FILED
Jan 11, 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. 13F-5476
13F-5486
13F-5475
13F-5477
13F-5479
13F-5480
13F-5483
13F-5484

PETITIONERS,

Vs.

[redacted]

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 12 Sarasota
UNIT: 88694

RESPONDENT.
_____/

ORDER OF DISMISSAL

The parties filed a Joint Status Report and Stipulation to Withdraw, dated December 18, 2015, which the Office of Appeal Hearings received on January 4, 2016. The parties agreed the issue was moot and Petitioner agreed to withdraw the above appeals. Therefore, the above appeals are hereby dismissed as withdrawn.

DONE and ORDERED this 11 day of January, 2016, in Tallahassee, Florida.

Danielle Murray
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700

Office: 850-488-1429
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Copies Furnished To: Roseann Liriano, Suncoast Region
Rebecca Kapusta, Esq.
[redacted]attorney of record for all listed Petitioners

FILED
Jan 20, 2016
Office of Appeal Hearings
Dept. of Children and Families

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

[redacted]

PETITIONER,

APPEAL NO. 15F-06590

Vs.

[redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 Dade
UNIT: 88677

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on November 18, 2015, at 1:00 p.m., in [redacted]

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Leslie Hinds, District Legal Counsel, Department of Children and Families (DCF).

STATEMENT OF ISSUE

At issue is the Department's action in denying the petitioner's application for SSI-Related Medicaid benefits on the basis he did not meet the disability requirements of the program. The petitioner carries the burden of proof.

PRELIMINARY STATEMENT

Present as the supervising attorney for the petitioner's representative was [redacted]

Present as witnesses for the respondent were Joseph Austry, Operations Management Consultant 1, and Oilda Guerra, Economic Self Sufficiency Specialist, both from DCF. Also present via telephone as a witness for the Respondent was Lauren Coe Program, Operations Administrator, with the Department of Health's Division of Disability Determinations.

Present as an interpreter via telephone was [redacted] employee of Propio Language Services, and later in the hearing, [redacted] also from Propio Language Services.

The record was left open for fourteen additional days in order for both parties to submit proposed orders. The petitioner submitted a proposed order.

The respondent submitted into evidence Respondent Exhibit 1 through 3.

The petitioner submitted into evidence Petitioner Exhibits 1,2,3,4,5,6,7,8,10,11, 12, and 13.

FINDINGS OF FACT

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

1. The petitioner filed an application for Medicaid benefits with the Department on March 23, 2015. An individual must be disabled, blind, or aged (65 years or older) to be eligible for SSI- Related Medicaid. As the petitioner has not turned sixty-five years of

age and is forty-nine years of age, his application was forwarded to DDD (Division of Disability Determination) for disability consideration.

2. The petitioner applied for social security benefits and was denied in February 2013. He has a pending hearing before an Administrative Law Judge with the Social Security Administration. DDD made an independent decision for this case.

3. DDD relies on the same rules and regulations that apply to the Social Security Administration (SSA) when making its determination. DDD considered the petitioner not disabled using the code N-32. N-32 code means "capacity for substantial gainful activity-other work." DDD denied the petitioner at step five of the five-steps of sequential evaluation. The Department denied the petitioner's application for Medicaid benefits on May 26, 2015 based on not being considered disabled.

4. The petitioner is currently not employed. He was previously employed as a delivery man, musician, composer and sound engineer. He does not speak English.

5. The petitioner has been diagnosed with a [redacted] specifically [redacted] per December 2012 MRI of the [redacted] Additionally, he has been diagnosed with [redacted]

6. Discharge summary records, dated May 2015 from Jackson Health System, show normal range of motion in the [redacted] and [redacted] (not followed up surgically). Discharge summary records, dated September of 2014 from [redacted] show a history of [redacted]

[redacted]and history of [redacted] A medical report submitted as part of Petitioner Exhibit 5, dated December 2012 and signed by Dr. Sidani, states: "The level of degenerative changes [redacted]

7. DDD completed a Physical Residual Functional Capacity Assessment (RFC) for the petitioner. For the "Exertional Limitations" part of this assessment, it notes the petitioner can occasionally lift and/or carry 20 pounds. It notes the petitioner can frequently lift and/or carry 10 pounds. It notes the petitioner can stand and/or walk about 6 hours in an 8 hour workday. It notes the petitioner can sit with normal breaks about 6 hours in an 8 hour workday. It notes the petitioner can push and/or pull unlimited and is not limited in his upper extremities. It notes the petitioner is limited in his lower extremities with the explanation: "Patient symptomatic with significant limitations of flexion, extension and pain radiating to feet."

8. For postural limitations, the assessment notes the petitioner has limitations climbing ramp/stairs and a ladder/rope/or scaffold. It notes the petitioner has limitations balancing. It notes the petitioner has occasional limitations with stooping, kneeling, crouching, and crawling.

9. For manipulative limitations, the assessment notes none established.

10. For visual limitations, the assessment notes none established.

11. For communicative limitations, the assessment notes none established.

12. For environmental limitations, the assessment notes none established except for hazards such as machinery and heights where he would have to avoid even moderate exposure.

13. Based on the above information, DDD determined the petitioner has the residual functional capacity to do "light" work. Also, DDD determined the petitioner was capable of doing such jobs as a Lens Inserter, Nuts Sorter, and a Surveillance System Monitor.

14. DDD completed a Psychiatric Review Technique assessment. This assessment; however, noted no medically determinable impairment. The respondent's DDD witness indicated based on this, DDD did not consider the petitioner's alleged mental condition as a severe impairment.

15. The petitioner submitted into evidence Petitioner Exhibit 6 through 8, which contains information regarding the petitioner's "mental disorder". The information submitted was not contained in the respondent's exhibits.

16. Petitioner Exhibit 6 is a copy of a Physical Residual Functional Capacity Questionnaire. It was completed and signed by the petitioner's treating physician, Dr. Rafatiah on June 19, 2013. This questionnaire is not the same as the above noted respondent Physical Residual Functional Capacity Assessment. The questionnaire indicates diagnoses of [redacted] The questionnaire indicates petitioner is able to sit, stand, and walk less than one hour in an eight-hour working day and unable to carry objects weighing more than five pounds. Further, the questionnaire states petitioner is constantly incapable of even low stress jobs.

17. The questionnaire indicates the petitioner could never, twist, bend, squat, crawl, climb ladders or climb stairs. When it comes to right and left hand function, the questionnaire indicates: "Due to pain, pushing and pulling may be unable to be performed. Due to concentration with the pain, simple grasps and manipulations would be difficult at times.

18. Petitioner Exhibit 11 shows a mental status exam, dated October 1, 2015, which states diagnoses of [redacted] The exam indicates petitioner overall feels slightly better but still with some anxiety. Energy and motivations is improved. Concentration is still poor. He is awake, alert, and oriented to person, place, and time. Thought process is organized and linear. No auditory or visual hallucinations elicited. No paranoia or delusions elicited. No suicidal ideations or homicidal ideations. Plan is to continue [redacted] continue [redacted] for [redacted] discontinue [redacted] and start [redacted].

