practitioner license number of the physician ordering the services is listed on the written prescription for the services, the claim for home health reimbursement, and the prior authorization request.

30. The findings show the petitioner is under 21 years of age. The undersigned concludes Early Periodic Screening, Diagnosis and Treatment (EPSDT) requirements apply to the evaluation of the petitioner's eligibility for personal care services as outlined in the above controlling authority.

31. 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.

32. 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].

33. The October 2014 Florida Medicaid Home Health Services Coverage and Limitations Handbook (Handbook) has been promulgated into rule by Fla. Admin. Code R. 59G-4.130(2). The Handbook describes services covered under the Florida Medicaid Home Health Services Program. Personal care is an included service for individuals under the age of 21.

34. The issue before the undersigned, therefore, focuses upon the amount of personal care which is medically necessary.

35. Page 1-2 of the Handbook states "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 recipient to accomplish tasks that they would normally be able to do for themselves if they did not have a medical condition or disability."

36. Page 1-2 also provides the types of ADLs for which a personal care provider can assist:

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

37. Page 2-12 of the Handbook also addresses excluded services which are not reimbursed by Medicaid. This list includes, in part:

- Respite care
- Baby-sitting
- Social services
- Escort services
- Care, grooming, or feeding of pets and animals
- Yard work, gardening, or home maintenance work
- Day care or after school care
- Assistance with homework
- Companion sitting or leisure activities

38. The Handbook, on page 1-3, provides the following definition of babysitting: "The act of providing custodial care, daycare, afterschool care, supervision,

or similar childcare unrelated to the services that are documented to be medically necessary for the recipient”.

39. The undersigned acknowledges the petitioner is a 14-year-old young man and the generic term “babysitting” might, at first glance, seem inappropriate. From the perspective of home health services, however, the definition also includes afterschool care and supervision.

40. Page 2-26, of the Handbook specifically addresses Flex or Banking of Hours:

Medicaid does not allow “banking of hours” or “flex hours”. Only the number of hours that are determined medically necessary by the QIO can be approved. Home health service providers must request only the number of hours that are expected to be used and must indicate the times of day and days per week the hours are needed. If a recipient requires additional hours due to unforeseen circumstances or change in medical or social circumstances, the home health service provider should submit a modification request to the QIO for the additional hours needed.

41. The undersigned concludes the requested personal care hours are for both personal care and supervision purposes. The undersigned further concludes the request for additional hours is, in part, to allow some respite, for the petitioner’s mother. The above controlling authorities show that Personal Care Services are not approved for respite.

42. Supervision activities can be provided by any responsible adult. The undersigned concludes supervision alone is not covered under personal care supports.

43. In regard to parental responsibility, the undersigned takes note of page 2-25 of the Handbook: “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.”

44. The above paragraph establishes the Home Health Services Program is designed to supplement care provided by parents.

45. Page 2-2 of the Handbook states: “Home health services are not considered emergency services.” This is interpreted to mean the role of personal care is to provide a specific block of services related to ADLs and does not include supervision should an emergency arise.

46. It is noted that the petitioner’s physician ordered a service frequency greater than approved by eQHealth. Fla. Admin. Code. R. 59G-1.010(166) (c), however, states a prescription does not automatically mean the requirements of medical necessity have been satisfied. The physicians from eQHealth not only considered the various conditions of medical necessity but also considered all applicable rules and regulations, including those found in respondent’s Handbook.

47. EPSDT and medical necessity requirements have been reviewed and applied to the totality of the evidence. In doing such, petitioner has not established, by the greater weight of the evidence, that an additional four hours per day of personal care; five days a week is medically necessary.

48. Petitioner’s request is in conflict with 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;

...

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

49. The undersigned notes the mother's overwhelming concern for her child and her exhausted state. However, the undersigned concludes personal care services do not cover the respite she is needing.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the 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 30 day of August, 2016,

in Tallahassee, Florida.



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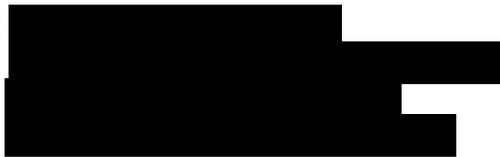
Melissa Roedel  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
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FINAL ORDER (Cont.)

16F-03638

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Copies Furnished To:



Aug 02, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

PETITIONER,

Vs.

APPEAL NO. 16F-03649  
16F-03650

CASE NO.

[REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 09 Orange  
UNIT: 66292

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on July 7, 2016 at 8:45 a.m. at [REDACTED]

[REDACTED]

**APPEARANCES**

For the petitioner: [REDACTED]

For the respondent: Marsha Shearer, ACCESS Economic Self-Sufficiency Specialist II

**STATEMENT OF ISSUE**

Petitioner is appealing the following:

- I. The respondent's action to reduce her Food Assistance Program (FAP) benefits from \$439.00 to \$194.00 effective June 2016. Petitioner is seeking a higher amount. The petitioner carries the burden of proof by a preponderance of the evidence.

II. The respondent's action to terminate the Medicaid benefits for the household.

The respondent carries the burden of proof by a preponderance of the evidence.

**PRELIMINARY STATEMENT**

By notice dated May 4, 2016, the respondent notified the petitioner that her FAP benefits would decrease from \$439.00 to \$194.00 beginning June 2016 due to removing her children as part of her household. On May 10, 2016, the petitioner timely requested a hearing to challenge the respondent's action to remove her children as part of her household, thus causing a decrease in her FAP benefits.

The petitioner is also appealing the termination of Medicaid benefits for her household. The respondent issued a Notice of Case Action to the petitioner on December 3, 2015. Said notice indicated the Medicaid benefits were ending on December 31, 2015. The hearing request (May 10, 2016) was not made within 90 days from the date of the notice at issue. Therefore, the undersigned lacks jurisdiction to review the matter as the request was made outside of the time allowed for a timely hearing request.

 petitioners' friend appeared to assist and support the petitioner.

Petitioner submitted two exhibits, entered as Petitioner's Exhibits "1" and "2". Respondent submitted seven exhibits, entered as Respondent's Exhibits "1" through "7". The record was held open until close of business on July 15, 2016 for submission of additional evidence from the petitioner. No additional evidence was received by the due date from the petitioner; therefore, the record closed on July 15, 2016.

### **FINDINGS OF FACT**

1. Prior to the action under appeal, the petitioner was receiving FAP benefits of \$194.00 for herself. Her certification period ended on February 29, 2016. On March 29, 2016, the petitioner submitted an on-line application for FAP benefits for her household, which included one child.
2. The petitioner shares custody of her two children with the children's father. During the application process, said child was already active and receiving FAP benefits in the father's FAP case.
3. On March 29, 2016, the petitioner completed a telephone interview. On April 1, 2016, the respondent sent a pending notice to the petitioner requesting school records and a statement indicating the children were residing with the petitioner. Based on the information provided by the petitioner, the respondent removed the children from their father's FAP case and authorized FAP benefits for the petitioner for a household size of three beginning May 2016.
4. The respondent erred in removing the petitioner's children from their father's case. It is unknown why the respondent removed both children and added them to the petitioner's FAP case in May 2016. Once the respondent realized it had erred in removing the children from their father's case, the children were then removed from the petitioner's case and added back to their father's case effective June 2016.
5. Petitioner is disputing the removal of the children from her case. Petitioner argued the children were on her case first since September 2015 and the school records for the children show her residence as the primary address for the children. Therefore, the

children should remain on her case. Additionally, the petitioner explained she and the children's father have court documents showing 50/50 parenting agreement. The parents have 50/50 timeshare custody.

6. The respondent presented evidence indicating joint custody is only a factor of eligibility for Temporary Cash Assistance (TCA) and Medicaid Assistance Programs.

The issue is not TCA.

7. On May 4, 2016, the respondent mailed a notice to the petitioner informing her two children were removed from her FAP case; therefore, reducing her FAP benefits beginning June 2016.

#### **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.

#### **MEDICAID ISSUE**

10. 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.

11. 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 relevant notice was issued on December 3, 2015 to the address provided by the petitioner. The petitioner requested a hearing on May 10, 2016, which is over the 90-day limit (from the date of the notice) for requesting an appeal.

12. Based on the above authority, the undersigned does not have jurisdiction over this matter.

### **FOOD ASSISTANCE ISSUE**

13. 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);

14. 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].

15. 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.”

16. 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.

17. The authorities cited set forth household requirements as well as 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. When the petitioner applied on March 29, 2016, the children were already receiving FAP benefits in their father’s household; therefore, the children should not have been included in the petitioner’s FAP eligibility determination.

18. Petitioner argued the respondent has erred in removing the children from her FAP benefits since September 2015. On September, October and December 2015, the respondent issued NOCA's informing the petitioner her FAP benefits amounts. These NOCA's issued to the petitioner included her appeal rights to request a hearing to challenge the FAP amount. As the petitioner did not exercise her right to a hearing within 90 days from the date of those notices, the undersigned can only address the NOCA issued on May 4, 2016.

19. Based on the controlling legal authorities, testimony and evidence, the undersigned concludes that the Department's action to remove the petitioner's children from her FAP benefits and reduce the petitioner's FAP benefits effective June 2016 was correct.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the Medicaid appeal (16F-03650) is dismissed as non-jurisdictional.

The FAP appeal (16F-03649) 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   02   day of   August  , 2016,

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

Aug 30, 2016

Office of Appeal Hearings  
Dept. of Children and FamiliesSTATE OF FLORIDA  
DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGSAPPEAL NO. 16F-03651  
APPEAL NO. 16F-03652

PETITIONER,

Vs.

CASE NO. FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT:   
UNIT: 883DTRESPONDENT.  

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**FINAL ORDER OF DISMISSAL**

Pursuant to notice, the undersigned telephonically convened two administrative hearings in the above-referenced matter on July 1, 2016 at 2:30 p.m.; and on July 27, 2016 at 2:32 p.m.  hereafter "petitioner") was present and testified at both hearings. Petitioner submitted no exhibits at the hearings. Respondent was represented by Fred Snedeker, Senior Human Services Program Specialist, with the Office of Public Benefits Integrity Program, Benefit Recovery Unit (hereafter "PBI", "Respondent" or "Agency") at both hearings. Mr. Snedeker testified. At the July 27, 2016 hearing, the respondent submitted two exhibits, which were accepted into evidence and marked as Respondent's Exhibits "1" through "2".

The issues under appeal are the respondent's actions to establish a Food Assistance (FA) overpayment claim in the amount of \$9,424 for the period of March 1, 2011 through August 31, 2012; and to establish a Medicaid overpayment claim in the

amount of \$11,930.02 for the period of March 1, 2011 through September 30, 2012. On July 26, 2016, the respondent submitted void requests to the claims unit for the petitioner's FA and Medicaid overpayment claims. The record was left open to allow the respondent to submit documentation that verified the petitioner's FA and Medicaid overpayment claims were voided. Respondent never submitted the requested documentation.

On August 18, 2016, a Preliminary Order of Dismissal was sent to both parties allowing an opportunity for either party to object to the dismissal. If either party had any objections, these had to be filed no later than ten (10) days from the date of the Preliminary Order of Dismissal.

On August 19, 2016, the respondent emailed the petitioner and the undersigned documentation that verified the petitioner's FA and Medicaid overpayment claims were voided. On August 22, 2016, the petitioner sent an email to the respondent and the undersigned indicating "that everything has been done and I am forever grateful".

To the date of this Order, neither party has submitted a written objection to the undersigned within the allotted timeframe. Instead, both parties submitted documentation that indicated the petitioner's two overpayment claims were voided and that the petitioner was satisfied with the outcome of her overpayment claims. As there were no objections to the dismissal and as the petitioner's Food Assistance and Medicaid overpayment claims have been voided, the appeals are hereby DISMISSED as moot as all issues have been resolved.

**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 August, 2016,

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

Jul 05, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-03658

PETITIONER,

Vs.

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

And

Humana

RESPONDENTS.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above matter on June 17, 2016 at 11:10 a.m.

**APPEARANCES**

For the Petitioner:



For the Respondents:

Dianna Chirino  
Agency for Healthcare Administration (AHCA)  
Senior Human Services Program Specialist

Mindy Aikman  
Humana  
Grievance and Appeals Specialist

**ISSUE**

Whether the denial of the following dental procedures was proper:

- D7240: Extraction of four impacted teeth covered by bone
- D9243: Intravenous (IV) Sedation

The burden of proof was assigned to the petitioner. The standard of proof in an administrative hearing is by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

Spanish and English translation was provided by Propio Language Services. Due to a problematic phone connection, three different interpreters were used during the proceeding.

At the hearing, a verbal request was made for Humana to be added as a party to this proceeding. The request was granted.

Petitioner entered no exhibits into evidence.

Present for the respondents from DentaQuest were Jackelyn Salcedo, Appeals and Grievance Specialist and Dr. Daniel Dorrego, D.D.S. Respondent's exhibit "1" was accepted into evidence.

### **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 March 23, 2000.
2. Petitioner receives Medicaid services through AHCA's Statewide Medicaid Managed Care Program. Specifically, the Managed Medical Assistance Program. Humana is the managed care entity which 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 procedures are in compliance with pertinent rules and regulations.
4. On or about April 28, 2016 DentaQuest received, on petitioner's behalf, a request for the following services:
  - D7240: Extraction of tooth #1; #16; #17; and # 32<sup>1</sup>
  - D9243: IV Sedation
5. With the request, petitioner's dentist submitted an x-ray and provided the following narrative: "Patient has been experiencing pain, pressure, and swelling. Patient has previously been treated with antibiotics for a chronic infection. Teeth are beyond the scope of the general dentist with very difficult access. Patient present phobia of needles."
6. Regarding the teeth at issue, the submitted x-rays show:
  - No root development
  - All are encapsulated in bone and not yet exposed to the oral cavity
  - No evidence of pathology
  - No presence of cysts or abscesses
  - No periodontal infection
7. A DentaQuest dentist thereafter reviewed submitted information. On May 3, 2016 a Notice of Action was issued denying both dental procedures. The extraction was determined not to be medically necessary. The notice also stated, in part:
  - We cannot approve this request to remove your tooth because the information that your dentist sent shows that your teeth are not bad enough to be removed and show no sign of infection or pain. We have told your dentist this also.

---

<sup>1</sup> All four teeth are known either as third molars or wisdom teeth.

- Your dentist has asked for anesthesia (a medicine to make you sleep) for a service that has been denied. Therefore, the request to make you sleep is also denied.

8. On May 11, 2016 petitioner's request for Medicaid Fair Hearing was timely received by the Office of Appeal Hearings.

9. Respondents argue the narrative provided by the referring dentist failed to address the intensity; frequency; and duration of pain. As such, the pain mentioned is most likely normal eruption discomfort. The narrative regarding infection was general in nature and failed to address the location and type of infection.

10. Petitioner's representative argues pain exists during the chewing process. Extraction would resolve the pain.

#### **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 preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7<sup>th</sup> Ed.).

15. 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.

16. 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.”

17. AHCA’s promulgated Dental Services Coverage Policy (Dental Policy) became effective in May 2016.

18. The Dental Policy states, in relevant parts:

### **1.1 Description**

Florida Medicaid dental services provide for the study, screening, assessment, diagnosis, prevention, and treatment of diseases, disorders, and conditions of the oral cavity.

#### **1.1.2 Statewide Medicaid Managed Care Plans**

This Florida Medicaid policy provides the minimum service requirements for all providers of dental services. This includes providers who contract with Florida Medicaid managed care plans (i.e., provider service networks and health maintenance organizations). Providers must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the Agency for Health Care Administration’s (AHCA) contract with the Florida Medicaid managed care plan. The provision of services to recipients in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

## **4.0 Coverage Information**

### **General Criteria**

Florida Medicaid reimburses for services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

#### **4.2.9 Surgical Procedures and Extractions**

Florida Medicaid reimburses for surgical procedures and extraction services for recipients under the age of 21 years.

19. 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...

...

20. 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 request for dental 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 ...

21. 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].

22. The Dental Policy establishes extractions are covered for Medicaid recipients under the age of 21 years. The Findings of Fact establish petitioner is under 21 years of age. As such, the issue before the undersigned focuses upon whether the dental procedures at issue meet medical necessity criteria.

23. The Findings of Fact establish the submitted x-ray showed no pathology; infection; cyst; or abscess. It is also noted the x-ray showed no root development and none of petitioner's wisdom teeth had yet erupted.

24. Petitioner's discomfort is noted. The intensity; duration; and frequency of that pain, however, was not clearly documented.

25. Extraction of wisdom teeth is a common procedure for most teenagers. The Florida Medicaid Program, however, requires each criteria of medical necessity be satisfied before a service can be approved.

26. After reviewing all testimony and documentary exhibits, petitioner has not established that dental procedure D7240 satisfies the following conditions of medical necessity.

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate **severe pain** [Emphasis Added];
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;

27. Since the requested extractions have not been demonstrated to be medically necessary, the IV sedation (D9243) associated with the extractions is moot.

28. The undersigned has reviewed EPSDT policy; medical necessity requirements; and applicable rules and regulations. After considering such, the petitioner has not established in a preponderant manner 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

FINAL ORDER (Cont.)

16F-03658

PAGE - 9

petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 05 day of July, 2016,

in Tallahassee, Florida.

*Frank Houston*

---

Frank Houston  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
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Copies Furnished To:

[REDACTED], PETITIONER  
RHEA GRAY, AREA 11, AHCA FIELD OFFICE MANAGER  
MINDY AIKMAN, HUMANA

Aug 08, 2016

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

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-03670

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on July 11, 2016, at 4:10 p.m.

**APPEARANCES**

For the Petitioner:

[REDACTED]

For the Respondent:

Stephanie Lang, R.N.  
Registered Nurse Specialist/Fair Hearing Liason  
Agency for Health Care Administration

**STATEMENT OF ISSUE**

Did the petitioner prove by a preponderance of the evidence that the respondent incorrectly denied his prior authorization request for removal of his colostomy bag and port?



6. The petitioner received adjuvant [REDACTED]y with minimal effect on the [REDACTED]burden and had a severe reaction to the [REDACTED]. As a result, he decided against receiving further chemotherapy.

7. The petitioner's surgeon inserted a colostomy bag and port into the petitioner at the time of his colostomy in July 2015.

8. The purpose of a colostomy bag is to collect waste.

9. The petitioner's surgeon advised him at the time of his colostomy in July 2015 that his colostomy bag and port were only temporary; that they would be removed once his colon healed.

10. The petitioner was scheduled to have his colostomy bag and port removed on or about April 1, 2016.

11. Sometime prior to the scheduled removal of the petitioner's colostomy bag and port, the petitioner's doctor submitted a prior authorization request to eQHealth Solutions requesting approval for the surgical procedure.

12. eQHealth Solutions is a Quality Improvement Organization contracted by the Agency for Health Care Administration to review prior authorization requests made by Medicaid recipients and/or their providers for medical necessity.

13. Shortly before the removal of the petitioner's colostomy bag and port, eQHealth Solutions advised the petitioner it was denying his prior authorization request for the procedure.

14. After the initial denial, the petitioner's doctor rescheduled the removal of the petitioner's colostomy bag and port for on or about June 15, 2016.

15. On April 29, 2016, the petitioner's doctor and a physician from eQHealth Solutions had a peer-to-peer consultation regarding the removal of the petitioner's colostomy bag and port.

16. After the peer-to-peer consultation on April 29, 2016, the doctor from eQHealth Solutions again denied the petitioner's request for removal of his colostomy bag and port citing that removal of the colostomy bag and port is an elective procedure, is being sought at the patient's request for comfort measures, and is not medically necessary.

17. The petitioner's doctor provided documentation to eQHealth Solutions indicating that the petitioner's colon has healed and removal of the colostomy bag and port are plausible.

18. The eQHealth Solutions Physician Reviewer appearing as a witness for the respondent at the hearing testified the petitioner's request was denied because it did not comport with the Interqual criteria.

19. The Interqual criteria are a set of standards used by insurance companies and others to determine if approval of a medical procedure is appropriate.

20. The respondent did not provide a copy of the Interqual criteria it used in deciding this matter to the hearing officer.

21. It is the position of the petitioner that the colostomy bag is a foreign object which impedes his quality of life and that his colon has healed and the device is no longer medically necessary. The petitioner is disheartened that the respondent refuses to approve the removal of the colostomy bag and port when he was told by his doctor

that the items were only temporary and would be removed when they were no longer medically necessary.

22. It is the position of the respondent that removal of the colostomy bag and port are solely a quality of life issue and are not medically necessary.

23. A colostomy bag and port are not a natural part of the human body; they are surgically implanted to assist with the removal of human waste when the colon is in distress.

24. A colostomy bag and port require regular maintenance including, but not limited to, emptying or changing the colostomy bag and doctor's visits to ensure they are operating properly. A colostomy bag and port carry an inherent risk of infection and other potential health problems to the individual.

### **CONCLUSIONS OF LAW**

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 § 120.80, Fla. Stat.

26. 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.

27. All goods and services requested under the Florida Medicaid Program must be shown to be medically necessary in order to be approved.

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

29. 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.

30. 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, 7<sup>th</sup> Ed.).

31. The Florida Medicaid program is authorized by Fla. Stat. ch 409 and Fla. Admin. Code R. 59G.

32. 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...

33. 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 ...

34. 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.

35. 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.

36. 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.

37. In the present case, the petitioner had a colostomy bag and port inserted at the time of his surgical procedure in July 2015. The colostomy bag and port were placed for the purpose of capturing and removing waste while the colon was unable to perform these functions after surgery and were intended to be only temporary. The petitioner's colon is now able to perform the natural bodily functions it is designed to do. The prolonged insertion of these foreign bodies in the petitioner will result in medical costs associated with their maintenance and potential bodily harm to the petitioner. The petitioner provided evidence from his doctor and testimony indicating that his colon has healed. The colostomy bag and port are no longer medically necessary. In accordance with the above statutes and regulations, since the items are no longer medically necessary and will result in additional costs to Medicaid, they should be removed.

38. 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. The respondent is directed to take whatever steps necessary to communicate approval of the removal of the petitioner's colostomy bag and port to the petitioner's doctor without delay.

**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 08 day of August, 2016,

in Tallahassee, Florida.



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Peter J. Tsamis  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To:

, Petitioner  
AHCA, Medicaid Fair Hearings Unit

**FILED**

Aug 04, 2016

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

Office of Appeal Hearings  
Dept. of Children and Families



APPEAL NO. 16F-03689

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION  
CIRCUIT: 11 DADE  
UNIT: AHCA.

And

HUMANA,

RESPONDENTS.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 17, 2016, at 3:00 p.m.

**APPEARANCES**

For the Petitioner:



For the Respondent: Dianna Chirino, Senior Program Specialist

**STATEMENT OF ISSUE**

At issue is the Agency action partially denying the petitioner's request for additional home health services (respite care) under the Long Term Care (LTC)

Program. The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

The petitioner submitted a neurologist report as evidence for the hearing, which was marked as Petitioner Exhibit 1.

Appearing as witnesses for the respondent were Dr. Pablo Calzada, Medical Director, and Mindy Aikman, Grievance and Appeals Specialist, from Humana, which is the petitioner's managed health care plan. Humana was included as an additional party to this proceeding pursuant to its request to be added as a party.

The respondent submitted documents as evidence for the hearing consisting of the following which were marked as Respondent Composite Exhibit 1: Case Summary, Denial Notice, Case Notes Reports, Medical Assessment Form, and Handbook provisions.

### **FINDINGS OF FACT**

1. The petitioner is eighty-one (81) years of age and lives with his wife and one of his sons. The petitioner's medical conditions include [REDACTED]

[REDACTED]. His wife is bed-bound and suffers from [REDACTED]

[REDACTED]. She also receives Long-Term Care services in the home.

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 Humana.

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 Humana provide services to Medicaid recipients pursuant to a contract with AHCA.

4. The Petitioner currently receives a total of fourteen (14) hours weekly of home health services through Humana, which is allocated as follows: five (5) hours weekly of personal care assistance, five (5) hours weekly of homemaker services, and four (4) hours weekly of respite care services. He also receives home delivered meals 7 days per week (1 meal daily).

5. On or about March 1, 2016, the petitioner made a request to Humana for 8 hours of respite care weekly. At that time, he was not receiving any respite care service hours. On March 11, 2016, Humana sent a letter to the petitioner partially denying his request for the respite care services as not being medically necessary. Humana advised him it had approved 4 hours weekly of respite care services, but it had denied the balance of the requested hours. The 4 respite care hours combined with the previously approved 10 hours weekly of personal care assistance and homemaker services resulted in the current approval of 14 total hours weekly.

6. The petitioner's son stated his father should be approved for the additional respite care hours because his health has declined and he has become more delusional. He has safety concerns due to his father's psychological problems. His father's caregiver (a different son) works during the day and is unable to completely provide care.

7. The respondent's witness, Dr. Calzada, stated that the medical guidelines suggested a need for 7 hours weekly of assistance in the home. He stated the health plan partially approved the requested respite care hours to provide additional assistance to the family in caring for 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 Fla. Stat. § 409.285. 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 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, 7<sup>th</sup> Ed.).

11. 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).

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

13. The petitioner requested a fair hearing because he believes his services under the Program should be increased.

14. Fla. Stat. § 409.98 lists the services which must be covered by Long-Term Care plans. Respite care services, personal care assistance, and homemaker services are among the services available from Long-Term Care plans and are addressed in the AHCA contract.

15. 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.

16. 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.

17. The petitioner also currently receives respite care services and is seeking an increase in respite care services, which are defined in the contract 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.

18. 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."

19. 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."

20. 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.

21. After considering the evidence and testimony presented, the hearing officer concludes that the petitioner has not demonstrated that his respite care services should be increased under the LTC Program. The petitioner clearly needs assistance with activities of daily living (ADLs). However, he is currently approved for 14 hours weekly of home health services to assist him with these activities and medical necessity for more hours has not been established in this case.

### **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 04 day of August, 2016,

in Tallahassee, Florida.

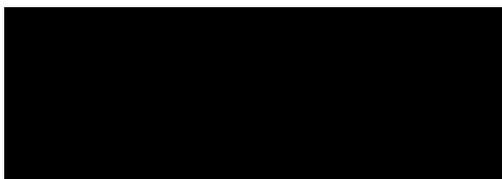


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Copies Furnished To: [REDACTED], PETITIONER  
AHCA, MEDICAID FAIR HEARINGS UNIT  
STACEY LARSEN, HUMANA

Aug 15, 2016

Office of Appeal Hearings  
Dept. of Children and FamiliesSTATE OF FLORIDA  
DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-03693

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND AGENCY  
FOR HEALTH CARE ADMINISTRATION  
CIRCUIT: 17 Broward  
UNIT: AHCARESPONDENT.  

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**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above referenced matter on July 11, 2016 at 8:32 a.m.

**APPEARANCES**

For the Petitioner: 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 in denying Petitioner's request for Occupational Therapy. Because the matter at issue involves a request for services, Petitioner carries the burden of proof.

### **PRELIMINARY STATEMENT**

Appearing as witnesses for the Respondent, from Petitioner's managed care plan Better Health, were Dr. Jeannette Rios, Medical Director, and Diana Ana, Grievance and Appeals Manager. Respondent submitted a 29-page document which was admitted into evidence and marked Respondent Exhibit 1.

### **FINDINGS OF FACT**

1. Petitioner is a 31 year-old recipient of the Medicaid program. Effective May 2, 2016, he enrolled as a member of the Better Health Managed Medical Assistance (MMA) plan.
2. Petitioner suffered a stroke in April 2016 which resulted in left sided weakness of his upper and lower extremities.
3. On May 10, 2016, Better Health received a prior authorization request for procedure code 97003-Occupational Therapy Evaluation and 97530-Occupational Therapy.
4. Better Health issued a Notice of Action to the Petitioner on May 12, 2016 denying his request for occupational therapy because the service is not a covered benefit.
5. Petitioner filed a timely request for a fair hearing on May 16, 2016.
6. Petitioner has been unable to work since suffering his stroke. Petitioner has been approved for physical therapy. His ambulation has improved as a result of this therapy. He states he needs occupational therapy for his hands so he can go back to work and support his family.

7. Respondent's medical director explained that physical therapy can be used for his hands as well as the weakness he has experienced on his left side. The medical director noted that occupational therapy is not a Medicaid covered service for those over 20 years of age. Respondent suggested Petitioner may also be eligible for Vocational Rehabilitation services. Petitioner was encouraged to work with his case manager in getting physical therapy for his hands and also explore his potential eligibility for Vocational Rehabilitation services.

### **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 Fla. Stat.

9. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code § 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. 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.

12. Fla. Admin. Code 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.

(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...

13. Florida Administrative Code Rule 59G-4.320 applies to all therapy services

providers enrolled in the Medicaid program. It states in relevant part:

(2) All therapy providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Therapy Services Coverage and Limitations Handbook, August 2013, available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-03069>, incorporated by reference.

14. On page 1-2 of the Florida Medicaid Therapy Services Coverage and Limitations

Handbook (Therapy Handbook), the following purpose of therapy services program is provided:

The purpose of the therapy services program is to provide medically necessary physical therapy (PT), occupational therapy (OT), respiratory therapy (RT) and speech-language pathology (SLP) services to recipients under the age of 21. The therapy services program also provides 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.

15. The Therapy Handbook, on page 2-1, sets forth who can receive therapy services:

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.** (Emphasis added.)

16. The July 2012 Florida Medicaid Provider General Handbook (Provider Handbook) is incorporated by reference into Fla. Admin. Code R. 59G-5.020. Page 1-30 of the Provider Handbook describes a Health Maintenance Organization's (HMO's) limitations and indicates "[a]n HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

17. Petitioner asserts he needs occupational therapy for his hands because he needs the use of his hands in order to return to work.

18. Respondent advised his approved physical therapy services can be used to provide therapy for his hands.

19. Respondent also explained that occupational therapy is not a Medicaid covered service for those over 20 years of age.

20. Respondent has approved physical therapy for the Petitioner which is above what Medicaid fee-for-service covers. Expanding Petitioner's benefit to receive physical

therapy does not obligate the Respondent to provide other expanded benefits.

Providing occupational therapy would be another expanded benefit because Medicaid fee-for-service makes it clear this is not a covered benefit for those over 20 years old. Respondent's denial of occupational therapy, therefore, is not more restrictive than Medicaid fee-for-service.

21. After considering the evidence and all of the appropriate authorities set forth above, the hearing officer concludes that the Petitioner has not met his burden of proof. The Therapy Handbook makes it clear that occupational therapy is not a covered service for the Petitioner.

### **DECISION**

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

DONE and ORDERED this 15 day of August, 2016,  
in Tallahassee, Florida.



Warren Hunter  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
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Copies Furnished To: [REDACTED] Petitioner  
AHCA, Medicaid Fair Hearings Unit  
Better Health Hearings Unit

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

**FILED**

Aug 04, 2016

Office of Appeal Hearings  
Dept. of Children and Families

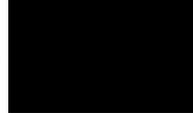


APPEAL NO. 16F-03723

PETITIONER,

Vs.

CASE NO.



FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 17 Broward  
UNIT: 02555

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on July 21, 2016 at approximately 10:30 a.m. CDT.

**APPEARANCES**

For the Petitioner:



For the Respondent: Ronda Lanum, Economic Self-Sufficiency Specialist  
Supervisor

**STATEMENT OF ISSUE**

Petitioner is appealing the Department's action of April 29, 2016 denying his application for SSI-Related Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

### **PRELIMINARY STATEMENT**

The petitioner submitted a packet of information that was admitted into evidence as Petitioner's Exhibit "1".

The respondent submitted a packet of information that was admitted into evidence as Respondent's Exhibits "1" through "8".

### **FINDINGS OF FACT**

1. The petitioner is a 44-year-old single male living with a roommate and no dependent minors from which to derive Medicaid eligibility.
2. On July 21, 2015, the petitioner submitted an application for SSI-Related Medicaid. It was denied in early August 2015. The petitioner's disability information was submitted to the Division of Disability Determination (DDD) to review the petitioner's claim for disability. (See Petitioner's Exhibit 7).
3. DDD did not make an independent disability determination because the Social Security Administration (SSA) determined that the petitioner was not disabled in December 2014 and the denial is under appeal. The Department adopted the SSA unfavorable decision and denied the petitioner's application for SSI-Related Medicaid noting "same allegations, hearing pending". (See Petitioner's Exhibit 7).
4. The petitioner completed an application for SSI-Related Medicaid and Food Assistance (FA) on April 27, 2016. On April 29, 2016, the FA was approved and the Medicaid denied. (See Petitioner's Exhibit 4). The respondent testified that this denial was based on the fact that SSA had previously denied Medicaid; that denial was on appeal; and, the petitioner claimed no new disabling conditions. The DDD denied the petitioner's claim for disability because his medical allegations were the same ones

reviewed in the SSA determination of disability, amputation of the left arm and lumbar pain, and that decision is under appeal.

5. The petitioner argues that adopting the SSA decision is contrary to the rule because the SSA decision was reached more than a year before the DDD adoption.

6. The petitioner testified that there were no new disabling conditioners not considered by SSA.

### **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 Section 409.285, Florida Statutes.

8. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

10. Fla. Admin. Code R. 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 less than 65 years of age to receive Medicaid, 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 (see §416.960(b)) or any other substantial gainful work that exists in the national economy...

11. Additionally, 42 C.F.R. § 435.541 Determination of Disability, states:

(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 requirement of the Act, and has not applied to SSA for a determination with respect to these allegations.

12. The Department's Program Policy Manual, CPOF 165-22, passage 1440.1205

Exceptions to State Determination of Disability (MSSI, SFP) states:

The state does not make a disability determination under the following conditions:

1. When an individual only applies to SSA (no application is filed with DCF and no SSI denial or ex parte is involved).

2. When an individual receives Title II disability or SSI benefits based on their own disability (not dependent or early retirement benefits).

3. When an earlier favorable federal or state determination of blindness/disability is still in effect and no unfavorable decision has been rendered by SSA.

4. When an individual is no longer eligible for SSI solely due to institutionalization.

**5. When the applicant is appealing an earlier decision from SSA and claims no new disabling condition (condition not previously considered by SSA). (emphasis added)**

13. The above authorities explain that the Department must make an independent disability determination if it has been more than 12 months since the most current SSA disability determination **and** the applicant alleges a new period of disability which meets the durational requirement of the Act, **and** he or she has not filed a disability claim with the SSA regarding the alleged medical conditions. Petitioner does not fit this criteria.

14. In this case, the petitioner is under 65 and has several medical conditions such as amputation of the left arm and lumbar pain. The findings show that these medical conditions were reviewed in the SSA disability determination. The findings show the petitioner applied for SSI-Related Medicaid more than 12 months after the most recent SSA denial; however, the petitioner has applied for and been denied SSA disability benefits with the alleged medical conditions and the SSA denial is also currently under appeal. Therefore, the undersigned concludes that the petitioner did not meet his burden of proof to show that the Department's action was incorrect. The undersigned concludes that the Department was correct to not make an independent disability decision. Until the petitioner meets the federal disability criteria (while under age 65) Medicaid cannot be approved.

### **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.

FINAL ORDER (Cont.)  
16F-03723  
PAGE -6

DONE and ORDERED this 04 day of August, 2016,  
in Tallahassee, Florida.



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Gregory Watson  
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

Aug 22, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 16F-03731

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 05 Marion  
UNIT: 88503

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 10:18 a.m. on July 22, 2016.

**APPEARANCES**

For the Petitioner: [REDACTED]

For the Respondent: Sylma Dekony, ACCESS  
Economic Self-Sufficiency Specialist II

**STATEMENT OF ISSUE**

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

### **PRELIMINARY STATEMENT**

By notice dated June 1, 2016, the respondent (or the Department) notified the petitioner her Medicaid application was denied. The petitioner timely requested a hearing to challenge the Medicaid denial.

