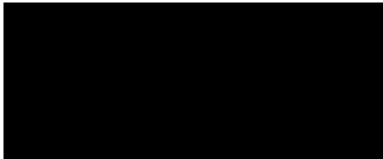
STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

FILED
Feb 22, 2016
Office of Appeal Hearings
Dept. of Children and Families



PETITIONER,

Vs.

APPEAL NO. 15F-10578
16F-00739

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 88999

RESPONDENT.
_________________________________/

ORDER OF DISMISSAL

An appeal in the above-styled matter is before the undersigned hearing officer. A Preliminary Order to Dismiss was issued on February 9, 2016 to allow the petitioner to respond in writing if she wished to continue with her appeals. The order included a 10 day response time. There was no response from the petitioner.

The appeal is hereby dismissed as abandoned in accordance with Fla. Admin. Code 65-2.061.

DONE and ORDERED this __22__ day of __February______, 2016, in Tallahassee, Florida.

Cassandra Perez
Hearing Officer
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1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished To: Petitioner
Office of Economic Self Sufficiency

FILED

Feb 29, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

PETITIONER,
Vs.

APPEAL NO. 16F-00334 and 16F-00802

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 10 Polk
UNIT: AHCA

RESPONDENT.
_______________________________/

FINAL ORDER OF DISMISSAL

The Office of Appeal Hearings received a verbal hearing request in the above matters on January 11, 2016 and January 26, 2016 regarding referral to a local in-network pain management provider. The issues were previously discussed and dismissed as non-jurisdictional during a fair hearing on December 2, 2015, related to appeal 15F-08776. The issues are discussed once more herein to provide guidance to Petitioner.

The parties convened for a telephonic status conference at 3:02 p.m. on February 10, 2016. Petitioner was present and represented himself. Stephanie Lang, R.N. Specialist and Fair Hearing Coordinator, represented the Respondent. Respondent's witnesses included India Smith (Grievance and Appeals Coordinator with Sunshine Health Plan) and Jason Sowinski (Claims Liaison with Sunshine Health Plan). The Agency for Health Care Administration is referred to as AHCA or Agency herein, and Sunshine Health Plan is referred to as Sunshine.

PETITIONER'S DIFFICULTIES WITH SUNSHINE

Petitioner wants a referral to a pain management doctor in his county. He has had numerous difficulties with Sunshine and its customer service, which are briefly outlined as follows:

Petitioner struggled to obtain referral to a pain management doctor. Sunshine could not find a doctor for him and after a period of months, Petitioner sought out a local doctor who agreed to see Petitioner under a single case agreement with Sunshine. Sunshine had difficulty getting the agreement approved, but eventually it was approved for a single visit. Petitioner saw this doctor once and then awaited approval for additional visits. Sunshine prior authorized the additional visits but Petitioner did not use them. Petitioner was unaware that the additional visits were approved because only his requesting doctor was notified. Further, Petitioner's doctor refused to see him after the first visit because Sunshine did not pay the claim. Sunshine determined the doctor did not properly submit the claim, and the doctor is unwilling to work with Sunshine any further to get the claim paid. Since the last hearing on this issue (which resulted in a dismissal), the doctor sent Petitioner a letter demanding payment and threatening a lawsuit. The doctor alleges Petitioner is responsible for the bill when Sunshine did not pay.

On December 2, 2015, during the hearing in appeal 15F-8776, Sunshine agreed to continue to help Petitioner find a new doctor. On December 8, 2016, Sunshine provided Petitioner with multiple doctors' names in an attempt to find a new pain management doctor to continue his care. Petitioner called the doctors Sunshine referred him to, but those doctors no longer take Sunshine. He still has not found

another doctor on his own, and Sunshine has not given him any doctors' names who are actively taking Sunshine patients. Based on a prior authorization request from Dr. Isar, Sunshine authorized Petitioner to see a pain management doctor for three visits between December 16, 2015 and January 31, 2016. Petitioner was unaware of the authorization and did not see a doctor, because only the requesting doctor was told of the approval. Dr. Panchanila was on the list Petitioner received, but Petitioner was informed by Dr. Panchanila's office that he does not accept Sunshine. He alleges that Sunshine's failure to provide contact information for an in-network doctor that is willing and able to take him amounts to a delay in care entitling him to a fair hearing on the issue.

Petitioner has been unhappy with Sunshine's case managers. He has been through multiple case managers and has the same complaints with all of them: the case managers fail to return phone calls or follow up with him. The case managers document that they called him, yet his phone has no missed calls. He is also unhappy that every time he calls Sunshine, he gets a new person unfamiliar with his case and has to start the process all over with getting information or care. He has also complained to the Agency for Health Care Administration, but insists that the Agency is not doing anything and gives him incorrect reference numbers to his numerous complaints.