19. The petitioner has been prescribed the following medications: [redacted] He indicated that he does get some relief of his conditions by the use of these medications but they have many side effects. He indicated that most of the time the medications do not work for him, especially [redacted] He indicated he is in constant pain.

20. The petitioner indicated that he has memory loss, due to his mental condition and due to the side effects of the medication. He indicated that based on the memory

loss, he is unable to adequately play any musical instrument or function as a composer or sound engineer.

CONCLUSIONS OF LAW

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

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

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

24. Federal Regulations at 42 C.F.R. § 435.541 sets standards regarding when it is appropriate for the state Medicaid agency to make a disability determination. The regulation states in relevant part:

> (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.

25. The Department's Florida Program Policy Manual, section 1440.1204 Blindness/Disability Determinations (MSSI, SFP), states "[i]f 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."

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

27. Federal Regulations at 42 C.F.R. § 435.541 indicate the state Medicaid agency's determination of disability must be in accordance with the requirements for evaluating evidence under the SSI program specified in 20 C.F.R. §§ 416.901 through 416.998.

28. Federal Regulations at 20 C.F.R. § 416.920, Evaluation of Disability of Adults, explains the five-step sequential evaluation process used in determining disability. The regulation states in part:

(a) General—(1) Purpose of this section. This section explains the five-step sequential evaluation process we use to decide whether you are disabled, as defined in § 416.905.

(2) Applicability of these rules. These rules apply to you if you are age 18 or older and you file an application for Supplemental Security Income disability benefits.

(3) Evidence considered. We will consider all evidence in your case record when we make a determination or decision whether you are disabled.

(4) The five-step sequential evaluation process. The sequential evaluation process is a series of five "steps" that we follow in a set order. If we can find that you are disabled or not disabled at a step, we make our determination or decision and we do not go on to the next step. If we cannot find that you are disabled or not disabled at a step, we go on to the next step. Before we go from step three to step four, we assess your residual functional capacity. (See paragraph (e) of this section.) We use this residual functional capacity assessment at both step four and at step five when we evaluate your claim at these steps. These are the five steps we follow:

(i) At the first step, we consider your work activity, if any. If you are doing substantial gainful activity, we will find that you are not disabled. (*See* paragraph

(b) of this section.)

(ii) At the second step, we consider the medical severity of your impairment(s). If you do not have a severe medically determinable physical or mental impairment that meets the duration requirement in § 416.909, or a combination of impairments that is severe and meets the duration requirement, we will find that you are not disabled. (*See* paragraph (c) of this section.)

(iii) At the third step, we also consider the medical severity of your impairment(s). If you have an impairment(s) that meets or equals one of our listings in appendix 1 to subpart P of part 404 of this chapter and meets the duration requirement, we will find that you are disabled. (*See* paragraph (d) of this section.)

(iv) At the fourth step, we consider our assessment of your residual functional capacity and your past relevant work. If you can still do your past relevant work, we will find that you are not disabled. (See paragraph (f) of this section and § 416.960(b).)

> (v) At the fifth and last step, we consider our assessment of your residual functional capacity and your age, education, and work experience to see if you can make an adjustment to other work. If you can make an adjustment to other work, we will find that you are not disabled. If you cannot make an adjustment to other work, we will find that you are disabled. (See paragraph (g) of this section and § 416.960(c).)

29. Federal Regulations at 20 C.F.R. § 416.967 sets forth physical exertion requirements. The regulation states in part:

> (b) Light work. Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, you must have the ability substantially all of these activities.

30. In evaluating the first step, the petitioner is not engaging in substantial gainful activity. Therefore, the first step is met.

31. In evaluating the second step, the impairments must last or be expected to last for a continuous period of at least 12 months to meet durational requirements. The petitioner has a diagnosis of [redacted] which could be considered severe. The second step is met.

32. In evaluating the third step, the impairment(s) would have to meet or equal one of the listings in appendix 1 to subpart P of part 404. The petitioner was evaluated under listing:

> **1.04** ***Disorders of the spine*** (e.g., herniated nucleus pulposus, spinal arachnoiditis, spinal stenosis, osteoarthritis, degenerative disc disease, facet arthritis, vertebral fracture), resulting in compromise of a nerve root (including the cauda equina) or the spinal cord. With:
> A. Evidence of nerve root compression characterized by neuro-anatomic distribution of pain, limitation of motion of the spine, motor loss (**atrophy** with associated muscle weakness or muscle weakness) accompanied by

sensory or reflex loss and, if there is involvement of the lower back, positive straight-leg raising test (sitting and supine);
OR
B. Spinal arachnoiditis, confirmed by an operative note or pathology report of tissue biopsy, or by appropriate medically acceptable imaging, manifested by severe burning or painful dysesthesia, resulting in the need for changes in position or posture more than once every 2 hours;
or
C. Lumbar spinal stenosis resulting in **pseudoclaudication**, established by findings on appropriate medically acceptable imaging, manifested by chronic nonradicular pain and weakness, and resulting in inability to ambulate effectively, as defined in 1.00B2b.

The petitioner has not met the listing above based on the medical records provided.

33. The petitioner was also evaluated under listing:

12.04 ***Affective disorders***: Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation.
The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.
A. Medically documented persistence, either continuous or intermittent, of one of the following:
1. Depressive syndrome characterized by at least four of the following:
a. Anhedonia or pervasive loss of interest in almost all activities; or
b. Appetite disturbance with change in weight; or
c. Sleep disturbance; or
d. Psychomotor agitation or retardation; or
e. Decreased energy; or
f. Feelings of guilt or worthlessness; or
g. Difficulty concentrating or thinking; or
h. Thoughts of suicide; or
i. Hallucinations, delusions, or paranoid thinking; or
2. Manic syndrome characterized by at least three of the following:
a. Hyperactivity; or
b. Pressure of speech; or
c. Flight of ideas; or
d. Inflated self-esteem; or
e. Decreased need for sleep; or
f. Easy distractibility; or

g. Involvement in activities that have a high probability of painful consequences which are not recognized; or
h. Hallucinations, delusions or paranoid thinking; or
3. Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes);

AND

B. Resulting in at least two of the following:
1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration;

OR

C. Medically documented history of a chronic affective disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:
1. Repeated episodes of decompensation, each of extended duration; or
2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or
3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

The petitioner has not met the listing above based on the medical records provided.

34. The fourth step is to determine whether or not the individual's impairment(s) prevents him/her from doing past relevant work. DDD has agreed the petitioner cannot return to his former work, thus the petitioner will be evaluated under the fifth step.

35. The fifth step is to determine if the petitioner can do other work in the national economy which requires considering petitioner’s Physical Residual Functional

Capacity Assessment, age, education, work experience, combination of conditions, inability to speak English and the effect of medications both positive and negative.