██████████, petitioner's friend, appeared as a witness for the petitioner. Petitioner submitted one exhibit, entered as Petitioner Exhibit "1". Respondent submitted five exhibits, entered as Respondent Exhibits "1" through "5". The record was closed on July 22, 2016.

### **FINDINGS OF FACT**

1. On March 29, 2016, the petitioner (age 48) submitted a web application for herself. There is no indication of what benefits she was applying for.
2. On April 29, 2016, the Department incorrectly denied the petitioner's March 29, 2016 application for not completing an interview.
3. On May 23, 2016, the Department completed the required interview with the petitioner and determined that the petitioner was applying for Medicaid Disability.
4. To be eligible for Family Medicaid, petitioner must have minor children. To be eligible for SSI-Related Medicaid, petitioner must be age 65 or older, or considered blind or disabled by the Social Security Administration (SSA) or the Division of Disability Determination (DDD). DDD determines Medicaid disability for the Department.
5. Petitioner does not have minor children, is not age 65 or older and has not been considered blind or disabled by the SSA or DDD.
6. Petitioner applied for disability through the SSA in September 2014. The SSA denied the petitioner disability in April 2015 and again in September 2015. The

petitioner appealed, through an attorney, the SSA denial in November 2015; a hearing date has not been scheduled.

7. The Department mailed the petitioner's medical documents to DDD for review on May 23, 2016.

8. On May 26, 2016, DDD denied the petitioner Medicaid Disability, due to adopting the SSA denial.

9. On June 1, 2016, the Department mailed the petitioner a Notice of Case Action, notifying her March 29, 2016 application was denied, due to not meeting the disability requirement.

10. Petitioner alleges additional medical disabilities from the disabilities reviewed by SSA. The additional medical disabilities include [REDACTED],

[REDACTED]  
[REDACTED].

11. Petitioner's witness stated they will make sure that the SSA is aware of the petitioner's additional medical disabilities.

#### **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 Section 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

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

14. 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 as SSI-Related Medicaid) for disabled adults and adults 65 or older.

15. Fla. Admin. 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...

16. Petitioner does not have children. Therefore, petitioner is not eligible for Family-Related Medicaid.

17. The Code of Federal Regulations at 42 C.F.R. § 435.541, Determinations 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...

18. The above authority explains the SSA determination is binding on the Department.

19. In accordance with the above authority, the Department denied the petitioner's March 29, 2016, Medicaid application; due to adopting the SSA September 2015 denial decision.

20. The above authority also states that 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", "Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations".

21. Petitioner argued having additional medical disabilities from the disabilities reviewed by SSA. The additional medical disabilities include [REDACTED]

[REDACTED]

[REDACTED]

22. Petitioner, through an attorney, is appealing the SSA September 2015 denial.

23. Petitioner's witness testified that they will make sure that the SSA is aware of the petitioner's additional medical disabilities.

24. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner did not meet her burden of proof. The undersigned agrees with the Department's action to deny petitioner Medicaid; due to adopting the SSA disability denial.

**DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, 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 22 day of August, 2016,

in Tallahassee, Florida.



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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

Aug 16, 2016

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

Office of Appeal Hearings  
Dept. of Children and Families



PETITIONER,

Vs.

APPEAL NO. 16F-03791  
16F-03839

CASE NO.



FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 09 Orange  
UNIT: 88601

RESPONDENT.

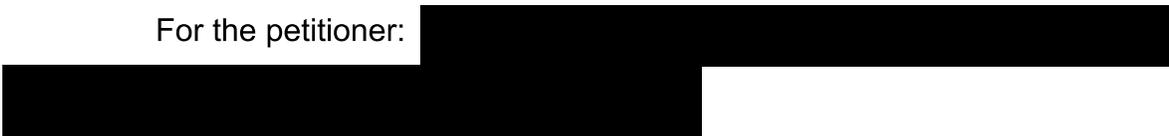
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**FINAL ORDER**

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter on June 20, 2016 at 9:45 a.m.

**APPEARANCES**

For the petitioner:



For the respondent: Marsha Shearer, ACCESS Economic Self-Sufficiency  
Specialist II

**STATEMENT OF ISSUE**

At issue is whether the respondent's action to deny the petitioner's application and retroactive months for the Medicare Savings Plan (MSP), under the Medicaid Qualifying Individual 1 (QI1) Program was proper. The petitioner carries the burden of proof by a preponderance of the evidence.

At issue is also the petitioner's enrollment in the Medically Needy (MN) Program with a share of cost (SOC). The petitioner carries the burden of proof by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

By notice dated May 10, 2016, the respondent notified the petitioner that his Medicaid QI1 application dated April 22, 2016 was denied due to income. Petitioner timely requested an appeal to challenge the denial.

At the outset of the hearing, the petitioner explained he did not request a hearing regarding the MN Program. Therefore, appeal 16F-03791 is dismissed as invalid.

Petitioner did not submit any exhibits. Respondent submitted five exhibits, entered into evidence as Respondent's Exhibits "1" through "5".

### **FINDINGS OF FACT**

1. On April 22, 2016, the petitioner submitted an application for MSP. Petitioner reported his sources of income were Social Security Disability Income (SSDI) and his part-time employment with [REDACTED]
2. The respondent reviewed the application for April 2016 and three retroactive months (January, February and March 2016). The respondent verified the petitioner's SSDI through the State of Florida on-line query.
3. The on-line query showed petitioner's SSDI amount was \$990.00. Petitioner submitted to the Department the following paystubs: April 8, 2016 gross pay of \$56.35, April 15, 2016 gross pay of \$257.61, April 22, 2016 gross pay of \$267.66 and April 29,

FINAL ORDER (Cont.)

16F-03791

16F-03839

PAGE - 3

2016 gross pay of \$265.65. The respondent calculated his monthly earned income by adding these paystubs, which totaled \$847.28.

4. The respondent calculated the countable unearned income as \$970.00, after a \$20.00 unearned income disregard was subtracted. The next step was the calculation of the countable earned income. The respondent calculated the earned income as \$847.28 and subtracted a \$65.00 earned income disregard. This totaled \$782.28, the Department then took \$782.28 and divided by two, the countable earned income amount was \$391.14. The respondent calculated the petitioner's total countable income as \$1,361.14 (\$970.00 + \$391.14).

5. The respondent used the \$1,381.14 total countable income and calculated the Q11 budget as follows:

```
TOTAL UNEARNED INCOME:      990.00   COUNTABLE EARNED INCOME:      391.14
PARENT'S DEEMED INCOME: +    .00   COUNTABLE UNEARNED INCOME: +   970.00
MISC. INCOME DISREGARDS: -    .00   MEDICALLY NEEDED DISREGARD: -    .00
UNEARNED INCOME DISREGARD: -   20.00   TOTAL COUNTABLE INCOME: =  1361.14
COUNTABLE UNEARNED INCOME: =   970.00

                                     INCOME STANDARD:      1325.00

SELF-EMP. ADJ. GROSS EARN.:    .00
ADDITIONAL EARNED INCOME: +   847.28
MISC. INCOME DISREGARDS: -    .00   TOTAL COUNTABLE INCOME:      .00
REM. UNEARNED INC. DISREGARD: -    .00   MNIL: -    .00
EARNED INCOME DISREGARD: -    65.00   SHARE OF COST: =    .00
1/2 REMAINING DISREGARD: -   391.14
BLIND WORK EXPENSES: -    .00   MED. INSURANCE PREMIUM: -    .00
COUNTABLE EARNED INCOME: =   391.14   RECURRING MED. EXPENSES: -    .00
                                     REMAINING SOC: =    .00
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AG HAS FAILED THE SSI-RELATED MEDICAID ELIGIBILITY DETERMINATION BUDGET

6. The income limit for an individual to qualify for Q11 benefits was \$1,325.00 prior to April 2016. The respondent determined that the petitioner's total countable income (\$1,361.14) exceeded the income limit to qualify for Medicaid Q11. However, as of April

2016, the income limit for an individual to qualify for QI1 benefits changed from \$1,325.00 to \$1,335.00. The petitioner's income continues to exceed the income limit to qualify for the Medicaid QI1 Program.

7. Petitioner's representative explained the petitioner works for a school through [REDACTED] [REDACTED] and there are months the petitioner does not work due to the school seasonal session ending. Furthermore, the representative explained the petitioner is a teacher aid and believes his earned income should be based on annual pay and divided by a twelve-month period instead of monthly. The representative did not understand how the respondent determined the petitioner's income exceeded the income limit for the retroactive months in question.

8. The respondent explained contracted school employees' income is budgeted over a twelve-month period. Petitioner has no contract because his employment is with [REDACTED] [REDACTED] an employment agency for temporary assignments. The respondent explained, the petitioner could submit a new application and current paystubs; the respondent would then re-evaluate the petitioner's eligibility.

#### **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 § 409.285, Fla. Stat. 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. Section 409.904, Fla. Stat., Optional payments for eligible persons addresses who qualifies for this Program and states in part:

The agency may make payments for medical assistance and related services on behalf of the following persons who are determined to be eligible subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

(1) Subject to federal waiver approval, a person who is age 65 or older or is determined to be disabled, whose income is at or below 88 percent of the federal poverty level, whose assets do not exceed established limitations, and who is not eligible for Medicare or, if eligible for Medicare, is also eligible for and receiving Medicaid-covered institutional care services, hospice services, or home and community-based services. The agency shall seek federal authorization through a waiver to provide this coverage.

12. 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. Petitioner met the disability criteria; the next step is to determine income eligibility.

13. Fla. Admin. Code R. 65 A-1.702, Medicaid Special Provisions, in relevant part states:

...

(9) Retroactive Medicaid. 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.** (emphasis added) A request for retroactive Medicaid can be made for a deceased individual by a designated representative or caretaker relative filing an application for Medicaid assistance. The individual or his or her representative has up to 12 months after the date of application for ongoing Medicaid to request retroactive Medicaid eligibility. 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).

...

(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.)

14. The Department of Children and Families published Transmittal No. P-15-09-0008 on September 15, 2015 relating to "Teacher and Contracted School Employee Income,"

it states in part:

This memorandum provides a policy change on how to budget income for teachers and other contracted school employees. This is a result of a clarification from the Food and Nutrition Service. This policy change applies to the Food Assistance, Temporary Cash Assistance and Medicaid programs.

Policy Change

The income for teachers and other contracted school employees is intended to cover a yearly period. Annual income received by contracted school employees, including teachers, must be budgeted over the 12-month period.

15. Fla. Admin. Code R 65A-1.713(1) further addresses the "SSI-Related Medicaid Income Eligibility Criteria" and explains:

(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:

...

(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.

16. Federal regulation at 42 C.F.R. § 435.631, General requirements for determining income eligibility in States using more restrictive requirements for Medicaid than SSI, states in part:

(a) Income eligibility methods. In determining income eligibility of aged, blind, and disabled individuals in a State using more restrictive eligibility requirements than SSI, the agency must use the methods for treating income elected under §§435.121 and 435.230, under §435.601. The methods used must be comparable for all individuals within each category of individuals under §435.121 and each category of individuals within each optional categorically needy group included under §435.230 and for each category of individuals under the medically needy option described under §435.800.

17. The above authorities explain that an individual must have income that is within the income limits established by federal and state laws as well as the Medicaid State Plan.

The Medicare Buy-in Programs under Medicaid are QMB, SLMB and QI1. An individual must have income greater than 120% of the federal poverty level but equal to or less than 135% of the federal poverty level to be eligible for Qualifying Individual (QI1). It only covers payment of the Part B Medicare premium through Medicaid.

18. The above-cited regulations also explain that the QI1 Program can provide state Buy-in benefits for people with income at higher levels than the other programs.

19. On April 2016, the Department's Program Policy Manual (Policy Manual), Appendix A-9, set the Medicaid QI1 individual maximum income limit as \$1,335.00:

**Eligibility Standards for SSI-Related Programs – April 2016**

Coverage Group	Income Limit	Asset Limit
Supplemental Security Income (SSI) Individual*	\$ 733	\$ 2,000
Supplemental Security Income (SSI) Couple*	\$ 1,100	\$ 3,000
ICP/HCBS/Hospice/HCDA Individual	\$ 2,199	\$ 2,000
ICP/HCBS/Hospice/HCDA Couple	\$ 4,398	\$ 3,000
MEDS-AD/ICP-MEDS/Individual (88% FPL)	\$ 872	\$ 5,000
MEDS-AD/ICP-MEDS/Couple	\$ 1,175	\$ 6,000
QMB Individual (100% FPL)	\$ 990	\$ 7,280
QMB Couple	\$ 1,335	\$ 10,930
SLMB Individual (100-120% FPL)	\$ 1,188	\$ 7,280
SLMB Couple	\$ 1,602	\$ 10,930
QI1 Individual (120-135% FPL)	\$ 1,337	\$ 7,280
QI1 Couple	\$ 1,803	\$ 10,930

20. These income standards change each year in accordance with federal law. It is unknown why the respondent determined the income limit for QI1 for an individual to be \$1,325.00 for April 2016. In comparing the household's income of \$1,361.14 and the correct QI1 income limit for an individual of \$1,335.00, the petitioner continued to exceed the \$1,335.00 Medicaid QI1 income limit. Retroactive months for Medicaid QI1 were denied because the petitioner was not found eligible in the month of his application (April 2016) due to his income exceeding the Medicaid QI1 income limit.

21. 20 C.F.R. § 416.1124(c)(12) establishes a \$20 disregard for "the first \$20 of any unearned income in a month" and unearned income can be reduced by that amount. Respondent deducted the \$20 unearned income disregard from the petitioner's \$990.00 SSDI. Petitioner's countable unearned income was \$970.00.

22. 20 C.F.R. § 416.1112(c)(5)(7) establishes "earned income we do not count. We do not count as earned income; \$65 of earned income in a month and one-half of remaining earned income in a month." After the \$65 earned income disregard (\$847.28

- \$65.00), the remaining balance was \$782.28. One-half of \$782.28 was \$391.14 (\$782.28 divided by 2), the petitioner's countable earned income. Petitioner's total countable income of \$1,361.14 (\$970.00 + \$391.14) exceeded the \$1,335.00 Medicaid QI1 income limit.

23. After careful review of the cited authorities and evidence, the undersigned concludes the respondent followed rule in denying the petitioner's April 22, 2016 application for Medicaid QI1 benefits due to his total countable income exceeding the income limit for the Program.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, appeal 16F-03839 regarding the Medicaid QI1 Program is denied and the Department's action is affirmed.

Appeal 16F-03791 regarding the MN Program is dismissed as invalid.

**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 August, 2016,

in Tallahassee, Florida.



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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

Aug 15, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 16F-03805

PETITIONER,

Vs.

CASE [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 15 PALM BEACH  
UNIT: 88249

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative telephonic hearing in the above-referenced matter on July 12, 2016 at 11:45 a.m.

**APPEARANCES**

For the Petitioner: [REDACTED]

For the Respondent: Emiliene Elien, supervisor

**STATEMENT OF ISSUE**

The petitioner is appealing the termination of full Medicaid benefits and enrollment in the Medically Needy Program with an estimated share of cost (SOC) at recertification. The burden of proof was originally assigned to the petitioner. After further review, it is reassigned to the Department by a preponderance of evidence.

### **PRELIMINARY STATEMENT**

The respondent presented one exhibit which was entered into evidence and marked as Respondent's Composite Exhibit 1. The petitioner did not present any exhibits. The record was held open until the end of business on July 12, 2016, for the Department to provide a Medicaid budget and income limits. The Medicaid budget and income limits were received, entered into evidence and marked as Respondent's Composite Exhibit 2. The record was closed on July 12, 2016.

George ID 219122 from the Language Line interpreted the hearing.

### **FINDINGS OF FACT**

1. On April 25, 2016, the petitioner submitted a recertification application for SSI-Related Medicaid benefits. He is the only household member. The petitioner receives Social Security Disability Income (SSDI) of \$583 and his Medicare Part B premium is paid by the state. The respondent determined he was ineligible for full Medicaid at his recertification but was eligible for the Medically Needy Program with a share of cost.
2. The respondent denied full Medicaid and proceeded to determine eligibility in the Medically Needy Program. A \$20 unearned income disregard was subtracted from his gross income of \$583 resulting to the petitioner's countable income of \$563. The medically needy income level (MNIL) of \$180 was subtracted resulting to \$383 as the SOC. The petitioner received his last month of full Medicaid April 2016, was recertified and enrolled in the Medically Needy Program effective May 2016.
3. On May 19, 2016, the petitioner requested a hearing to challenge the respondent's action to enroll him in the Medically Needy Program.

4. The petitioner does not dispute the gross income included in the Department's calculations. The petitioner argued that his income has not changed and he was receiving full Medicaid.

5. The respondent explained when the petitioner became eligible for Medicare, he became ineligible for full Medicaid. The respondent erred in the past as full Medicaid benefits were approved for the petitioner while he was receiving Medicare.

### **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 Section 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

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

8. The Department determined the petitioner's Medicaid benefits under the SSI Related Program.

9. Fla. Admin. Code at R. 65A-1.711 (1) SSI-Related Medicaid Non Financial Eligibility Criteria, states, "For MEDS-AD Demonstration Waiver, the individual must be age 65 or older, or disabled as defined in 20 C.F.R. §416.905..."

10. 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. (emphasis added)

11. 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. The petitioner receives Medicare, thereby making him ineligible to receive full Medicaid benefits.

12. 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...”

13. 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.”

14. Fla. Admin. Code R. 65A-1.701 (30) states, “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.”

15. The methods of determining the share of cost for Medically Needy Program benefits is set forth in the Fla. Admin. Code R. 65A-1.713. It states:

(1)(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 cost...

16. Fla. Admin. Code R. 65A-1.716 (2), Income and Resource Criteria, states, “Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows: Size 1 Level \$180.”

17. The Department's Program Policy Manual, CFOP 165-22 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.

18. The undersigned reviewed the respondent's budget calculations and the petitioner's reported income using the rules cited above and did not find a more favorable outcome other than the SOC assigned by the respondent. Eligibility for full Medicaid is not found.

19. The undersigned concludes the respondent's action to deny full Medicaid benefits and to enroll the petitioner in the Medically Needy Program with the estimated SOC of \$383 is within the rules of the Program.

### **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

FINAL ORDER (Cont.)  
16F-03805  
PAGE -6

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 August, 2016,

in Tallahassee, Florida.



---

Christiana Gopaul-Narine  
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]  
Office of Economic Self Sufficiency

Aug 16, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 16F-03791  
16F-03839

PETITIONER,  
Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 09 Orange  
UNIT: 88601

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter on June 20, 2016 at 9:45 a.m.

**APPEARANCES**

For the petitioner: [REDACTED]

For the respondent: Marsha Shearer, ACCESS Economic Self-Sufficiency

Specialist II

**STATEMENT OF ISSUE**

At issue is whether the respondent's action to deny the petitioner's application and retroactive months for the Medicare Savings Plan (MSP), under the Medicaid Qualifying Individual 1 (QI1) Program was proper. The petitioner carries the burden of proof by a preponderance of the evidence.

At issue is also the petitioner's enrollment in the Medically Needy (MN) Program with a share of cost (SOC). The petitioner carries the burden of proof by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

By notice dated May 10, 2016, the respondent notified the petitioner that his Medicaid QI1 application dated April 22, 2016 was denied due to income. Petitioner timely requested an appeal to challenge the denial.

At the outset of the hearing, the petitioner explained he did not request a hearing regarding the MN Program. Therefore, appeal 16F-03791 is dismissed as invalid.

Petitioner did not submit any exhibits. Respondent submitted five exhibits, entered into evidence as Respondent's Exhibits "1" through "5".

### **FINDINGS OF FACT**

1. On April 22, 2016, the petitioner submitted an application for MSP. Petitioner reported his sources of income were Social Security Disability Income (SSDI) and his part-time employment with [REDACTED]
2. The respondent reviewed the application for April 2016 and three retroactive months (January, February and March 2016). The respondent verified the petitioner's SSDI through the State of Florida on-line query.
3. The on-line query showed petitioner's SSDI amount was \$990.00. Petitioner submitted to the Department the following paystubs: April 8, 2016 gross pay of \$56.35, April 15, 2016 gross pay of \$257.61, April 22, 2016 gross pay of \$267.66 and April 29,

FINAL ORDER (Cont.)

16F-03791

16F-03839

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2016 gross pay of \$265.65. The respondent calculated his monthly earned income by adding these paystubs, which totaled \$847.28.

4. The respondent calculated the countable unearned income as \$970.00, after a \$20.00 unearned income disregard was subtracted. The next step was the calculation of the countable earned income. The respondent calculated the earned income as \$847.28 and subtracted a \$65.00 earned income disregard. This totaled \$782.28, the Department then took \$782.28 and divided by two, the countable earned income amount was \$391.14. The respondent calculated the petitioner's total countable income as \$1,361.14 (\$970.00 + \$391.14).

5. The respondent used the \$1,381.14 total countable income and calculated the Q11 budget as follows:

```
ABSB          SSI-RELATED MA ELIGIBILITY DETERMINATION          [REDACTED]
[REDACTED]
TOTAL UNEARNED INCOME:      990.00    COUNTABLE EARNED INCOME:      391.14
PARENT'S DEEMED INCOME: +    .00    COUNTABLE UNEARNED INCOME: +   970.00
MISC. INCOME DISREGARDS: -    .00    MEDICALLY NEEDED DISREGARD: -    .00
UNEARNED INCOME DISREGARD: -   20.00    TOTAL COUNTABLE INCOME: =  1361.14
COUNTABLE UNEARNED INCOME: =   970.00
                                     INCOME STANDARD:      1325.00
SELF-EMP. ADJ. GROSS EARN.:    .00
ADDITIONAL EARNED INCOME: +   847.28
MISC. INCOME DISREGARDS: -    .00    TOTAL COUNTABLE INCOME:      .00
REM. UNEARNED INC. DISREGARD: -    .00    MNIL: -    .00
EARNED INCOME DISREGARD: -   65.00    SHARE OF COST: =    .00
1/2 REMAINING DISREGARD: -   391.14
BLIND WORK EXPENSES: -    .00    MED. INSURANCE PREMIUM: -    .00
COUNTABLE EARNED INCOME: =   391.14    RECURRING MED. EXPENSES: -    .00
                                     REMAINING SOC: =    .00
AG HAS FAILED THE SSI-RELATED MEDICAID ELIGIBILITY DETERMINATION BUDGET
```

6. The income limit for an individual to qualify for Q11 benefits was \$1,325.00 prior to April 2016. The respondent determined that the petitioner's total countable income (\$1,361.14) exceeded the income limit to qualify for Medicaid Q11. However, as of April

2016, the income limit for an individual to qualify for QI1 benefits changed from \$1,325.00 to \$1,335.00. The petitioner's income continues to exceed the income limit to qualify for the Medicaid QI1 Program.

7. Petitioner's representative explained the petitioner works for a school through [REDACTED] [REDACTED] and there are months the petitioner does not work due to the school seasonal session ending. Furthermore, the representative explained the petitioner is a teacher aid and believes his earned income should be based on annual pay and divided by a twelve-month period instead of monthly. The representative did not understand how the respondent determined the petitioner's income exceeded the income limit for the retroactive months in question.

8. The respondent explained contracted school employees' income is budgeted over a twelve-month period. Petitioner has no contract because his employment is with [REDACTED] [REDACTED] an employment agency for temporary assignments. The respondent explained, the petitioner could submit a new application and current paystubs; the respondent would then re-evaluate the petitioner's eligibility.

#### **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 § 409.285, Fla. Stat. 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. Section 409.904, Fla. Stat., Optional payments for eligible persons addresses who qualifies for this Program and states in part:

The agency may make payments for medical assistance and related services on behalf of the following persons who are determined to be eligible subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

(1) Subject to federal waiver approval, a person who is age 65 or older or is determined to be disabled, whose income is at or below 88 percent of the federal poverty level, whose assets do not exceed established limitations, and who is not eligible for Medicare or, if eligible for Medicare, is also eligible for and receiving Medicaid-covered institutional care services, hospice services, or home and community-based services. The agency shall seek federal authorization through a waiver to provide this coverage.

12. 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. Petitioner met the disability criteria; the next step is to determine income eligibility.

13. Fla. Admin. Code R. 65 A-1.702, Medicaid Special Provisions, in relevant part states:

...

(9) Retroactive Medicaid. 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.** (emphasis added) A request for retroactive Medicaid can be made for a deceased individual by a designated representative or caretaker relative filing an application for Medicaid assistance. The individual or his or her representative has up to 12 months after the date of application for ongoing Medicaid to request retroactive Medicaid eligibility. 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).

...

(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.)

14. The Department of Children and Families published Transmittal No. P-15-09-0008 on September 15, 2015 relating to "Teacher and Contracted School Employee Income,"

it states in part:

This memorandum provides a policy change on how to budget income for teachers and other contracted school employees. This is a result of a clarification from the Food and Nutrition Service. This policy change applies to the Food Assistance, Temporary Cash Assistance and Medicaid programs.

Policy Change

The income for teachers and other contracted school employees is intended to cover a yearly period. Annual income received by contracted school employees, including teachers, must be budgeted over the 12-month period.

15. Fla. Admin. Code R 65A-1.713(1) further addresses the "SSI-Related Medicaid Income Eligibility Criteria" and explains:

(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:

...

(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.

16. Federal regulation at 42 C.F.R. § 435.631, General requirements for determining income eligibility in States using more restrictive requirements for Medicaid than SSI, states in part:

(a) Income eligibility methods. In determining income eligibility of aged, blind, and disabled individuals in a State using more restrictive eligibility requirements than SSI, the agency must use the methods for treating income elected under §§435.121 and 435.230, under §435.601. The methods used must be comparable for all individuals within each category of individuals under §435.121 and each category of individuals within each optional categorically needy group included under §435.230 and for each category of individuals under the medically needy option described under §435.800.

17. The above authorities explain that an individual must have income that is within the income limits established by federal and state laws as well as the Medicaid State Plan.

The Medicare Buy-in Programs under Medicaid are QMB, SLMB and QI1. An individual must have income greater than 120% of the federal poverty level but equal to or less than 135% of the federal poverty level to be eligible for Qualifying Individual (QI1). It only covers payment of the Part B Medicare premium through Medicaid.

18. The above-cited regulations also explain that the QI1 Program can provide state Buy-in benefits for people with income at higher levels than the other programs.

19. On April 2016, the Department's Program Policy Manual (Policy Manual), Appendix A-9, set the Medicaid QI1 individual maximum income limit as \$1,335.00:

**Eligibility Standards for SSI-Related Programs – April 2016**

Coverage Group	Income Limit	Asset Limit
Supplemental Security Income (SSI) Individual*	\$ 733	\$ 2,000
Supplemental Security Income (SSI) Couple*	\$ 1,100	\$ 3,000
ICP/HCBS/Hospice/HCDA Individual	\$ 2,199	\$ 2,000
ICP/HCBS/Hospice/HCDA Couple	\$ 4,398	\$ 3,000
MEDS-AD/ICP-MEDS/Individual (88% FPL)	\$ 872	\$ 5,000
MEDS-AD/ICP-MEDS/Couple	\$ 1,175	\$ 6,000
QMB Individual (100% FPL)	\$ 990	\$ 7,280
QMB Couple	\$ 1,335	\$ 10,930
SLMB Individual (100-120% FPL)	\$ 1,188	\$ 7,280
SLMB Couple	\$ 1,602	\$ 10,930
QI1 Individual (120-135% FPL)	\$ 1,337	\$ 7,280
QI1 Couple	\$ 1,803	\$ 10,930

20. These income standards change each year in accordance with federal law. It is unknown why the respondent determined the income limit for QI1 for an individual to be \$1,325.00 for April 2016. In comparing the household's income of \$1,361.14 and the correct QI1 income limit for an individual of \$1,335.00, the petitioner continued to exceed the \$1,335.00 Medicaid QI1 income limit. Retroactive months for Medicaid QI1 were denied because the petitioner was not found eligible in the month of his application (April 2016) due to his income exceeding the Medicaid QI1 income limit.

21. 20 C.F.R. § 416.1124(c)(12) establishes a \$20 disregard for "the first \$20 of any unearned income in a month" and unearned income can be reduced by that amount. Respondent deducted the \$20 unearned income disregard from the petitioner's \$990.00 SSDI. Petitioner's countable unearned income was \$970.00.

22. 20 C.F.R. § 416.1112(c)(5)(7) establishes "earned income we do not count. We do not count as earned income; \$65 of earned income in a month and one-half of remaining earned income in a month." After the \$65 earned income disregard (\$847.28

- \$65.00), the remaining balance was \$782.28. One-half of \$782.28 was \$391.14 (\$782.28 divided by 2), the petitioner's countable earned income. Petitioner's total countable income of \$1,361.14 (\$970.00 + \$391.14) exceeded the \$1,335.00 Medicaid QI1 income limit.

23. After careful review of the cited authorities and evidence, the undersigned concludes the respondent followed rule in denying the petitioner's April 22, 2016 application for Medicaid QI1 benefits due to his total countable income exceeding the income limit for the Program.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, appeal 16F-03839 regarding the Medicaid QI1 Program is denied and the Department's action is affirmed.

Appeal 16F-03791 regarding the MN Program is dismissed as invalid.

**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 August, 2016,

in Tallahassee, Florida.



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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

Jul 21, 2016

Office of Appeal Hearings  
Dept. of Children and FamiliesSTATE OF FLORIDA  
DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-03845

PETITIONER,

Vs.

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

And

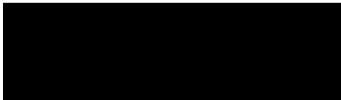
UNITED HEALTHCARE

RESPONDENTS.  
\_\_\_\_\_ /**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above matter on June 28, 2016 at 1:43 p.m.

**APPEARANCES**

For the Petitioner:



For the Respondents:

Lisette Knott  
Program Administrator  
Agency for Healthcare AdministrationSloan Karver, M.D.  
United Healthcare**STATEMENT OF ISSUE**

Whether respondent's denial of petitioner's request for a beach walker was proper. The burden of proof was assigned to the petitioner. The standard of proof

in an administrative hearing is by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

Present for petitioner were her husband, [REDACTED] and friends, [REDACTED]

[REDACTED]. Petitioner's exhibit "1" was accepted into evidence.

Present for respondents from United Healthcare was Christian Laos, Senior Compliance Analyst. Respondent's exhibit "1" was accepted into evidence.

On May 24, 2016 United Health requested to be added as a party to this proceeding. The request was granted. As such, United Healthcare is a co-respondent in this matter.

### **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 enrolled in respondents Long Term Managed Care (LTMC) Program. Services are provided by United Healthcare.
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 LTMC Program.
3. Petitioner was, at all times relevant to this proceeding, Medicaid eligible.
4. Petitioner is 55 years of age and resides with her husband.
5. Petitioner's diagnoses include: [REDACTED] [REDACTED]

[REDACTED] She has an unsteady gait and experiences spasticity.

6. Durable medical equipment used by petitioner includes a walker. The walker is used inside the home and outdoors when on hard surfaces.

7. On or about March 3, 2016 petitioner submitted a request to United Healthcare for a beach walker.

8. All walkers are classified as durable medical equipment.

9. A beach walker is not covered by the Florida Medicaid Program.

10. A beach walker is not an expanded benefit provided by United Healthcare.

11. On March 22, 2016 United Healthcare issued a Notice of Action which denied the request. The notice stated, in part: "You asked for a special walker to walk on the beach. The long term care health plan does not cover this. It is not a covered benefit. The request is not approved."

12. Petitioner thereafter requested reconsideration of the above denial. On May 16, 2016 United Healthcare issued correspondence upholding the original denial. The correspondence stated: "This does not meet FS 409.98, Service definitions found in Florida AHCA Statewide Model LTC Contract with DME and Medicaid Supply Services Provider Fee Schedule."

13. On May 17, 2016 petitioner's request for a fair hearing was timely received by the Office of Appeal Hearings.

14. In support of the beach walker, petitioner wrote, in part:

[REDACTED]

15. Benefits of a beach walker enumerated by the petitioner include; spending beach time with her husband; lessened depression; additional exercise; lower blood pressure; reduce inflammation; improved balance and walking; strengthened muscles; and no muscle atrophy.

16. Respondent asserts a beach walker is not covered by the Florida Medicaid Program.

### **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, 7<sup>th</sup> 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. Section 409.973, Fla. Stat. addresses the minimum benefits provided under Medicaid managed care plans and states, in part:

- (1) MINIMUM BENEFITS. – Managed care plans shall cover, at a minimum, the following services:
- (p) Medical supplies ...

22. Fla. Admin. Code R. 59G-1010(163) defines medical supplies as “medical or surgical items that are consumable, expendable, disposable or non-durable and that are used for treatment or diagnosis of a patient’s specific illness, injury, or condition...”

23. In addition to the above, respondent’s LTMC contract with United Healthcare provides the following definition:

(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.

24. The Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook (DME Handbook) – July 2010 has been incorporated, by reference, into Florida Administrative Code Rule 59G-4.070(2).

25. The DME Handbook provides the following relevant information:

Page 2-32:

Ambulatory Aids

Description: An ambulatory aid is a medically necessary item that is required by a recipient with impaired ambulation. Ambulatory aids include canes, crutches, and walkers that are to be complete with tips, pads, and grips.

Note: Various types of walkers and walker accessories are listed on the DME and Medical Supply Services Provider Fee Schedules.

26. Fee schedules are found at:

[http://portal.flmmis.com/flpublic/Provider\\_ProviderServices/Provider\\_ProviderSupport/Provider\\_ProviderSupport\\_FeeSchedules/tabid/51/desktopdefault+/Default.aspx](http://portal.flmmis.com/flpublic/Provider_ProviderServices/Provider_ProviderSupport/Provider_ProviderSupport_FeeSchedules/tabid/51/desktopdefault+/Default.aspx)

27. Relevant to this matter is the Durable Medical Equipment Provider Fee Schedule (DME Fee Schedule) for Recipients of All Ages. The DME Fee Schedule enumerates seven types of rigid; folding and heavy duty walkers covered by the Florida Medicaid Program. A beach walker is not identified.

28. Petitioner's medical conditions are noted. The Findings of Fact establish petitioner has access to a regular walker. As such, she can ambulate with that walker both in her home and outdoors when on hard surfaces.

29. The item at issue is a specialized walker that would be used at the beach. That type of walker is not included on the DME Fee Schedule.

30. The undersigned lacks jurisdiction to order respondents to provide DME not identified on the fee schedule.

31. As a beach walker is not covered by either the Medicaid State Plan or an expanded benefit covered by United Healthcare, a medical necessity review was not warranted.

32. The Findings of Fact establish petitioner is over 21 years of age. As such, policy associated with Early Periodic Screening, Diagnosis, and Treatment is not applicable.

33. Petitioner has not demonstrated by the required evidentiary standard that the denial of a beach walker was improper.

**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 21 day of July, 2016,

in Tallahassee, Florida.

*Frank Houston*

---

Frank Houston  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
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████████████████████, PETITIONER  
AGENCY FOR HEALTH CARE ADMINISTRATION,  
MEDICAID FAIR HEARINGS UNIT  
UHC MEDICAID FAIR HEARING

Aug 16, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-03848

PETITIONER,

Vs.

AMERIGROUP, AND  
AGENCY FOR HEALTH CARE ADMINISTRATION  
CIRCUIT: 09 Osceola  
UNIT: AHCA

RESPONDENTS.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on July 14, 2016 at approximately 3:30 p.m.

**APPEARANCES**

For Petitioner:



For Respondent:

Carlene Brock  
Quality Operations Nurse  
Amerigroup

**STATEMENT OF ISSUE**

At issue is Amerigroup's denial of Petitioner's request for extraction of a wisdom tooth, along with I.V. sedation. The burden of proof is assigned to Petitioner.

**PRELIMINARY STATEMENT**

Amerigroup presented the following witnesses:

- Omeshia Smith – Complaints & Grievances Specialist – Amerigroup

- Dr. Daniel Dorrego – Dental Consultant – DentaQuest

Lisa Sanchez, Medical/Health Care Program Analyst with the Agency for Health Care Administration (“AHCA” or “Agency”) observed the hearing. Petitioner did not move any exhibits into evidence. Amerigroup moved Exhibits 1 – 9 into evidence. A Spanish language interpreter was present.

### **FINDINGS OF FACT**

1. Petitioner is an 18-year-old male. Petitioner is enrolled with Amerigroup as his Managed Medical Assistance (“MMA”) plan. DentaQuest is Amerigroup’s dental vendor.
2. On May 10, 2016, Petitioner visited an oral surgeon for evaluation of his wisdom tooth, specifically, tooth # 17, for possible extraction. Petitioner’s chief complaint was: “My tooth has been hurting me for the past 3 months and lately my mouth has been sore.” (Respondent’s Exhibit 3).
3. The oral surgeon reported Petitioner’s tooth was “grossly decayed and non restorable.” He also said there was pathology associated with the tooth. The treatment plan was to have the tooth extracted under I.V. Sedation.
4. On May 10, 2016, Amerigroup received Petitioner’s request for the extraction of tooth # 17 with I.V. sedation. On May 11, 2016, DentaQuest issued an Authorization Determination, denying the request. (Respondent’s Exhibit 5). It states: “Per Dental Director review, service is denied. There is no sign of infection or other medical reason for tooth removal.” The sedation is automatically denied if the extraction is denied.

5. Amerigroup issued its Notice of Action denying the request on May 11, 2016.

(Respondent's Exhibit 6). It states, in pertinent part: "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."

6. An internal appeal was requested. On May 26, 2016, DentaQuest upheld the denial.

The Dental Consultant Review Form, Respondent's Exhibit 9, states:

Dental Consultant Reply:

We received and reviewed all submitted documentation (Appeal form, radiographs, photographs, narrative, notes, study models, digital models etc.) for requested appeal determination. The denial(s) are UPHeld for extraction(s) of teeth #17 (D7240). To qualify for this benefit under this plan, a case must demonstrate evidence of *current* pathology, infection, aberrant position, and/or continuous and/or reoccurring pain beyond normal eruption. This plan also requires root formation to be radiographically demonstrated. This/These service is/are DENIED with the associated anesthetic services, because documentation submitted does not demonstrate the required criteria have been met at this time. Prophylactic removal of third molars is not a covered benefit under this plan.

7. DentaQuest's Criteria for Dental Extractions, Respondent's Exhibit 7, states, in pertinent part:

The prophylactic removal of asymptomatic teeth (i.e. third molars) or teeth exhibiting no overt clinical pathology (except for orthodontics) is not a covered service. DentaQuest will not reimburse for any surgical extraction of third molars which are asymptomatic or do not exhibit any evidence of pathology or which were extracted for prophylactic reasons only.

....

Pain with no pathology – On a per tooth basis, provider must furnish a narrative that describes pain that is more than normal eruption pain – for example: a description of duration, intensity, medications, or other factors that are more than normal eruption pain – the description of such factors is necessary to demonstrate need.

8. Dr. Dorrego testified that Petitioner's tooth does not yet have any root formation.

Petitioner's pain is not chronic. It hurts when he chews. Dr. Dorrego said this is consistent with normal pain caused by tooth eruption.

9. Dr. Dorrego said the tooth is currently in a position to where it can erupt normally and is not affecting the tooth next to it. He said the x-ray shows the tooth is fully encapsulated by bone and it would have to be fully eruptive in order to be decayed and non-restorable. He said there was no pathology present. He said the tooth must be at least partially erupted for the pathology to occur. He said it would be prophylactic to remove the tooth at this time.

#### **CONCLUSIONS OF LAW**

10. 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.

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

12. This is a Final Order, pursuant to Sections 120.569 and 120.57, Fla. Stat.

13. 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, 7<sup>th</sup> Ed.).

14. 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.

15. The Florida Medicaid Dental Services Coverage Policy, May 2016 (“Dental Handbook”), is promulgated into law by Chapter 59G of the Florida Administrative Code.

16. Page 4 of the Dental Handbook provides:

**Surgical Procedures and Extractions**

Florida Medicaid reimburses for surgical procedures and extraction services for recipients under the age of 21 years.

....

**Early and Periodic Screening, Diagnosis, and Treatment**

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid’s authorization requirements policy

17. The Dental Handbook therefore provides coverage for wisdom teeth extractions for children under age 21. The Dental Handbook requires that all procedures be medically necessary.

18. 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.

19. Since 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. Section 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.

20. Under the above statute, the Agency offers dental services as an EPSDT service to Medicaid-eligible recipients less than 21 years of age.

21. 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 may present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)) (emphasis added).

22. 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.

23. In the instant-matter, Dr. Dorrego did not find any evidence the tooth needs to be removed. He said discomfort due to eruption of the tooth is normal and that the tooth appears to be coming in straight. He also saw no evidence of pathology.

24. Petitioner is experiencing some pain when he chews his food. Absent pathology, DentaQuest requires a narrative explaining the cause of the pain on a tooth-by-tooth basis, and the pain must be severe enough to exceed normal eruption.

25. The undersigned concludes there is not sufficient evidence that Petitioner is experiencing pain beyond that of normal eruption. Further, Dr. Dorrego was very specific regarding the lack of any current pathology.

26. Petitioner has failed to meet his burden of proof to show, by the greater weight of the evidence, that removal of the tooth is medically necessary.

27. Petitioner is encouraged to monitor the status of his tooth. In the event removing it becomes medically necessary in the future, Petitioner can put in another request at that time.

### **DECISION**

Based upon the foregoing, Petitioner's appeal is DENIED and Amerigroup'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 August, 2016,

in Tallahassee, Florida.



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Rick Zimmer  
Hearing Officer  
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Copies Furnished To: [REDACTED], Petitioner  
AHCA, Medicaid Fair Hearings Unit  
Amerigroup Hearings Unit

Aug 15, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-03858

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 June 21, 2016, at 3:00 p.m.

**APPEARANCES**

For the Petitioner:



For the Respondent: Dianna Chirino, Senior Program Specialist

**STATEMENT OF ISSUE**

At issue is the Agency action denying the petitioner's request for additional home health services (personal care assistance) under the Long Term Care (LTC) Program.

The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

The petitioner did not submit any documents as evidence for the hearing.

Appearing as witnesses for the Respondent were Dr. Mary Colburn, Medical Director, and Carlene Brock, Quality Operations Nurse, from Amerigroup, which is the petitioner's managed health care plan. Also present witnesses were Tamara Montesino, the petitioner's Case Manager from United Home Care, and Angie Cano, the Program Manager at United Home Care.

The respondent submitted documents as evidence for the hearing consisting of the following which were marked as Respondent Composite Exhibit 1: Hearing Summary, Notice of Action, Care Plan, and Medical Assessment Form.

### **FINDINGS OF FACT**

1. The petitioner is seventy-seven (77) years of age and lives with his son and his son's family. He suffered a [REDACTED] and is paralyzed on one side of his body. He is [REDACTED] and uses adult diapers. He uses a walker for ambulation. He needs assistance with activities of daily living such as bathing, toileting, and feeding.

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 Amerigroup.

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 Amerigroup provide services to Medicaid recipients pursuant to a contract with AHCA.

4. The petitioner attends an adult day care program for approximately 8 hours daily, Monday to Friday. The petitioner is also currently approved for a total of seventeen (17) hours weekly of home health services through Amerigroup, including 14 hours of personal care assistance and 3 hours of homemaker services. Those services are currently being provided daily in the home in the mornings only.

5. On or about May 9, 2016, the petitioner made a request to Amerigroup for 14 additional hours weekly of personal care services. On May 12, 2016, Amerigroup sent a letter to the Petitioner denying the requested additional hours based on medical necessity considerations.

6. The petitioner's son stated he is requesting 3 additional hours daily of personal care services for his father in the afternoons due to his father's medical conditions and need for assistance.

7. The respondent's witness, Dr. Colburn, stated the currently approved hours – 40 hours weekly of adult day care and 17 hours weekly of home care services – should be sufficient to meet the petitioner's needs, especially if the hours are re-distributed to provide assistance both in the morning and afternoon.

#### **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 § 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 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, 7<sup>th</sup> Ed.).

11. 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).

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

13. The petitioner requested a fair hearing because he believes his personal care services under the Program should be increased.

14. Fla. Stat. § 409.98 lists the services which must be covered by Long-Term Care plans. Personal care assistance and homemaker services are among the services available from Long-Term Care plans and are addressed in the AHCA contract.

15. 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.

16. 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.

17. 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."

18. Fla. Stat. § 409.912 requires that the respondent "purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care."

19. 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.

20. After considering the evidence and testimony presented, the hearing officer concludes that the petitioner has not demonstrated that his personal care services should be increased under the LTC Program. The petitioner clearly needs assistance with activities of daily living (ADLs). However, he is currently approved for 40 hours weekly of adult day care and 17 hours weekly of home health services to assist him with these activities. The petitioner might also be better served by adjusting the currently approved hours to provide for assistance both in the mornings and afternoons.

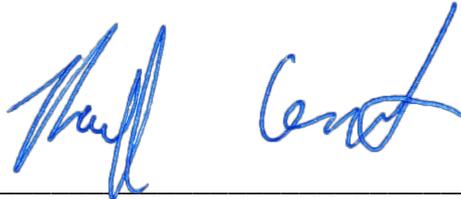
**DECISION**

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 indigence 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 August, 2016,  
in Tallahassee, Florida.



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Copies Furnished To: [REDACTED], PETITIONER  
AHCA, Medicaid Fair Hearings Unit

Aug 16, 2016

Office of Appeal Hearings  
Dept. of Children and FamiliesSTATE OF FLORIDA  
DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-03863

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION  
CIRCUIT: 17 Broward  
UNIT: AHCARESPONDENT.  

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**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above referenced matter on July 11, 2016 at 10:04 a.m.

**APPEARANCES**

For the Petitioner: 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 Petitioner's managed medical assistance (MMA) plan Humana, in denying Petitioner's request for incontinence supplies (pull-ups). Because the matter at issue involves a request for services, Petitioner carries the burden of proof.

### **PRELIMINARY STATEMENT**

Dr. Ian Nathansen, Medical Director, and Mindy Aikman, Grievance and Appeals Specialist for Humana, appeared as witnesses for the Respondent. Respondent's Exhibit 1 was entered into evidence.

### **FINDINGS OF FACT**

1. Petitioner is a 48 year-old recipient of the Medicaid program. He enrolled with the Humana Family managed medical assistance (MMA) plan effective January 25, 2016.

2. Petitioner is diagnosed with [REDACTED] resulting from [REDACTED]. He has been wearing adult diapers since 2013.

3. On March 10, 2016, Petitioner's primary care physician wrote a prescription for [REDACTED] supplies ([REDACTED]).

4. On March 18, 2016, Humana sent the Petitioner a Notice of Action denying his request for adult diapers (pull-ups) because the requested service is not a covered benefit.

5. Petitioner filed an appeal with Humana on April 1, 2016.

6. On May 12, 2016 Humana sent An Update on Your Request to the Petitioner in response to his appeal. It states in relevant part:

The diagnosis is [REDACTED] for which authorization of diapers (T4526) has been requested. The medical record indicates that the member is 47 years old and the Florida Medicaid Handbook indicates that these items are not supplied after age 20 years. The Florida Administrative Code Chapter 59G-1.010 (166) states medically necessary or medical necessity means that the medical or allied care, goods, or services furnished and for which no equally effective and more conservative or less costly treatment is available statewide. The requested service is therefore considered not reasonable and necessary. The requested service is not medically necessary under Medicaid and the

Humana plan and the initial determination is upheld.

7. On May 18, 2016, Petitioner filed a timely request for a fair hearing.

8. Petitioner has been using adult diapers since August 2013. Because of his limited income, family and friends buy the adult diapers for him. Petitioner explained his physician has prescribed adult diapers as medically necessary due to his [REDACTED]

[REDACTED]

9. Respondent's medical director explained that Petitioner's [REDACTED] is the result of his [REDACTED]. He noted that [REDACTED] supplies are not a Medicaid cover service for those over 20 years of age.

#### **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 Fla. Stat.

11. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code § 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. 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.

14. Fla. Admin. Code 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.

(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...(Emphasis added.)**

15. Section 59G-4.070 of the Florida Administrative Code incorporates Florida Medicaid's Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook- July 2010 (Handbook). On page 2-48 of the Handbook, it states:

Disposable incontinence briefs, diapers, protective underwear, pull-ons, liners, shields, guards, pages, and undergarments **are covered for recipients four (4), when a child would normally be expected to achieve continence, through twenty (20) years of age.** (Emphasis added)

16. Petitioner is 48 years of age. His medical need for incontinence supplies (adult diapers) is not in dispute. However, the Medicaid handbook makes it clear that incontinence supplies are not a covered service for those over 20 years of age.

17. After considering the evidence and the appropriate authorities set forth above, the hearing officer concludes that the Petitioner has not met his burden of proof. The requested service (incontinence supplies) is not a Medicaid covered service because the Petitioner is over 20 years of age. He is encouraged to explore his potential eligibility for Medicaid's Long-Term Care program, which does cover incontinence supplies for those in that program.

### **DECISION**

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

DONE and ORDERED this 16 day of August, 2016,

in Tallahassee, Florida.



Warren Hunter  
Hearing Officer  
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Copies Furnished To: [REDACTED], Petitioner  
AHCA, Medicaid Fair Hearings Unit  
Humana Hearings Unit

Aug 19, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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

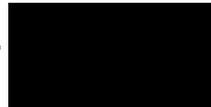


APPEAL NO. 16F-03884

PETITIONER,

Vs.

CASE NO.



FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 04 Duval  
UNIT: 88328

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 3, 2016 at 10:26 a.m.

**APPEARANCES**

For the Petitioner: The petitioner was present and represented herself.

For the Respondent: Ernestine Bethune, Economic Self-Sufficiency Specialist II for the Department of Children and Families (DCF).

**ISSUE**

At issue is the Department's action on May 9, 2016 to terminate Family Related Medicaid for the petitioner effective June 1, 2016, due to her becoming 21 years of age.

The respondent held the burden of proof by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

The hearing was originally scheduled to convene on July 12, 2016 at 10:15 a.m. The respondent requested a continuance to review the petitioner's case. The petitioner did not object and the hearing was scheduled to convene on August 3, 2016 at 10:15 a.m.

The respondent submitted evidence that was entered as the Respondent's Exhibits 1 through 2. No evidence was submitted by the petitioner.

The record was closed at the conclusion of the hearing on August 3, 2016.

### **FINDINGS OF FACT**

1. Prior to the action under appeal, the petitioner (age 21) was receiving Family-Related Medicaid under the coverage group for children ages 19 through 21. The petitioner lives with her grandmother and turned 21 in March 2016.

2. The petitioner completed an application to recertify for Family-Related Medicaid on May 6, 2016. The petitioner marked on her application that she is not disabled. Therefore, the Department did not refer her case to the Division of Disability Determination (DDD) and terminated her Medicaid coverage. The Respondent's Exhibit 2, page 10, includes the Running Record Comments (CLRC) which shows that the petitioner contacted the Department on May 20, 2016 after receiving the Notice of Case Action informing her of the termination of her Medicaid benefits. The petitioner was informed that since she turned 21, her Medicaid coverage under NOY was closing, effective May 31, 2016. The petitioner requested a hearing at that time.

3. The petitioner does not have any minor children and there is no evidence to show that the petitioner is pregnant.

4. The petitioner disputes the termination of her Medicaid coverage as she alleges that she is disabled.

5. The Department asserts that the petitioner's application dated May 6, 2016 was not referred to the DDD because she applied for Family-Related Medicaid and did not mark on the application that she was disabled. The Department's records show that the petitioner completed an application for SSI-Related Medicaid on July 22, 2016. The Department explained that the petitioner missed the telephone call for the DDD interview. The Department will attempt to reschedule the interview so that the petitioner's SSI-Related Medicaid application can be forwarded to the DDD. The petitioner's application for SSI-Related Medicaid is currently in pending status as of the date of this hearing.

6. The petitioner explained that she did not mark on her application that she is disabled because she was in the process of applying for disability benefits. The petitioner believes she first applied for Supplemental Security Income (SSI) in May 2015 or June 2015 and was denied in July 2015. The petitioner believes she filed an appeal the same night she received the Social Security Administration (SSA) denial letter in July 2015. The petitioner completed another application for SSI on May 19, 2016 and has not received a decision as of the date of the hearing.

### **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 Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

9. The Fla. Admin. Code R. 65A-1.703 Family-Related Medicaid Coverage Groups 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...

(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.

10. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, Passage 1430.0500, Age (MFAM) states: "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."

11. The Policy Manual, Passage 1430.0504, Definition of a Child (MFAM) states:

An individual is considered a child if under the age of 21, and unmarried, and not legally emancipated. A child is unmarried when the child has never been married or was married and the marriage was annulled.

Children ages 19 to 21 may be eligible for Medicaid based on the same MAGI federal poverty level of a parent or caretaker relative.

A child is eligible to receive assistance on the factor of age through the month of the child's appropriate birthday unless born on the first day of the month. Eligibility then ceases effective the birth month.

12. The above authorities provide potential Family-Related Medicaid coverage group for a child under age 21, but not 21 and over. Therefore, the undersigned concludes that the petitioner, who is now age 21, is no longer considered a minor child.

13. In this case, the petitioner turned 21 in March 2016. The petitioner completed an application to recertify for Family-Related Medicaid on May 6, 2016. The petitioner's Medicaid was terminated due to her turning 21 years of age. The petitioner completed an application for SSI disability benefits on May 19, 2016. The application for SSI disability benefits is currently pending. The petitioner contacted the Department on May 20, 2016 to inquire about the termination of her Medicaid benefits for children under the age of 21. The petitioner subsequently applied for SSI-Related Medicaid after her request for a hearing was submitted. The findings show that this application is currently in pending status.

14. Based on the evidence and testimony, the undersigned concludes that the petitioner did not apply for SSI-Related Medicaid and did not notify the Department of her alleged disability status until after its termination of her Medicaid coverage. Therefore, the undersigned concludes that the Department was correct to not forward the petitioner's application to the DDD for review.

15. Based on the evidence, testimony, and the controlling authorities, the undersigned concludes that the Department correctly determined that the petitioner is

no longer eligible for Family Related Medicaid benefits as she does not meet the age requirements.

16. The Department is currently reviewing the petitioner's application for SSI-Related Medicaid dated July 22, 2016. The Department is to issue a Notice of Case Action with appeal rights upon its completion of a determination of eligibility for Medicaid coverage based on the petitioner's claim of a disability.

### **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.

FINAL ORDER (Cont.)

16F-03884

PAGE - 7

DONE and ORDERED this 19 day of August, 2016,

in Tallahassee, Florida.



Paula Ali

Hearing Officer

Building 5, Room 255

1317 Winewood Boulevard

Tallahassee, FL 32399-0700

Office: 850-488-1429

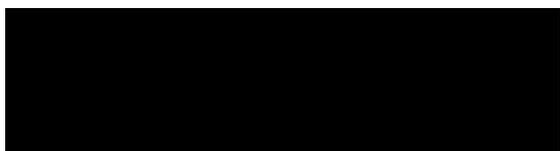
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Copies Furnished To [REDACTED] Petitioner

Office of Economic Self Sufficiency

Aug 11, 2016

Office of Appeal Hearings  
Dept. of Children and FamiliesSTATE OF FLORIDA  
DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-03942

PETITIONER,

Vs.

CASE NO. FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 11 Dade  
UNIT: 88673RESPONDENT.  

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**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on July 16, 2016 at 9:04 a.m. All parties appeared telephonically from different locations.

**APPEARANCES**For the Petitioner: 

For the Respondent: Joseph Austrie, Operations Management Consultant I

**STATEMENT OF ISSUE**

At issue is the respondent's action to terminate the petitioner's full Medicaid and enroll the two adults in Medically Needy (MN) with a Share of Cost (SOC) at recertification. The burden of proof was assigned to the respondent by a preponderance of evidence.

### **PRELIMINARY STATEMENT**

The petitioner submitted no evidence. The department submitted 33 pages of evidence which were marked and entered as Respondent's Composite Exhibit "1". The record was left open for additional evidence including, notice of case action dated May 21, 2016, ME I policy, family Medicaid income limits, policy related to determining the Medically Needy Share of Cost, and policy related to determining the standard filing unit. On July 7, 2016 the respondent provided 11 additional pages of evidence including the notice of case action, policy related to budgeting family-related Medicaid, and family Medicaid Standard Filing Unit rules, which were marked and entered as Respondent's Composite Exhibit "2". The record was closed on July 8, 2016.

### **FINDINGS OF FACT**

1. Transitional Medicaid is an additional 12 months of Medicaid coverage received after recipients are no longer eligible for full Medicaid due to income.
2. Prior to the action under appeal, the petitioner and her husband were both receiving full Transitional Medicaid effective July 1, 2015.
3. On April 22, 2016 the petitioner submitted an application of recertification of Medicaid for her household.
4. The petitioner's household includes the petitioner (DB), her husband (BC), and their two mutual children. Both the petitioner and her husband are filing taxes separately with the two mutual children tax dependent on the petitioner only.
5. BC is employed with [REDACTED] and earning \$2,500 biweekly. DB is receiving Unemployment Compensation (UC) benefits of \$275 week.

6. The respondent calculated BC's income as \$5,000 per month ( $\$2,500 \times 2$ ). DB's income was calculated as \$1,100 per month ( $\$275 \times 4$ ). The total household income was calculated as \$6,100.
7. The respondent asserts the total household income is over the Family Medicaid income limit for a household of 4.
8. The respondent enrolled the petitioner and her husband in the Medically Needy (MN) program with a Share of Cost (SOC).
9. The respondent determined DB's Standard Filing Unit (SFU) as four and BC's SFU as two based on their individual tax filing status.
10. The petitioner's SOC was calculated as follows:

\$6,100	total household income
- 585	medically needy income limit (MNIL) for an SFU of 4
\$5,515	share of cost (SOC)
11. Using the above methodology, the BC's SOC was calculated using \$387, the MNIL for an SFU of 2, arriving at a final \$5,713 SOC.
12. On May 21, 2016, the respondent sent the petitioner a Notice of Case Action (NOCA) informing her full Medicaid for DB and BC would be terminated effective April 30, 2016 and they would be enrolled in MN with a SOC.
13. The petitioner timely requested the hearing.
14. The petitioner does not understand why she and her husband were not included in the full Medicaid coverage effective June 1, 2016.
15. The respondent asserts the household income is over the income limit required for full Medicaid.

**CONCLUSIONS OF LAW**

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 Section 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

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

**Termination of the Transitional Medicaid will be addressed first:**

18. 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.

19. Federal regulation 42 C.F.R. § 435.110 Parents and other caretaker relatives stated in pertinent part:

...(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.

20. Fla. Admin. Code R. 65-1.702 Special Provisions states in the pertinent 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...

(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.

21. The Department's Program Policy Manual, CFOP 165-22 (The Policy Manual) at 2030.0203 Transitional Coverage (MFAM) defines transitional coverage:

Transitional coverage provides extended coverage for up to 12 months, beginning with the month of ineligibility...

Conditions that must be met:

1. The 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...

22. In accordance with the above cited authority and policy, the petitioner's income caused the petitioner and her husband to be determined ineligible for full Medicaid. The respondent determined the petitioner's eligibility under a new Medicaid coverage, prior to terminating the full Medicaid. The petitioner received transitional Medicaid due to full Medicaid being terminated solely due to income. The respondent provided the transitional coverage beginning July 1, 2016 through April 30, 2016. The respondent is required to provide Medicaid for a minimum of 12 months to all household members once the Medicaid has been lost due to income, based on department policy.

23. Based on the testimony provided, the respondent provided the transitional Medicaid effective July 1, 2015. The respondent provided conflicting testimony concerning the actual time period of coverage. The undersigned concludes the transitional Medicaid was terminated prior to month 12. The respondent has not met the burden of proof to show it should have been terminated prior to the twelfth month.

24. In careful review of the testimony and evidence, the undersigned concludes the petitioner was entitled to the transitional Medicaid through June 30, 2016. The respondent erred in terminating the Medicaid prior to June 30, 2016.

**Full Medicaid will now be addressed**

25. Fla. Admin. Code R. 65-1.707 Family-Related Medicaid Income and Resource

Criteria states in pertinent 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...”

26. The above cited authority explains Family-Related Medicaid eligibility is based on income, earned or unearned, received within the household. In accordance with the above cited authority, the petitioner’s UC income and her husband’s earned income were included in the Medicaid budget calculations.

27. Fla. Admin. Code R. 65-1.716 Income and Resource Criteria explains: “(2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size...”

28. The Family-Related Medicaid income criteria is set forth in 42 C.F.R § 435.603 - Application of modified gross income (MAGI). It 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.

(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...

(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...

(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.

29. Federal regulations at 42 C.F.R. § 435.603 Application of modified gross income

(MAGI) (d) defines Household Income. It states:

(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.

30. 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).

31. The Policy Manual, Appendix A-7, effective April, 2016 lists the Family-Related Medicaid income limits for a household of four for adults as \$364, the Standard Disregard is \$221, and the Medically Needy Income Limit (MNIL) is \$585

32. In accordance with the above cited controlling authorities, the undersigned calculated Medicaid eligibility for the petitioner and her husband but did not find them eligible for full Medicaid as the household's MAGI is more than the income limit of \$364 for a household of four. Step 1. The petitioner's UC income of \$1,100 ( $\$275 \times 4$ ) was added to her husband's income of \$5,000 ( $\$2,500 \times 2$ ) resulting in \$6,100 as the MAGI. Step 2. There are no deductions provided, as there was no tax return provided. Step 3. The total income of \$6,100 less the standard disregard of \$221 is \$5,879. Step 4. The

total countable net income of \$5,879 was greater than the income standard for a household of four of \$364 for full Medicaid. Step 5. With no MAGI disregard, the countable balance remains at \$5,879. The petitioner's income was greater than the income limit for full Medicaid. The undersigned concludes the petitioner is ineligible for full Medicaid. The undersigned further concludes Medically Needy (MN) eligibility must be explored.

**Enrollment in Medically Needy and Share of Cost amount will now be addressed:**

33. The Policy Manual at passage 2630.0502 Enrollment (MFAM), states:

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.

34. Fla. Admin. Code 65A-1.701 "Definitions" 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".

35. Fla. Admin. Code 65A-1.702 "Special Provisions" states in part:

(10) Enrollment. The enrollment period under the Medically Needy program begins with the month the individual satisfies the non-financial and resource eligibility criteria, but not earlier than the third month prior to the month of application.

(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.

36. The Policy Manual at 2230.0400 Standard Filing Unit (MFAM) states:

The SFU is determined for each individual by following one of three rules based on intended tax filing status for the upcoming tax year as reported by the applicant/recipient. Individuals cannot receive Medicaid benefits under more than one assistance group, but can have their income included in more than one assistance group.

Filer Rule: If the individual being tested for eligibility expects to file a tax return for the tax year in which eligibility is being determined and does not expect to be claimed as a tax dependent by someone else, the SFU includes the:

- 1. individual,**
- 2. individual's spouse, if any, even if the individual and the individual's spouse are living separately and filing a joint tax return, and**
- 3. all claimed tax dependents of the individual living inside or outside of the household. (*emphasis added*)**

Tax Dependent Rule: If the individual being tested for eligibility expects to be claimed as a tax dependent for the tax year in which eligibility is being determined, the SFU includes the:

1. individual,
2. individual's spouse, even if the individual and the individual's spouse are living separately and filing a joint return,
3. tax filer,
4. tax filer's spouse, if any, even if the tax filer and tax filer's spouse are living separately and filing a joint return, and
5. all claimed tax dependents of the tax filer living inside or outside of the household.

37. In accordance with the above controlling authorities, the department determined DB's SFU as a household of four based on her tax filing status of filing taxes separately and the two minor children being tax dependent on her only. The department determined BC's SFU as a household of two based on his tax filing status of married filing taxes separately with no tax dependents.

38. In accordance with the above controlling authorities, the respondent determined the petitioner's countable household income to be \$6,100. The MNIL of \$585 was subtracted from the income to determine DB's SOC of \$5,515. The MNIL of \$387 was subtracted from the income to determine BC's SOC of \$5,713.

39. The undersigned found no exception to these calculation. It is concluded that a more favorable SOC could not be deteremined.

40. Based on the testimony, evidence, and a review of the respondnet's budget calculations, the undersigned has concluded that the respondent's action to deny the petitioner and her husband full Medicaid and enroll them in the Medically Needy program with a \$5,515 and \$5,713 SOC, respectively, was proper.

#### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted in part and denied in part. The department incorrectly terminated the transitional Medicaid prior to June 30, 2016. However, the department correctly denied full Medicaid ongoing and enrolled the petitioner in the Medically Needy Program as outlined in the Conclusions of Law. **The respondent is ordered to restore full Medicaid eligibility for the months of May 2016 and June 2016.**

**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 11 day of August, 2016,

in Tallahassee, Florida.



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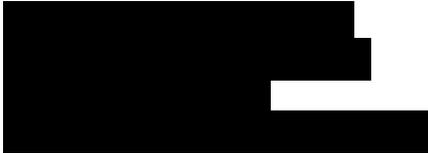
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Copies Furnished To: [REDACTED] Petitioner  
Office of Economic Self Sufficiency

Jul 22, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-03950

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION  
CIRCUIT: 15 PALM BEACH  
UNIT: AHCA

And

MOLINA HEALTHCARE

RESPONDENTS.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, a telephonic administrative hearing in the above matter was convened on June 30, 2016 at 9:34 a.m.

**APPEARANCES**

For the Petitioner:



For the Respondents:

Cindy Henline  
Medical/Healthcare Program Analyst  
Agency for Healthcare Administration (AHCA)

Natalie Fernandez  
Government Contract Specialist  
Molina Healthcare (Molina)

### **ISSUE**

Whether the denial of petitioner's request for orthodontic services (braces) was proper. The burden of proof was assigned to the petitioner. The standard of proof in an administrative hearing is by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

Petitioner entered no exhibits into evidence.

Present for respondents from DentaQuest were Dr. Susan Hudson, Dental Consultant and Jackelyn Salcedo, Complaints and Grievance Specialist. Respondent's exhibit "1" was accepted into evidence.

On June 7, 2016 Molina requested to be added as a party to this proceeding. The request was granted. As such, Molina is a co-respondent in this matter.

### **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 March 26, 2003.
2. Petitioner receives Medicaid services through AHCA's Statewide Medicaid Managed Care Program. Specifically, the Managed Medical Assistance Program. Molina is the managed care entity which provides petitioner's Medicaid services.
3. DentaQuest is Molina's dental vendor. All requests for dental services are reviewed by DentaQuest. DentaQuest determines whether the requested procedures are in compliance with pertinent rules and regulations.
4. Orthodontic procedures, when certain criteria are satisfied, are available to Florida Medicaid recipients under the age of 21.

5. On May 1, 2016 petitioner's orthodontist submitted a prior authorization request for orthodontic treatment (dental procedures D8670 and D8080). The submission included an Initial Assessment Form (IAF)<sup>1</sup>; photographs; and an x-ray.

6. The IAF is used by the Florida Medicaid Program to determine the severity of dental conditions, including the malocclusion of teeth. Scoring is assigned by both diagnostic observation and dental measurement.

7. An IAF score of "26" or more indicates orthodontic treatment is warranted.

8. The referring 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 indentation)
- 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

9. The above conditions can be considered as "auto-qualifiers" for braces.

10. The IAF directs" IF BOTH ANTERIOR CROWDING AND ECTOPIC ERUPTION ARE PRESENT IN THE ANTERIOR PORTION OF THE MOUTH, SCORE ONLY THE MOST SEVERE CONDITION. DO NOT SCORE BOTH CONDITIONS."

11. Petitioner's orthodontist identified no "auto qualifier" for braces. As such, the scoring portion of the IAF was completed.

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<sup>1</sup> The IAF is also known as the Orthodontic Initial Assessment

12. Petitioner’s orthodontist made the following IAM scoring:

Condition:	Score:
Overjet in mm	2
Overbite in mm	2
Ectopic eruption	15
Anterior crowding	10
Labio-Lingual spread in mm	2
Total Score	31

13. A licensed dentist with DentaQuest thereafter reviewed submitted photographs and x-rays. No “auto qualifier” for braces was found. The dentist then completed IAF scoring. The scoring was:

Condition:	Score:
Overjet in mm	
Overbite in mm	
Ectopic eruption	
Anterior crowding	15
Labio-Lingual spread in mm	
Total Score	15

14. On May 3, 2016 Molina issued to petitioner a Notice of Action which denied orthodontic treatment. The notice stated, in part:

To qualify for braces you need to get 26 points on a test. The test gives points for crowded, missing, and rotated teeth as well as spacing. Our Dental Director scored your teeth. You do not qualify for braces. We have told your dentist. Please talk to your dentist. You reached a score of 15 points.

15. On May 20, 2016 the Office of Appeal Hearings timely received petitioner’s request for a fair hearing.

16. Petitioner argues several dentists, due to crowding of teeth, have recommended braces.

17. Respondent asserts petitioner's orthodontist incorrectly completed the IAF by scoring both anterior crowding and ectopic eruption. Only the more severe of the two should have been scored.

### **CONCLUSIONS OF LAW**

18. By agreement between AHCA and the Department of Children and Families, jurisdiction has been conveyed to the Office of Appeal Hearings to conduct this hearing pursuant to § 120.80, Fla. Stat.

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

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

21. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7<sup>th</sup> Ed.).

22. 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.

23. 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.”
24. AHCA’s promulgated Dental Services Coverage Policy (Dental Policy) became effective in May 2016.
25. The Dental Policy states, in relevant parts:

### **1.1 Description**

Florida Medicaid dental services provide for the study, screening, assessment, diagnosis, prevention, and treatment of diseases, disorders, and conditions of the oral cavity.

#### **1.1.2 Statewide Medicaid Managed Care Plans**

This Florida Medicaid policy provides the minimum service requirements for all providers of dental services. This includes providers who contract with Florida Medicaid managed care plans (i.e., provider service networks and health maintenance organizations). Providers must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the Agency for Health Care Administration’s (AHCA) contract with the Florida Medicaid managed care plan. The provision of services to recipients in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

### **4.0 Coverage Information**

#### **General Criteria**

Florida Medicaid reimburses for services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

26. Medical necessity is defined 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. 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 orthodontic procedures are allowed for Medicaid recipients under the age of 21 to ameliorate a dental condition. The Findings of Fact also establish petitioner is under the age of 21. The issue before the undersigned, therefore, focuses upon whether the requested orthodontic services meet Florida's medical necessity criteria.

30. Regarding orthodontic treatment, the Dental Policy states:

#### **4.2.4 Orthodontic Services**

Florida Medicaid reimburses for orthodontic services for recipients under the age of 21 years with handicapping malocclusions as follows:

Twenty-four units within a 36 month period, which includes the removal of the appliances and retainers at the end of treatment

– One replacement retainer(s) per arch, per lifetime

#### **7.2 Specific Criteria**

Providers must obtain authorization from the quality improvement organization for orthodontic and prosthodontic related services when indicated on the applicable Florida Medicaid fee schedule(s).

Providers must include the following additional information with the authorization request for orthodontic services:

- Orthodontic initial assessment
- Clinical photographs (prints or slides) showing:
  - Frontal view, relaxed, teeth in occlusion
  - Profile, right or left
  - Intraoral, right or left sides, teeth in occlusion
  - Intraoral, frontal, teeth in occlusion
  - Occlusal view (if photos are submitted without complete records)
- Study models
- Lateral cephalometric radiograph
- Panoramic radiograph

31. The Findings of Fact establish petitioner's orthodontist incorrectly completed the IAF by scoring both anterior crowding (10) and ectopic eruption (15). This error resulted

in an overstatement on the IAF of 10 points. The correct score on the IAF, therefore, should have been 21 as opposed to 31.

32 The conflict between IAFs completed by petitioner's orthodontist and that of DentaQuest is noted. Regardless, the correct scoring by petitioner's orthodontist is 21 points. DentaQuest scored the IAF at 15 points. Both are under 26 points.

33. The Findings of Fact establish a score of 26 or greater is indicative orthodontic treatment is warranted.

34. It is also noted no IAF established an "auto-qualifier" for braces existed.

35. It is not disputed the petitioner has a misalignment of teeth. The greater weight of evidence, however, does not establish her orthodontic status rises to the stringent requirement of "handicapping malocclusions". A handicapping malocclusion is identified by the IAF scoring process.

36. Although braces have been recommended by petitioner's orthodontist, Fla. Admin Code. R. 59G-1.010 (166) specifies that service recommendations do not automatically make the service medically necessary.

37. 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 action in this matter was incorrect.

38. The petitioner's request for braces has not satisfied the following condition of medical necessity:

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program ...

**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 22 day of July, 2016,

in Tallahassee, Florida.

*Frank Houston*

---

Frank Houston  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
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Copies Furnished To: [REDACTED], PETITIONER  
AGENCY FOR HEALTH CARE ADMINISTRATION,  
MEDICAID FAIR HEARINGS UNIT  
ALICE QUIROS, MOLINA HEALTHCARE

Aug 22, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-03983

PETITIONER,

Vs.

CASE NO.

MANAGED CARE ORGANIZATION, AND  
AGENCY FOR HEALTH CARE ADMINISTRATION  
CIRCUIT: 06 Pasco  
UNIT: AHCA

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on July 18, 2016, at 4:10 p.m.

**APPEARANCES**

For the Petitioner:



For the Respondent:

Robert Walker  
Regulatory Research Coordinator  
Staywell

**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 alveoplasty?

**PRELIMINARY STATEMENT**

██████████ (“petitioner”), the petitioner, appeared on her own behalf.

Robert Walker, Regulatory Research Coordinator for Staywell (“respondent”), appeared on behalf of Staywell. Andrea Spurr, DDS, Dental Consultant for Liberty Dental Plan, appeared as a witness on behalf of Staywell. Stephanie Lang, R.N., Registered Nurse Specialist and Fair Hearing Liaison with the Agency for Health Care Administration (“AHCA” or “Agency”), was present solely for the purpose of observation.

The respondent introduced Exhibits “1” through “8”, 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 July 19, 2016 for the respondent to submit an additional contractual provision it intended to introduce. Once received, the information was accepted into evidence and marked as Exhibit “9”

**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 51-year-old female.
2. The petitioner was eligible to receive Medicaid at all times relevant to this proceeding.
3. The petitioner is an enrolled member of Staywell. Staywell is a health maintenance organization contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in Florida.
4. The petitioner participates in the Staywell Managed Medical Assistance (“MMA”) Program.

5. Petitioner's effective date of enrollment with Staywell was June 1, 2014.

6. Staywell provides certain dental benefits to its members. With regard to its members over age 21, these benefits include denture-related procedures.

7. 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.

8. The petitioner had all of her upper teeth extracted by her previous dentist on January 5, 2015.

9. The petitioner had her upper teeth extracted in preparation for receiving dentures.

10. The petitioner returned to her dentist in March 2015, April or May 2015, and September 2015 for follow-up visits to determine if the area was ready for dentures.

11. Each time the petitioner returned to her dentist, he informed her the area was still rigid and not yet ready for dentures.

12. When the petitioner visited her dentist in September 2015, he advised her he was no longer a part of the Staywell network and provided her with the business card of an oral surgeon.

13. The petitioner found a new dentist for the purpose of continuing treatment in order to receive her upper dentures.

14. After taking x-rays and evaluating the petitioner, her new dentist advised the petitioner her upper gums are rigid and need to be smoothed down before she can be fitted for dentures.

15. On or about April 6, 2016, the petitioner's new dental provider submitted a prior authorization request to Liberty Dental for an alveoplasty.

16. An alveoplasty is a surgical procedure that is used to smooth and reshape a patient's jawbone in areas where teeth have been extracted or otherwise lost.

17. In a Notice of Action dated April 8, 2016, Staywell informed the petitioner it was denying her request for an alveoplasty.

18. The Notice of Action states, in part: "The procedure is not covered based on an applicable plan limitation or exclusion. *See your Evidence of Coverage Booklet "EOC" for details.*"

19. Staywell dental policy states that Staywell will pay for one alveoplasty per lifetime per quadrant. This was reiterated during the testimony of the Dental Consultant from Liberty Dental at the hearing.

20. The Dental Consultant from Liberty Dental, appearing as a witness for the respondent, at the hearing testified internal records at Liberty Dental reflect that Liberty Dental paid the dentist who extracted the petitioner's upper teeth on January 5, 2015 for an alveoplasty.

21. The petitioner testified an alveoplasty was not completed at the time she had her upper teeth extracted on January 5, 2015.

22. Liberty Dental has approved upper dentures for the petitioner; however, the petitioner cannot receive the dentures until after she has an alveoplasty.

23. The petitioner explained at the hearing that bones are still protruding from her gums; consequently she cannot place dentures over the gums because they will not fit properly and result in pain.

24. The petitioner has been without upper teeth for over one-and-a-half years, since January 5, 2015.

25. The respondent is not contending that an alveoplasty is not medically necessary under the circumstances, only that it has already paid a claim for the service to the petitioner's previous dentist.

### **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 Chapter 120.80, Florida Statutes.

27. This is a final order pursuant to § 120.569 and § 120.57, Florida Statutes.

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

29. 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.

30. 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, 7<sup>th</sup> Ed.).

31. The Florida Medicaid program is authorized by Chapter 409, Fla. Stat. and Chapter 59G, Fla. Admin. Code. The Medicaid program is administered by respondent.

32. 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...

33. 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.

34. 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 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.

35. 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.

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-5.020. 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.

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...”

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. The Dental Services Coverage Policy – May 2016 is incorporated by reference in the Medicaid Service Rules by Fla. Admin. Code Rule 59G-4.060.

40. The Dental Services Coverage Policy – May 2016, on Page 4 at 4.2.7, explains Medicaid will reimburse for one upper, lower, or complete set of full or removable partial dentures per recipient.

41. The Medicaid MMA Contract, the contract between the Agency for Health Care Administration and Staywell, at Section V.A.I.a.(8).a.b., states as follows:

The Managed Care Plan shall provide Dental Services to enrollees under the age of 21 years, emergency dental services to enrollees age 21 and older, and denture and denture-related services and oral and maxillofacial surgery services to all enrollees. The Managed Care Plan shall provide medically necessary, emergency dental procedures to alleviate pain or infection to enrollees age 21 and older. Emergency dental care for enrollees 21 years of age and older is limited to a problem focused oral evaluation, necessary radiographs in order to make a diagnosis, extractions, and incision and drainage of an abscess. Full and removable partial dentures and denture-related services are also covered services for enrollees 21 years of age and older. The Managed Care Plan shall provide full dental services for all enrollees age 20 and below. The Managed Care Plan shall provide medically necessary oral and maxillofacial surgery for all eligible Medicaid recipients regardless of age.

42. The Staywell MMA Handbook, on Page 20, explains dental services for adults (over age 21) include “Full and removable partial dentures” and “Denture-related procedures”.

43. In the present case, the respondent’s witness testified that an alveoplasty falls within the definition of a denture-related procedure and that a Staywell member is

entitled to one alveoplasty per lifetime per quadrant. The respondent's witness is also not disputing that an alveoplasty is medically necessary for the petitioner, only that the respondent paid a claim for such a procedure to the petitioner's previous dentist. At the same time, the petitioner provided credible testimony explaining that the procedure was not completed by her previous dentist and it needs to be done in order for her to receive the dentures which Liberty Dental has already approved.

44. After careful review of the testimony and evidence presented in this case, along with the relevant laws set forth above, the undersigned concludes the petitioner has demonstrated by a preponderance of the evidence that the respondent incorrectly denied her request for an alveoplasty. If Staywell discovers that it paid a claim to the petitioner's previous dentist for this procedure after it completes its due diligence, it is incumbent upon Staywell or AHCA to pursue recovery of the funds from the dentist and not deny the petitioner with medically necessary services it is contractually obligated to approve. The petitioner has been without upper teeth for one-and-a-half years while working diligently to resolve this issue; this time-frame is far from reasonable.

### **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

FINAL ORDER (Cont.)

16F-03983

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funds to assist in this review.

DONE and ORDERED this 22 day of August, 2016,  
in Tallahassee, Florida.

*Peter J. Tsamis*

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Peter J. Tsamis  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
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Copies Furnished To:

██████████ Petitioner  
AHCA, Medicaid Fair Hearings Unit  
Ray Walker

Aug 16, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-03985

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 June 24, 2016 at 10:00 a.m. in 

**APPEARANCES**

For the Petitioner:



For the Respondent:

Fathima Leyva, 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 physical therapy services was correct. The petitioner has the burden of proving her case by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

The petitioner submitted a one-page medical record as evidence for the hearing, which was marked as Petitioner Exhibit 1.

Appearing telephonically as witnesses for the respondent were Michelle Rigler, Compliance Office, and Dr. Gabriel Novoa, Medical Director, from Magellan Complete Care, which is the petitioner's managed health care plan.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Composite Exhibit 1: Authorization Request, Denial Notices, and Therapy Handbook provisions.

### **FINDINGS OF FACT**

1. The petitioner is a fifty-seven (57) 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 Magellan.
2. On or about May 10, May 17, and May 18, 2016, the petitioner's treating physician and/or physical therapist (hereafter referred to as "the provider"), submitted prior authorization requests to Magellan for approval of physical therapy services. On or about May 11 and May 19, 2016, Magellan denied the requested physical therapy services. The denial notices stated the requests were denied since the requested services were not a covered benefit under the plan.
3. The petitioner stated she needs physical therapy services due to muscle weakness from lying flat in a hospital bed for two months after undergoing spinal surgery.

4. The respondent's witness stated that physical therapy is not a covered service for individuals age 21 and over according to Florida Medicaid guidelines.

5. Physical therapy services under the Medicaid State Plan in Florida are provided in accordance with the respondent's Therapy Services Coverage and Limitations Handbook ("Therapy Handbook"), effective August, 2013.

### **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 Fla. Stat. § 120.80.

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

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 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, 7<sup>th</sup> 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. The Therapy Handbook incorporated by reference in Chapter 59G-4, Florida Administrative Code.

11. The Therapy 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.

12. The Florida Medicaid Program provides limited physical therapy services for adults. The Therapy Handbook describes the covered services for adults as follows:

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.

13. Managed care plans, such as Magellan, may provide more generous benefits but cannot be more restrictive than the Medicaid guidelines contained in the Therapy Handbook.

14. 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 Magellan. The requested physical therapy services are non-covered services for adults under the Medicaid guidelines referenced above.

Accordingly, the hearing officer cannot make a determination that this service must be covered by the petitioner's health 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 16 day of August, 2016,

in Tallahassee, Florida.



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Rafael Centurion  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700

FINAL ORDER (Cont.)

16F-03985

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Copies Furnished To: [REDACTED], PETITIONER  
AHCA, MEDICAID FAIR HEARINGS UNIT

Jul 21, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-03986

PETITIONER,

Vs.

AGENCY FOR HEALTH  
CARE ADMINISTRATION  
CIRCUIT: 07 Volusia  
UNIT: AHCA

And

STAYWELL HEALTH PLAN

RESPONDENTS.

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**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 20, 2016 at 1:07 p.m.

**APPEARANCES**

For the Petitioner:



For the Respondent: Sheila Broderick, registered nurse specialist with AHCA

**STATEMENT OF ISSUE**

Whether it the petitioner is eligible to receive a blood pressure machine through Medicaid. The petitioner holds the burden of proof by a preponderance of the evidence.

### **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. Staywell Health Plan (Staywell) is the contracted HMO in the instant case.

By notice May 16, 2016, Staywell informed the petitioner that his request for a blood pressure machine through Medicaid was denied. The notice reads in pertinent part:

On May 11, 2016, we received a request from [REDACTED] for a blood pressure machine. Your plan covers all medical necessary durable medical equipment covered by Florida Medicaid. Florida Medicaid defines durable medical equipment 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). A blood pressure machine is not a covered benefit according to the standard of Florida Medicaid as the item requested does not meet these requirements. Therefore it is not covered by Florida Medicaid or your health plan. Referencing: Florida Medicaid's Durable Medical Equipment and Medical Supply Coverage and Limitations Handbook.

The petitioner requested reconsideration.

By notice dated May 27, 2016, Staywell informed the petitioner that the original denial decision was upheld.

The petitioner timely requested a hearing to challenge the denial decision.

There were no additional witnesses for the petitioner. The petitioner did not submit documentary evidence.

Present as witnesses for the respondent from Staywell: Stephanie Schupe, regulatory research coordinator and Troy Stanley, supervisor of durable medical equipment care coordination. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

The record was held open until close of business on the day of the hearing for the respondent to submit legal authorities, passages from the Medicaid Durable Medical Supply Services and Coverage Limitations Handbook, which is promulgated into law by Chapter 59G of the Florida Administrative Code. The handbook passages were received and administratively noticed.

#### **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 70) is a Florida Medicaid recipient.
2. The petitioner is enrolled in the Managed Care Plan with Staywell HMO.
3. The petitioner's diagnoses includes [REDACTED], [REDACTED], [REDACTED], and [REDACTED]; he also has a pace maker and history of cardiac issues, not otherwise specified.
4. The petitioner's treating physician advised him to check his blood pressure daily. The petitioner currently uses blood pressure machines at his local grocery stores.
5. The petitioner's treating physician submitted a request to Staywell for a personal blood pressure machine on May 10, 2016. The request form lists hypertension as the reason the medical equipment is necessary for the petitioner. Under directions for use, the request form reads, "check BP once daily."

6. Specified Medicaid goods and services, including durable medical equipment, require prior service authorization. Staywell reviews the authorization request form and all supporting documentation during the assessment process.

7. Staywell denied the petitioner's request as a non-covered benefit on May 16, 2016 and again on May 27, 2016.

8. Stephanie Schupe, Staywell regulatory research coordinator, explained that that not all medical goods and services are covered by Medicaid. The provision of goods and services is subject to applicable exclusions and limitations. Medicaid does not cover blood pressure machines under any circumstances for recipients age 21 and over.

9. The petitioner argued that the Medicaid eligibility criteria for durable medical equipment specifies that the equipment be medically necessary equipment that can withstand repeated use, serves a medical purpose, and is appropriate for use in the recipient's home. The petitioner argued that the requested blood pressure machine meets all the listed requirements: it is medically necessary due to his hypertension diagnosis; it can withstand repeated use; and it is to be used in his home.

10. On rebuttal, Troy Stanley, Staywell supervisor of durable medical equipment care coordination, explained that a medical necessity determination is not performed for non-covered goods and services.

#### **CONCLUSIONS OF LAW**

11. 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 Section 120.80, Florida Statutes.

12. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.

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

14. In accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof was 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. 65-2.060(1)). The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7<sup>th</sup> Ed.).

16. The Florida Medicaid Program is authorized by Chapter 409 Florida Statutes and Fla. Admin. Code Chapter 59G.

17. The July 2010 Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook (“DME Handbook”) is promulgated into law by Chapter 59G of the Florida Administrative Code.

18. Page 2-97 of the DME Handbook addresses non-covered goods and reads in pertinent part:

The following list of items and services are not reimbursed through the Medicaid DME and Medical Supply Services Program; however some of these items may be reimbursed through other Medicaid programs, such as the Medicaid State Plan, Home and Community-Based Waiver Programs, or other state-operated programs:

- \*Audiology services
- \***Blood pressure monitoring devices** (emphasis added)
- \*Car seats or car beds
- \*Clinically unproven equipment
- \*Computers and computer-related equipment

...

19. Page 2-98 of the DME Handbook addresses non-covered exceptions: "Exceptions for Non-Covered Services and Exclusion are only for eligible recipients under 21 years of age...." The DME handbook goes on to explain that requests for exception must: 1) meet Florida Medicaid's definition of Medical Necessity and 2) include required prior service authorization documentation.

20. The cited DME Handbook passages explain that the Medicaid Managed Care Plan only covers blood pressure monitoring devices for recipients under age 21 and only when the equipment has been determined to be medically necessary.

21. The respondent denied the petitioner's request for a blood pressure machine as a non-covered benefit. The evidence proves that the petitioner does not meet the non-covered benefit exception of being under age 21. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the respondent's decision in this matter is correct.

### **DECISION**

The appeal is denied. The respondent's decision in this matter is upheld.

### **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 July, 2016,  
in Tallahassee, Florida.



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  
AHCA, Medicaid Fair Hearings Unit  
Ray Walker, WellCare Health Plans

Aug 17, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-03988

PETITIONER,

Vs.

CASE NO.

MANAGED CARE ORGANIZATION, AND  
AGENCY FOR HEALTH CARE ADMINISTRATION  
CIRCUIT: 06 Pinellas  
UNIT: AHCA

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on July 18, 2016, at 2:40 p.m.

**APPEARANCES**

For the Petitioner:



For the Respondent:

Stephanie Lang, R.N.  
Registered Nurse Specialist/Fair Hearing Liaison  
Agency for Health Care Administration

**STATEMENT OF ISSUE**

Did the respondent prove by a preponderance of the evidence that it correctly denied the petitioner's request for Personal Care Assistant ("PCA") services?

### **PRELIMINARY STATEMENT**

Donna Cosenza, the petitioner's mother, appeared on behalf of the petitioner, Frank Cosenza ("petitioner"), who was not present. Frank Cosenza, the petitioner's father, appeared as a witness on behalf of the petitioner. Mrs. Cosenza may sometimes hereinafter be referred to as the petitioner's "representative".

Stephanie Lang, R.N., Registered Nurse Specialist and Fair Hearing Liaison with the Agency for Health Care Administration ("AHCA" or "Agency"), appeared on behalf of the Agency for Health Care Administration. Rakesh Mittal, M.D., Physician Reviewer for eQHealth Solutions, appeared as a witness on behalf of the Agency.

The petitioner introduced Exhibits "1" through "7", inclusive, at the hearing, all of which were accepted into evidence and marked accordingly. The respondent introduced Exhibits "1" through "7", inclusive, which were also accepted into evidence and marked accordingly.

At the respondent's request, the hearing officer took administrative notice of Section 409.905, Florida Statutes as well as the following Florida Administrative Code Rules: 59G-1.001; 59G-1.010; and 59G-4.130.

### **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 19-year-old male.
2. The petitioner was eligible to receive Medicaid benefits through Medicaid State Plan at all times relevant to this proceeding.

3. The Medicaid State Plan is administered by the Agency for Health Care Administration.
4. The petitioner participates in the CDC+ Program within the Medicaid State Plan.
5. The CDC+ Program allows for the financial compensation of a parent for providing servicing to their child.
6. The petitioner's Personal Care Assistant is his father.
7. The petitioner was approved to receive Personal Care Assistant services in the amount of six hours per day, seven days per week, in the prior certification period which began on January 1, 2016 and ended on June 30, 2016.
8. On or about May 5, 2016, the petitioner's home health agency submitted a prior authorization request to eQHealth Solutions for Personal Care Assistant services to be approved for eight hours per day, seven days per week, for the certification period July 1, 2016 through December 31, 2016.
9. eQHealth Solutions is the Quality Improvement Organization contracted by the Agency for Health Care Administration to review requests by Medicaid recipients for services available under the Home Health Services Program.
10. The Home Health Services Program includes various types of assistance including Registered Nurse Services, Licensed Practical Nurse Services, and Personal Care Services. Personal Care Assistant services and Home Health Aide services are types of Personal Care Services.
11. eQHealth Solutions is charged with the responsibility of determining if a requested service is medically necessary under the terms of the Medicaid Program.

12. A request for Personal Care Services is submitted directly to eQHealth Solutions by a petitioner's home health agency. Once eQHealth Solutions receives the information, it completes a prior authorization review – it reviews the written request to determine if the number of hours requested are medically necessary.

13. The petitioner's request was reviewed by an eQHealth Solutions Physician Reviewer on May 12, 2016. The Physician Reviewer denied all of the requested hours and supplied the following rationale for the decision:

[REDACTED]

14. At the request of the petitioner's representative, eQHealth Solutions completed a reconsideration review on or about May 27, 2016. The Physician Reviewer who completed the reconsideration review upheld the initial denial of all Personal Care Assistant services noting the following:

[REDACTED]



15. The petitioner resides in the family home with both parents. There are no siblings in the home.

16. The petitioner is diagnosed with the following: 



17. The petitioner is ambulatory but requires the assistance of a wheelchair for long distances.

18. The petitioner is continent of both bowel and bladder but he does have occasional accidents.

19. The petitioner does not have a G-tube or a tracheostomy.

20. The petitioner is on a regular diet.

21. The petitioner can feed himself but requires assistance cutting his food. He needs to be supervised during meal times to minimize the risk of potential choking.

22. The petitioner requires assistance with shaving, oral care, bathing, and dressing.

23. The petitioner has behavioral problems, including elopement.

24. Some of the petitioner's behavioral problems place his health and safety at risk.

25. The petitioner requires monitoring and supervision due to his behavioral problems.

26. The petitioner attends school on weekdays from 8:00 a.m. until 3:00 p.m. During the summer, the petitioner attended adult day training from 8:00 a.m. until 2:30 p.m.

27. The petitioner's mother works outside of the home on Tuesdays from 8:30 a.m. to 12:30 p.m. and sometimes later.

28. The father's sole employment is as a Personal Care Assistant for the petitioner. It was not disclosed to the Agency during the determination process that the petitioner's father is his Personal Care Assistant.

29. The petitioner's parents do not have any physical limitations which limit their ability to provide care to the petitioner. However, the petitioner's mother is unable to successfully intervene and resolve many of the petitioner's behavioral problems due to the petitioner's size and strength.

30. The petitioner's Personal Care Services Plan of Care lists the services to be performed by a Personal Care Assistant as follows: bathing and grooming; toileting and elimination; and oral hygiene.

31. The Plan of Care lists the petitioner's functional limitations as follows: requires assistance to ambulate over 1/8 mile; tires easily when moving about; and speech difficulty.

32. The petitioner's Physician Visit Documentation Form describes the petitioner's ongoing need for home health services as follows: "For safety reasons, patient needs 100% supervision and assistance with daily living".

33. Eating, bathing, dressing, oral care, skin care, toileting and elimination, incontinent care, and range of motion and positioning are considered to be activities of daily living (“ADLs”).

34. The petitioner requires substantial assistance for the completion of his ADLs.

35. Personal Care Assistant services may be approved by the Agency for Health Care Administration for the purpose of assisting a patient with activities of daily living, if a parent or caregiver is not available to provide the service.

36. Personal Care Assistant services may not be approved by the Agency for Health Care Administration for the purposes of providing monitoring and supervision.

37. After learning the petitioner participates in the CDC+ Program and toward the conclusion of the hearing, the eQHealth Solutions Physician Reviewer appearing as a witness for the respondent modified the denial in this case and stipulated the approval of two hours per day of Personal Care Assistant services in the morning and two hours per day of Personal Care Assistant services in the evening (for a total of four hours per day), seven days per week, to assist the petitioner with his activities of daily living. He testified four hours per day of Personal Care Assistant Services is sufficient to assist the petitioner with his Activities of Daily Living.

#### **CONCLUSIONS OF LAW**

38. 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.

39. The Florida Medicaid Program is authorized by Chapter 409, Fla. Stat., and Chapter 59G, Florida Administrative Code. The Program is administered by AHCA.

40. The Florida Medicaid Home Health Services Coverage and Limitations Handbook October 2014 ("Handbook") is promulgated into rule by Fla. Admin. Code R. 59G-4.130(2).

41. The Handbook describes the Home Health Services Program, which consists of various services including: Registered Nurse services; Licensed Practical Nurse services; and Personal Care Services. All services provided under this Program, including Personal Care Assistant services, must be determined to be medically necessary in order to be approved under Florida Medicaid.

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

43. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof with regard to the proposed reduction of the petitioner's services from six hours per day to no hours per day is on the respondent. With regard to the requested increase in the petitioner's services from six to eight hours per day, the burden of proof is assigned to the petitioner.

44. 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, 7<sup>th</sup> Ed.).

45. 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. ...

(c) The agency may not pay for home health services unless the services are medically necessary ...

46. 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.

...

(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.

47. 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.

48. 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.

49. 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.

50. For Personal Care Assistant services to be approved, the services must not only be medically necessary but must also meet any further requirements set forth in the Handbook.

51. Page 1-2 of the Handbook states "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."

52. Page 1-2 of the Medicaid Handbook provides a list of personal care (ADL) services. These services include:

- Eating (oral feedings and fluid intake);
- Bathing;
- Dressing;
- Toileting;

- Transferring; and
- 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).

53. Personal Care Services are confined by the limitations specified in the Handbook. An individual's service needs relating to behavioral or supervisory issues do not supersede Handbook provisions.

54. The hearing officer acknowledges the petitioner may need to be monitored or supervised due to his medical condition. However, monitoring and supervision may be provided by any responsible adult; a medically trained professional is not necessary.

55. The Handbook, on Page 1-3, defines babysitting as: "The act of providing custodial care, daycare, afterschool care, supervision, or similar childcare unrelated to the services that are documented to be medically necessary for the recipient."

56. The Handbook, on Pages 2-12 and 2-13, lists babysitting, day care or after school care, as examples of services that are not reimbursable under the Medicaid home health services program.

57. Eating, bathing, dressing, oral care, skin care, incontinent care, and assistance with toileting may be summarized as activities of daily living. These services may be approved and provided by a Home Health Aide if it is determined they are medically necessary and a primary caregiver is unavailable to provide the care." (See Fla. Admin. Code R. 59G1.010 (111), *Definition of "Home Health Aide (HHA)"*).

58. Appendix L of the Handbook discusses "Medicaid Review Criteria for Personal Care Services" and sets forth each of the allowable personal care tasks and general time allowance for each task. The sum of time for all of the individual tasks

performed by the petitioner's Personal Care Assistant is equal to or less than the two (2) hours per visit approved by the Agency.

59. The definition of medical necessity set forth in Fla. Admin. Code R. 59G-1.010 (166)(a) explains goods or services furnished or ordered must:

(5) Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

This information is echoed on Page 2-2 of the Handbook.

60. The Handbook, on Page 2-25, discusses the requirement of parental responsibility. It explains:

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.

Medicaid can reimburse personal care services rendered to a recipient whose parent or legal guardian is not able to provide ADL or IADL care. Supporting documentation must accompany the prior authorization request in order to substantiate a parent or legal guardian's inability to participate in the care of the recipient.

61. The above paragraphs highlight that the Home Health Services Program is a supplemental program. It is designed to supplement the care provided by the parents or caregivers and is not intended to assume the care of the patient under any circumstances. Parents and caregivers must participate in providing care to the fullest extent possible. However, since the petitioner in the present case participates in the CDC+ Program which provides for financial compensation to a parent for services they