After the December 2, 2015 hearing, due to Petitioner's ongoing dissatisfaction with Sunshine, the Agency provided Petitioner with a list of other managed care plans in his area so he could submit a good cause plan change request. Petitioner does not understand the differences in plans, and is unsure whether one would be any different

from what he currently has. Petitioner is encouraged to review his other options; however the Agency cannot advise Petitioner which plan to choose.

HEARING JURISDICTION ON DELAY AND CUSTOMER SERVICE

42 U.S.C. section 1396a(a)(3) provides that a State plan for medical assistance must "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." In regard to this matter, an individual's right to a fair hearing is set forth in Title 42 Part 431 of the Code of Federal Regulations (CFR). The CFR provides in pertinent part:

> § 431.220 When a hearing is required.
>
> (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.
> …
>
> § 431.201 Definitions.
> Action means a termination, suspension, or reduction of Medicaid eligibility or covered services. …

42 U.S.C. section 1396u-2(b)(4) provides "[e]ach medicaid managed care organization shall establish an **internal grievance procedure** under which an enrollee who is eligible for medical assistance under the State plan under this title, or a provider on behalf of such an enrollee, **may challenge the denial of coverage of or payment for such assistance** [emphasis added]. This MCO grievance system must include an internal grievance process, an internal appeal process, and *access* to the State's fair

hearing system, as warranted by section 1902(a)(3)) of the Social Security Act. See 42 CFR 438.402(a). The CFR provides similar information regarding the MCO grievance system. The relevant portions of Title 42, Subsection 438 are as follows:

> § 438.400 Statutory basis and definitions.
> (a) Statutory basis. This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.
> (1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.
> (2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.
> (3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.
>
> (b) Definitions. As used in this subpart, the following terms have the indicated meanings:
> Action means—
> In the case of an MCO or PIHP—
> (1) The denial or limited authorization of a requested service, including the type or level of service;
> (2) The reduction, suspension, or termination of a previously authorized service;
> (3) The denial, in whole or in part, of payment for a service;
> (4) The failure to provide services in a timely manner, as defined by the State;
> (5) The failure of an MCO or PIHP to act within the timeframes provided in § 438.408(b); or
> (6) For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.
>
> Appeal means a request for review of an action, as "action" is defined in this section.
>
> Grievance means an expression of dissatisfaction about any matter other than an action, as "action" is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO or PIHP level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to,

> the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.)

Statutes and case law interpreting the federal regulations limit a fair hearing's jurisdiction when it comes to a provider payment dispute once services have been rendered, and will be discussed further in another section.

The hearing officer's jurisdiction does not extend to the plan's poor customer service. The hearing officer also lacks jurisdiction over providers and their actions, such as unwillingness to follow billing claims procedure. Petitioner's issues related to Sunshine are matters properly suited for the grievance process, not a fair hearing.

Petitioner argues he has the right to a fair hearing because Sunshine has caused delays in his care by general incompetence and failure to provide a referral to another doctor. Sunshine promptly responded to all of Petitioner's complaints and requests. Petitioner received a list of doctors in his area but the list was not inspected to ensure the information was still accurate. It is not a matter of delay on acting on his request, just a matter of providing verified and correct information. Again, this goes to customer service, which the hearing officer does not have jurisdiction to rule on.

Petitioner's request for a pain management doctor is not the same as a claim for services. It is apparent that his request for visits would be approved if the provider properly submitted a claim. The issue is a plan provider network issue. The hearing officer cannot order any relief because there is no action (as defined above) or failure to act (delay) by the plan to review. The plan promptly gave Petitioner referrals following the last hearing, and Petitioner admitted such. Although the providers were unusable, the plan promptly provided information. The hearing officer cannot change the plan's

available network or order a provider to accept the plan or Petitioner. If the hearing officer found that the plan's failure to provide accurate information was a delay as intended by the regulations, the only remedy would be to order the plan to provide prompt information, which is what the plan agreed to in a past hearing and attempted to do. The plan is encouraged to continue to provide prompt information. At this time, having a full hearing on the matter and ordering the plan to provide prompt information would serve no purpose as the plan is already doing that.

Petitioner's complaints of an insufficient network may best be resolved by contacting the Agency for Health Care Administration, as this relates to the plan's contract with AHCA. Petitioner has already filed complaints with AHCA, which are pending.