36. The respondent's position is that the petitioner is able to do certain jobs in the national economy such as a Lens Inserter, Nuts Sorter or a Surveillance System Monitor. All of these jobs are considered are considered as "light duty work".

37. For the case at hand, although the DDD adjudicator determined the petitioner's affective disorder was not a medically determinable impairment, the evidence presented shows to the contrary. The evidence shows diagnoses of [redacted] The October 2015 mental status exam submitted by the petitioner, however, indicates continued improvement in his mental condition with current medication management.

38. Although the evidence shows petitioner does suffer from [redacted] the stringent criteria necessary to meet Listing of Impairment 1.04 was not met. Further, the petitioner's medical source opinion, per the treating source's RFC, is not supported by the objective medical evidence. For example, the evidence failed to support statements which limited fine manipulation, grasp, and upper extremity strength. Therefore, the treating source's RFC is afforded little weight.

39. The hearing officer agrees with the respondent overall conclusion for the petitioner that he can do other work in the national economy. Based on all of the above, the hearing officer concludes the petitioner does not meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905 and is not considered disabled. The petitioner has not met his burden of proof.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this 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 January, 2016, in Tallahassee, Florida.

Robert Akel

Robert Akel
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
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Copies Furnished To: [redacted] Petitioner
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Javier Ley-Soto, Esq.
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Michael Deutsch

FILED
Jan 27, 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-07001

PETITIONER,

Vs.

[redacted]

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pinellas
UNIT: 88269

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on October 2, 2015 at 9:00 a.m., December 10, 2015 at 9:00 a.m., and December 30, 2015 at 11:00 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the petitioner [redacted]

For the respondent: Signe Jacobson, Senior Economic Self Sufficiency Specialist.

STATEMENT OF ISSUE

Petitioner is appealing the Department's action to deny her application for Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

On July 27, 2015, the Department sent the petitioner a Notice of Case Action (NOCA) informing her that her application for Medicaid was denied because "you or a member(s) of your household do not meet the disability requirement." The petitioner timely appealed this action on August 13, 2015.

The petitioner presented a total of 116 pages of evidence for the undersigned to consider, which was entered into the record as Petitioner's Composite Exhibit 1. The Department presented a total of 70 pages of evidence for the undersigned to consider, which was entered into the record as Respondent's Composite Exhibit 1. The record was closed on December 30, 2015.

FINDINGS OF FACT

1. On July 20, 2015, the petitioner applied for Medicaid for herself. She is 51 years old and has no children under the age of 18 in her household. The petitioner claimed to be disabled. On September 9, 2015, the Department sent a Disability Determination and Transmittal form to the Division of Disability Determination (DDD) to make a disability determination.

2. The petitioner filed a disability application with the Social Security Administration (SSA) which was denied on March 5, 2013. She appealed this decision and was again denied on February 19, 2015 by an Administrative Law Judge (ALJ) for the SSA. The petitioner appealed this denial to the Appeals Council and that appeal is currently pending.

3. On September 15, 2015, DDD returned the transmittal to the Department informing it that an adoption of the SSA's decision was made. DDD did not conduct an

independent review, instead, it denied the petitioner's disability claim by adopting the SSA denial.

4. The code used to deny was N31, which is non-pay- capacity for substantial gainful activity-customary past work, no visual impairment. The primary diagnosis was [redacted] and the secondary diagnosis was [redacted] from the SSA Blue Book.

5. On July 27, 2015, the Department sent the petitioner a NOCA informing her that she was ineligible for Medicaid. The Department did not provide a subsequent denial NOCA after DDD adopted the SSA decision on September 15, 2015.

6. The petitioner reported that she had new disabling conditions, which were [redacted] and she went from stage 4 to stage 5 in [redacted] The petitioner indicated that these conditions have been reported to the SSA.

7. In the denial letter from the SSA dated February 19, 2015, the ALJ wrote the following:

"…The claimant testified that she can stand for ten minutes and that her ankles swell if she sits for too long, and that she spends most of her day in a recliner…Dr. Winkler diagnosed the claimant with [redacted] (Page 5 of ALJ decision)

"…He further indicated that the claimant is a [redacted] with a concern with need for dialysis in next 12 months and that the claimant experienced fatigue that affects her ability to concentrate…He further reported that the claimant has [redacted] with progressive decline in renal function and that he anticipated her symptoms will worsen over the next 12 months…The undersigned gives the opinion of Dr. Sharma some, albeit little, weight, as his opinion is inconsistent with his own history of minimal findings, as described above…As such, the medical evidence of record is absent an evaluation for [redacted]."(Page 8 of ALJ decision)

8. All of the alleged new disabling conditions the petitioner reported during the hearing were addressed in the ALJ's decision.

CONCLUSIONS OF LAW

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

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

11. Fla. Admin. Code, Section 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. For an individual to receive Medicaid who are less than 65 years of age, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. The regulation states, in part:

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

12. The Code of Federal Regulations at 42 C.F.R. § 435.541 Determination of Disability states:

> (a) *Determinations made by SSA*. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.
> (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in

> § 435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under § 435.909.
> (b) *Effect of SSA determinations*.
> (1) Except in the circumstances specified in paragraph (c)(3) of this section-
> (i) **An SSA disability determination is binding on an agency until the determination is changed by SSA**. [emphasis added]
> (ii) If the SSA determination is changed, the new determination is also binding on the agency.
> (2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.
> (c) *Determinations made by the Medicaid agency*. The agency must make a determination of disability in accordance with the requirements of this section if any of following circumstances exist…
> (4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and-
> (i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or
> (ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.
> (iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—
> (A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or
> (B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

13. The above federal regulation explains that the respondent may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.912 on the same issues presented in the Medicaid application. The respondent is bound by the federal agency's decision unless there is evidence of a new disabling condition not reviewed by SSA. The petitioner

reported that she had new disabling conditions, but the undersigned found reference to each in the ALJ's denial decision dated February 19, 2015. SSA denied the petitioner's disability claim on February 19, 2015 because it determined she was not disabled under their rules. The petitioner disagreed with SSA's disability denial and has filed an appeal with SSA, which is still pending. The respondent adopted SSA's decision and denied the petitioner's Medicaid application.

14. In careful review of the evidence and controlling legal authorities, the undersigned concludes that the respondent followed rule in adopting the SSA disability denial from February 19, 2015 and denying the petitioner's Medicaid disability application.

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 27 day of January, 2016,

in Tallahassee, Florida.

Brandy Ricklefs
Hearing Officer
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Copies Furnished To [redacted]
Office of Economic Self Sufficiency
[redacted]

FILED
Jan 29, 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-07509

PETITIONER,

Vs.

[redacted]

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

RESPONDENT.
_____/

FINAL ORDER

The undersigned convened an administrative hearing by phone in the above-referenced matter on November 17, 2015 at 10:29 a.m. One continuance was granted for the respondent.