would otherwise be legally obligated to provide, the respondent may approve Personal Care Assistant services for the petitioner during the times his father is at home.

62. In the present case, the two hours per day of Personal Care Assistant services in the morning and two hours per day of Personal Care Assistant services in the evening, seven days per week, stipulated to by the respondent's witness during the hearing are sufficient to assist the petitioner with his activities of daily living. The hearing officer recognizes the petitioner requires monitoring and supervision due to his behavioral problems resulting from his diagnoses. However, page 2-2 of the Handbook indicates "[h]ome health services are not considered emergency services." Monitoring and supervision are outside the scope of the Home Health Services program and services may not be properly approved for these functions.

63. Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the petitioner has not met his burden of proof that the Agency incorrectly denied his request for additional Personal Care Assistant services whereas the respondent has met its burden of proof with regard to the reduction of the petitioner's Personal Care Assistant services from six hours per day, seven days per week, to four hours per day, seven days per week.

64. In rendering this decision, the undersigned hearing officer considered all of the testimony and documentary evidence submitted at the hearing and reviewed all conditions of "medical necessity" and Personal Care Assistant duties set forth in the Florida Administrative Code and the rules governing the Florida Medicaid program.

65. The hearing officer hereby affirms the decision of the Agency for Health Care Administration to approve Personal Care Assistant services four hours per day, seven days per week.

**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 17 day of August, 2016,

in Tallahassee, Florida.

*Peter J. Tsamis*

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Peter J. Tsamis  
Hearing Officer  
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Copies Furnished To: [REDACTED], Petitioner  
AHCA, Medicaid Fair Hearings Unit

**FILED**

Aug 12, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-03990

PETITIONER,

Vs.

AGENCY FOR HEALTH  
CARE ADMINISTRATION (AHCA)  
CIRCUIT: 07 Flagler  
UNIT: AHCA

And

STAYWELL HEALTH PLAN

RESPONDENTS.

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**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 20, 2016 at 3:08 p.m.

**APPEARANCES**

For the Petitioner: 

For the Respondent: Selwyn Gossett, medial health care analyst

**STATEMENT OF ISSUE**

At issue is the denial of the petitioner's request for five dental fillings.

### **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. Staywell Health Plan (Staywell) is the contracted health care organization in the instant case. Staywell subcontracts with Liberty Dental to provide dental services to its enrollees.

By notice dated March 30, 2016, Liberty Dental informed the petitioner that her request for five resin-based composites (dental fillings) was denied as a non-covered benefit.

The petitioner timely requested a hearing to challenge the denial decision on May 23, 2016.

There were no additional witnesses for the petitioner. The petitioner did not submit documentary evidence.

Present as respondent witnesses from Staywell and Liberty Dental: Stephanie Shupe, regulatory research coordinator and Dr. Richard Hague, dental director. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

The record was held open until close of business on June 21, 2016 for the submission of additional evidence. Evidence was received from the respondent and admitted as Respondent's Exhibit 2. The record was closed on June 21, 2016.

### **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 21) is a Florida Medicaid recipient. The petitioner is enrolled with Staywell HMO. Staywell subcontracts with Liberty Dental to provide dental services to its enrollees.

2. In March 2016, the petitioner's treating dentist requested authorization for five resin dental fillings (teeth #8, #10, #22, #26, #28).

3. Liberty Dental denied the request as a non-covered benefit on March 30, 2016.

4. The respondent explained the Medicaid dental services for enrollees age 21 and over are limited to: 1) dentures and work related to preparation for dentures and 2) emergency dental services. The request submitted by the petitioner's treating dentist contained no supporting clinical data which showed the dental fillings were emergent in nature. The request only listed the procedure and the teeth numbers.

5. The petitioner is disabled due to cerebral palsy. She is non-verbal and non-ambulatory. She requires total care. The petitioner's dentist discovered five cavities during a routine cleaning and recommended that the teeth be filled. The petitioner's mother argued that an exception to the age-related benefit coverage limitation is in order because of the petitioner's medical condition and inability to communicate her needs.

6. The petitioner's mother argued that they live on limited funds and she cannot afford to pay out of pocket for the dental fillings.

7. On rebuttal, the respondent reiterated that emergency dental services and denture/denture related services are the only exceptions for enrollees age 21 and over. Medicaid rule does not include an exception to the dental services limitations based on any other medical condition.

8. The respondent noted that HMOs cannot be more restrictive than Medicaid rule. However, HMOs may provide additional services above and beyond what is listed in Medicaid rule, if the HMO chooses to do so and the additional services provision is included in the HMOs contract with AHCA. Staywell does not chose to provide additional dental services above and beyond those set forth in AHCA rule.

#### **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 Section 120.80, Florida Statutes.

10. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.

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 petitioner.

13. 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, 7<sup>th</sup> Ed.).

14. The Florida Medicaid Program is authorized by Chapter 409 Florida Statutes and Fla. Admin. Code Chapter 59G.

15. At the time of the denial at issue, respondent's Dental Services Coverage and Limitations Handbook, November 2011 (Dental Handbook) was in effect.

16. The Dental Handbook addresses adult dental services 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.

17. The petitioner's dentist requested authorization for five dental fillings. The respondent denied the request as a non-covered benefit.

18. The petitioner is 21 years old. There is no evidence that the requested dental procedures are medically necessary emergencies or preparation of the petitioner's mouth for dentures. As such, in accordance with the controlling legal authorities, the procedures are not covered by Medicaid. The undersigned found no exception in rule for the petitioner's medical condition or her inability to communicate verbally or physically.

19. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the respondent's decision in this matter was correct.

**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 12 day of August, 2016,

in Tallahassee, Florida.



Leslie Green  
Hearing Officer  
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Office: 850-488-1429  
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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner  
AHCA, Medicaid Fair Hearings Unit  
Ray Walker

Aug 16, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-03998

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 July 7, 2016 at 11:30 a.m.

**APPEARANCES**

For the 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 wisdom teeth extractions was correct. The petitioner has the burden of proving his case by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

The Petitioner did not submit any documents as evidence for the hearing.

Appearing as witnesses for the respondent were Dr. Susan Hudson, Dental Consultant, and Jackeline Salcedo, Complaint and Grievance Specialist, from DentaQuest, which is the Petitioner's dental services organization. Also present as witnesses for the respondent were Lisa Williams, Quality Operations Nurse, and Laura Withrow, Quality Department Manager, from Amerigroup, which is the petitioner's managed health care plan.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Composite Exhibit 1: Case Summary, Authorization Request, Authorization Determination, Denial Notice, and Dental Services Criteria.

### **FINDINGS OF FACT**

1. The petitioner is a seventeen (17) 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 Amerigroup, which utilizes DentaQuest for review and approval of dental services.
2. On or about April 18, 2016, the Petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from DentaQuest and/or Amerigroup to perform extractions of four wisdom teeth (Teeth 1, 16, 17, and 32). Amerigroup denied this request on April 20, 2016 based on medical necessity considerations.
3. The denial notice also stated the following regarding the reason for the denial:

Your dentist has asked to remove your tooth. To approve this service you must severe pain in your tooth, the tooth must be in a position that will not let it break through the gum by itself, and your gums or bone around the teeth are diseased. The root of your tooth must also be completely formed. Our dentist looked at the x-ray and information from your dentist. It does not appear that this tooth needs to be removed. This service is not medically necessary. We have told your dentist this also. Please talk to your dentist about other treatment choices.

4. The petitioner's mother testified her son needs the extractions because he is in pain and he cannot eat hard foods. She also stated the incoming wisdom teeth are bending his other teeth.

5. The Respondent's expert witness, Dr. Hudson, stated that the denial of the wisdom teeth extractions was appropriate because there was incomplete root formation shown on the dental x-ray. Pain can also be a basis to justify extraction of the wisdom teeth, but the report of pain must be specific as to which teeth are affected.

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, 7<sup>th</sup> 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 service at issue, tooth extraction, is a covered service for individuals under age twenty-one (21) in the Florida Medicaid Program. DentaQuest and/or Amerigroup denied the wisdom teeth extractions due to medical necessity considerations.

14. The petitioner's mother believes the extractions should be approved because her son is in pain and he cannot eat hard foods.

15. The respondent's witness stated the denial of the extractions was appropriate since there was incomplete root formation in the teeth and there was non-specific information regarding the location of the tooth pain.

16. After considering the evidence presented and relevant authorities set forth above, the undersigned concludes the petitioner has not demonstrated that the denial of the request for the extractions was incorrect. The petitioner has not established that the request for this service is medically necessary as defined by Fla. Admin. Code R. 59G-1.010(166). Although the petitioner's dentist requested the extractions, this does not establish it is medically necessary. The respondent's witness testimony supports the denial of the requested service.

### **DECISION**

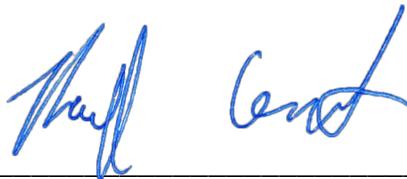
Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is DENIED.

**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 16 day of August, 2016,

in Tallahassee, Florida.



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Rafael Centurion  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], PETITIONER  
AHCA, MEDICAID FAIR HEARINGS UNIT

Aug 19, 2016

Office of Appeal Hearings  
Dept. of Children and FamiliesSTATE OF FLORIDA  
DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-04016

PETITIONER,

Vs.

CASE NO. FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 18 Brevard  
UNIT: 55118RESPONDENT.  

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**FINAL ORDER**

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 10:45 a.m. on June 29, 2016.

**APPEARANCES**

For the Petitioner:



For the Respondent:

Sylma Dekony, ACCESS  
Economic Self-Sufficiency Specialist II**STATEMENT OF ISSUE**

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

### **PRELIMINARY STATEMENT**

By notices dated June 2, 2016 and June 22, 2016, the respondent (or the Department) notified the petitioner he was denied Medicaid disability. Petitioner timely requested a hearing to challenge the Medicaid denial.

[REDACTED], petitioner's mother, appeared as a witness for the petitioner. Petitioner submitted one Exhibit, entered as Petitioner Exhibit "1". Respondent submitted seven exhibits, entered as Respondent Exhibits "1" through "7". The record was closed on June 29, 2016.

### **FINDINGS OF FACT**

1. On May 9, 2016, the petitioner (age 39) submitted a Food Assistance and SSI-Related Medicaid application for himself and his mother; petitioner does not have children. Medicaid for the petitioner is the only issue.
2. To be eligible for SSI-Related Medicaid, petitioner must be age 65 or older, or considered disabled by the Social Security Administration (SSA) or the Division of Disability Determination (DDD). DDD is responsible for making disability determinations on behalf of the Department.
3. Petitioner last applied for disability through the SSA in February 2015. SSA denied petitioner in September 2015. Petitioner appealed the SSA denial in October 2015 through an attorney; a hearing date has not been scheduled.
4. Petitioner described his disabilities as [REDACTED], stomach and back problems. Petitioner does not have any new or worsened medical conditions that the SSA is unaware of.

5. On June 2, 2016, the Department incorrectly mailed the petitioner a Notice of Case Action (NOCA) denying the May 9, 2016 Medicaid application.
6. On June 16, 2016, the Department forwarded petitioner's disability documents to DDD for review. DDD denied petitioner Medicaid Disability on June 21, 2016; due to adopting the SSA denial decision.
7. On June 22, 2016, the Department mailed the petitioner another NOCA, denying his May 9, 2016 Medicaid application, "Reason: You or a member(s) of your household do not meet the disability requirement."

#### **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. The Code of Federal Regulations at 42 C.F.R. § 435.541, Determinations 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...

11. The above authority explains the SSA determination is binding on the Department.

12. In accordance with the above authority, the respondent denied petitioner's May 9, 2016 Medicaid application; due to adopting the SSA September 2015 denial decision.

13. In careful review of the cited authority, evidence and testimony, the undersigned concludes the petitioner did not meet the burden of proof. The undersigned agrees with the Department's action to deny 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  19  day of  August , 2016,

in Tallahassee, Florida.



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Priscilla Peterson  
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

Aug 18, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-04037

PETITIONER,

Vs.

AGENCY FOR HEALTH  
CARE ADMINISTRATION  
CIRCUIT: 07 Volusia  
UNIT: AHCA

And

STAYWELL HEALTH PLAN

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 29, 2016 at 10:09 a.m.

**APPEARANCES**

For the Petitioner: 

For the Respondent: Sheila Broderick, registered nurse specialist

**STATEMENT OF ISSUE**

Whether the petitioner is eligible for reimbursement of out-of-pocket prescription expenses. The petitioner holds the burden of proof by a preponderance of the evidence.

### **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. Staywell Health Plan (Staywell) is the contracted health care organization in the instant case.

By notice dated May 6, 2016, Staywell informed the petitioner that her request for reimbursement of out-of-pocket prescription expenses was denied because the dispensing pharmacy was an out-of-network provider.

The petitioner requested reconsideration.

By notice dated May 26, 2016, Staywell informed the petitioner that the original denial decision was upheld.

The petitioner timely requested a hearing to challenge the denial decision on May 26, 2016.

There were no additional witnesses for the petitioner. The petitioner did not submit documentary evidence.

Present as respondent witnesses from Staywell: Alexandra Hicks, regulatory research specialist and Erika Hatchman, manager of pharmacy services. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

The record was held open until close of business on July 5, 2016 for the submission of additional evidence. Evidence was received from the respondent and admitted as Respondent's Exhibit 2. The record was closed on July 5, 2016.

### **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 58) is a Florida Medicaid recipient. The petitioner was enrolled with Staywell HMO during the time period in question.
2. The petitioner suffers from back pain due to arthritis and herniated discs. Her doctor prescribed [REDACTED] to address her pain.
3. Prior to the action under appeal, the petitioner filled her monthly [REDACTED] [REDACTED] prescription at Publix pharmacy.
4. In late 2015, Staywell sent a letter to its enrollees informing them that effective January 2016, Publix was no longer a participating pharmacy and that they would need to switch to a participating pharmacy. The notice included a list of participating pharmacies; the list included CVS, Winn Dixie, Walmart, and Target. The notice further informed members that Staywell would cover a three month transition period, January 2016 – March 2016, to allow for continuity of care (uninterrupted services) during the transition to a new pharmacy. Members were informed that the transition to a participating pharmacy must occur no later than March 31, 2016.
5. The petitioner received Staywell's transition notice. This fact was not disputed.

6. On April 2, 2016, the petitioner had her [REDACTED] prescription filled at Publix, an out-of-network pharmacy. She paid out-of-pocket for the prescription, \$204.95. The petitioner filed a reimbursement request with Staywell. By written notice and collateral contact, Staywell informed the petitioner it does not reimburse for out-of-network prescription drug services. However, Staywell agreed to make a one-time exception because of the recent policy changes. Staywell issued a reimbursement check to the petitioner in the amount of \$204.95 in May 2016. Staywell informed the petitioner that it would make no further reimbursement exceptions, she would need to switch to a participating pharmacy immediately. Staywell provided the petitioner with a list of 10 participating pharmacies within five miles of her home.

7. In May 2016, the petitioner had her monthly [REDACTED] prescription filled at Publix, an out-of-network pharmacy. She paid out-of-pocket for the prescription, \$204.95. The petitioner filed a reimbursement request with Staywell. Staywell denied the petitioner's request for reimbursement because she used an out-of-network pharmacy. The petitioner requested reconsideration. Upon reconsideration, Staywell upheld the original denial decision. The petitioner requested a hearing to challenge the decision.

8. The petitioner explained that she has been filling her prescriptions at Publix for 19 years. The store is familiar with her circumstances and has always been able to fill her prescription orders the same day. [REDACTED] is a narcotic that many pharmacies stock in limited quantity. She contacted Staywell's participating

pharmacies; CVS, Winn Dixie, Walmart, and Target and was told that it would take 7 to 10 days, at a minimum, to fill her order.

9. The petitioner argued that Staywell should make an exception in her case because her pain is severe; the medication must stay in her system to be effective, she cannot go without her medication for a week to 10 days.

10. Staywell acknowledged that [REDACTED] is in high demand and some pharmacies have limited stock available. Staywell advised the petitioner to place her refill order in a timely manner as instructed by the participating pharmacy, 7 to 10 days in advance of exhausting her current prescription. Staywell asserted that the petitioner was fully aware of its rules regarding non-reimbursement for out-of-network services when she paid out-of-pocket for her prescription in May 2016. Staywell stands by its denial decision.

11. The petitioner switched from Staywell HMO to Molina HMO in June 2016. Molina includes Publix as a participating pharmacy. Publix fills her prescriptions the same day, accordingly the petitioner has no ongoing prescription refill issues. Her only remaining issue is reimbursement from Staywell for May 2016 out-of-pocket prescription costs.

### **CONCLUSIONS OF LAW**

12. 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 Section 120.80, Florida Statutes.

13. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.

14. This hearing was held as 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 was assigned to the petitioner.

16. 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, 7<sup>th</sup> Ed.).

17. The Florida Medicaid Program is authorized by Chapter 409 Florida Statutes and Fla. Admin. Code Chapter 59G.

18. Fla. Admin Code R 59G-5110, “Claim Payments” provides information regarding the conditions under which direct payments can be made and read, at the time of the action under appeal, as follows:

(1)(a) The agency provides eligible individuals with access to Medicaid services and goods by direct payment to the Medicaid provider upon submission of a payable claim to the fiscal agent contractor. Except as provided for by law or federal regulation, payments for services rendered or goods supplied shall be made by direct payment to the provider except that payments may be made in the name of the provider to the provider’s billing agent if designated in writing by the provider. **Direct payment may be made to a recipient who paid for medically necessary, Medicaid-covered services received from the beginning date of eligibility (including the three-month retroactive period) and paid for during the period of time between an erroneous denial or termination of Medicaid eligibility and a successful appeal or an agency determination in the recipient’s favor.** The services must have been covered by Medicaid at the time they were provided. Medicaid will send

payment directly to the recipient upon submission of valid receipts to the Agency for Health Care Administration. All payments shall be made at the Medicaid established payment rate in effect at the time the services were rendered. Any services or goods the recipient paid before receiving an erroneous determination or services for which reimbursement from a third party is available are not eligible for reimbursement to the recipient. [Emphasis Added]

19. Effective June 2, 2016, Fla. Admin. Code R. 59G-5110 was modified and now reads:

(1) Purpose. This rule describes the circumstances when the Agency for Health Care Administration (AHCA) may directly reimburse eligible Florida Medicaid recipients; how AHCA reimburses recipients; and documentation requirements for direct reimbursement.

(2) Determination Criteria. Florida Medicaid recipients may be eligible for direct reimbursement if:

(a) Medical goods and services were paid for by the recipient or a person legally responsible for their bills from the date of an erroneous denial or termination of Florida Medicaid eligibility to the date of a reversal of the unfavorable eligibility determination.

20. Both the older and current versions of the cited rule state that direct payment can be made to a Medicaid recipient who paid for medically necessary and covered services during a period of an erroneous denial of Medicaid eligibility coupled with a successful appeal or agency determination in the recipients favor.

21. There is no evidence that the petitioner experienced an erroneous denial of Medicaid eligibility. The Findings of Fact establish that the petitioner was Medicaid eligible at all times relevant to this proceeding. The petitioner paid a non-network provider out-of-pocket for prescription services because the provider could accommodate same day refills. Participating providers required week to 10 days

advanced notice to order the petitioner's prescription. The rules do not include a reimbursement provision for reasons of expediency or immediate availability.

22. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the petitioner did not prove by a preponderance of the evidence that she is eligible for reimbursement of out-of-pocket prescription expenses incurred in May 2016.

### **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 18 day of August, 2016,

in Tallahassee, Florida.



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Leslie Green  
Hearing Officer  
Building 5, Room 255  
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Tallahassee, FL 32399-0700  
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Copies Furnished To: [REDACTED], Petitioner  
AHCA, Medicaid Fair Hearings Unit  
Ray Walker

Jul 22, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 16F-04046

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION  
CIRCUIT: 15 PALM BEACH  
UNIT: AHCA

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, a telephonic administrative hearing was convened on June 29, 2016 at 8:49 a.m.

**APPEARANCES**

For the Petitioner:

[REDACTED]

For the Respondent:

Dianne Soderlind  
Registered Nurse Specialist

**ISSUE**

Whether the denial of petitioner's request for an additional two hours per day; seven days a week of personal care services was proper. The burden of proof was assigned to the petitioner. The standard of proof in an administrative hearing is by a preponderance of the evidence.

**PRELIMINARY STATEMENT**

Present for the petitioner was her pediatrician, [REDACTED], Also present were [REDACTED], Behavior Assistant and [REDACTED], Nursing Case Manager - [REDACTED]. Petitioner's exhibit "1" was accepted into evidence.

Present for the respondent from eQHealth Solutions (eQHealth) was Dr. Rakesh Mittal, Physician Consultant. Respondent's exhibit "1" was accepted into evidence.

At the onset of this proceeding, Dr. Mittal requested a private conference with petitioner's parents. The conference was neither recorded nor observed by the undersigned.

**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 has not transitioned to the Statewide Managed Care Program. Her services are provided through the Medicaid State Plan.
3. Petitioner resides with her parents; a twin brother; and a sister. Both the petitioner and twin brother are disabled. No other household member has a documented disability.
4. The certification period at issue is May 14, 2016 through November 09, 2016. Immediately prior to this certification period, petitioner was approved to receive four hours per day; seven days a week of personal care services.
5. The four hours were shared with her twin brother.

6. When hours are shared, the provider bills the entire unit rate for one individual and 50% of the hourly unit rate for the second individual.
7. Regarding the certification period at issue, the personal care hours approved for the twin brother were increased from four per day to six hours per day; seven days a week.
8. Petitioner is diagnosed with [REDACTED]. She experiences behavioral problems and has both speech and language delay. Petitioner experiences [REDACTED]. She is ambulatory but requires assistance with all activities of daily living. Due to elopement activity, petitioner requires supervision.
9. During the academic year, petitioner attends school Monday through Friday until 2:00 p.m.
10. Petitioner's mother is a flight attendant. Although residing in Palm Beach County, she is based in New York City. Her preferred flight assignment is JFK Airport in New York City to Tokyo. She flies from Palm Beach County to New York City the day prior to the international flight. She flies to Tokyo the second day. The third day is a rest day. The fourth day she returns to JFK. The fifth day she returns to Palm Beach County. Her normal schedule is four round trips between New York City and Tokyo per month. The schedule, however, can change monthly.
11. Petitioner's father is self-employed. He works between 40-60 hours per week.
12. On petitioner's behalf, [REDACTED] submitted a request for an additional two hours per day; seven days a week of personal care services. The hours would be 2:30 p.m. to 8:30 p.m. each weekday and 9:00 a.m. to 3:00 p.m. on weekends.

13. eQHealth is the Peer Review Organization contracted by the respondent to perform prior authorization reviews for home health services. Personal care is a home health service.

14. █████ submitted the request for two additional hours per day through an internet based system. The submission included, in part, information about the petitioner's medical conditions; her functional limitations; and other pertinent information related to the household.

15. Part of Trinity's submission included a Plan of Care (POC). The document addresses petitioner's medical conditions and type of assistance required. The POC was signed by petitioner's physician.

16. Functional limitations noted on the POC were endurance and speech. Regarding the petitioner, the POC identified:

- A behavioral disorder
- Is non-verbal/vocal
- Uses gestures; finger pointing; and shaking of head to make needs known
- Self-abusive behaviors when upset
- Attempts to leave the house when unsupervised

17. The POC also identified the personal care provider would assist with dressing; grooming; bathing; preparing a "prescribed diet"; and maintaining safety precautions.

18. The POC also stated: "Parents requesting increase in hours due to work schedules ..."

19. The physician ordered personal care six hours per day; seven days a week.

20. A physician reviewer at eQHealth thereafter reviewed all information submitted by Trinity. The reviewer is board certified in pediatrics.

21. On May 13, 2016 notices were issued by eQ to the petitioner; her physician; and [REDACTED]. In the notice to the physician and [REDACTED], the physician reviewer wrote, in part: "4 hours of shared personal care services each day is adequate to assist with activities of daily living. The request for any additional personal care services is excessive. Caregivers are expected to provide care to the fullest extent possible. Constant supervision and monitoring are not covered benefits."

22. The above notice stated should the parent, provider, or physician disagree with the decision, reconsideration could be requested within five business days. Additional information could be provided with the request.

23. Reconsideration was timely requested.

24. With reconsideration Trinity provided a statement stating, in part:

- The additional two hours are not for supervision
- Petitioner requires partial to total assist for all personal care
- Petitioner's twin was reviewed by a different eQHealth physician and was approved for two additional hours per day
- Petitioner has more behavioral issues than her twin brother

25. A second physician reviewer thereafter reviewed all submitted information. On May 23, 2016 a notice was issued upholding the original denial of six hours per day; seven days a week of personal care. Petitioner remained authorized to receive four hours per day; seven days a week of the service.

26. On May 26, 2016 petitioner request for a Fair Hearing was timely received by the Office of Appeal Hearings.

**CONCLUSIONS OF LAW**

27. By agreement between AHCA and the Department of Children and Families, jurisdiction has been conveyed to the Office of Appeal Hearings to conduct this hearing pursuant to § 120.80, Fla. Stat.
28. This is a final order pursuant to § 120.569 and § 120.57, Fla. Stat.
29. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.
30. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7<sup>th</sup> Ed.).
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...

(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. ...

(c) The agency may not pay for home health services unless the services are medically necessary ...

32. 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.

33. 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 ...

34. 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].

35. The October 2014 Florida Medicaid Home Health Services Coverage and Limitations Handbook (Handbook) has been promulgated into rule by Fla. Admin. Code R. 59G-4.130(2). The Handbook describes services covered under the Florida Medicaid Home Health Services Program. Personal care is an included service for individuals under the age of 21.

36. The Findings of Fact establish petitioner is under 21 years of age.

37. The issue before the undersigned, therefore, focuses upon the amount of personal care which is medically necessary.

38. Page 1-2 of the Handbook states "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 recipient to accomplish tasks that they would normally be able to do for themselves if they did not have a medical condition or disability."

39. Page 1-2 also provides the types of ADLs for which a personal care provider can assist:

- Eating (oral feedings and fluid intake);
- Bathing;

- Dressing;
- Toileting;
- Transferring; and
- 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).

40. Page 2-12 of the Handbook also addresses excluded services which are not reimbursed by Medicaid. This list includes, in part:

- Respite care
- Baby-sitting
- Day care or after school care
- Escort services
- Companion sitting or leisure activities

41. The Handbook, on page 1-3, provides the following definition of babysitting: “The act of providing custodial care, daycare, afterschool care, supervision, or similar childcare unrelated to the services that are documented to be medically necessary for the recipient”.

42. The undersigned acknowledges the petitioner is a young woman and the generic term “babysitting” might, at first glance, seem inappropriate. From the perspective of home health services, however, the definition also includes afterschool care and supervision.

43. The Findings of Fact establish petitioner attends school until 2:00 p.m. each weekday. The request for the additional six hours is to commence at 2:30 p.m. each school day.

44. It is not clear why some personal care hours are not allocated for weekday mornings, specifically before school.

45. Appendix L of the Handbook discusses “Review Criteria for Personal Care Services” and sets forth each of the allowable personal care tasks and general time allowance for each task. The time estimates for bathing; dressing; eating; and toileting are collectively within the currently approved four hour per day timeframe.
46. The undersigned concludes the requested personal care hours are for both personal care and supervision purposes.
47. Supervision can be provided by any responsible adult.
48. In regard to parental responsibility, the undersigned takes note of page 2-25 of the Handbook:

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.

49. The above paragraph establishes the Home Health Services Program is designed to supplement care provided by parents.
50. Page 2-2 of the Handbook states: “Home health services are not considered emergency services.” This is interpreted to mean the role of personal care is to provide a specific block of services related to ADLs and does not include supervision should an emergency arise.
51. Page 2-26 of the Handbook states, in part: “If a recipient requires additional hours due to unforeseen circumstances or change in medical or social circumstances, the home health service providers should submit a modification request to the PRO for

the additional hours needed.” Should a change occur in the household dynamics which require additional personal care, such can be addressed through the modification process.

52. It is noted that the petitioner’s physician ordered a service frequency greater than approved by eQHealth. Fla. Admin. Code. R. 59G-1.010(166) (c), however, states a prescription does not automatically mean the requirements of medical necessity have been satisfied. The physicians from eQHealth not only considered the various conditions of medical necessity but also considered all applicable rules and regulations, including those found in respondent’s Handbook.

53. It is understood petitioner’s twin brother with whom she shares personal care was approved for an additional two hours per day; seven days a week. That matter, however, is not before the undersigned. Only evidence and testimony pertinent to the petitioner was considered.

54. EPSDT and medical necessity requirements have been reviewed and applied to the totality of the evidence. In doing such, petitioner has not established, by the greater weight of the evidence, that an additional two hours per day of personal care; seven days a week is medically necessary.

55. Petitioner’s request is in conflict with 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;
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 Conclusions of Law, the 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 indigence 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 22 day of July, 2016,

in Tallahassee, Florida.

*Frank Houston*

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Frank Houston  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
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Copies Furnished To:

██████████ PETITIONER  
AHCA, MEDICAID FAIR HEARINGS UNIT

Aug 16, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-04073

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 June 28, 2016 at 10:00 a.m.

**APPEARANCES**

For the 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 (partial dentures) was correct. The petitioner has the burden of proving his case by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

The Petitioner did not submit any documents as evidence for the hearing.

Appearing as witnesses for the respondent were Dr. Ronald Ruth, Dental Director, and Maryanna Acevedo, Grievance and Appeals Manager, from MCNA Dental, which is the petitioner's dental services review organization. Also present as witnesses for the respondent were Dr. Jorge Cabrera, Medical Director, Maureen McNamara, Grievances Manager, Summer Brooks, Contract Manager, and Denise Kissane, Clinical Services Director, from Coventry Healthcare, which is the petitioner's managed health care plan.

Respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Composite Exhibit 1: Statement of Matters, Notice of Action, and dental x-ray.

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

### **FINDINGS OF FACT**

1. The Petitioner is a fifty-eight (58) 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 Coventry, which utilizes MCNA Dental for review and approval of dental services.

2. On or about May 17, 2016, the petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from Coventry and/or MCNA Dental for upper partial dentures. Coventry denied this request on May 18, 2016.

3. Coventry's denial notice to the petitioner advised him of the following reason for the denial of his request for the dentures:

The dental service that your or your dentist asked for are not approved because you have already used the benefits for these services. The Florida Medicaid Dental Services Coverage and Limitations Handbook states that you are allowed this benefit once per lifetime.

4. The petitioner stated that he needs the partial dentures because he is missing five teeth and has difficulty eating and talking. He is also depressed about his appearance. He also stated he received dentures for other teeth about two years ago.

5. Ms. Acevedo from MCNA Dental stated that the petitioner received partial upper and lower dentures two years ago. She also said a new partial denture may be appropriate if medically necessary, but new x-rays would need to be submitted to show the current condition of the teeth.

6. Dr. Ruth from MCNA Dental stated that the provider took x-rays of the petitioner in 2016 but did not submit that x-ray with the request for dentures. Instead, the 2014 x-rays were submitted with the request.

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.

**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, 7<sup>th</sup> 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 the 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. Page 2-32 of the Dental Handbook contains a limitation on this service, as follows:

Full and removable partial dentures may be reimbursed once for an upper, a lower or a complete set per the lifetime of the recipient.

17. The Dental Handbook also contains an exception to this limitation, as follows:

Exceptions to the limitation of one set of dentures per lifetime of the recipient, may be considered for dentures if the dental provider determines the:

- Full or partial dentures are no longer functional, because of the physical condition of the recipient; or
- Full or partial dentures are no longer functional, because of the condition of the denture

18. The petitioner stated he needs new dentures because of his missing teeth and difficulty with eating and talking.

19. The respondent's witnesses stated the petitioner may be able to obtain new partial dentures even though he received dentures two years ago, but new x-rays would need to be submitted to support the request.

20. After considering the evidence and testimony presented, the undersigned concludes the respondent correctly denied the petitioner's request for the upper partial dentures based on the information submitted with the request. The petitioner should work with his provider to submit a new x-ray showing the current condition of his teeth, so that his request for the dentures can be re-reviewed based on current information.

### **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

FINAL ORDER (Cont.)

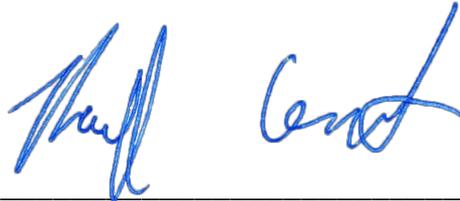
16F-04073

PAGE - 7

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 indigence 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 16 day of August, 2016,

in Tallahassee, Florida.



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Rafael Centurion  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
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Copies Furnished To: [REDACTED], PETITIONER  
AHCA, MEDICAID FAIR HEARINGS UNIT

Aug 16, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-04110

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 June 28, 2016 at 11:30 a.m.

**APPEARANCES**

For the 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 partial denial of the petitioner's request for wisdom teeth extractions was correct. The petitioner has the burden of proving his case by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

The petitioner did not submit any documents as evidence for the hearing.

Appearing as witnesses for the respondent were Dr. Frank Mantega, Dental Consultant, and Jackeline Salcedo, Complaint and 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 the petitioner's managed health care plan.

Respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Exhibits: Exhibit 1 – Case Summary and Member Eligibility Information; Exhibit 2 – Claim Form; Exhibit 3 – X-ray Exhibit 4 – Authorization Determination; Exhibit 5 – Notice of Action; and Exhibit 6 – Dental Criteria.

### **FINDINGS OF FACT**

1. The petitioner is an eighteen (18) 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 April 28, 2016, the petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from DentaQuest to perform extractions of four wisdom teeth (Teeth 1, 16, 17, and 32). DentaQuest partially denied this request on May 2, 2016 – approving two extractions and denying two extractions.

3. The denial notice stated the two extractions were denied as not being medically necessary. This denial notice also stated the following regarding the reason for the denial:

We cannot approve this request to remove your tooth because the information that your dentist sent shows that your teeth are not bad enough to be removed and show no sign of infection or pain. We have told your dentist this also. Please talk to your dentist about your choices to treat your teeth.

4. The petitioner's mother testified her son was in pain and it was uncertain which wisdom teeth were causing the pain. He had all four wisdom teeth extracted by his dentist, and his mother paid out-of-pocket for the two extractions which had been denied.

5. The respondent's expert witness, Dr. Mantega, stated that the extraction of tooth 1 and tooth 16 were denied because the teeth did not show any sign of infection and they were not impacted teeth. The other two teeth, numbers 17 and 32, were approved for extraction because they were in an aberrant position.

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, 7<sup>th</sup> 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 service at issue, tooth extraction, is a covered service for individuals under age twenty-one (21) in the Florida Medicaid Program. DentaQuest approved extractions of two teeth (17 and 32) but denied the extraction of tooth 1 and tooth 16 due to medical necessity considerations.

14. The petitioner's mother believes the extractions should have been approved because her son was in pain and it was unclear which wisdom teeth were causing the pain.

15. The respondent's witness stated that the denial of the two extractions was appropriate because those teeth did not show any signs of infection or other reason to justify extraction.

16. After considering the evidence presented and relevant authorities set forth above, the undersigned concludes the petitioner has not demonstrated that the denial of the request for extraction of tooth 1 and tooth 16 was incorrect. The petitioner has not established that the request for this service is medically necessary as defined by Fla. Admin. Code R. 59G-1.010(166). Although the petitioner's dentist requested the extractions, this does not establish it is medically necessary. The respondent's witness testimony supports the denial of the requested service.

### **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 16 day of August, 2016,

in Tallahassee, Florida.



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Rafael Centurion  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
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Copies Furnished To: [REDACTED]  
AHCA, MEDICAID FAIR HEARINGS UNIT

Aug 26, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-04161

PETITIONER,

Vs.

CASE NO.

MANAGED CARE ORGANIZATION, AND  
AGENCY FOR HEALTH CARE ADMINISTRATION  
CIRCUIT: 13 Hillsborough  
UNIT: AHCA

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on July 26, 2016, at 4:20 p.m.

**APPEARANCES**

For the Petitioner:



For the Respondent:

Robert Walker  
Regulatory Research Coordinator  
Staywell

**STATEMENT OF ISSUE**

Did the petitioner prove by a preponderance of the evidence that the respondent incorrectly denied his request for two crowns?

**PRELIMINARY STATEMENT**

██████████, the petitioner's grandmother, appeared on behalf of the petitioner, ██████████ ("petitioner"). ██████████ may sometimes hereinafter be referred to as the petitioner's "representative".

Robert Walker, Regulatory Research Coordinator for Staywell ("respondent"), appeared on behalf of Staywell. The following individuals appeared as witnesses on behalf of the respondent: Alexandria Hicks, Regulatory Research Coordinator with Staywell; Jamira Dixon, National Ancillary Coordinator at Staywell; and Richard Hague, D.M.D., Dental Director for Liberty Dental Plan. Stephanie Lang, R.N., Registered Nurse Specialist and Fair Hearing Coordinator with the Agency for Health Care Administration ("AHCA" or "Agency"), appeared solely for the purpose of observation.

The respondent introduced Exhibits "1" through "11", inclusive, at the hearing. All of the exhibits were accepted into evidence and marked accordingly.