BILLING

Petitioner's prior provider has sent him a bill and is threatening him with collections. Although Petitioner is not requesting a hearing on this issue, the following information will be provided for Petitioner's knowledge and guidance. Information regarding provider billing is available in the Florida Medicaid Provider General Handbook on pages 1-6 and 1-7. The Handbook is promulgated into law by Florida Statutes 409.908 and Florida Administrative Code Chapter 59G-5.020(1). Specifically, page 1-6 states:

> **A provider who bills Medicaid** for reimbursement of a Medicaid-covered service **must accept payment from Medicaid as payment in full**. This does not include Medicaid copayments and Medicaid coinsurance.
> …
> **A provider who fails to bill Medicaid correctly and in a timely manner may not bill the recipient.** (emphasis added)

Page 1-7 of the Handbook explains when a provider can bill a Medicaid recipient directly:

> Other than Medicaid copayments and Medicaid coinsurance, **the provider cannot seek payment from a recipient for a compensable service for which a claim has been submitted, regardless of whether the claim has been approved, partially approved or denied except under the following circumstances**:
>
> - The recipient is not eligible to receive Medicaid services on the date of service;
> - The service the recipient receives is not covered by Medicaid;
> - The provider has verified that the recipient has exceeded the Medicaid coverage limitations or frequency cap. The provider must inform the recipient that he has exceeded the frequency cap for the specific service to be rendered. (An exception is for prenatal visits. Payment for prenatal care is based on a total amount for complete care. Reimbursement for the 10 or 14 visits is the maximum reimbursement for the full course of prenatal care. If additional visits are provided, payment is considered already made in full. The provider may not bill the additional visits to Medicaid or the recipient.);
> - The recipient is enrolled in a Medicaid managed care program or Medipass and has been informed that the particular service has not been authorized by the recipient's managed care plan or primary care provider;
> - The recipient is enrolled in managed care program and has been informed that the treating provider is not a member of the recipient's managed care network; and
> - The provider has informed the recipient in advance that he does not accept Medicaid payment for the specific service to be rendered. The provider must document in the recipient's medical record that the recipient was informed and agrees to the service. (emphasis added)

The above authorities explain that a Medicaid provider, such as Petitioner's pain management doctor, should not be billing him directly unless certain criteria are met. However, it is beyond the hearing officer's jurisdiction to resolve the provider's payment issue with the plan. Billing issues are between the provider and the plan and are not a

service authorization issue as contemplated by federal regulations excerpted in the previous section. The law requires an MCO to have an internal grievance procedure to remedy billing disputes. Jurisdiction over provider payment disputes in the fair hearing process is limited by the above rules, as well as other rules, statutes, and case law. See, e.g., Fla. Admin. Code R. 59G-5.110; J.W. v. Agency for Health Care Admin., 2015 WL 7075133 (Fla. 1st DCA November 13, 2015). Since a Medicaid recipient is not required to pay for services except in limited circumstances which are not alleged here, the recipient does not have standing to bring a fair hearing request on a payment issue for services already rendered.

As discussed during the status conference, Petitioner should fax the collections letter and bill to the Agency and to his plan so that they can follow up with the provider and resolve the issue. If Petitioner is served with a lawsuit, Petitioner is encouraged to contact an attorney to defend his case. Petitioner may search for a free or low cost legal aid attorney in his area at the following website: http://www.lsc.gov/find-legal-aid.

SUGGESTED FUTURE ACTIONS

Petitioner has options to request a plan change if he does not want to stay with Sunshine. Sunshine will continue attempts to find an in-network, in-county pain management physician to see Petitioner. If Petitioner is unable to locate a physician to take him, or if Sunshine does not otherwise assist Petitioner with his needs, he may file another complaint with the Agency for Health Care Administration at 888-419-3456. If Petitioner requests a service in the future and it is delayed or denied, he may file for a Fair Hearing with the Office of Appeal Hearings.

Although the hearing officer lacks jurisdiction over the issue and therefore cannot order any action, the plan is encouraged to promptly provide Petitioner a list of in-network pain management physicians which a plan employee has verified with the physicians on the list for accuracy.

DISMISSAL DECISION

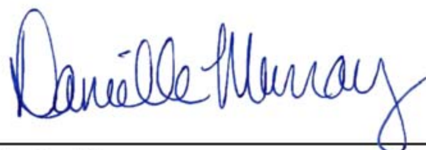
Petitioner's requests for hearing based on alleged plan delay in providing a referral are dismissed. The hearing officer finds no apparent delay in an Agency or plan decision on a claim for service which would provide hearing rights, and even if there were a delay, there would be no available or practical remedy this office could provide. No further hearing on this issue will be scheduled.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this ___29___ day of ___Februarv___, 2016,

in Tallahassee, Florida.



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Copies Furnished To [redacted] Petitioner
Don Fuller, Area 6, AHCA Field Office Manager