APPEARANCES

For Petitioner: [redacted] pro se

For Respondent: Christine McKee, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether respondent's action in denying petitioner's application for SSI-Related Medicaid benefits is correct. The burden of proof is assigned to the petitioner by the preponderance of the evidence.

PRELIMINARY STATEMENT

Petitioner was present and testified. Petitioner submitted one exhibit, which was accepted into evidence and marked as Petitioner's Exhibit "1". Respondent was

represented by Christine McKee with the Department of Children and Families (hereafter “DCF”, “Respondent” or “Agency”). Respondent submitted four exhibits, which were accepted into evidence and marked as Respondent’s Exhibits “1” through “4”.

On November 4, 2015, the respondent filed a Motion for Dismissal requesting petitioner’s appeal be dismissed as she had requested a judicial review of the Final Order for appeal 15F-00051, which addressed the respondent’s action to deny petitioner’s application for SSI-Related Medicaid benefits effective July 2014 and ongoing. The second District Court of Appeals dismissed petitioner’s appeal of the Final Order for 15F-00051 as untimely. The undersigned denied the respondent’s Motion for Dismissal as petitioner does not seek approval of SSI-Related Medicaid benefits for the time period addressed in 15F-00051.

The undersigned left the record open until November 30, 2015 to allow the respondent and the petitioner to provide additional documentation. On November 18, 2015, the petitioner submitted additional documentation that was marked and entered into evidence as Petitioner’s Exhibit “2”. On November 19, 2015, the respondent submitted additional documentation that was marked and entered into evidence as Respondent’s Exhibits “5” through “11”. On December 4, 2015, the petitioner contacted the undersigned requesting an extension of time for her to provide additional documentation. The undersigned granted the extension and the record was left opened until December 6, 2015. On December 8, 2015, the petitioner submitted additional documentation that was marked and entered into evidence as Petitioner’s Exhibit “3”. The record closed on December 8, 2015.

FINDINGS OF FACT

1. On January 30, 2014, the petitioner applied for Supplemental Security Income (SSI) benefits from the Social Security Administration (SSA). On April 23, 2014, SSA denied petitioner's SSI application using the code N32. N32 means "Non-pay-Capacity for substantial gainful activity – other work, no visual impairment". Petitioner is currently appealing the denial of her SSI application and has requested a hearing before an Administrative Law Judge.

2. Respondent utilized the State of Florida SSA State On-Line Query Screens (Respondent's Exhibit 3) to verify when petitioner's SSI application was denied by SSA. The Query screens verified petitioner's SSI application was denied in April 2014 and her hearing request was in October 2014.

3. On August 24, 2015, petitioner submitted an application for Food Assistance (FA) and Medicaid benefits. FA benefits are not an issue. The application listed petitioner as claiming to be disabled; and having prescription co-pays as an ongoing medical expense. However, the application did not report petitioner had a new or worse medical condition.

4. On August 26, 2015, the respondent mailed petitioner a Notice of Case Action indicating her Medicaid application dated August 24, 2015 was denied as, "You or a member(s) of your household do not meet the disability requirement" and "No household members are eligible for this program".

5. Respondent determined petitioner is not eligible for Family-Related Medicaid benefits as she has no children under the age of eighteen living with her and is not

pregnant; and is not eligible for SSI-Related Medicaid benefits as she is under the age of 65 and has not been determined disabled by SSA.

6. Petitioner argued she needs Medicaid benefits for her medical conditions. She asserted she has a new and worsening condition that has been reported to SSA.

7. Respondent offered to complete an interview with petitioner and then submit the necessary documentation and medical records to the Department of Health Division of Disability Determination (DDD) to determine if petitioner is disabled. Petitioner declined the respondent's offer to complete the interview.

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 Florida Administrative Code R. 65-2.056.

10. 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…

11. According to the above authority, to be eligible for Family-Related Medicaid

benefits, petitioner must have a minor child under age 18 living in the household with her or she must be pregnant. Since petitioner does not have a minor child under age 18 living in the household and since she is not pregnant, she does not meet the technical requirement to be eligible for Family-Related Medicaid benefits.

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

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

13. Pursuant to the above authority, to be eligible for SSI-Related Medicaid, petitioner must be determined to be disabled as she is under the age of 65.

14. Federal Regulation at 42 C.F.R. § 435.541 provides standards for state disability determinations and states, in part:

> (a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.
> ….
>
> (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is

made by SSA automatically confers Medicaid eligibility, as provided for under §435.909.

(b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c)(3) of this section—

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.

(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:

(1) The individual applies for Medicaid as a non-cash beneficiary and has not applied to SSA for SSI cash benefits, whether or not a State has a section 1634 agreement with SSA; or an individual applies for Medicaid and has applied to SSA for SSI benefits and is found ineligible for SSI for a reason other than disability.

(2) The individual applies both to SSA for SSI and to the State Medicaid agency for Medicaid, the State agency has a section 1634 agreement with SSA, and SSA has not made an SSI disability determination within 90 days from the date of the individual's application for Medicaid.

(3) The individual applies to SSA for SSI and to the State Medicaid agency for Medicaid, the State does not have a section 1634 agreement with SSA, and either the State uses more restrictive criteria than SSI for determining Medicaid eligibility under its section 1902(f) option or, in the case of a State that uses SSI criteria, SSA has not made an SSI disability determination in time for the State to comply with the Medicaid time limit for making a prompt determination on an individual's application for Medicaid.

(4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and—

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

15. Petitioner was denied SSI benefits on April 23, 2014 pursuant to code N32. On August 25, 2015, the petitioner applied for Medicaid benefits with the respondent. Respondent offered to complete an interview with petitioner as she asserted a new or worsening condition; however, the petitioner refused the respondent's offer to complete an interview. Since petitioner refused to complete an interview, the respondent was unable to submit the required documentation and medical records to DDD to determine if petitioner is disabled.

16. Respondent was correct to deny petitioner's application for Medicaid benefits as she does not meet the technical requirements to receive either Family-Related or SSI-Related Medicaid benefits.

17. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner has not met her burden of proof to indicate the respondent incorrectly denied her August 24, 2015 application for SSI-Related Medicaid benefits.

18. Petitioner is encouraged to continue appealing her Supplemental Security Income denial with the Social Security Administration, so she can derive eligibility for Medicaid benefits through an approval of her Supplemental Security Income application.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is DENIED.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 29 day of January, 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
Eugeme Rehak, Esq.

FILED
Jan 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. 15F-07582

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 November 30, 2015 at 11:30 a.m.

APPEARANCES

For the Petitioner: [redacted]

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

STATEMENT OF ISSUE

At issue is whether the Respondent's denial of Petitioner's request for a retinal scan and related office visits 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 Susan Frischman, Senior Compliance Analyst, Stephanie Wells, Health Services Director, and Dr. Miguel Fernandez, Chief Medical Officer, from United Healthcare, which is the Petitioner's managed health care plan.

Respondent submitted the following documents as evidence for the hearing: Exhibit 1 – Statement of Matters; Exhibit 2 – Grievance/Appeal Investigation screenshots; and Exhibit 3 – Denial Notice.