**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 14-year-old male.
2. The petitioner was eligible to receive Medicaid at all times relevant to this proceeding.
3. The petitioner is an enrolled member of Staywell. Staywell is a health maintenance organization 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. These benefits are set forth in the Covered Services section of the Staywell Member Handbook.

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 May 23, 2016, Liberty Dental received a pre-treatment authorization request from the petitioner's dental provider for the following services:

1. Crown, porcelain fused to predominantly base metal, #8;
2. Crown, porcelain fused to predominantly base metal, #9.

8. On May 24, 2016, Liberty Dental denied the pre-treatment authorization request due to not receiving a detailed narrative from the petitioner's dental provider regarding the reason for the service.

9. Staywell mailed a Notice of Action dated May 24, 2016 to the petitioner informing him of the denial and explaining additional information was requested from his dentist.

10. On June 23, 2016, Liberty Dental completed an internal reconsideration of its decision to deny the petitioner's services. Liberty Dental set forth its findings from this review in a letter to Staywell dated June 23, 2016. The letter states as follows:

On June 23, 2016, LIBERTY's Dental Director, Dr. Richard Hague, a licensed dentist who did not participate in the initial decision, reviewed pre-treatment authorization [REDACTED] and all of the available documentation. LIBERTY determined that the initial denial of the aforementioned services on pre-treatment authorization [REDACTED] appears to be appropriate because according to [Petitioner]'s Staywell FL Child Medicaid Plan, crown (D2751) is listed as a benefitted procedure of this plan with an applicable limitation of "*Crowns are covered only if the tooth is endodontically treated, and cannot be restored with an amalgam or resin restoration*", and based on LIBERTY's records, teeth #s 8 and 9

have not been endodontically treated. Therefore, LIBERTY recommends that the denial of the aforementioned services of pre-treatment authorization [REDACTED], remain upheld.

11. The petitioner's representative requested a fair hearing in a timely manner and this proceeding ensued.

12. The petitioner has multiple medical and other conditions that affect his eyesight and coordination.

13. The petitioner fell and hit his mouth on the ground breaking his two front teeth towards the top when he was in fifth grade.

14. The petitioner's dentist repaired the two front teeth and referred him to an orthodontist because his teeth were protruding from his mouth.

15. The petitioner received braces after they were approved by Medicaid.

16. After the petitioner's braces were inserted, his front tooth cracked again. As a result, the petitioner's orthodontist removed the bracket, repaired the tooth, and re-inserted the bracket in a higher position.

17. The petitioner's braces were removed on or about May 18, 2016.

18. After the petitioner's braces were removed, the petitioner fell out of his chair at school and his tooth came out again.

19. The petitioner's grandmother paid to have the tooth repaired as Medicaid would not cover the cost because it had paid to have the tooth repaired previously. However, a crown is still necessary to reinforce the tooth and minimize the risk of it breaking again.

20. The petitioner's grandmother has paid for a special retainer that will place less pressure on the petitioner's front teeth and is less likely to break the teeth.

21. The Staywell Member Handbook states that crowns are a covered service for children under the age of 21 (*Resp. Exhibit 8*).

22. The schedule of benefits set forth in the Staywell FL Child Medicaid Plan Benefits (*Resp. Exhibit 5*) identifies procedure code D2721, crown with predominantly based metal, as a covered service for children under the age of 21 but contains a limitation that the tooth must have been endodontically treated and cannot be restored with an amalgam or resin restoration.

### **CONCLUSIONS OF LAW**

23. 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.

24. This is a final order pursuant to § 120.569 and § 120.57, Florida Statutes.

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

26. 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.

27. 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, 7<sup>th</sup> Ed.).

28. The Florida Medicaid program is authorized by Chapter 409, Fla. Stat. and Chapter 59G, Fla. Admin. Code. The Medicaid program is administered by respondent.

29. 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...

30. 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.

31. 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.

32. 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 may present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)) (emphasis added).

33. 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.

34. 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.

35. 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.

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-5.020. 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.

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...”

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. The Dental Services Coverage Policy – May 2016 is incorporated by reference in the Medicaid Service Rules by Fla. Admin. Code Rule 59G-4.060.

40. The Dental Services Coverage Policy – May 2016, on Page 4 at 4.2.8, explains Florida Medicaid reimburses for all-inclusive restorative services for recipients under the age of 21 including crowns.

41. The Florida Medicaid Dental Services Coverage Policy does not limit the approval of crowns for recipients under 21 years of age to only teeth that have been endodontically treated.

42. Contrary to the provision contained on Page 1-30 of the Florida Medicaid Provider General Handbook, Staywell dental policy is more restrictive than that set forth in the Florida Medicaid Dental Services Coverage Policy. Therefore, this appeal will be evaluated in accordance with the Florida Medicaid Dental Services Coverage Policy.

43. The Medicaid MMA Contract, the contract between the Agency for Health Care Administration and Staywell, at Section V.A.I.a.(8).a.b., states as follows:

The Managed Care Plan shall provide Dental Services to enrollees under the age of 21 years, emergency dental services to enrollees age 21 and older, and denture and denture-related services and oral and maxillofacial surgery services to all enrollees. The Managed Care Plan shall provide medically necessary, emergency dental procedures to alleviate pain or infection to enrollees age 21 and older. Emergency dental care for enrollees 21 years of age and older is limited to a problem focused oral evaluation, necessary radiographs in order to make a diagnosis, extractions, and incision and drainage of an abscess. Full and removable partial dentures and denture-related services are also covered services for enrollees 21 years of age and older. The Managed Care Plan shall provide full dental services for all enrollees age 20 and below. The Managed Care Plan shall provide medically necessary oral and maxillofacial surgery for all eligible Medicaid recipients regardless of age.

44. After careful review of the testimony and evidence presented in this case, along with the relevant laws set forth above, the undersigned concludes the petitioner has demonstrated by a preponderance of the evidence that the respondent incorrectly denied his request for crowns on his front two teeth. The petitioner's representative provided credible testimony that the crowns are medically necessary and Medicaid

policy provides for all-inclusive restorative treatment for recipients under the age of 21, including crowns.

**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 26 day of August, 2016,

in Tallahassee, Florida.

*Peter J. Tsamis*

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Peter J. Tsamis  
Hearing Officer  
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Copies Furnished To: [REDACTED] Petitioner  
AHCA, Medicaid Fair Hearings Unit  
Stephanie Shupe

Aug 15, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

APPEAL NO. 16F-04178

PETITIONER,

Vs.

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

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER OF DISMISSAL**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on July 7, 2016 at 10:00 a.m.

**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 denial of the petitioner's request for two wisdom teeth extractions was correct. The petitioner has the burden of proving his case by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

The petitioner submitted photographs and x-rays as evidence for the hearing, which were marked as Petitioner Exhibit 1

Appearing as a witness for the respondent was Jackeline Salcedo, Complaint and Grievance Specialist, from DentaQuest, which is the petitioner's dental services organization. Also present as a witness for the respondent was Stacey Larsen, Clinical Analyst from Humana, which is the petitioner's managed health care plan.

Respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Exhibits: Exhibit 1 – Case Summary and Member Eligibility Information; Exhibit 2 – Claim Form; Exhibit 3 – X-ray; Exhibit 4 – Authorization Determination; Exhibit 5 – Notice of Action; Exhibit 6 – Criteria; and Exhibit 7 – Dental Director Review Form.

### **FINDINGS OF FACT**

1. The Petitioner is a fifteen (15) 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 April 5, 2016, the Petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from DentaQuest to perform extractions of wisdom teeth. DentaQuest denied the request for extraction of two of the wisdom teeth

(Tooth 1 and Tooth 16) on April 7, 2016. DentaQuest approved the request for extraction of the other two wisdom teeth.

3. The denial notice stated the two extractions were denied as not being medically necessary. This denial notice also stated the following regarding the reason for the denial:

To approve this service you must have severe pain in your tooth, the tooth must be in a position that will not let it break through the gum by itself, and your gums or bone around the tooth are diseased. The root of your tooth must also be completely formed. Our dentist looked at the x-ray and the information from your dentist. It does not appear that this tooth needs to be removed.

4. On or about June 14, 2016, DentaQuest performed a re-review of the requested services and approved the extraction of Tooth 1 and Tooth 16, which had been initially denied.

5. However, in the interim period between the initial denial and the subsequent approval, the petitioner had all four of his wisdom teeth removed by his dentist. The petitioner's mother is now seeking reimbursement for her out-of-pocket payment for the extractions that were initially denied.

6. The DentaQuest representative stated the petitioner should make a request for reimbursement to the provider, since DentaQuest has now approved and paid the provider for those services.

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.

**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), Fla. Admin. Code. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7<sup>th</sup> 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 Dental Handbook are incorporated by reference in Chapter 59G-4, Florida Administrative Code.

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. The service at issue, tooth extraction, is a covered service for individuals under age twenty-one (21) in the Florida Medicaid Program. DentaQuest initially denied the extraction of two of the wisdom teeth due to medical necessity considerations.

However, those extractions were subsequently approved by DentaQuest; therefore, medical necessity is no longer an issue.

15. The petitioner's mother is seeking reimbursement for her out-of-pocket payment for two of the extractions which were performed and paid for after the initial denial but before the subsequent approval by DentaQuest.

16. After considering the evidence presented, the undersigned concludes there is no further relief which can be afforded to the petitioner through the Medicaid fair hearing process since the requested services were ultimately approved by DentaQuest. The petitioner can seek reimbursement from the provider for her payment since DentaQuest subsequently approved and paid the claim. However, the hearing officer does not have any jurisdiction over the provider and cannot order any reimbursement.

**DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is  
DISMISSED.

**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 15 day of August, 2016,

in Tallahassee, Florida.



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Rafael Centurion  
Hearing Officer  
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Copies Furnished To: [REDACTED] PETITIONER  
AHCA, MEDICAID FAIR HEARINGS UNIT  
MINDY AIKMAN, HUMANA

Aug 30, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 16F-04189

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 11 Dade  
UNIT: 88651

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on July 11, 2016 at 3:15 p.m.

**APPEARANCES**

For the petitioner: [REDACTED]

For the respondent: Kenesha Hanley, ACCESS Operations and Management Consultant

**STATEMENT OF ISSUE**

Petitioner is appealing the respondent's action to terminate full Medicaid benefits for her son and instead enroll him in the Medically Needy (MN) Program with a share of cost (SOC). Petitioner is seeking full Medicaid for her son. The respondent carries the burden of proof by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

By notice dated June 1, 2016, the respondent notified the petitioner that her son's full Medicaid would end on June 30, 2016 and that he would be enrolled in the MN Program with a SOC of \$2,825.00 beginning July 2016. The petitioner timely requested this administrative hearing to challenge the respondent's action.

Petitioner submitted one exhibit, entered as Petitioner's Exhibit "1". Respondent submitted five exhibits, entered as Respondent's Exhibits "1" through "5". The record was held open until close of business on July 19, 2016 for submission of additional evidence from the respondent. No additional evidence was received from the respondent by the due date; therefore, the record closed on July 19, 2016. On August 23, 2016, the undersigned received an email from the respondent. The email included a Notice of Case Action (NOCA) issued to the petitioner on July 18, 2016. The undersigned reopened the record and entered this additional evidence as Respondent's Exhibit "6".

### **FINDINGS OF FACT**

1. Prior to the action under appeal, the petitioner was receiving full Medicaid benefits for her son, age 1, and SOC for herself. The petitioner's son's Medicaid benefits were certified from July 2015 through June 30, 2016. Medicaid benefits for the petitioner's son is the only issue.
2. On May 16, 2016, the petitioner submitted an application to apply for Food Assistance Program (FAP) and to recertify for Medicaid benefits. Petitioner reported her only source of income was her employment with Bounds Law Office; she is paid twice a month.

3. On May 19, 2016, the petitioner submitted the following two paychecks to verify her income: April 29, 2016 - \$1,712.50 gross pay and May 13, 2016 - \$1,500.00 gross pay. Petitioner completed a phone interview on May 26, 2016. The respondent calculated the petitioner's monthly gross income as \$3,212.50 by adding the gross earnings from the two paychecks she provided (\$1,712.50+\$1,500.00).
4. The respondent determined Medicaid benefits for the petitioner's son. The household income of \$3,212.50 was compared to the Medicaid income limit for a child between the ages of 1 through 5 in a household size of two (\$1,776.00), the respondent determined the petitioner's son was not eligible for full Medicaid benefits.
5. The respondent explained that the petitioner's son was not eligible for full Medicaid benefits because the household income exceeded the Family-Related Medicaid income limit for his age group.
6. The respondent enrolled the petitioner's son in the MN Program. 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 household income of \$3212.50, resulting in a SOC amount of \$2,825.00. The respondent calculated the petitioner's son's SOC amount as follows:

EARNED INCOME:+	3212.50	SFU SIZE:	2
UNEARNED INCOME:+	.00	INCOME STANDARD:	.00
TOTAL REPORTED INCOME:=	3212.50	MNIL:-	387.00
ALLOWABLE TAX DEDUCTIONS:-	.00	SHARE OF COST:=	2825.00
MODIFIED ADJUSTED GROSS INC:=	3212.50	MED INSURANCE PREMIUM:-	.00
STANDARD DISREGARD:-	.00	RECURRING MED EXPENSE:-	.00
MAGI DISREGARD (5% OF FPL) :-	.00	REMAINING SOC:=	2825.00
COUNTABLE NET INCOME:=	3212.50	COUNT OF OOTHS:	0

7. Petitioner disputed the income utilized by the respondent in the Medicaid budget.

Petitioner asserted she reported, during her interview, that her hours and income were decreasing beginning on June 2016.

8. At the hearing, the petitioner presented the following two paychecks to verify her income had decreased: June 15, 2016 - \$875.00 gross pay and June 30, 2016 - \$868.75 gross pay. Based on these most recent paychecks, the household's income would be \$ 1,743.75 (\$875.00 + \$868.75); this amount is less than the Medicaid income limit for a child between the ages of 1 through 5 in a household size of two household size of two (\$1,776.00).

9. The respondent explained it would review the information and update the petitioner's case accordingly after the hearing. Respondent agreed to review the petitioner's son's Medicaid eligibility for July 2016 and ongoing.

10. The respondent also agreed to send the petitioner a NOCA with appeal rights, with the results of its review, and a copy to the undersigned. The record was held open to

allow the respondent to complete this review. On July 18, 2016, the respondent mailed a NOCA to the petitioner notifying her that her son was approved for full Medicaid beginning July 2016.

### **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 Section 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

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

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. Federal Regulations at 42 C.F.R. § 435.603 “Application of modified adjusted gross income (MAGI)” states in 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...

(3)(b) Family size means the number of persons counted as members of an individual's household...

(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.

(f) Household...

(2) Basic rule for individuals claimed as a tax dependent. In the case of an individual who expects to be claimed as a tax dependent by another taxpayer for the taxable year in which an initial determination or renewal of eligibility is being made, the household is the household of the taxpayer claiming such individual as a tax dependent...

15. 42 C.F.R. §435.118 addresses income standards for children under age 19.

(b) Scope. The agency must provide Medicaid to children under age 19 whose household income is at or below the income standard established by the agency in its State plan, in accordance with paragraph (c) of this section.

(c) Income standard. (1) The minimum income standard is the higher of—

**(i) 133 percent FPL for the applicable family size; or...**

**(2) The maximum income standard for each of the age groups of infants under age 1, children age 1 through age 5, and children age 6 through age 18 is the higher of—(emphasis added)**

(i) 133 percent FPL;

16. According to the above-cited rules, the assistance group’s income must not exceed 133% of the Federal Poverty Level (FPL) to be eligible for full Medicaid. The

Department's Policy Manual, Appendix A-7, Family-Related Medicaid Income Limits, sets the income limit for a child 1 through 5 in a household size of two as \$1,776.00:

Family-Related Medicaid Income Limits									
Family Size	100% FPL	Adults		Pregnant Women		Infants		Children	
		Parents, Caretakers, Children 19 & 20	Standard Disregard	Including PEPW		< 1		1 through 5	
				185% FPL	Standard Disregard	200% FPL	Standard Disregard	133% FPL	Standard Disregard
1	990	180	109	1,832	59	1,960	59	1,317	69
2	1,335	241	146	2,470	80	2,670	80	1,776	93

17. During the hearing, the petitioner submitted copies of the paychecks she received in June 2016. The petitioner's gross income of \$1,743.75 (\$875.00 + \$868.75) is less than 133% of the FPL for a household size of two (\$1,776.00). The respondent agreed to review the documentation submitted by the petitioner and determine if this changed the petitioner's son's Medicaid eligibility beginning July 2016. On July 18, 2016, the respondent approved full Medicaid for the petitioner's son beginning July 2016.

18. Based on the respondent's action to approve full Medicaid for the petitioner's son beginning July 2016, which is the remedy the petitioner was seeking, the undersigned does not have an action to review.

**DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is dismissed as MOOT.

**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 August, 2016,

in Tallahassee, Florida.



Cassandra Perez  
Hearing Officer  
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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished [REDACTED] Petitioner  
Office of Economic Self Sufficiency

Aug 18, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-04191

PETITIONER,

Vs.

CASE NO.

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 01 Santa Rosa  
UNIT: 88630

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on July 21, 2106 at 1:11 p.m.

**APPEARANCES**

For the Petitioner:

For the Respondent: Anne Marie Sport, ACCESS Supervisor

**STATEMENT OF ISSUE**

Petitioner is appealing the Department's action of March 21, 2016 approving her for Adult-Related Medically Needy. The petitioner wants to receive full Adult-Related Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

**PRELIMINARY STATEMENT**

The petitioner submitted evidence prior to hearing, which was entered as Petitioner's Exhibit 1. The Department submitted evidence prior to hearing, which was entered as Respondent's Exhibit 1.

The record closed on July 21, 2016.

**FINDINGS OF FACT**

1. The petitioner receives Social Security widow's benefits in the amount of \$1,012 per month.
2. The petitioner has not been established as disabled by either Social Security or the Division of Disability Determinations.
3. The petitioner's date of birth is [REDACTED]. She was age 60 at the time of her application filing in February 2016.
4. The Department issued a Notice of Case Action on March 21, 2016 enrolling the petitioner in Medically Needy with a share of cost of \$812.
5. The petitioner does not receive Medicare at this time.
6. The petitioner has household expenses such as car insurance and prescriptions that she believes should count in the determination of her eligibility for Medicaid. The petitioner explained she does not have money to pay doctors upfront and has health conditions that require medical attention.
7. The petitioner reported a rental obligation increase during the hearing.
8. The Department explained the only deductions that can count in determination of Adult-Related Medicaid is a \$20 unearned income disregard and other insurance premiums.
9. The Department further explained the only deductions allowed in Adult-Related Medically Needy are the \$20 unearned income disregard, the Medically Needy Income Level, and other insurance premiums.

10. The Department took action during the hearing to adjust the petitioner's Food Assistance benefits due to the increase in rental obligation reported.

**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 Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

13. Fla. Admin. Code R. 65A-1.710 "SSI-Related Medicaid Coverage Groups" states in relevant 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.

14. Fla. Admin. Code R. 65A-1.711 "SSI-Related Medicaid Non-Financial Eligibility Criteria" states in relevant part:

To qualify for Medicaid an individual must meet the general and categorical requirements in 42 C.F.R. Part 435, subparts E and F (2007) (incorporated by reference), with the exception that individuals who are neither aged nor disabled may qualify for breast and cervical cancer treatment, and the following program specific requirements as appropriate. Individuals who are in Florida temporarily may be considered residents of

the state on a case-by-case basis, if they indicate an intent to reside in Florida and can verify that they are residing in Florida.

(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 (2007) (incorporated by reference).

15. Federal Regulations at 20 C.F.R. § 416.1121 “Types of unearned income” states in relevant part: “(a) Annuities, pensions, and other periodic payments. This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veterans benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits.”

16. 20 C.F.R. § 416.1124 “Unearned income we do not count” states in relevant part:

(c) Other unearned income we do not count. We do not count as unearned income—

...

(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.

17. The Department’s Program Policy Manual, CFOP 165-22, Appendix A-9 effective July 1, 2015 lists the income limit for an individual to receive MEDS-AD is \$871.

18. The findings show the petitioner is presently 61 years old and has not been established as disabled. The findings also show the petitioner was enrolled in Medically Needy with a share of cost of \$812. The undersigned can find no more favorable outcome.

**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 18 day of August, 2016,

in Tallahassee, Florida.



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Melissa Roedel  
Hearing Officer  
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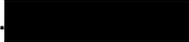
Aug 26, 2016

Office of Appeal Hearings  
Dept. of Children and FamiliesSTATE OF FLORIDA  
DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-04206

PETITIONER,

Vs.

CASE NO. FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 11 Dade  
UNIT: 88673RESPONDENT.  

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**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on July 13, 2016 at 1:54 p.m. and July 22, 2016 at 9:10 a.m. All parties appeared telephonically from different locations.

**APPEARANCES**For the Petitioner: 

For the Respondent: John Roche, Operations Management Consultant I

**STATEMENT OF ISSUE**

At issue is the respondent's action to increase the petitioner's Share of Cost (SOC) from \$157 to \$857 at recertification. The burden of proof was assigned to the petitioner by a preponderance of evidence.

### **PRELIMINARY STATEMENT**

A hearing was convened on July 13, 2016. Jose Suyama, Designated Reviewer with the Department of Children and Families, provided interpreter services. The petitioner did not object to the interpreter provided. The petitioner became disconnected during the hearing.

A second hearing was convened on July 22, 2016. Alvaro Pazas, Economic Self-Sufficiency Supervisor with the Department of Children and Families, provided interpreter services. The petitioner did not object to the interpreter provided.

The petitioner submitted no exhibits. The respondent submitted 33 pages of information which were marked and entered into evidence as Respondent's Composite Exhibit "1". The record was left open through July 25, 2016 for additional evidence including the actual paycheck stubs used to calculate the petitioner's SOC. The above mentioned information was submitted on July 22, 2016 and marked and entered into evidence as Respondent's Composite Exhibit "2". The record was closed on July 25, 2016.

### **FINDINGS OF FACT**

1. Prior to the issue under appeal, the petitioner was receiving Medically Needy (MN) Program benefits with a \$158 Share of Cost (SOC).
2. On April 15, 2016 the petitioner submitted an application for recertification of Food Assistance Program (FAP) benefits and Medicaid for the household.
3. The petitioner's household consists of the petitioner (RF), his wife (LF), and their mutual 13 year-old child. Both adults are filing taxes jointly.

4. LF works with [REDACTED] and is paid bi-weekly. RF does not work and was denied disability by the Social Security Administration.

5. The respondent determined the household's income using paystubs provided by the petitioner. The countable income is as follows:

<u>[REDACTED]</u>	<u>Date</u>	<u>Gross Amount</u>
	3/28/2016	\$488.25
	4/12/2016	\$855.00
		<u>\$1,343.25</u>

6. The income limit for Family-Related Medicaid for a household of three is \$303.

7. The petitioner's household income is over the income limit to be determined eligible for full Medicaid.

8. The Medically Needy Program is the Medicaid coverage for recipients that are over the income limit for full Medicaid.

9. The respondent determined the petitioner's SOC as follows:

\$1,343.25	earned countable income (rounded down)
<u>- 486.00</u>	<u>Medically Needy Income Limit (MNIL)</u>
\$ 857.00	SOC

10. On May 6, 2016 the respondent mailed the petitioner a Notice of Case Action (NOCA) notifying him he was enrolled in the Medically Needy Program with an increased SOC from \$158 to \$857.

11. The petitioner timely requested the hearing.

12. The petitioner asserts that he is sick and cannot cover his medical costs, including doctor's visits, with the increased SOC. He also states his wife does not normally earn the amount of money that was provided on the paystubs.

13. The respondent advised the petitioner to submit a change if the income in the household has changed and the SOC can be reevaluated.

### **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 Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

16. The Family-Related Medicaid income criteria is set forth in 42 C.F.R 435.603. It 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.

(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.

17. Federal regulation 42 C.F.R. § 435.603 Application of modified gross income

(MAGI) (f) defines a Household for Medicaid:

(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.

18. 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.

19. In accordance with the above controlling authorities and policy, the Medicaid household group is the petitioner, his wife, and their minor child. The respondent determined the petitioner's eligibility with a household size of three. The undersigned concludes the respondent correctly determined the petitioner's household size as three for Medicaid eligibility purposes.

20. 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.

21. 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).

22. The Policy Manual at Appendix A-7, effective April, 2016, lists the Family-Related Medicaid income limits for a household of three for adult as \$303 the Standard Disregard is \$183, and the Medically Needy Income Limit (MNIL) is \$486

23. 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 \$1,343.25 (\$488.25 + \$855). Step 2. There are no deductions provided as there was no tax return. Step 3. The total income of \$1,343.25 less the standard disregard of \$183 is \$1,160.25. Step 4. The balance of \$1,160.25 is greater than the income limit of \$303 for the petitioner to receive full Medicaid. Step 5. With no MAGI disregard, the countable balance remains at \$1,160.25. The undersigned concludes the petitioner is ineligible for full Medicaid. The undersigned further concludes Medically Needy eligibility must be explored for the petitioner.

24. 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.

25. Fla. Admin. Code R. 65-1.701 "Definitions" 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."

26. Fla. Admin. Code R. 65A-1.702 "Special Provisions" states in part:

(10) Enrollment. The enrollment period under the Medically Needy program begins with the month the individual satisfies the non-financial and resource eligibility criteria, but not earlier than the third month prior to the month of application.

(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.

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. To determine the SOC the respondent subtracted the MNIL of \$486 from the household income of \$1,343.25 resulting in an \$857 SOC. The undersigned carefully

reviewed the respondent's budget calculations and found no errors. It is concluded that a more favorable SOC could not be determined.

29. The undersigned concludes the respondent's action to increase the petitioner's SOC was within rule of the program based on the testimony and evidence provided.

**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 26 day of August, 2016,

in Tallahassee, Florida.

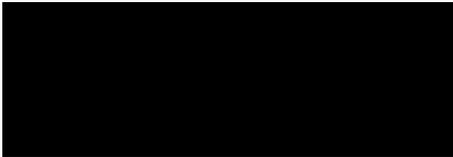


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Copies Furnished To: [REDACTED], Petitioner  
Office of Economic Self Sufficiency

Jul 25, 2016

Office of Appeal Hearings  
Dept. of Children and FamiliesSTATE OF FLORIDA  
DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-04226

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION  
CIRCUIT: 19 ST. LUCIE  
UNIT: AHCARESPONDENT.  

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**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above- matter on July 5, 2016 at 8:35 a.m.

**APPEARANCES**

For the Petitioner:



For the Respondent:

Lisa Sanchez  
Medical/Healthcare Program Analyst**STATEMENT OF ISSUE**

Whether respondent's denial of Prescribed Pediatric Extended Care (PPEC) services was proper. The burden of proof was assigned to the petitioner. The standard of proof in an administrative hearing is by a preponderance of the evidence.

**PRELIMINARY STATEMENT**

Petitioner's exhibits "1" and "2" were accepted into evidence.

Present for the respondent from eQHealth Solutions (eQHealth) was Dr. Darlene Calhoun, M.D. Respondent's exhibits "1" through "3" were accepted into evidence.

The record was held open through July 12, 2016 for Dr. Calhoun to respond to petitioner's exhibits "1" and "2". A response was timely received and entered as respondent's exhibit "4".

An unsolicited post hearing submission by the petitioner was received on July 19, 2016. The correspondence was forwarded by the undersigned to Ms. Sanchez.

To determine if a continuation of PPEC services was warranted, an Order for Respondent to Provide Information Regarding Continuation of Benefits was issued on June 14, 2016. It was thereafter determined prior PPEC services ended in mid-December 2016. A new application was submitted on or about March 25, 2016. The request was denied on April 4, 2016 and again on May 12, 2016. Petitioner's request for a fair hearing was received by the Office of Appeal Hearings on June 2, 2016.

#### **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 is a six-year-old male with a date of birth of [REDACTED]. He was Medicaid eligible at all times relevant to this proceeding.
2. A PPEC Center provides non-residential services to children with medically complex conditions. Attendees receive both medical and therapeutic services at the PPEC facility. PPEC facilities are staffed with skilled nurses.

3. Since approximately one year of age, petitioner was approved for PPEC services. The service continued until mid-December 2015 when services were terminated due to nonappearance at a previous fair hearing.

4. Petitioner resides with his mother and her husband. He attends a private school during the academic year.

5. Petitioner was born 26 weeks premature and experienced an [REDACTED] r [REDACTED]. Additionally, [REDACTED] was present. The syndrome resulted in amputation of his lower right leg. Petitioner was fitted with an artificial limb. Skin on his stump is easily inflamed and is monitored several times a day. Should the skin become inflamed, he is unable to use the prosthesis. He also experiences tightness and spasms in that leg.

6. Petitioner has [REDACTED].

7. Other diagnoses include: [REDACTED]  
[REDACTED] Medication for [REDACTED] ended at six months of age.

8. Petitioner has an unsteady gait and falls often. He is unable to ambulate more than 15 feet without experiencing shortness of breath.

9. Petitioner's height and growth levels are delayed.

10. When previously attending a PPEC Center, petitioner received speech; occupational; and physical therapies at the facility.

11. Petitioner requires numerous medications on a daily basis, in particular, medications for respiratory purposes.

12. Petitioner's medical status does not include:

- A gastrostomy tube for feeding
- A tracheostomy
- A ventilator
- Need for suctioning
- The use of any type of catheter
- A colostomy or ileostomy
- Intravenous medications or fluids
- Augmentative communication devices

13. Petitioner is occasionally incontinent of bladder and bowel.

14. eQHealth is the Peer Review Organization contracted by the respondent to perform prior authorization reviews for PPEC services.

15. On March 25, 2016 Patches, a PPEC Center, submitted a request to eQHealth. The certification period is identified as March 2, 2016 through August 28, 2016.

16. Information submitted by Patches included a Plan of Care (POC) signed, in March 2016, by petitioner's physician. Equipment and supplies identified on the POC include a nebulizer machine and pulse oximeter.

17. Under the POC heading "General Care" the following is recorded:

- Nurse to complete daily head-to-toe assessment
- Daily Hygiene Requirements
- Nurses to do daily follow-up of developmental therapies/goals including but not limited to ROM (Range of Motion) and in accordance with therapists plan of care
- Daily medication administration – monitor effects
- Nurse to assess family/caregiver knowledge & compliance with child's care needs and provide education/reinforcement of skills as indicated

18. Under the section "Current Medical Condition" the following, in part is recorded:

[REDACTED]

[REDACTED]

[REDACTED] erformed daily with special attention to skin surrounding stump.

19. Medications listed on the POC are taken by mouth; nasally; or inhaled.
20. On March 30, 2016 an eQHealth board certified pediatrician completed a review of submitted information.
21. On April 4, 2016 a Notice of Outcome –Denial of Prescribed Pediatric Extended Care Services was issued to the petitioner’s parent; physician; and PPEC Center. The notice sent to the physician stated, in part:

[REDACTED]

22. The above notice stated should the parent, provider, or physician disagree with the decision, reconsideration could be requested within 10 business days. Additional information could be provided with the request.

23. Reconsideration was requested. An additional letter was submitted by petitioner's mother.
24. A second physician reviewer thereafter reviewed all information submitted both before and after the initial denial. On May 12, 2015 eQHealth issued a Notice of Reconsideration Determination. The original denial was upheld.
25. On June 2, 2016 the Office of Appeal Hearings timely received petitioner's request for a Fair Hearing. As PPEC services had ended in December 2016, the service was not continued pending the outcome of this proceeding.
26. Petitioner argues three inhalers for respiratory purposes are needed on a daily basis. Additionally, a nurse can best assess skin issues related to the artificial limb.

#### **CONCLUSIONS OF LAW**

27. 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.
28. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.
29. 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, 7<sup>th</sup> Ed.).
30. 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.

31. Respondent's PPEC Handbook (September 2013) has been promulgated into rule by Fla. Admin. Code R. 59G-4.260.

32. 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."

33. 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.

34. 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.

35. 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.”

36. 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.

37. 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.

38. PPEC services are available through the Florida Medicaid Program. As such, analysis is further directed to whether the service is medically necessary.

39. To qualify for PPEC services, petitioner must be either medically complex or medically fragile.

40. Analysis is first directed to the definition of medically complex.

41. Petitioner requires numerous medications. Many are for respiratory purposes.

The Findings of Fact establish medications are taken by mouth; inhaled; or through the nose. The greater weight of evidence does not establish any medication must be administered solely by a skilled nurse.

42. The Findings of Fact also establish medications are no longer administered for seizure activity.

43. A Finding of Fact was not made establishing petitioner receives skilled nursing while attending school hours or while at home.

44. Petitioner receives certain therapies at the PPEC Center. Respondent's promulgated Therapy Services Coverage and Limitations Handbook states, in part:

Page 1-2

The purpose of the therapy services program is to provide medically necessary physical therapy (PT), occupational therapy (OT), respiratory therapy (RT) and speech-language pathology (SLP) services to recipients under the age of 21

P2-17

Physical, occupational, and respiratory therapy and speech language pathology treatment services can be provided in the recipient's place of residence or other community setting, such as school, Prescribed Pediatric Extended Care (PPEC) centers, or day care centers.

45. The above authority establishes the therapies received by the petitioner can also be provided in a setting other than a PPEC Center.

46. Petitioner has an unsteady gait. The greater weight of evidence does not establish a skilled medical professional must provide assistance with walking.

Consequently, the level of assistance needed could be provided by any responsible adult who is both cognitively and physically able.

47. Petitioner's need for respiratory monitoring is noted. The PPEC Handbook states on Page 1-2 "PPEC services are not emergency services." Monitoring for the sole purpose should a medically emergency arise is not within the parameters of the PPEC Program.

48. Compelling evidence was not presented that skin evaluations around petitioner's stump must be performed solely by a skilled nurse.

49. The greater weight of evidence does not establish petitioner currently meets the definition of being medically complex. This definition must be satisfied to qualify for PPEC services.

50. Regarding the definition of medically fragile, Fla. Admin Code R. 59G-1.010 (165) requires the individual be both medically complex and technologically dependent on medical equipment to sustain life.

51. Although the undersigned concludes petitioner does not meet the definition of being medically complex, it is noted that petitioner does not require the use of a

ventilator; does not have a colostomy or ileostomy; and has no catheters. No evidence was presented any medication is administered intravenously. Additionally, compelling evidence was not presented that petitioner requires an advanced level of medical supervision to sustain life and the absence of such would lead to death.

52. The greater weight of evidence does not, at this time, establish petitioner meets the definition required by Florida Administrative Code of being either medically complex or medically fragile.

53. When considering the requirements of EPSDT; the PPEC Handbook; and medical necessity criteria, petitioner has not established in a preponderant manner that respondent's denial of PPEC service was improper.

54. 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;

### **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

FINAL ORDER (Cont.)

16F-04226

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the court fees required by law or seek an order of indigence 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 July, 2016,

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  
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Copies Furnished To: [REDACTED], PETITIONER  
AHCA, MEDICAID FAIR HEARINGS UNIT

Aug 30, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-04229

PETITIONER,

Vs.

CASE NO.

MANAGED CARE ORGANIZATION, AND  
AGENCY FOR HEALTH CARE ADMINISTRATION  
CIRCUIT: 06 Pasco  
UNIT: AHCA

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on August 9, 2016, at 10:50 a.m.

**APPEARANCES**

For the Petitioner:



For the Respondent:

Brian Zimmerman, M.D.  
Physician Clinical Advisor  
Magellan Complete Care

**STATEMENT OF ISSUE**

Did the petitioner prove by a preponderance of the evidence that the respondent incorrectly denied her request for magnetic resonance imaging ("MRI") of the brain?

**PRELIMINARY STATEMENT**

██████████ the petitioner's stepmother, appeared on behalf of the petitioner, ██████████ ("petitioner"), who was not present. ██████████, the petitioner's father, appeared as a witness on behalf of the petitioner. ██████████ may sometimes hereinafter be referred to as the petitioner's "representative".

Brian Zimmerman, M.D., Physician Clinical Advisor for Magellan Complete Care, appeared on behalf of the respondent, Magellan Complete Care. Michelle Riegler, Compliance Officer with Magellan Complete Care, appeared as a witness on behalf of Magellan Complete Care. Stephanie Lang, R.N., Registered Nurse Specialist and Fair Hearing Liaison with the Agency for Health Care Administration ("AHCA" or "Agency"), was present solely for the purpose of observation.

The respondent introduced 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 August 12, 2016 in order for the Agency to provide the Agency guidelines for the approval of an MRI for headaches. Once received, the 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 17-year-old female.
2. The petitioner was eligible to receive Medicaid at all times relevant to this proceeding.

3. The petitioner has a history of chronic migraine headaches associated with photophobia (sensitivity to light), phonophobia (sensitivity to sound), and vomiting.

4. The petitioner began having migraine headaches approximately six years ago.

5. The petitioner spends multiple hours in the dark to alleviate the pain and discomfort associated with her migraine headaches. She is absent from school approximately 25 days per year due to her migraine headaches.

6. On or about May 13, 2016, the petitioner's neurologist submitted a prior authorization request for magnetic resonance imaging of the brain to Magellan Complete Care.

7. Magellan Complete Care sent requests to the petitioner's neurologist on May 13, 2016 and May 14, 2016 attempting to secure additional information as to why magnetic resonance imaging of the petitioner's brain was necessary.

8. On May 16, 2016, the petitioner's neurologist sent the clinical notes from an office visit with the petitioner on May 4, 2016 to Magellan Complete Care.

9. The prior authorization documents indicate magnetic resonance imaging of the brain was being requested as a prerequisite for prescribing the medication [REDACTED] to the petitioner.

10. [REDACTED] is a prescription drug commonly used for the treatment of migraine headaches.

11. It is not standard medical practice to require magnetic resonance imaging of the brain prior to prescribing [REDACTED].

12. The petitioner may be prescribed [REDACTED] without having an MRI.

13. After reviewing all of the prior authorization documents received from the petitioner's neurologist, Magellan Complete Care determined the petitioner did not meet the clinical criteria for magnetic resonance imaging of the brain.

14. Magellan Complete Care sent a Notice of Action dated May 17, 2016 to the petitioner denying her request for magnetic resonance imaging of the brain. It also sent a Notice of Action to the petitioner's neurologist on that same date advising her of its decision.

15. The petitioner does not meet any of the six clinical indications under which magnetic resonance imaging of the brain would be deemed to be medically necessary.

#### **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 Section 120.80, Florida Statutes.

17. This is a Final Order pursuant to § 120.569 and § 120.57, Florida Statutes.