FINDINGS OF FACT

1. The Petitioner is an adult Medicaid recipient over the age of twenty-one (21) who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. She receives services under the plan from United Healthcare.

2. On or about August 14, 2015, Petitioners' treating physician submitted an authorization request to United Healthcare for approval of an office visit and a retinal scan.

3. On or about August 21, 2015, United Healthcare denied the pre-authorization request for the office visit and retinal scan. The denial notice stated the following:

> You have a problem with your eye. Your doctor asked for an office visit and a scan of the retina. This is denied. Your health plan requires information from your doctor to show you need this service. We did not get this information. We need to know what symptoms you are having.

> Once we get this information from your doctor we will look at this request again. Please ask your doctor to send the information we need.

4. The Petitioner testified she had surgery for a detached retina in March, 2015. Her primary care physician thereafter referred her to [redacted] for a retinal scan and three office visits. She stated the retinal scan was performed in September, 2015 but two follow-up office visits were denied. She also stated she had not yet been billed for the retinal scan.

5. The Respondent's witnesses stated that the provider of the retinal scan, [redacted] is not a participating provider within the United Healthcare network and the service was not approved as an out-of-network service due to a lack of clinical information submitted by the provider. They also stated that there are retinal specialists within the United Healthcare network available to perform this type of service.

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 § 120.80, Fla. Stat.

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

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

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

11. The Florida Medicaid Program is authorized by Chapter 409, Fla. Stat. and Chapter 59G, Fla. Admin. Code. The Medicaid Program is administered by the Respondent.

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 undersigned concludes that there is no relief which can be afforded to the Petitioner as part of the Medicaid fair hearing process with respect to the

issue of the retinal scan since the Petitioner had the retinal scan procedure performed on her in September, 2015. Therefore, that issue is now moot.

14. With regard to the denial of the follow-up office visits related to the retinal scan, the undersigned concludes that United Healthcare properly denied those requested services since the provider was not part of the United Healthcare network and the provider did not submit the clinical information requested by United Healthcare. Therefore, the second prong of the medical necessity criteria was not satisfied – that the service must be "individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs."

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is DENIED.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this __25__ day of __January_____, 2016,

in Tallahassee, Florida.

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

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

FILED
Feb 04, 2016
Office of Appeal Hearings
Dept. of Children and Families

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

[redacted]

PETITIONER,

APPEAL NO. 15F-07619

vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice and agreement, Hearing Officer Patricia Antonucci convened administrative hearing in the above-captioned matter on October 22, 2015 at approximately 11:30 a.m. and November 3, 2015 at approximately 3:00 p.m. All parties and witnesses appeared via teleconference.

APPEARANCES

For the Petitioner: [redacted] Petitioner

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

STATEMENT OF ISSUE

At issue is a decision by Respondent, the Agency for Health Care Administration (AHCA or "the Agency") through the Department of Elder Affairs (DOEA), to terminate Petitioner's enrollment in the Medicaid Long Term Care (LTC) Program. Respondent

bears the burden of proving, by a preponderance of the evidence, that said termination/disenrollment is proper.

PRELIMINARY STATEMENT

Via Notice of Hearing, both parties were informed that this matter would convene for telephonic hearing on October 22, 2015 at 11:30 a.m. Prior to hearing, Respondent AHCA, represented by Selwyn Gossett, filed a Motion to Dismiss. At hearing on October 22, 2015, the Agency was present on the conference line, along with witnesses from Petitioner's LTC health plan (United Healthcare Community Plan), and from the DOEA's Comprehensive Assessment and Review for Long-Term Care Services (CARES) Unit.

While ruling that dismissal of the appeal was denied, the undersigned rescheduled hearing for November 3, 2015 so as to research whether AHCA or the Department of Children and Families (DCF) was the proper respondent to this appeal. It was CARES' opinion that AHCA was the correct respondent, because Petitioner's disenrollment was based strictly on medical eligibility.

When hearing convened on November 3, 2015, Mr. Gossett again appeared as the Agency's representative. Appearing as Respondent's witnesses from Petitioner's former LTC health plan, United Healthcare Community Plan (United), were Christian Laos, Senior Compliance Analyst, and Marc Kaprow, D.O, Executive Director of the Long Term Care Plan. Appearing from the DOEA CARES Unit were Susan Hanley, Ocala Program Operations Administrator, and Jane Bendula, Senior CARES Assessor. Petitioner appeared as her own representative and witness. Sara Catherine Spillers,

Esq., Assistant General Counsel, and Hearing Officer Greg Watson, observed the proceedings without objection from either party.

Respondent's Exhibits 1 through 8, inclusive, were entered into evidence. The record was held open so that Respondent might provide the following, additional documentation:

- Notice of LTC Termination via Health Tracks
- Certification of re-sending evidence packet from 10/04/15 (Petitioner did not receive)
- Notice of Case Action from United LTC
- Form 834 file (showing active/terminated enrollment) from United

Petitioner requested a copy of this supplemental documentation for her records, as well as a copy of the original evidence packet. Upon review of the supplement, it was determined that a copy had not been furnished to Petitioner, and that no certification of service documenting re-mailing of the original packet was filed. The undersigned issued an Order Sharing Supplement to accomplish provision of all evidence to the Petitioner. Said Order also gave Petitioner until January 4, 2016 to file any response to same. No further correspondence from Petitioner was received.

Respondent's supplemental evidence is hereby entered, as follows:

▪ Respondent's Exhibit 9: Notification from AHCA's Helpline, dated August 14, 2015 (1 page)

▪ Respondent's Exhibit 10: November 5, 2015 e-mail from Christian Laos of United (2 pages)

▪ Respondent's Exhibit 11: Disenrollment information (chart form, one page).

FINDINGS OF FACT

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

1. Petitioner is a 65-year-old female. Prior to the action under review, Petitioner was determined to meet a certain Level of Care, and was receiving benefits through a Long Term Care (LTC) Home and Community-Based Services (HCBS) Plan, via United Healthcare. United Healthcare is contracted by AHCA to provide services to LTC recipients

2. The Comprehensive Assessment and Review for Long-term Care Services (CARES) unit of the DOEA operates under the regulatory oversight of AHCA via inter-agency agreement, and is mandated to conduct Level of Care (LOC) assessments for individuals applying for or receiving LTC services. On or about July 10, 2015, United requested that CARES complete an annual recertification review and LOC for Petitioner.

3. Following a desk/file review of United's own assessment, CARES determined that Petitioner did not appear to meet Level of Care requirements to continue under the LTC Waiver; however, CARES scheduled a face-to-face assessment of their own, to evaluate Petitioner's continued eligibility.