18. This hearing was held as 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 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, 7<sup>th</sup> Ed.

21. The Florida Medicaid program is authorized by Chapter 409, Florida Statutes and Rule 59G, Fla. Admin. Code.

22. The Florida Medicaid Program is administered by the Agency for Health Care Administration.

23. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Rule 59G-5.020.

24. Page 1-22 of the Florida Medicaid Provider General Handbook provides a list of Medicaid covered services. These services include X-ray services.

25. 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 patient’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.

26. 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, Florida Statutes, 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.

27. 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 may present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)) (emphasis added).

28. 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.

29. Fla. Admin. Code R. 59G-1.010(226) defines prior authorization as follows:

“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.

30. The Florida Medicaid Practitioner Services Coverage and Limitations Handbook April 2014 was incorporated by reference in the Medicaid Services Rules by

Fla. Admin. Code R. 59G-4.205. This Handbook was effective at the time the decision in this matter was made but has since been repealed.

31. The Florida Medicaid Practitioner Services Coverage and Limitations Handbook April 2014 addresses prior authorization of outpatient non-emergent diagnostic imaging on Page 2-99 and explains as follows

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. Florida Medicaid contracts with QIO entities to safeguard against unnecessary utilization and to assure the quality of care provided to Medicaid recipients. All diagnostic imaging providers are required to adhere to the established requirements and submit the necessary information to Florida Medicaid or the Medicaid QIO currently in place for this process.

Note: The current QIO PA process is available on the Web at [www.medsolutions.com/implementation/AHCA](http://www.medsolutions.com/implementation/AHCA).

32. The Magellan Complete Care criteria for approval of magnetic resonance imaging of the brain require one or more of the following:

- Chronic headache with a change in character/pattern (e.g. more frequent, increased severity or duration).
- Sudden onset (within the past 3 months) of a headache described by the patient as the worst headache of their life OR a “thunderclap” type headache. (*Concerned with aneurysm*). Note: The duration of a thunderclap type headache lasts more than 5 minutes. A headache that lasts less than 5 minutes in duration is not neurological.
- New severe unilateral headache with radiation to or from the neck. Associated with suspicion of carotid or vertebral artery dissection.
- Acute, sudden onset of headache with personal or family history (parent, sibling or child of patient) of stroke, brain aneurysm or AVM (arteriovenous malformation).
- Patient with history of cancer or HIV or immunocompromised with new onset of headache.
- New onset of headache in pregnancy.

33. In the present case, the petitioner provided no testimony or evidence to support a conclusion that she meets any of the six indications listed in the previous paragraph for magnetic resonance imaging of the brain.

34. After careful review of the testimony and evidence presented in this case, along with the relevant laws set forth above, the undersigned concludes the petitioner has not demonstrated by a preponderance of the evidence the respondent incorrectly denied her request for magnetic resonance imaging of the brain.

### **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.

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FINAL ORDER (Cont.)

16F-04229

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DONE and ORDERED this 30 day of August, 2016,

in Tallahassee, Florida.

*Peter J. Tsamis*

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Peter J. Tsamis  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
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Copies Furnished To:

██████████ petitioner  
AHCA, Medicaid Fair Hearings Unit  
Maria Anaya

Jul 01, 2016

Office of Appeal Hearings  
Dept. of Children and FamiliesSTATE OF FLORIDA  
DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-04232

PETITIONER,

Vs.

CASE NO. FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 07 Volusia  
UNIT: 88265RESPONDENT.  

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**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 23, 2016 at 11:32 a.m.

**APPEARANCES**

For the Petitioner: The petitioner was present and represented himself.

For the Respondent: Stephanie Ross, Economic Self-Sufficiency Specialist II with the Department of Children and Families (DCF).

**ISSUE**

The petitioner is appealing the Department's action to deny his SSI-Related Medicaid application on March 17, 2016 as he did not meet the disability requirement.

The petitioner held the burden of proof by a preponderance of the evidence.

**PRELIMINARY STATEMENT**

Evidence was received and entered as the Respondent's Exhibits 1 through 2.

The record was held open until 5:00 p.m. on June 2, 2016 to allow the respondent and the petitioner to submit additional evidence. Evidence was received and entered as the Respondent's Exhibit 3. No evidence was received from the petitioner. The record was closed as of 5:00 p.m. on June 2, 2016.

### **FINDINGS OF FACT**

1. On March 16, 2016, the petitioner (age 48) completed a manual application for SSI-Related Medicaid with the Department as a disabled adult.

2. On March 17, 2016, the Department mailed a Notice of Case Action to inform petitioner that his application for SSI-Related Medicaid was denied due to not meeting the disability requirement. He previously applied for and was denied disability benefits by the Social Security Administration (SSA).

3. The Department's records show that the petitioner applied for Social Security disability on September 10, 2015 and was denied on November 10, 2015 with a denial code of "N32", which the Department defined as "Non-pay-Capacity for substantial gainful activity-other work, no visual impairment." The petitioner filed an appeal on February 23, 2016 (*Respondent's Exhibit 3, page 16*).

4. The petitioner explained that he worked as a roofer his entire work history; he would not be able to return to his work as a roofer with his current medical condition.

The petitioner lists his disabling conditions as [REDACTED]

[REDACTED]. The petitioner believes that his [REDACTED] began about two months ago and may be separate from his [REDACTED]. The petitioner explained that his back is shattered and that he needs x-rays. The petitioner contends that his condition

has worsened. The petitioner reports that it hurts for him to sit and that he has to lay down most of the time. The petitioner believes that the Social Security Administration reviewed the medical condition with his back. The petitioner explained that his back pain is his main concern. The petitioner argues that his stress level is high. The petitioner believes he has a hearing scheduled for May 2017 for the SSA denial. The petitioner did not provide a copy of the SSA denial letter or any medical records of his disabling medical conditions.

5. The Department explained that it adopts the SSA disability decision. The Department contends that the petitioner may complete a new application with the SSA if his condition has worsened or if he has any new disabling medical conditions.

#### **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 Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

8. Fla. Admin. Code R. 65A-1.710 sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. For an individual less than 65 years of age to receive Medicaid, he 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 (see §416.960(b)) or any other substantial gainful work that exists in the national economy...

9. The findings show petitioner is 48 years old. In this case, before Medicaid eligibility can be determined, petitioner must meet the federal definition of disabled.

10. Additionally, 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)...

(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

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

If the individual has not received a disability decision from SSA, a blindness/disability application must be submitted to the Division of Disability Determinations (DDD) for individuals under age 65 who are requesting Community Medicaid under community MEDS-AD, Medically Needy, and Emergency Medicaid for Alien Programs.

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.

12. The above authorities explain that a disability application must be sent to the Division of Disability Determination to be reviewed for applicants who are under the age of 65, who are requesting Community Medicaid under community MEDS-AD, Medically Needy, and Emergency Medicaid for Alien programs. However, if SSA has denied disability within the past year, or if the denial is under appeal, the SSA decision is to be adopted. If the individual applies for Medicaid within one year of an SSA denial and provides evidence of a new disabling condition that was not considered by SSA, the Department must make an independent disability decision. The petitioner provided no evidence of a new disabling condition, not considered by the SSA. There was no

evidence of the conditions reviewed by the SSA. The SSA denial is currently under appeal.

13. The findings show that the petitioner has reported his disabling condition of back pains to the SSA. The petitioner reported chest and shoulder pains, which came about two months ago. There was no evidence submitted to indicate this as a disabling condition. The petitioner argues that he has severe back pains and needs Medicaid in order to be treated for his condition. His concern and situation is recognized, however, the Department is required to follow the rules and regulations set forth by the governing authorities. The undersigned concludes that the petitioner did not meet his burden of proof to show that the Department's action was incorrect. The undersigned concludes that the Department was correct to adopt the SSA denial from February 2016 (within 12 months of the Medicaid application with the Department) which resulted in the Medicaid denial.

### **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

FINAL ORDER (Cont.)

16F-04232

PAGE -7

petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 01 day of July, 2016,

in Tallahassee, Florida.



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Paula Ali  
Hearing Officer  
Building 5, Room 255  
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Tallahassee, FL 32399-0700  
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Copies Furnished To: [REDACTED] Petitioner  
Office of Economic Self Sufficiency

Aug 30, 2016

Office of Appeal Hearings  
Dept. of Children and FamiliesSTATE OF FLORIDA  
DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-04331

PETITIONER,

Vs.

MOLINA HEALTHCARE, AND  
AGENCY FOR HEALTH CARE ADMINISTRATION  
CIRCUIT: 09 Osceola  
UNIT: AHCARESPONDENTS.  

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**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on August 3, 2016 at approximately 10:00 a.m.

**APPEARANCES**

Petitioner:



For Molina:

Carlos Galvez  
Government Contracts Specialist**STATEMENT OF ISSUE**

At issue is whether or not Respondent's denial of Petitioner's request for an upper partial denture was correct. The burden of proof is assigned to Petitioner.

**PRELIMINARY STATEMENT**

The following individuals were present as witnesses for Molina:

- Dr. Susan Hudson – Dental Consultant – DentaQuest
- Jackelyn Salcedo – Complaints & Grievances Specialist – DentaQuest
- Evie Labady – Complaints & Grievances Specialist – DentaQuest
- Dr. Katherine Deffke – Dental Consultant Trainer – DentaQuest

Petitioner gave oral testimony, but did not move any exhibits into evidence.

Molina moved Exhibits 1 – 7 into evidence at the hearing.

### **FINDINGS OF FACT**

1. Petitioner is a 43-year-old male. Petitioner is enrolled Molina Healthcare (“Molina”) as his Managed Medical Assistance (MMA) plan. DentaQuest is Molina’s dental vendor.
2. Petitioner’s dentist submitted a prior authorization request for an upper partial denture, which was received by DentaQuest on May 24, 2016. DentaQuest denied the request.
3. Also on May 24, 2016, Molina issued a Notice of Action, Respondent’s Exhibit 6, denying Petitioner’s request as not medically necessary. The Notice stated, in pertinent part:

The facts that we used to make our decision are:

- Our dentist looked at the information your dentist sent, and says you are not missing enough teeth to affect your chewing function. We have also told your dentist. Please talk to your dentist.

The DentaQuest guideline or policy used to support this decision was:

- DentaQuest Clinical Criteria for Removable Prosthodontics

4. DentaQuest’s Criteria for Removable Prosthodontics (Full and Partial Dentures) is found in Respondent’s Exhibit 5. It provides:

#### **Criteria**

Prosthetic services are intended to restore oral form and function due to premature loss of permanent teeth that would result in significant occlusal dysfunction.

- A denture is determined to be an initial placement if the patient has never worn a prosthesis. This does not refer to just the time a patient has been receiving treatment from a certain Provider.
- Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.
- Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50% supported in bone.
- As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis
- In general, if there is a pre-existing removable prosthesis (includes partial and full dentures), it must be at least 5 years old and unserviceable to qualify for replacement.

The replacement teeth should be anatomically full sized teeth.

Approval for removable prosthesis will not meet criteria:

- If there is a pre-existing prosthesis which is not at least 5 years old and unserviceable.
- If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.
- If there are untreated cavities or active periodontal disease in the abutment teeth.
- If abutment teeth are less than 50% supported in bone.
- If the recipient cannot accommodate and properly maintain the prosthesis (i.e. Gag reflex, potential for swallowing the prosthesis, severely handicapped).
- If the recipient has a history or an inability to wear a prosthesis due to psychological or physiological reasons.
- If a partial denture, less than 5 years old, is converted to a temporary or permanent complete denture.

- If extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the recipient. However, adding teeth and/or a clasp to a partial denture is a covered benefit if the addition makes the denture functional
5. Petitioner already has an upper right partial denture. He lost two (2) of his upper left teeth, specifically tooth # 12 and tooth # 13. Dr. Hudson testified that he currently has 12 posterior teeth in occlusion.
  6. Petitioner said tooth # 15 also needs to be pulled. Dr. Hudson testified if tooth # 15 was pulled there would be 10 teeth in occlusion. She said there must be less than eight (8) back teeth in occlusion for dentures to be approved.
  7. Petitioner said he is experiencing pain and is already having difficulty chewing. He uses painkillers to help manage the pain. He said he has been reluctant to have tooth # 15 pulled because it could cause problems, such as shifting of the teeth and speech problems.

### **CONCLUSIONS OF LAW**

8. 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, Florida Statutes.
9. The hearing was held as a *de novo* proceeding, in accordance with Florida Administrative Code Rule 65-2.056.
10. This is a Final Order, pursuant to Sections 120.569 and 120.57, Florida Statutes.
11. 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, 7<sup>th</sup> Ed.).

12. 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.

13. The Florida Medicaid Dental Services Coverage Policy, May 2016 (“Dental

Handbook”) is promulgated into law by Chapter 59G of the Florida Administrative Code.

14. Page 4, Section 4.2.9 of the Dental Handbook states, in pertinent part: “Florida

Medicaid reimburses for emergency dental services for recipients age 21 years and older to alleviate pain, infection, or both, and procedures essential to prepare the mouth for dentures.”

15. Page 5, Section 5.2 of the Dental Handbook addresses Specific Non-Covered

Criteria. It says that Medicaid will not reimburse for “Partial dentures where there are eight or more posterior teeth in occlusion.”

16. The plain language of the Dental Handbook excludes partial dentures for individuals

with eight (8) or more posterior teeth in occlusion. Petitioner presently has 12 posterior teeth in occlusion. If tooth # 15 is pulled he will still have 10 posterior teeth in occlusion. The undersigned concludes it was proper for Molina to deny Petitioner’s request.

17. Petitioner is encouraged to work with his dentist regarding his condition. In the

event his condition worsens to where he would meet the requirements for the dentures, he can submit a new request at that time.

**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 August, 2016,

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  
AHCA, Medicaid Fair Hearings Unit

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

**FILED**

Aug 31, 2016

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-04476

PETITIONER,

Vs.

AGENCY FOR HEALTH  
CARE ADMINISTRATION  
CIRCUIT: 04 Duval  
UNIT: AHCA

And

STAYWELL HEALTH PLAN

RESPONDENTS.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on August 12, 2016 at 1:06 p.m.

**APPEARANCES**

For the Petitioner: [REDACTED]

For the Respondent: Stephanie Shupe, regulatory research coordinator

### **STATEMENT OF ISSUE**

At issue is the respondent's decision denying the petitioner's request for prescription medication through Medicaid. The petitioner holds the burden of proof at the level of preponderance of the evidence.

### **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. Staywell Health Plan (Staywell) is the contracted health care organization in the instant case.

By notice dated June 2, 2016, Staywell informed the petitioner that her request for the prescription medication [REDACTED] auto-injector was denied. The notice reads in pertinent part: "The drug that you requested is not on the preferred drug list. We reviewed your medication history and/or your prescriber's supporting documentation (or medical records). You have not had previous trial and failure on preferred drug(s): [REDACTED] syringe, [REDACTED] nasal spray, [REDACTED] tablet, [REDACTED] tablet."

The petitioner timely requested a hearing on June 13, 2016 to challenge the denial decision.

There were no additional witnesses for the petitioner. The petitioner did not submit documentary evidence.

The respondent presented one witness from Staywell: Lauren Barnes, clinical pharmacist. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

The record was held open until close of business on August 15, 2016 for the submission of additional evidence. Evidence was received from the respondent and admitted as Respondent's Exhibit 2. No evidence was received from the petitioner. The record closed on August 15, 2016.

### **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 40) is a Florida Medicaid recipient. The petitioner is enrolled with Staywell HMO.
2. The petitioner has a history of severe migraine headaches. She has tried many medications over the years without any long term success.
3. The petitioner was treated at the Family Care Center in late April 2016/early May 2016 due to several consecutive days of severe migraines. The clinical notes read: "Migraine...occurs daily, has varies duration, and is worse. Location is entire head, ocular left and ocular right...The patient describes it as blinding, sharp, stabbing, throbbing and worst ever." The petitioner was given an injectable pain medication at the center which eased her pain and lasted much longer than the other medications she has tried over the years. Prior to discharge, the treating physician wrote the petitioner a prescription for the brand name drug [REDACTED] [REDACTED]

4. The petitioner took the prescription to a local pharmacy to be filled. The petitioner's physician checked "no" to the question on the prescription which asks if the brand medication was medically necessary. Because the treating physician answered "no" to this question, the pharmacy (in what the respondent testified is common industry practice) substituted the brand name [REDACTED] [REDACTED] with the generic brand of the medication, [REDACTED] auto-injector, when filing the prior service authorization request with Staywell.

5. Specified Medicaid goods and services, including some medications, require prior authorization that is performed by the respondent, a contracted HMO or other designee, Staywell is the agent in the instant case. In regards to coverage of prescription medication, Medicaid rules require its enrollees first use drugs published on its Preferred Drug List (PDL) prior to using other medications, unless there is clinical documentation which proves that the drug on the PDL has been tried and failed or is contra-indicated by clinical records.

6. [REDACTED] is included on Medicaid's PDL and does not require prior service authorization. [REDACTED] the generic form of [REDACTED], is not included on Medicaid's PDL. Dr. Lauren Barnes, clinical pharmacist with Staywell, explained that Staywell denied the prior service authorization request in the instant case because there was no evidence that the brand medication had been tried and failed or that the brand medication was contra-indicated in the petitioner's clinical records.

7. When questioned why Staywell did not approve the treating physician's original prescription for the brand name medication [REDACTED]

versus denying the generic medication [REDACTED] [REDACTED] substituted by the pharmacy, Dr. Barnes testified that it is Staywell's practice to act on the medication request filed, in this case [REDACTED]; however, Staywell believes it explained that Imitrex was a covered medication in the body of the denial notice which states: "You have not had previous trial and failure on preferred drug(s): [REDACTED]..." Staywell concluded that this language was sufficient to inform the petitioner that she did not need prior authorization for the [REDACTED]

8. The petitioner was not aware of the generic brand medication substitution which took place at the pharmacy. She thought the pharmacy had requested prior service authorization for the drug prescribed by her doctor, [REDACTED] auto-injectors. In addition, she did not discern from the language used in Staywell's denial notice that the medication she was seeking, [REDACTED], could be obtained without prior authorization. The petitioner expressed concern that administrative decisions, beyond her control and knowledge, resulted in deprivation of the only medication proven effective in managing her severe migraine headaches.

9. In response to the petitioner's concerns, Dr. Barnes noted that this problem (substitution of non-covered generic medications) could be remedied by the petitioner telling the providing pharmacy that generic substitutions for [REDACTED] auto-injectors are not covered by Medicaid. The pharmacy would submit the prescribed [REDACTED] and see that it does not require prior service authorization. The petitioner could receive her prescription the same day.

### **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 Section 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 Fla. Admin. Code R. 65-2.056.

13. 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, 7<sup>th</sup> Ed.).

15. The Florida Medicaid Program is authorized by Chapter 409 Florida Statutes and Fla. Admin. Code Chapter 59G.

16. 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:

“Medical 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 patient'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.

17. Regarding the PDL, the Medicaid Drug Handbook states on pages 2-4 and 2-5:

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.

...

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 cited authorities explain that Medicaid will only cover drugs on its PDL unless there is evidence that the drugs have been tried and failed or the PDL drugs are contra-indicated. Drugs on the PDL do not require prior service authorization.

19. The petitioner's physician prescribed the brand name medication [REDACTED] [REDACTED] to treat her severe migraine headaches. This medication is on the respondent's PDL and does not require prior service authorization. Following an industry practice of substituting generic brands unless the prescription form expressly says "brand medication only", the petitioner's pharmacy switched the requested medication to the generic brand [REDACTED] which is not on the respondent's PDL. Staywell denied the request.

20. The uncontroverted evidence proves that the medication prescribed by the petitioner's physician [REDACTED] is on the respondent's PDL and does not require prior service authorization. The petitioner, with a current prescription form that clearly notes that the brand name cannot be substituted for a

generic brand, can obtain the desired medication. The undersigned can order no more advantageous outcome than the petitioner obtaining the medication that she desires.

21. After careful review, the undersigned concludes that the issue under appeal is moot. It is noted, however, that the undersigned shares the petitioner's concern that administrative decisions, beyond her control and knowledge, resulted in deprivation of medication proven effective in treating her severe migraine headaches and that the communication she received did not make it clear that she could obtain the desired medication without prior authorization or an administrative hearing.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is dismissed as moot.

### **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.

FINAL ORDER (Cont.)  
16F-04476  
PAGE - 10

DONE and ORDERED this 31 day of August, 2016,  
in Tallahassee, Florida.



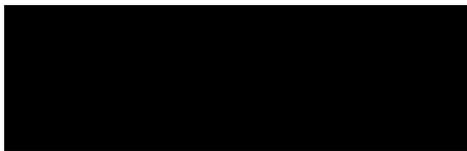
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Copies Furnished To [REDACTED]  
AHCA, Medicaid Fair Hearings Unit  
Ray Walker

Jul 21, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 16F-04483  
APPEAL NO. 16F-04484

PETITIONER,

Vs.

CASE NO.



FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 04 Clay  
UNIT: 88316

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on July 8, 2016 at 9:30 a.m.

**APPEARANCES**

For the Petitioner: The petitioner was present and represented himself.

For the Respondent: Kenneth Wilson, Economic Self-Sufficiency Specialist II for the Department of Children and Families.

**STATEMENT OF ISSUE**

Petitioner is appealing the Department's action on June 3, 2016 to approve his Food Assistance Program (FAP) benefit allotment in the amount of \$69.

Also in dispute is the Department's action on July 5, 2016 to enroll the petitioner into the Medically Needy (MN) program with an estimated Share of Cost (SOC) in the amount of \$894.

The petitioner carries the burden of proof by the preponderance of evidence.

### **PRELIMINARY STATEMENT**

The respondent submitted evidence that was entered as the Respondent's Exhibits 1 through 2. The petitioner did not submit any evidence.

The record was closed on July 8, 2016.

### **FINDINGS OF FACT**

1. On May 31, 2016, the petitioner (age 56) completed a manual application for FAP and SSI-Related Medicaid benefits for himself only. The petitioner received FAP benefits in the state of New Hampshire for the month of April 2016.

2. The petitioner was originally approved for FAP benefits in the amount of \$16 but was determined to be eligible for a larger benefit allotment after including his shelter costs. The petitioner was issued supplemental benefits in the amount \$53 each for the months of May 2016 and June 2016, as he was already issued \$16 for those months.

3. The Department's calculations include Social Security income in the amount of \$1094. The standard deduction of \$155 was subtracted to calculate \$939 adjusted income. The adjusted net income was multiplied by 50% to result in a \$469.50 shelter standard. The petitioner was allowed a shelter cost in the amount of \$650 for rent and the standard utility allowance in the amount of \$345, for a total shelter cost in the amount of \$995. The Department subtracted \$469.50 from the \$995 total shelter to equal to a \$525.50 excess shelter deduction. The excess shelter deduction was subtracted from the total shelter which resulted in \$413.50 net income. The Department multiplied the adjusted net income by 30% to result in a \$125 benefit reduction. The

Department calculated the FAP benefits by subtracting the \$125 benefit reduction from the \$194 maximum FAP benefit allotment for a one person household to result in a \$69 benefit allotment.

4. The Department calculated the MN budget by including the petitioner's gross monthly Social Security income in the amount of \$1094. The total gross income was subtracted by the unearned income disregard in the amount of \$20 to result in \$1074 total countable income. The total countable income was subtracted by the Medically Needy income limit (MNIL) in the amount of \$180 to result in a monthly SOC in the amount of \$894.

5. The petitioner does not dispute the income and deductions included in the Department's calculations. The petitioner believes he is eligible for a larger allotment because he was receiving FAP benefits in the amount of \$170 in New Hampshire. The petitioner does not report any out-of-pocket medical expenses.

6. The petitioner argues that his SOC amount is too large. The petitioner argues that his SOC amount in Florida is double the amount of what it was in New Hampshire. The petitioner is receiving Medicare and is approved for the Special Low-Income Medicare Beneficiary (SLMB) program. The petitioner is not receiving any institutional care services (ICP), hospice services, or community based waiver services at this time.

#### **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

Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

The \$69 FAP benefit allotment will be addressed first:

9. Federal Food Assistance Regulations at 7 C.F.R. § 273.10 Determining household eligibility and benefit levels states in relevant part:

(e) *Calculating net income and benefit levels*—(1) *Net monthly income.* (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, minus income exclusions, to determine the household's total gross income.

10. Federal Food Assistance Regulations at 7 C.F.R. §273.9 "Income and deductions" states:

(b) *Definition of income.* Household income shall mean all income from whatever source excluding only items specified in paragraph (c) of this section.

(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; oldage, survivors, or social security benefits;

...

11. The above regulation defines income as all income from any source and includes Social Security income as unearned income. Therefore, the undersigned concludes that the petitioner's Social Security income were correctly included in the Department's calculations as required by controlling federal regulations.

12. Federal Food Assistance Regulations at 7 C.F.R. §273.9 (d) “Income deductions” states in relevant part:

Deductions shall be allowed only for the following household expenses:

(1) Standard deduction....

(3) Excess medical deduction. That portion of medical expenses in excess of \$35 per month, excluding special diets, incurred by any household member who is elderly or disabled as defined in § 271.2.

...

(ii) Excess shelter deduction.

(A) Continuing charges for the shelter occupied by the household, including rent...

(C) The cost of fuel for heating; cooling; electricity or fuel used for purposes other than heating or cooling;

(iii) Standard utility allowances.

13. The above regulation explains that a household is allowed a standard deduction, excess medical deduction, excess shelter deduction, cost for rent, and a standard utility allowance. The findings show that the petitioner did not report any out-of-pocket medical expenses. The findings also show that the petitioner was allowed a standard deduction and a deduction for his rent and utility costs. Therefore, the undersigned concludes that the petitioner was given all allowable deductions to his income.

14. After carefully reviewing the governing authorities and evidence presented, the undersigned concludes that the Department’s calculation of the petitioner’s FAP benefits in the amount of \$69 was correct.

The petitioner’s enrollment in the Medically Needy Program will be now be addressed:

15. Federal Regulations at 20 CFR § 416.1121 Types of unearned income states:

Some types of unearned income are—

(a) *Annuities, pensions, and other periodic payments.* This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veterans benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits.

...

16. The above authority explains that unearned income, such as Social Security income, are included as income in determining eligibility for the Medicaid programs.

The findings show that the petitioner is receiving Social Security income. Therefore, the undersigned concludes that the Department was correct to include the petitioner's Social Security income in its calculations.

17. Federal Regulations at 20 CFR § § 416.1124 Unearned income we do not count states:

(c) *Other unearned income we do not count.* We do not count as unearned income—

(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.

18. 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.

...

(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.

19. 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. The program does not cover nursing facility care, intermediate care for the developmentally disabled services, or other long-term care services.

20. 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:

(h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses.

(2) (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.

21. The Medicaid income limits are set forth in the Fla. Admin. Code at R. 65A-

1.716 :

(1) The monthly federal poverty level figures based on the size of the filing unit...

(2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows...

Size...1 Level \$180...

22. The petitioner's share of cost was calculated by including his countable gross monthly income less the standard disregard and Medically Needy Income Level (MNIL) for an individual. The gross monthly household unearned income of \$1094, less the \$20 standard disregard and MNIL of \$180, equals a share of cost of \$894. The hearing officer found no exception to this calculation. The undersigned concludes that

the respondent's action to enroll the petitioner into the Medically Needy Program and to determine the amount of the monthly share of cost as \$894 was a correct action.

**DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, both 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 21 day of July, 2016,

in Tallahassee, Florida.



\_\_\_\_\_  
Paula Ali  
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

Aug 16, 2016

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

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-04603

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 12 Sarasota  
UNIT: 88287

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on August 4, 2016 at approximately 10:00 a.m. CDT.

**APPEARANCES**

For the Petitioner:

[REDACTED]

For the Respondent: Nicole Nuriddin, economic self-sufficiency specialist II

**STATEMENT OF ISSUE**

Petitioner is appealing the Department's action of June 17, 2016 denying Family Related Medicaid for his son while enrolling him in the Medically Needy Program (MN) with a Share of Cost (SOC). The petitioner carries the burden of proof by the preponderance of evidence.

### **PRELIMINARY STATEMENT**

The petitioner submitted a packet of information that was entered into evidence as Petitioner's Exhibits "1" and "2".

The respondent submitted a packet of information that was entered into evidence as Respondent's Exhibits "1" through "6".

The hearing was originally scheduled for July 19, 2016. Respondent's representative Mary Dahmer and the undersigned met and waited 15 minutes for the petitioner. The hearing was subsequently placed into a pending status prior to abandoning. The petitioner called the next day, stated she had gotten confused about the date and asked that the hearing be rescheduled.

### **FINDINGS OF FACT**

1. On December 2, 2015, the petitioner submitted an application to the Department for Food Assistance (FA) and family Medicaid for a household of three, husband, wife and son. At the time of this application, the wife was employed and the son attending college part-time. The son was enrolled in the MN with a SOC of \$6,522.
2. On January 5, 2016, the petitioner submitted another application to the Department, this one for family Medicaid for the son. A notice of case action (NOCA) was mailed out January 8, 2016 with the son remaining enrolled in the MN.
3. On June 17, 2016, the petitioner reported a change, the loss of the son's and the wife's income. Verification was requested and received and the son's SOC decreased to \$2,039.
4. The petitioner states that the son needs medical care and the household cannot afford it. The son had been Medicaid eligible through his 18<sup>th</sup> birthday as he was

adopted. The petitioner testifies the he lives with them but is independent of them, working and filing his own tax returns.

5. The parties do not dispute the figures used to determine income and SOC. Both the husband and wife receive Social Security (husband's \$1,754.90 wife's \$980.80) and Medicare (premiums of \$104.90 each) and as of the June reported change, there is no earned income in the household. Petitioner's interest is getting Medicaid coverage for her son.

### **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 Section 409.285, Florida Statutes.

7. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

9. 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...

10. 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.

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

12. 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....

13. The Department's Program Policy Manual, CFOP 165-22 (The Policy Manual), 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.

14. The Policy Manual, passage 2230.0401, Definition of Terms (MFAM) states: "A child is an individual under the age of 21, who has never been emancipated, is not married or whose marriage was annulled, and whose eligibility is being determined."

15. The above policy explains that Family-Related Medicaid is determined by how the family files federal taxes and the relationships of individuals in the family that live together. 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, as an unemployed, part-time college student, the SFU for the son would include himself and both of his parents. The undersigned concludes that the Department was correct to include all three household members in the SFU.

16. The Policy Manual, 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).

17. The Policy Manual at Appendix A-7 indicates that for a household size of three, the income limit for a 19-year-old to receive full Medicaid is \$303 per month and the MNIL is \$486. 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."

18. The undersigned completed a manual budget to determine if the Department's calculations were correct. For the month of June 2016 and ongoing, a standard disregard of \$182 was subtracted from the gross income of \$2,735.70 (\$1,754.90+980.80), to result in a countable income of \$2,553.70. The MAGI disregard (5% of federal poverty limit) deduction for a household size of three is \$84. The adjusted income would be \$2,469.70 after the MAGI disregard was subtracted. As the petitioner's countable income of \$2,469.70 is over the income limit of \$303 per month, the undersigned concludes that the Department was correct in its action to deny

eligibility for full Medicaid and enroll the son 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.

19. The Policy Manual at 2630.0506.01 Allowable Medical Expenses (MFAM) states in relevant part: "There are two types of allowable medical expenses: 1. Recognized health insurance costs...Only allowable medical expenses can be used to meet Share of Cost" To reach the SOC, the Department deducted the Medicare Part-B premium from the gross income. The undersigned concludes that the Department was correct in doing so.

20. 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 \$2,735.70 for June 2016 and ongoing, and the MNIL for a household size of three is \$486. Gross income less \$210 in on-going medical expenses (Medicare Part-B premiums) is \$2,525.70. Subtract from that the MNIL and drop the cents to determine the SOC of \$2,039. Therefore, the Department was correct in its calculation of a SOC amount of \$2,039 for the petitioner. The undersigned completed a manual budget for June 2016 using the above methodology and found no error in the Department's calculation of the petitioner's MN SOC amount.

21. 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 June 2016. 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 16 day of August, 2016,

in Tallahassee, Florida.



---

Gregory Watson  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
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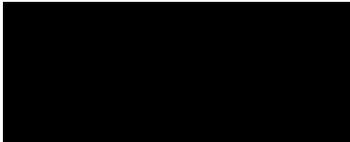
Copies Furnished To: [REDACTED], Petitioner  
Office of Economic Self Sufficiency

**FILED**

Aug 31, 2016

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

Office of Appeal Hearings  
Dept. of Children and Families



APPEAL NO. 16F-04836  
16F-05591  
16F-05592

PETITIONER,

Vs.

CASE NO



FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 08 Bradford  
UNIT: 88369

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on July 26, 2016 at 11:37 a.m.

**APPEARANCES**

For the Petitioner:



For the Respondent: Ernestine Bethune, Economic Self-Sufficiency Specialist II

**STATEMENT OF ISSUE**

Petitioner is appealing the Department's action of June 7, 2016 decreasing his Food Assistance benefit, increasing his Medically Needy Share of Cost, closing his Special Low-Income Medicare Part B Medicaid (SLMB) and opening Qualifying Individuals 1 (QI 1). The petitioner carries the burden of proof by the preponderance of evidence.

### **PRELIMINARY STATEMENT**

The Department submitted evidence prior to the hearing that was entered as Respondent Exhibit 1. The record was held open through August 3, 2016 to allow the petitioner to provide additional information to the Department and the Department to review and provide updates to the Office of Appeal Hearings.

The Department submitted additional information on July 29, 2016. This was entered as Respondent Exhibit 2. The petitioner made no submission directly to the Office of Appeal Hearings while the record remained open.

The record closed on August 3, 2016.

### **FINDINGS OF FACT**

1. The petitioner filed an application for recertification on May 3, 2016. The household consists of the petitioner and his wife.
2. The petitioner is age 62 and disabled. His wife is age 59 and not disabled.
3. The petitioner receives Social Security Disability in the amount of \$1,086 per month.
4. The petitioner and his wife own [REDACTED] which is a subsidiary of [REDACTED]. The petitioner explained he made the nursery a subsidiary so he is only required to purchase one business license.
5. The petitioner does not believe his tax return is an accurate record of the income and expenses. He stated this was the first time he has ever been requested to submit his business tax return.

6. The petitioner pays quarterly income tax based off a \$2,000 salary for the year. However, she does not receive that salary; it is just how they set up to pay so she could receive Social Security when she retires.

7. The petitioner explained he did not show the full amount of expenses on his tax return this year so that the business would show a small profit and he could avoid a possible audit by the Internal Revenue Service.

8. During the recertification, the Department included the gross sales as gross income earned by the business. Annual gross sales were \$17,756. The Department divided this amount by 12 to reach a monthly amount of \$1,479.67.

9. In the recertification, the Department allowed the following expenses listed in monthly amounts: IP or Insurance for the Business of \$52.08; IR or IRS Allowable Business Expense of \$28.25; BP or Business Phone Expense of \$58.58; OM or "Oper. Motor Vehicle for Bus" of \$57.25; OS or Office Supplies of \$21.42; and UT or Utilities of \$82.17. These expenses total \$299.75

10. During the recertification process, the Department calculated the gross earnings after expenses at \$1,179.92 ( $\$1,479.67 - \$299.75 = \$1,179.92$ ).

11. During the review of the case post hearing, the Department included the gross sales as gross income earned by the business. Annual gross sales were \$17,756. The Department divided this amount by 12 to reach a monthly amount of \$1,479.67.

12. In the review of the case, the Department continued to include the expenses listed in paragraph 9 above. The Department also added the following expenses in monthly amounts: AD or Advertising of \$60.40; BL or Business License of

\$59.58; and RP or "Repairs/Maint. Bus. Prop" of \$17.50. The addition of these expenses bring the total expense amount to \$437.23 ( $\$299.75 + \$60.40 + \$59.58 + \$17.50 = \$437.23$ ).

13. During the review of the case, the Department calculated the gross earnings after expenses at \$1,042.44 ( $\$1,479.67 - \$437.23 = \$1,042.44$ ).

14. The undersigned did not receive profit/loss statements from the petitioner to review in comparison to the tax return submitted.

15. The petitioner has reported medical expenses included in the budget of \$110.66.

16. The Department submitted the Food Assistance budget calculations post hearing based on the updates from the review. (Respondent 2, page 30)

17. The petitioner did not understand why his Special Low-Income Medicare Beneficiary Medicaid (SLMB) ended. He believe the Department would no longer pay his Medicare premium.

18. The Department explained that due to the change in income budgeted, the petitioner moved from the SLMB program to Qualifying Individuals 1 (QI1). The Department further explained both programs pay for the Medicare part B premium. The difference between the two programs is the income standard for QI 1 is higher than for SLMB.

#### **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 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

#### FOOD ASSISTANCE

21. Federal Food Assistance Regulations at 7 C.F.R. § 273.9 "Income and Deductions states in relevant part:

(b) Definition of income. Household income shall mean all income from whatever source excluding only items specified in paragraph (c) of this section.

(1) Earned income shall include: (i) All wages and salaries of an employee.

(ii) The gross income from a self-employment enterprise, including the total gain from the sale of any capital goods or equipment related to the business, excluding the costs of doing business as provided in paragraph (c) of this section. Ownership of rental property shall be considered a self-employment enterprise; however, income derived from the rental property shall be considered earned income only if a member of the household is actively engaged in the management of the property at least an average of 20 hours a week. Payments from a roomer or boarder, except foster care boarders, shall also be considered self-employment 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; strike benefits; foster care payments for children or adults who are considered members of the household; gross income minus the cost of doing business derived from rental property in which a household member is not actively engaged in the management of the property at least 20 hours a week.