4. On July 20, 2015, CARES completed its own Comprehensive Assessment (701B), which documents Petitioner's responses to prompts regarding her status and health care needs and is designed to evaluate a recipient's functionality, mental status, medication, and therapeutic requirements. Petitioner's Assessment notes that she is alert and oriented, in fair health, and feels about the same as she did in July of the

previous year. Petitioner requires total assistance with heavy chores, and some assistance with housekeeping; however, she is able to complete her activities of daily living (ADLs), and can prepare her own meals, manage money and medication, shop, and use transportation, on her own. She is able to climb two or three steps, requires no assistance with bathing, dressing, eating, or preparing meals, does not use any medical gasses, does not undergo bladder/bowel treatment, does not require wound care, nor does she participate in therapies. She properly manages her own medication, but does not participate in activities outside the home. The Petitioner suffers from [redacted] She has occasional [redacted] has [redacted] and uses a [redacted] She is on a low sodium diet, takes approximately six medications per day, and (at the time of the assessment) was receiving home delivered meals. She was noted to be 5 feet, 8 inches tall, and to weigh approximately 400 pounds, and found to *not* be at imminent risk of nursing home placement.

5. CARES also reviewed Petitioner's medical records and medical progress notes. Notes from a doctor's visit on or about April 1, 2013 reflect diagnoses/a medical history including [redacted]

6. Following completion of the 701B, CARES conducted a staffing meeting on or about August 11, 2015, to review Petitioner's Assessment, medical records, and medical progress notes with the Program Operations Administrator and with CARES' physician consultant. CARES determined that Petitioner *does* need assistance with

housekeeping, but does not meet the LOC required for LTC services. Case Recording Form notes generated after said meeting reflect, in part:

> The client has been diagnosed with chronic medical conditions including [redacted], [redacted] Client does not meet Level of Care due to not requiring extensive health related care and client is not physically or mentally incapacitated. She does exhibit mild physical impairments related to her weight. However she is very capable at managing her own health related care. She requires no assistance with ADLS or IADLS. She schedules her doctor[']s appointments and transports herself to these appointments.

7. On August 11, 2015, CARES' physician consultant signed off on DOEA's 'Notification of Level of Care' form, indicating that Petitioner did not meet LOC Criteria, and was thus not recommended for any program or specified placement.

8. CARES subsequently notified United of its LOC determination. Per United, an 834 disenrollment file was received on August 14, 2015, with an effective date of August 31, 2015. United processed this file, but did not generate a Notice of Action based upon same. Per post-hearing e-mail correspondence from Christian Laos, Senior Compliance Analyst:

> Unfortunately, our system made an error and a termination letter was never issue[d] for the member, we are investigating the reason for the emission [*sic*] and why the issue was not identify [*sic*] previously, all findings will be shared.[1]

9. On or about August 14, 2015, AHCA's Health Tracks system generated a Notice to Petitioner, which stated, in pertinent part:

> Thank you for calling the Helpline. You asked to leave your current plan because:
> No longer needs LTC services.
> This change will happen on 9/1/2015…

[1] No further correspondence was received from United with regard to this error.

> After this change,… [you] will not be able to receive Long-term Care services using Medicaid. You can also choose to join another plan for Medicaid Long-term Care services, but will have to go through the long-term care approval process again.

10. Petitioner recalls receiving a Notice that stated she "opted out" of services, but denies that she, herself, elected to stop receiving same.

11. On or about September 2, 2015, Petitioner contacted her (former) case manager with United, and was informed that she was no longer enrolled as a member. Petitioner was unaware of the disenrollment, noted that she would check into the situation, and requested hearing on September 3, 2015, to challenge her resultant loss of services.

12. At hearing, Petitioner explained that she requires assistance to clean her house and to cook, as she is unable to stand or walk for long periods of time. She can use a microwave, but due to [redacted], she is unable to prepare meals on the stove or to perform housekeeping. She had been receiving homemaking services and home-delivered meals from United, but these services stopped once she was disenrolled from the plan. She now has a friend who assists her with shopping, but she would like further assistance in meeting her needs. Petitioner expressed that she did understand why she met the LOC previously, and qualified for LTC services in the past, but was then deemed ineligible while her living and health situation remained the same.

13. Susan Hanley, Program Operations Administrator with CARES, explained that before Medicaid transitioned to managed care in March of 2014 (and rolled over recipients of fee-for-service Medicaid to managed care in May of 2014), recipients were qualified for LTC-like services via eligibility for the Aged and Disabled Adult Waiver. At

that time, CARES reviewed and relied upon assessments completed by (in Petitioner's case) Marion County Senior Services. Marion County reported that Petitioner utilizes medical gas (oxygen) through her [redacted] however, it was later determined that the [redacted] uses only forced room air. Whereas administration of medical gas requires medical oversight, and might qualify a recipient for LTC services, use of a [redacted] does not.

14. Ms. Hanley also testified that CARES agrees with Petitioner that she requires assistance with housekeeping, but that this, alone, does not mean she meets LOC, nor does the fact that she can only heat food using a microwave.

15. In comparing Petitioner's needs to the criteria for Intermediate Care Services (Level I and Level II), as contained within Fla. Admin. Code R. 59G-4.180, CARES determined that Petitioner did not meet the overarching criteria of a need for "24-hour observation and care and the constant availability of medical and nursing treatment and care" (*see* 59G-4.180(2)(a)).[2] CARES noted that Petitioner's areas of need are related to instrumental activities of daily living, and are not sufficiently medically complex that without LTC services, Petitioner would require placement in a nursing facility.

16. At hearing, in reviewing the criteria of Fla. Admin. Code R. 59G-4.180, Petitioner noted that she utilizes protective bed sheets for occasional [redacted] which she is unable to change on her own. She self-administers medications, can ambulate short distances, and can complete her own ADLs. However, Petitioner reiterated her need for assistance with meals and housekeeping.

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[2] As this portion of the Rule, defining "Intermediate care nursing home resident," is somewhat confusing, the reader is directed to Fla. Stat. § 409.985 for a clearer explanation of the requirement for constant availability of care.

17. CARES advised Petitioner that as a result of disenrollment, CARES had contacted the Aging and Disability Resources Center (ADRC), requesting that they place Petitioner on a wait list to receive senior services through Community Care for the Elderly (CCE). CARES noted that these services are provided through Elder Options, and suggested that Petitioner follow up to check her status on the wait list, by calling 1-800-963-5337.

18. AHCA confirmed that Petitioner is still eligible for and has continued to receive Medicaid, though now through a Medicaid Managed Care (MMA) plan, instead of LTC.

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 Fla. Stat § 409.285. This Order is the final administrative decision of the Department of Children and Families under Fla. Stat. § 409.285.

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

21. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof is assigned to Respondent, who, through CARES, has disenrolled Petitioner from LTC coverage (*See, e.g.*, Fla. Stat. § 409.978 and § 409.985, delegating certain LTC duties to the Department of Elder Affairs and CARES).

22. In accordance with Fla. Stat. § 409.979:

> (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 <u>18 or older and eligible for Medicaid by reason of a disability</u>.