22. The findings show the petitioner has income from self-employment. The findings also show the petitioner has income from Social Security income of \$1,086.

The undersigned concludes the Department correctly included both incomes in determination of eligibility.

23. 7 C.F.R. § 273.11 “Action on households with special circumstances” states in relevant part:

(a) Self-employment income. The State agency must calculate a household's self-employment income as follows:

(1) Averaging self-employment income. (i) Self-employment income must be averaged over the period the income is intended to cover, even if the household receives income from other sources. If the averaged amount does not accurately reflect the household's actual circumstances because the household has experienced a substantial increase or decrease in business, the State agency must calculate the self-employment income on the basis of anticipated, not prior, earnings.

...

(2) Determining monthly income from self-employment. (i) For the period of time over which self-employment income is determined, the State agency must add all gross self-employment income (either actual or anticipated, as provided in paragraph (a)(1)(i) of this section) and capital gains (according to paragraph (a)(3) of this section), exclude the costs of producing the self-employment income (as determined in paragraph (a)(4) of this section), and divide the remaining amount of self-employment income by the number of months over which the income will be averaged. This amount is the monthly net self-employment income. The monthly net self-employment income must be added to any other earned income received by the household to determine total monthly earned income.

...

(3) Capital gains. The proceeds from the sale of capital goods or equipment must be calculated in the same manner as a capital gain for Federal income tax purposes. Even if only 50 percent of the proceeds from the sale of capital goods or equipment is taxed for Federal income tax purposes, the State agency must count the full amount of the capital gain as income for SNAP purposes. For households whose self-employment income is calculated on an anticipated (rather than averaged) basis in accordance with paragraph (a)(1) of this section, the State agency must count the amount of capital gains the household anticipates receiving during the months over which the income is being averaged.

(b) Allowable costs of producing self-employment income. (1) Allowable costs of producing self-employment income include, but are not limited to, the identifiable costs of labor; stock; raw material; seed and fertilizer; payments on the principal of the purchase price of income-producing real estate and capital assets, equipment, machinery, and other durable

goods; interest paid to purchase income-producing property; insurance premiums; and taxes paid on income-producing property.

**(2) In determining net self-employment income, the following items are not allowable costs of doing business:**

**(i) Net losses from previous periods;**

**(ii) Federal, State, and local income taxes, money set aside for retirement purposes, and other work-related personal expenses (such as transportation to and from work), as these expenses are accounted for by the 20 percent earned income deduction specified in §273.9(d)(2);**

**(iii) Depreciation;**  
(emphasis added)

24. The findings show upon review of the petitioner's self-employment income of \$1,479.67 and allowable expenses, which total \$437.23, the petitioner's self-employment income gross monthly income, is \$1,042.44. The petitioner did not submit any documentation to dispute the calculated income to the hearing officer. The undersigned cannot find a more favorable outcome.

25. The undersigned concludes the household's total income is \$2,128.44 (\$1,086 + \$1,042.44).

26. 7 C.F.R. § 273.9 "Income and Deductions states in relevant part:

(d) Income deductions. Deductions shall be allowed only for the following household expenses:

(1) Standard deduction—

...

(2) Earned income deduction. Twenty percent of gross earned income as defined in paragraph (b)(1) of this section. Earnings excluded in paragraph (c) of this section shall not be included in gross earned income for purposes of computing the earned income deduction, except that the State agency must count any earnings used to pay child support that were excluded from the household's income in accordance with the child support exclusion in paragraph (c)(17) of this section.

(3) Excess medical deduction. That portion of medical expenses in excess of \$35 per month, excluding special diets, incurred by any household member who is elderly or disabled as defined in §271.2. Spouses or other persons receiving benefits as a dependent of the SSI or disability and

blindness recipient are not eligible to receive this deduction but persons receiving emergency SSI benefits based on presumptive eligibility are eligible for this 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 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. For fiscal year 2001, effective March 1, 2001, the maximum monthly excess shelter expense deduction limits are \$340 for the 48 contiguous States and the District of Columbia, \$543 for Alaska, \$458 for Hawaii, \$399 for Guam, and \$268 for the Virgin Islands. FNS will set the maximum monthly excess shelter expense deduction limits for fiscal year 2002 and future years by adjusting the previous year's limits to reflect changes in the shelter component and the fuels and utilities component of the Consumer Price Index for All Urban Consumers for the 12 month period ending the previous November 30.

...

(A) Continuing charges for the shelter occupied by the household, including rent, mortgage, condo and association fees, or other continuing charges leading to the ownership of the shelter such as loan repayments for the purchase of a mobile home, including interest on such payments.  
(B) Property taxes, State and local assessments, and insurance on the structure itself, but not separate costs for insuring furniture or personal belongings.

...

(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);

27. 7 C.F.R. § 273.10 "Determining Eligibility and Benefit Levels" states in

relevant part:

(e) Calculating net income and benefit levels—(1) Net monthly income. (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, minus income exclusions, to determine the household's total gross income. Net

losses from the self-employment income of a farmer shall be offset in accordance with §273.11(a)(2)(iii).

(B) Multiply the total gross monthly earned income by 20 percent and subtract that amount from the total gross income; or multiply the total gross monthly earned income by 80 percent and add that to the total monthly unearned income, minus income exclusions....

(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. If there is no excess shelter cost, the net monthly income has been determined. If there is 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.

(ii) In calculating net monthly income, the State agency shall use one of the following two procedures:

(A) Round down each income and allotment calculation that ends in 1 through 49 cents and round up each calculation that ends in 50 through 99 cents; or

(B) Apply the rounding procedure that is currently in effect for the State's Temporary Assistance for Needy Families (TANF) program. If the State TANF program includes the cents in income calculations, the State agency may use the same procedures for food stamp income calculations. Whichever procedure is used, the State agency may elect to include the cents associated with each individual shelter cost in the computation of the shelter deduction and round the final shelter deduction amount.

Likewise, the State agency may elect to include the cents associated with each individual medical cost in the computation of the medical deduction and round the final medical deduction amount.

(2) Eligibility and benefits. (i)(A) Households which contain an elderly or disabled member as defined in §271.2, shall have their net income, as calculated in paragraph (e)(1) of this section (except for households considered destitute in accordance with paragraph (e)(3) of this section),

compared to the monthly income eligibility standards defined in §273.9(a)(2) for the appropriate household size to determine eligibility for the month.

(B) In addition to meeting the net income eligibility standards, households which do not contain an elderly or disabled member shall have their gross income, as calculated in accordance with paragraph (e)(1)(i)(A) of this section, compared to the gross monthly income standards defined in §273.9(a)(1) for the appropriate household size to determine eligibility for the month.

(C) For households considered destitute in accordance with paragraph (e)(3) of this section, the State agency shall determine a household's eligibility by computing its gross and net income according to paragraph (e)(3) of this section, and comparing, as appropriate, the gross and/or net income to the corresponding income eligibility standard in accordance with §273.9(a) (1) or (2).

(D) If a household contains a member who is fifty-nine years old on the date of application, but who will become sixty before the end of the month of application, the State agency shall determine the household's eligibility in accordance with paragraph (e)(2)(i)(A) of this section.

(E) If a household contains a student whose income is excluded in accordance with §273.9(c)(7) and the student becomes 18 during the month of application, the State agency shall exclude the student's earnings in the month of application and count the student's earnings in the following month. If the student becomes 18 during the certification period, the student's income shall be excluded until the month following the month in which the student turns 18.

(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 reduced by 30 percent of the household's net monthly income as calculated in paragraph (e)(1) of this section. If 30 percent of the household's net income ends in cents, the State agency shall round in one of the following ways:

(1) The State agency shall round the 30 percent of net income up to the nearest higher dollar; or

(2) The State agency shall not round the 30 percent of net income at all. Instead, after subtracting the 30 percent of net income from the appropriate Thrifty Food Plan, the State agency shall round the allotment down to the nearest lower dollar.

(B) If the calculation of benefits in accordance with paragraph (e)(2)(ii)(A) of this section for an initial month would yield an allotment of less than \$10 for the household, no benefits shall be issued to the household for the initial month.

(C) Except during an initial month, all eligible one- and two-person households shall receive minimum monthly allotments equal to the minimum benefit and all eligible households with three or more members

which are entitled to \$1, \$3, and \$5 allotments shall receive allotments, of \$2, \$4, and \$6, respectively, to correspond with current coupon book determinations.

28. The Department's Program Policy Manual, CFOP 165-22, Appendix A-1 "Food Assistance Income Eligibility Standards and Deductions" effective October 1, 2015 lists the following income limits and standards for a household size of two: Monthly 200% Gross Income Limit is \$2,655. Monthly 100% Net Income Limit is \$1,328. The Standard Deduction is \$155. The Standard Utility Allowance is \$345. Effective October 1, 2014 the Maximum Benefit amount for a two-person household is \$357. The Minimum Allotment for a one or two member household is \$16.

29. The Department's Policy Transmittal C-13-10-0007 "Food Assistance Minimum Benefit" dated October 11, 2013 states in relevant part:

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 or
- The AG contains an individual disqualified for an intentional program violation, felony drug trafficking, fleeing felon, or serving an employment and training sanction and has income less than or equal to the 130% gross and the 100% net income limits.

30. The findings show the petitioner is disabled. The petitioner has reported medical expenses of \$110.66. The petitioner has not verified any additional expenses. The above controlling authorities explain the amount of medical expenses exceeding \$35 is allowed as an excess medical expense. The petitioner's medical expenses of \$110.66 less \$35 leaves an excess medical expense of \$75.66.

31. The undersigned reviewed the Food Assistance benefit calculations as follows: The household's monthly gross earned income \$1,042.44 multiplied by 20 percent equals the earned income disregard of \$208.48. The household's total income of \$2,128.44 less the earned income disregard of \$208.48 and the standard deduction of \$155 and the excess medical expense of \$75.66 leaves an adjusted income of \$1,689.30. The adjusted income of \$1,689.30 multiplied by 50 percent gives a shelter standard of \$844.65. The petitioner's shelter costs are reported at \$129.21. The petitioner was given the Standard Utility Allowance (SUA) as he has the ability to heat and cool his home. The shelter cost of \$129.21 added to the SUA of \$345 totals \$474.21. As the shelter standard of \$844.65 exceeds the total of the shelter and utility costs of \$474.21, the undersigned concludes there is no deduction for excess shelter expense. The adjusted net income is the same as the adjusted income or \$1,689.30. The undersigned concludes the petitioner's adjusted net income exceeds the net income allowance of \$1,328.

32. The adjusted net income of \$1,689.30 was multiplied by 30 percent to reach the benefit reduction amount of \$507. The maximum monthly allotment of Food Assistance benefits is \$357. As the benefit reduction amount of \$507 exceeds the maximum monthly allotment of \$357, the petitioner is not eligible for Food Assistance. The undersigned concludes as the petitioner's household is a two-person household, the above controlling authority allows the petitioner to receive the minimum allotment for a one or two-person household which is \$16. The undersigned can find no more favorable outcome.

ADULT RELATED MEDICALLY NEEDY AND MEDICARE BUY-IN PROGRAMS

33. Fla. Admin. Code R. 65A-1.702 “Special Provisions states in 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. 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.)

34. Fla. Admin. Code R. 65A-1.713 “SSI-Related Medicaid Income Eligibility

Criteria” states in relevant 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:

...

(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.

(h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses.

...

(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.

35. 20 C.F.R. § 416.1121 “Types of unearned income” states in relevant part:

“(a) Annuities, pensions, and other periodic payments. This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security

benefits, disability benefits, veterans benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits.”

36. 20 C.F.R. § 416.1124 “Unearned income we do not count” states in relevant part:

(c) Other unearned income we do not count. We do not count as unearned income—

...

(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.

37. The findings show the petitioner has \$1,086 in social security benefits.

The above controlling authority requires \$20 of this income be disregarded. The undersigned concludes only \$1,066 of the petitioner’s social security is countable in his eligibility determination for Medically Needy and Medicare Buy-In.

38. Federal Regulations at 20 C.F.R. § 416.1111 “How we count earned income” states in relevant part:

(b) Net earnings from self-employment. We count net earnings from self-employment on a taxable year basis. However, we divide the total of these earnings equally among the months in the taxable year to get your earnings for each month. For example, if your net earnings for a taxable year are \$2,400, we consider that you received \$200 in each month. If you have net losses from self-employment, we divide them over the taxable year in the same way, and we deduct them only from your other earned income.

39. The findings show upon review of the petitioner’s self-employment income of \$1,479.67 and allowable expenses which total \$437.23, the petitioner’s self-employment income gross monthly income is \$1,042.44.

40. 20 C.F.R. § 416.1112 "Earned income we do not count" states in relevant part:

(c) Other earned income we do not count. We do not count as earned income—

(1) Any refund of Federal income taxes you receive under section 32 of the Internal Revenue Code (relating to earned income tax credit) and any payment you receive from an employer under section 3507 of the Internal Revenue Code (relating to advance payment of earned income tax credit);

...

(4) Any portion of the \$20 monthly exclusion in §416.1124(c)(10) which has not been excluded from your unearned income in that same month;

(5) \$65 of earned income in a month;

...

(7) One-half of remaining earned income in a month;

41. The above controlling authority requires that the gross monthly self-employment income of \$1,042.44 have the following deductions applied. The undersigned notes the \$20 exclusion was used completely on the unearned income. The self-employment income of \$1,042.44 less \$65 earned income disregard is \$977.44. One-half of the remaining self-employment income of \$977.44 is disregarded as well ( $\$977.44 / 2 = \$488.72$ ). The undersigned concludes the countable earned income after all disregards is \$488.72.

42. The undersigned concludes the unearned income of \$1,066 added to the self-employment income of \$488.72 equals a total countable income of \$1,554.72.

43. The Department's Program Policy Manual, CFOP 165-22, Appendix A-9 effective April 1, 2016 lists the income limit for a couple to receive QMB as \$1,335, SLMB as \$1,602 and QI1 as \$1,803.

44. Fla. Admin. Code R. 65A-1.716 "Income and Resource Criteria" (2) lists the Medicaid income and payment eligibility standards and Medically Needy income level for a household size of two as \$241.

45. The undersigned concludes the petitioner's countable income of \$1,554.72 is less than the income standard for the petitioner to receive SLMB. The undersigned notes the Department has already corrected the petitioner's case to be eligible for SLMB rather than QI 1. The undersigned notes there was no loss of program benefits in the instant case as the QI 1 program also pays the Medicare Part B premium.

46. The petitioner's countable income of \$1,554.72 less the Medically Needy Income level of \$241 leaves a share of cost of \$1,313. The undersigned notes the Department also corrected the case to reflect the correct share of cost. The undersigned can find no more favorable outcome.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied. 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.

FINAL ORDER (Cont.)  
16F-04836, 16F-05591 and 16F-05592  
PAGE - 17

DONE and ORDERED this 31 day of August, 2016,  
in Tallahassee, Florida.



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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

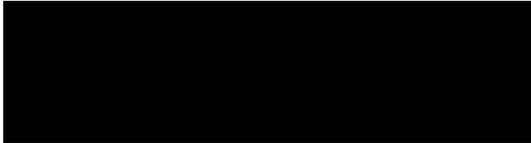
Jul 05, 2016

Office of Appeal Hearings  
Dept. of Children and FamiliesSTATE OF FLORIDA  
DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16N-00033

PETITIONER,

Vs.

RESPONDENT.  

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**FINAL ORDER**

Pursuant to notice, the undersigned convened a nursing home discharge hearing in the above-referenced matter on June 28, 2016 at 11:46 a.m., at 

**APPEARANCES**

For the petitioner:



For the respondent:

Trevor Matchin, Administrator

**STATEMENT OF ISSUE**

At issue is whether the facility's intent to discharge the petitioner due to non-payment of a bill for services based on federal regulations found at 42 C.F.R. § 483.12 is correct. The facility has the burden of proof to establish by clear and convincing evidence that the discharge is appropriate.

**PRELIMINARY STATEMENT**

Also present as witness for the petitioner was [REDACTED], daughter-in-law.

Witness for the respondent was Linda Harmon, director of social services.

At the request of the undersigned, the Agency for Health Care Administration (AHCA) conducted an on-site inspection of the facility and found no violations.

The petitioner presented one exhibit which was accepted, entered into evidence and marked as Petitioner's Composite Exhibit 1. The respondent presented one exhibit, which was accepted into evidence and marked as Respondent's Composite Exhibit 1. The Agency for Health Care survey letter was entered as Hearing Officer's Exhibit 1.

**FINDINGS OF FACT**

1. The petitioner entered the nursing facility on November 14, 2015. She came as a Medicare resident and was converted to a private pay resident on January 8, 2016 when her Medicare coverage expired.
2. On March 29, 2016, the respondent issued a Discharge Notice to the petitioner's Power of Attorney (POA), informing him that the petitioner was to be discharged from the nursing facility effective April 29, 2016, due to non-payment of bill for services.
3. On April 6, 2016, the petitioner requested a hearing to challenge the facility's action.
4. The nursing facility asserts it provided the petitioner with monthly statements with the balance owed each month. The outstanding balance owed for January 2016/ \$5,004, February 2016/\$13,018, March 2016/\$22,088, April 2016/\$30,878, May 2016/ \$39,930, June 2016/ \$48,690 and projected for July 31, 2016 is \$57,742. The petitioner's POA did not dispute receiving the monthly statements or the balance owed

to the facility. On March 4, 2016, the petitioner's POA made a payment of \$454 towards the petitioner's outstanding bill.

5. On June 28, 2016, the petitioner's POA applied for Medicaid. The Medicaid application is currently pending.

6. The respondent informed that even if the petitioner was to be approved for Medicaid, the past due balance is still owed and the facility cannot bill the petitioner as a Medicaid resident, as she was not occupying a Medicaid bed; she was in a private pay bed. As of the date of this hearing, the amount owed has not been paid.

7. The facility is willing to rescind the discharge notice if the petitioner pays the past due balance in full.

8. The petitioner's representative is unable to pay the past due amount as neither he nor the petitioner has the money to pay the past due amount.

#### **CONCLUSIONS OF LAW**

9. 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 section 400.0255(15), Fla. Stat. In accordance with that section, this order is the final administrative decision of the Department of Children and Families.

10. 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 involuntarily 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 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.

11. The undersigned's jurisdiction is limited to the above six reasons and will only consider if the discharge is for a legal reason based on any of the six allowable reasons listed above.

12. The petitioner was originally admitted with Medicare paying for her stay. When those benefits expired, she was converted to private pay. She incurred an outstanding bill for services as a private pay status. The outstanding balance is currently \$48,690. The petitioner's POA acknowledged that he received monthly statements for her stay at the facility and has not disputed the amount owed. Although the petitioner's representative has applied for Medicaid for her on June 28, 2016, the facility is unable to bill Medicaid for her stay when the outstanding balance was incurred. The petitioner is not in a Medicaid certified bed and therefore the facility cannot bill Medicaid for it.

13. According to the above authority, the facility may not discharge except for certain reasons, one of which is when the resident has failed, after reasonable and appropriate

notice, to pay for the stay at the facility. The petitioner has an unpaid bill for her care at the facility.

14. The hearing officer concludes that the facility has given the petitioner reasonable and appropriate notice to pay for her stay at the facility. Based on the evidence presented, the nursing facility established the petitioner failed, after reasonable and appropriate notice, to pay for her stay at the facility.

15. Establishing 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.

16. 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.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied, as the facility's action to discharge the petitioner is in accordance with Federal Regulations. The facility may proceed with the discharge, in accordance with all applicable Federal Regulations, Florida Statutes, and Agency for Health Care Administration requirements.

**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 05 day of July, 2016,

in Tallahassee, Florida.

*Christiana Gopaul Narine*

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Christiana Gopaul-Narine  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
Office: 850-488-1429  
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Copies Furnished To:



Jul 14, 2016

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

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16N-00038

PETITIONER,

Vs.

[REDACTED]

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, an administrative hearing was convened before the undersigned at 2:07 p.m. on June 10, 2016 at [REDACTED], Florida.

**APPEARANCES**

For the Petitioner: The petitioner was not present and was represented by her husband, [REDACTED].

For the Respondent: Stephen Iglesias, Attorney for [REDACTED]  
[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 the petitioner's needs cannot be met at the facility because its ventilator unit at [REDACTED]

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 April 1, 2016, 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.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

A letter dated May 18, 2016 from the Agency for Health Care Administration (AHCA) indicated that it found no facility violations based on its interviews and the facility's documentation. This was entered as the Hearing Officer Exhibit I.

The facility's attorney submitted a Motion for Production. The undersigned requested clarification of the attorney's Motion for Production during the hearing. The facility's attorney believes the facility was entitled to receive a copy of the petitioner's request for a hearing. The undersigned was unable to locate a governing authority that requires for the respondent to be given a copy of the hearing request. In addition, on April 20, 2016, the Office of Appeal Hearings mailed to the respondent an Order to Produce Notice and Begin Hearing Process, which informed the facility that a request for a hearing was filed by the petitioner on April 19, 2016 in response to the respondent's action to discharge. Therefore, the undersigned concludes that the respondent was given adequate notification of the petitioner's request for a hearing.

The North Regional Manager for the Local Long Term Care Ombudsman Council requested for the undersigned to take judicial notice of 42 C.F.R. § 483.12 as he argues that the Nursing Home Transfer and Discharge Notice was deficient due to its inclusion of two discharge locations; he believes that for the Discharge Notice to be adequate, it should only include one discharge location. The manager also believes the Discharge Notice is deficient because the effective date is April 1, 2016 but was not signed by the physician until April 14, 2016. The federal regulations at 42 C.F.R § 483.12(a)(2)(i) requires documentation from the resident's physician when discharge is necessary due to the resident's needs cannot be met in the facility. The federal regulations at 42 C.F.R § 483.12(a)(6) discusses the content of the notice and requires the discharge location to be listed. The discharge notice was signed by the resident's physician. The notice to discharge includes two discharge locations. Therefore, the undersigned cannot

conclude that the petitioner was harmed by the discharge notice being signed by the physician on April 14, 2016 or by the discharge notice including two discharge locations.

Evidence was received and entered as the Respondent's Exhibits 1 through 2.

The record was closed on June 10, 2016.

### **FINDINGS OF FACT**

1. The petitioner (age 74) is a ventilator-dependent resident in [REDACTED]

[REDACTED] which is separate from the rest of the facility.

2. The facility's corporate office determined that the ventilator unit at [REDACTED]

[REDACTED] is not viable as the need for the unit has not materialized.

The closest facility with a ventilator unit is [REDACTED]. [REDACTED]

the other facility with a ventilator unit.

3. The respondent contends that the petitioner and her family was informed that the ventilator unit is closing on April 1, 2016. The respondent contends that once the [REDACTED], its remaining staff cannot provide the care the petitioner needs, as it will no longer have ventilator staff. The respondent contends that its physician gave the petitioner medical clearance to be transported by Century Ambulance Services to the facility located in [REDACTED]. The Respondent's Exhibit 2 includes Progress Notes dated June 10, 2016, page 2 of 2, which is e-signed by the facility's physician, [REDACTED], and states: "Despite patients high risk as mentioned she is hemodynamically stable at this point and is stable for medical transport with professional supervision and ventilator support."

4. The respondent explained that the petitioner will be air-lifted to its sister facility by [REDACTED]. The respondent contends that [REDACTED] responds to emergency situations and is well-qualified to coordinate the transfer.

5. The respondent also explained that the facility in [REDACTED] has the equipment and staff needed to provide care to ventilator-dependent patients. The respondent contends that the care provided at the ventilator unit in [REDACTED] will be the same as the care that was provided at [REDACTED] before its closure; the petitioner's care will continue at [REDACTED].

6. The ombudsman argues that the petitioner's family relied on the facility to provide care to the petitioner and that the facility has terminated its contract. The petitioner's husband believes the petitioner will not survive the trip to [REDACTED]. The petitioner's husband argues that he has trouble driving at night and will not be able to spend as much time with her at [REDACTED]. He works fulltime and would like for the ventilator unit to remain open.

7. The respondent realizes it is an unfortunate situation that its ventilator unit is closing but it has provided services to ensure a safe and orderly discharge to its sister facility in [REDACTED].

#### **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

Section 400.0255(15), Florida Statutes. In accordance with said authority, this order is the final administrative decision of the Department of Children and Families.

9. Federal Regulations appearing 42 C.F.R. § 483.12, sets forth the reasons a facility may involuntarily 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.

10. 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; ..."

11. 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.

12. Based on the evidence presented, the nursing facility has established that the petitioner's needs cannot be met since its ventilator unit is closing. This is one of the six reasons provided in federal regulation (42 C.F.R. § 483.12) for which a nursing facility may involuntarily discharge a resident.

13. 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.

### **DECISION**

This appeal is denied, as the facility's action to discharge the petitioner is in accordance with Federal Regulations. The respondent may proceed with the discharge, as describe in the Conclusions of Law and in accordance with applicable Agency for Health Care Administration requirements.

### **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 14 day of July, 2016,

in Tallahassee, Florida.



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Paula Ali  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
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Copies Furnished To:



**FILED**

Jul 14, 2016

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

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16N-00041

PETITIONER,

Vs.

[REDACTED]

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, an administrative hearing was convened before the undersigned at 3:38 p.m. on June 10, 2016 at [REDACTED] Florida.

**APPEARANCES**

For the Petitioner: The petitioner was not present and was represented by his daughter, [REDACTED]

For the Respondent: Stephen Iglesias, Attorney for [REDACTED]  
[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 the petitioner's needs cannot be met at the facility because its ventilator unit at [REDACTED] is closing.

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 April 1, 2016, the respondent informed the petitioner that it was seeking to discharge/transfer him from its facility because his 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]

[REDACTED]

Present as witnesses for the respondent were John Simmons, Executive Administrator for [REDACTED], Veronica Cotton, Director of Nursing for [REDACTED], Claire Schwartz, Director of Respiratory for [REDACTED], Will Wygale, Social Worker for [REDACTED], Lisa Lungren, Director of Respiratory for [REDACTED], and Katrina Padilla, Director of Nursing at [REDACTED]

A letter dated May 18, 2016 from the Agency for Health Care Administration (AHCA) indicated that it found no facility violations based on its interviews and the facility's documentation. This was entered as the Hearing Officer Exhibit I.

The facility's attorney submitted a Motion for Production. The undersigned requested clarification of the attorney's Motion for Production during the hearing. The facility's attorney believes the facility was entitled to receive a copy of the petitioner's request for a hearing. The undersigned was unable to locate a governing authority that requires for the respondent to be given a copy of the petitioner's hearing request. On April 25, 2016, the Office of Appeal Hearings mailed to the respondent an Order to Produce Notice and Begin Hearing Process, which informed the facility that a request for a hearing was filed by the petitioner on April 22, 2016 in response to the respondent's action to discharge. Therefore, the undersigned concludes that the respondent was given adequate notification of the petitioner's request for a hearing.

The North Regional Manager for the Local Long Term Care Ombudsman Council requested for the undersigned to take judicial notice of 42 C.F.R. § 483.12 as he argues that the Nursing Home Transfer and Discharge Notice was deficient due to its inclusion of two discharge locations; he believes that for the Discharge Notice to be adequate, it should only include one discharge location. The manager also believes the Discharge Notice is deficient because the effective date is April 1, 2016 but was not signed by the physician until April 14, 2016. The facility's administrator pointed out that the Agency for Health Care Administration reviewed the discharge notice and found the notice was in compliance. The federal regulations at 42 C.F.R § 483.12(a)(2)(i) requires documentation from the resident's physician when discharge is necessary due to the resident's needs cannot be met in the facility. The federal regulations at 42 C.F.R § 483.12(a)(6) discusses the content of the notice and requires the discharge location to

be listed. The discharge notice was signed by the resident's physician. The notice to discharge includes two discharge locations. Therefore, the undersigned cannot conclude that the petitioner was harmed by the discharge notice being signed by the physician on April 14, 2016 or by the discharge notice including two discharge locations.

Evidence was received and entered as the Respondent's Exhibits 1 through 2.

The record was closed on June 10, 2016.

### **FINDINGS OF FACT**

1. The petitioner (age 83) is a [REDACTED] [REDACTED] is separate from the rest of the facility.

2. The facility's corporate office determined that the [REDACTED] [REDACTED] is not viable as the need for the unit has not materialized. The closest facility with a [REDACTED] is the other facility with a ventilator unit.

3. The respondent contends that the petitioner and his family was informed, verbally, on two occasions, that its ventilator unit is closing on April 1, 2016. The respondent contends that the facility can no longer meet the petitioner's needs once the ventilator unit closes because he cannot be taken off of the ventilator. The respondent contends that once the ventilator unit closes at [REDACTED], it will no longer have staff to provide ventilator services. The respondent contends that its physician gave the petitioner medical clearance to be transported by [REDACTED] to the facility located in [REDACTED]. The Respondent's Exhibit 2 includes Progress Notes, page 2 of 2, dated June 10, 2016, which is e-signed by the facility's physician,

Shawn Chopra, MD, and states: "...he is stable for transport via medical transport with ventilator support and professional supervision."

4. The respondent explained that the petitioner will be air-lifted to its sister facility by [REDACTED]. The respondent contends that [REDACTED] responds to emergency situations and is well-qualified to coordinate the transfer. The Respondent's Exhibit 2 includes the [REDACTED] Medical Standard Operating Guidelines (March 2016).

5. The respondent also explained that the facility in [REDACTED] has the equipment and staff needed to provide care to ventilator-dependent patients. The respondent contends that the care provided at the ventilator unit in [REDACTED] will be the same as the care that was provided at [REDACTED] before its closure; the petitioner's care will continue at [REDACTED].

6. The petitioner's son would like for the petitioner to stay at the present facility because his mother cannot drive and depends on him to take her to see her husband. The petitioner's daughter believes the transfer to [REDACTED] will create a hardship for her mother. The petitioner's daughter is not sure if the petitioner will be able to handle the move to [REDACTED] due to his medical conditions. The petitioner's daughter argues that the facility is being paid to take care of the petitioner. The petitioner's daughter argues that the petitioner is fine as long as he can see her mother.

7. The respondent contends that the facility's ventilator unit is not viable and that it has made arrangements to facilitate the move. The respondent contends that it has

continuity of care services in place to ensure the least amount of burden as possible on the petitioner and his family.

### **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 Section 400.0255(15), Florida Statutes. In accordance with said authority, this order is the final administrative decision of the Department of Children and Families.

9. Federal Regulations appearing 42 C.F.R. § 483.12, sets forth the reasons a facility may involuntarily 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.

10. 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; ..."

11. 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.

12. Based on the evidence presented, the nursing facility has established that the petitioner's needs cannot be met since its ventilator unit is closing. This is one of the six reasons provided in federal regulation (42 C.F.R. § 483.12) for which a nursing facility may involuntarily discharge a resident.

13. 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.

### **DECISION**

This appeal is denied, as the facility's action to discharge the petitioner is in accordance with Federal Regulations. The respondent may proceed with the discharge,

as describe in the Conclusions of Law and in accordance with applicable Agency for Health Care Administration requirements.

**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 14 day of July, 2016,

in Tallahassee, Florida.



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Paula Ali  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
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Copies Furnished To:



Jul 20, 2016

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 16N-00044

PETITIONER,

Vs.

[REDACTED]

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, a telephonic administrative hearing was convened on July 1, 2016, at 11:24 a.m.

**APPEARANCES**

For the Petitioner: The petitioner was not present and was represented by his son and power of [REDACTED]

For the Respondent: Cheryl Fredsall, Facility Administrator for [REDACTED]  
[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 at 42 C. F. R. § 483.12. The nursing home is seeking to discharge the petitioner because the

petitioner's "bill for services at this facility has not been paid after reasonable and appropriate notice to pay."

The respondent carries the burden of proof by clear and convincing evidence that the petitioner's discharge is in accordance with the requirements of the Code of Federal Regulations at 42 C.F.R. §483.12(a) and Section 400.0255, Florida Statutes (2009).

### **PRELIMINARY STATEMENT**

By notice dated April 27, 2016, the respondent informed the petitioner that the facility was seeking to discharge/transfer him due to nonpayment. On May 2, 2016, the petitioner timely requested a hearing to challenge the discharge/transfer.

The hearing was originally scheduled to convene for an in-person hearing on June 22, 2016 at 11:15 a.m. On June 13, 2016, the petitioner's son contacted the undersigned to request for the hearing to be rescheduled as he was going to be out of town. His request was granted and the hearing was rescheduled to July 1, 2016 at 11:15 a.m.

On June 27, 2016, the petitioner's son contacted the undersigned to request for the hearing to be held by telephone. His request was granted.

Appearing as witnesses for the respondent were Nora Wood, Business Office Manager and Chantel Johnson, Social Services Director.

A letter dated May 23, 2016 from the Agency for Health Care Administration (AHCA) was sent to the undersigned and it stated that the representative(s) did not find

the facility in violation of any laws or rules. This was entered as Hearing Officer Exhibit 1.

Evidence was submitted and entered as the Respondent's Exhibits 1 through 3.

The record was held open until 5:00 p.m. on July 8, 2016 to allow the respondent to provide additional evidence. Evidence was received and entered as the Respondent's Exhibit 4.

The petitioner did not submit any evidence.

The record was closed at 5:00 p.m. on July 8, 2016.

#### **FINDINGS OF FACT**

1. The petitioner was admitted into the facility on November 15, 2015; his payor source was Humana until January 12, 2016.

2. On January 11, 2016, the facility contends that it contacted the petitioner's son to inform him that the petitioner's level of care changed and that he would be needing long term care at the facility (*Respondent's Exhibit 4*).

3. The respondent's evidence includes Departmental Notes that indicate on January 12, 2016, the facility's administrator discussed with the petitioner's son to apply for Institutional Care Program (ICP) Medicaid (*Respondent's Exhibit 2, page 1*). The respondent contends that the petitioner owns personal property and that it advised the petitioner's son to contact an attorney to assist with the asset and with applying for ICP Medicaid.

4. The Respondent's Exhibit 2 includes billing statements sent to the petitioner and to the petitioner's son beginning December 31, 2015. As of the date of the hearing, the current balance owed to the facility was \$37530.

5. The respondent contends that it made several attempts to contact the petitioner's son by telephone to discuss balance owed but he refused to accept the phone calls. The respondent contends that the petitioner's son does not hand over the petitioner's Social Security check to pay the facility for its care to the petitioner. The respondent argues that it has not had any communication with the petitioner's son for several months. The respondent's records show that the last payment to the facility was in February 2016.

6. The petitioner's son argues that he received a billing statement for the first time when he learned of the facility's intent to discharge the petitioner from the nursing home. The petitioner's son argues he did not receive the monthly statements because they were mailed to his father's address at [REDACTED]. The petitioner's son explained that his address is [REDACTED]. The petitioner's son explained that he did not answer the facility's phone calls because they were harassing him about his father's property. The petitioner's son also explained that he attends school during the day and was unable to answer the phone calls from the facility.

7. The petitioner's son contends that he will apply for ICP Medicaid and sell his father's property when a survey is completed. The petitioner's son does not feel as if he is responsible for paying his father's bill. The petitioner's son believes he was informed

by Humana that they were still paying for his father's care but was unable to provide evidence to support his statement.

8. The petitioner's son explained that he is paying for his father's bills with the Social Security income his father receives. The petitioner's son contends that he depleted the petitioner's bank accounts in February 2016 and March 2016 to pay the facility.

9. The respondent contends that the billing statements were mailed to the address provided by the petitioner's son upon admission. The respondent contends that its business records do not show any returned billing statements; therefore, it is believed that the petitioner's son checked the mail at the address provided and received the billing statements. The respondent contends that the certified mail (discharge notice) dated April 28, 2016 is the only mail that was returned from 25 Buckley Drive, Debary, FL 32713.

#### **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 Section 400.0255(15), Florida Statutes. In accordance with said authority, this order is the final administrative decision of the Department of Children and Families.

11. Federal Regulations appearing 42 C.F.R. § 483.12, sets forth the reasons a facility may involuntarily 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.

12. Based on the evidence presented, the nursing facility has established that the resident has failed to pay the facility after reasonable and appropriate notice. This is one of the six reasons provided in federal regulation (42 C.F.R. § 483.12) for which a nursing facility may involuntarily discharge a resident.

13. The petitioner's son argues that he did not receive any billing statements until April 2016. However, the petitioner's son acknowledges paying the facility in February 2016. The petitioner's son also acknowledges that he refused to answer the phone calls from the facility because they were harassing him regarding his father's property. The respondent's business records do not indicate any returned mail prior to April 2016. Therefore, the undersigned concludes that the petitioner's son received reasonable and appropriate notice prior to issuing the discharge notice.

14. Based on the findings and the federal and state controlling authorities, the undersigned concludes the facility's discharge is proper.

15. 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.

16. 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.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied. The facility may proceed with the discharge action in accordance with the Agency for Health Care Administration's rules and guidelines.

### **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 20 day of July, 2016,

in Tallahassee, Florida.



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