(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).
(2) Medicaid recipients who, on the date long-term care managed care plans become available in their region, reside in a nursing home facility or are enrolled in one of the following long-term care Medicaid waiver programs are eligible to participate in the long-term care managed care program for up to 12 months without being reevaluated for their need for nursing facility care as defined in s. 409.985(3):
(a) The Assisted Living for the Frail Elderly Waiver.
(b) The Aged and Disabled Adult Waiver.
(c) The Consumer-Directed Care Plus Program as described in s. 409.221.
(d) The Program of All-inclusive Care for the Elderly.
(e) The Channeling Services Waiver for Frail Elders.
…

23. Petitioner transitioned to LTC services on or about May 1, 2014. She maintained these services for at least one year following said transition, but was then re-evaluated by CARES.

24. Per Fla. Stat. § 409.985 (Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program):

(3) The CARES program shall determine if an individual requires nursing facility care and, if the individual requires such care, assign the individual to a level of care as described in s. 409.983(4). When determining the need for nursing facility care, consideration shall be given to the nature of the services prescribed and which level of nursing or other health care personnel meets the qualifications necessary to provide such services and the availability to and access by the individual of community or alternative resources. For the purposes of the long-term care managed care program, the term "nursing facility care" means the individual:

(a) Requires nursing home placement as evidenced by the need for medical observation throughout a 24-hour period and care required to be performed on a daily basis by, or under the direct supervision of, a registered nurse or other health care professional and requires services that are sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse because of a mental or physical incapacitation by the individual;

(b) Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and care and the constant

availability of medical and nursing treatment and requires services on a daily or intermittent basis that are to be performed under the supervision of licensed nursing or other health professionals because the individual is incapacitated mentally or physically; or

(c) Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and care and the constant availability of medical and nursing treatment and requires limited services that are to be performed under the supervision of licensed nursing or other health professionals because the individual is mildly incapacitated mentally or physically.

25. These levels of care correspond to the provisions of Fla. Admin. Code R. 59G-4.290 for "Skilled Services" (daily needs, medically complex), 59G-4.180(4)(a) "Intermediate Care Services Level I" (daily or intermittent, extensive health needs due to physical incapacitation), and 59G-4.180(4)(c) "Intermediate Care Services Level II" (limited needs, due to mild physical incapacitation), respectively.

26. Based upon her 701B Assessment and testimony at hearing, Petitioner does not require the type of skilled services contemplated by Fla. Admin. Code R. 59G-4.290. However, to determine if she qualifies for Intermediate Care Services, review of 59G-4.180 is required.

27. Level I Services are defined in Fla. Admin. Code R. 59G-4.180(4) as:

(a) Intermediate Care Service Level I is extensive health related care and service required by an individual who is incapacitated mentally or physically.
(b) Examples of services that qualify as Intermediate Care Services Level I:
1. Administration of routine or stabilized dosages of oral medication, eye drops or ointments;
2. Routine administration of intramuscular or subcutaneous medication and observation of the individual's response and side effects;
3. Administration and adjustment of medication for pain and the monitoring of results and side effects;
4. Routine administration of insulin to a diabetic resident whose condition is stable, but who is unable to self-administer due to physical, mental or medical reasons;

5. Routine oral suctioning;

6. Tracheostomy care when the individual's condition is stable, but the individual is unable to care for the tracheostomy due to physical, mental or medical reasons;

7. Routine intermittent positive pressure breathing (IPPB) therapy after a regimen of therapy has been established or therapy is performed by the resident with nursing supervision;

8. Routine care of stoma and surrounding skin in the presence of colostomy, gastrostomy or ileostomy, excluding the initial period of training, teaching or intensive care, and special problems, for example, bleeding, severe diarrhea, or stricture;

9. Routine care of a supra-pubic catheter, excluding special care in cases of hemorrhage, frequent obstruction, frequent changes;

10. Routine services to maintain satisfactory functioning of indwelling bladder catheters, including routine insertion of catheter and, excluding special care in cases of infection, hemorrhage, frequent obstruction, frequent changes of the catheter, irrigations more than two times daily, or the use of special medications for irrigation and instillation;

11. Changes of dressings, sterile or aseptic, for noninfected postoperative or chronic conditions;

12. Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor and noninfected skin problems;

13. Routine care of the incontinent resident, including the use of diapers and protective sheets;

14. General maintenance care in connection with a plaster cast;

15. Routine care in connection with temporary casts, splints, braces or similar devices, excluding observing for circulatory or skin changes in unstable cases;

16. Decubitus care involving superficial, noninfected lesions and preventive measures when a resident is susceptible to decubitic formation;

17. Bowel and bladder control training and maintenance after a successful program has been established;

18. Care of a resident with an amputation or a fracture requiring routine care of a stabilized condition and reinforcement of an established rehabilitation plan;

19. Use of heat as a palliative and comfort measure, such as whirlpool and hydrocollator, including the use of special baths with whirl-type action when not required to be performed by a physical therapist or licensed nurse;

20. Routine administration of medical gases after a regimen of therapy has been established by a physician and is administered by the resident;

21. Assistance or supervision in dressing, eating and toileting;

22. Periodic positioning or repositioning;

23. General supervision of exercises which have been taught to the resident, including the carrying out of a maintenance program, for example, the performance of repetitive exercises required to maintain functions in paralyzed extremities, assisted walking, and similar procedures;

24. Administration of oxygen on an emergency or short-term basis;

25. Rehabilitative restorative care, passive range of motion (ROM) exercise;

26. Routine use of physical restraints or protective devices; and
27. Routine dietary management.

(emphasis added to highlight pertinent criteria within the rule).

28. Per Respondent, Petitioner previously qualified for LTC services as a result of an assessment that noted she required the use of medical gasses/oxygen, administered through her [redacted] This notation was later discovered to be erroneous, as Petitioner uses her [redacted] only to obtain forced-air to address [redacted]

29. Although Petitioner does experience occasional [redacted] she does not require the overarching "constant" availability of medical care or 24-hour observation for incontinence, as needed to qualify for Intermediate Care Level I services under Florida Statute. Indeed, such Level I services require "routine" care of incontinence, and Fla. Admin. Code R. 59G-4.180(2)(c) defines "routine" as "… in accordance with an established or predetermined schedule and performed for individuals whose medical needs are stabilized or chronic." Petitioner is not on an established schedule for incontinent care.

30. Fla. Admin. Code R. 59G-4.180(4) also sets forth service examples for Level II Care, noting:

(c) Intermediate Care Services Level II is limited health related care and services required by an individual who is mildly incapacitated or ill to a degree to require medical supervision. Individuals requiring this level of care shall:
1. Be ambulatory, with or without assistive devices,
2. Demonstrate independence in activities of daily living, and
3. Not require the administration of psychotropic drugs on a daily or intermittent basis or exhibit periods of disruptive or disorganized behavior requiring 24-hour nursing supervision.

(d) Examples of services, in addition to medical supervision, that qualify as intermediate care Level II:
1. Administration of routine oral medication;
2. Assistance with mobilization, helping a resident maintain balance when transferring from bed to chair and providing necessary help when climbing steps or

manipulating wheelchair in difficult places;

3. Assistance with bathing, that is, assembling towels, soap, and other necessary supplies, helping the recipient in and out of the bathtub or shower, turning the water on and off, adjusting water temperature, washing and drying portions of the body which are difficult for the recipient to reach and being available while the recipient is bathing himself;

4. Assistance with dressing, that is, helping the recipient to choose and to put on appropriate clean clothing, and fastening hooks, buttons, zippers and ties;

5. Assistance with meals, that is, helping with cutting up food and pouring beverages;

6. Assistance with grooming, that is, helping the recipient to shave, wash, comb and curl hair, and to clean and file fingernails and toenails. Fingernails or toenails should not be cut by the recipient unless approved by the physician;

7. Provision of social and leisure services which are arranged for and individually designed to reduce isolation and withdrawal and to enhance communication and social skills;

8. Self-administration of medical gases, oral medications, subcutaneous medication after a regimen of therapy has been established and self-administration approved by the physician;

9. Ongoing medical and social evaluations to determine the point when a recipient's progress has reached the stage at which medical and related needs can be met appropriately outside of the nursing facility or through alternative placement or services;

10. Application of dressings and treatments prescribed by the physician for small or superficial areas requiring a dressing;

11. Application of elastic stockings, when prescribed, if the recipient cannot manage independently;

12. Administration of oxygen or intermittent positive pressure breathing when prescribed by the physician and performed by the recipient;

13. Assistance with colostomy care, that is, helping the recipient care for permanent colostomy which the recipient ordinarily cares for;

14. Routine measurement and recording of vital signs and weights, including being alert to symptoms and readings corresponding to abnormal conditions of the residents;

15. Routine restorative and rehabilitation procedures, that is, the encouragement and incorporation of range of motion exercises in the daily activities schedule.

(emphasis added to highlight pertinent criteria within the rule).

31. Again, although initially thought to utilize medical gasses, Petitioner has since been found to utilize a regular [redacted]. In terms of meal preparation, Petitioner does not require the detail-focused assistance of cutting up food or pouring beverages,

and is able to cook for herself using a microwave. Most importantly, the assistance she does require for housekeeping and chores is not “in addition to medical supervision,” (Fla. Admin. Code R. 59G-4.180(4)(d)) but rather, solely for completion of instrumental activities of daily living. As such, these needs do not correspond to the broader Florida Staute requirements of LTC services, i.e., 24-hour observation or constant medical care.

32. It is understood that Petitioner requires assistance around her home, and that she may benefit from home delivered meals and/or services designed to foster community inclusion; however, absent an underlying, constant need for medical care, these needs do not make her eligibile to receive LTC services.

33. Respondent has met its burden to show that disenrollment/termination from LTC was proper.

34. Petitioner is encouraged to contact Elder Options, as well as to pursue services through her MMA plan and/or to seek out the availability of Medicare benefits. Should Petitioner feel that she requires LTC services in the future, she may contact the Department of Children and Families (DCF), AHCA, DOEA, or the Aging and Disability Resources Center for assistance in determining eligibility.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner’s appeal is DENIED.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency

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

DONE and ORDERED this 04 day of February, 2016,

in Tallahassee, Florida.

Patricia C. Antonucci
Hearing Officer
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Tallahassee, FL 32399-0700
Office: 850-488-1429
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Email: appeal.hearings@myflfamilies.com

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

FILED
Jan 15, 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.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 17 Broward
UNIT: AHCA

RESPONDENT.
_____/

APPEAL NO. 15F-07641

[redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 20, 2015, at 10:35 a.m.

APPEARANCES

For the Petitioner: [redacted] the petitioner's wife.

For the Respondent: Jackie Pughsley, Economic Self Sufficiency Specialist, Department of Children and Families (DCF).

STATEMENT OF ISSUE

At issue is the Department's action in approving the petitioner for Institutional Care Program Medicaid (ICP) benefits with a patient responsibility of $228.77 a month and allow the community spouse a diverted $867.23 a month, as opposed to the petitioner having $0 patient responsibility and the community spouse receiving a

diverted amount of $1,096 a month. The petitioner carries the burden of proof by a preponderance of evidence.

PRELIMINARY STATEMENT

The respondent submitted into evidence Respondent Exhibit 1 through 4. The petitioner submitted into evidence Petitioner Exhibit 1.

FINDINGS OF FACT

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

1. The petitioner currently lives in a nursing home and was found eligible by the Department to receive ICP benefits. The Department determined the petitioner has a patient responsibility as part of his stay in a nursing home.

2. The petitioner's wife lives in her home and has been designated as the "community spouse" in regards to the petitioner's eligibility for the ICP Program.

3. In determining the amount of an ICP recipient's patient responsibility and the community spouse's income allowance, the Department has specific formulas.

4. The Department's Maintenance Need Allowance Budget, submitted as part of Respondent Exhibit 2, shows the community spouse's shelter cost of $1,488. This cost is a total of the community spouse's shelter cost and utility cost combined. The shelter cost includes the community spouses' monthly mortgage and monthly property tax. Next, the Department subtracted thirty percent of the MMMIA (Minimum Monthly Maintenance Income Allowance), which is $590, from the shelter cost to arrive at the excess shelter cost of $898.

5. Next, the Department added the MMMIA amount of $1,966 to the above noted excess shelter cost to arrive at the Allowable Shelter Deduction of $2,864. Next, the Department subtracted the community spouse's gross income of $2,452.10 from the above noted Allowable Shelter Deduction to arrive at the Community Spouse Income Allowance amount of $411.90.

6. Next, the Department subtracted $600 from the MMMIA amount of $1,966 to arrive at a subtotal of $1,366. This amount is then divided by three (3), which created a "Family Allowance" amount of $455.33. The $600 noted above is derived from the petitioner and community spouses' (minor) daughter's unearned income. The Family Allowance noted above and the Community Spouse Income Allowance amount of $411.90 added together equals $867.23, which is the community spouse's total Maintenance Need Allowance amount.

7. Also submitted as part of Respondent Exhibit 2 is a copy of the Department's Patient Responsibility Budget sheet. This sheet includes the petitioner's Total Gross Unearned Income amount of $1,201 derived from the petitioner's Social Security payment. Subtracting the Personal Need Allowance of $105 along with the Maintenance Need Allowance of $867.23 allowed the Department to arrive at the petitioner's patient responsibility amount of $228.77.

8. The petitioner's representative submitted as part of Petitioner Exhibit 1 copies of her household bills and a handwritten list of these household bills and expenses. She argued that the Department should also take into consideration her household bills such as car payment, car insurance, cable bills, and lawn maintenance bills when determining the petitioner's patient responsibility amount. She indicated that the lawn

maintenance costs is unavoidable as the petitioner himself used to do the lawn maintenance and she cannot do this activity. Additionally, she indicated that the cost of owning and operating a car is unavoidable. The petitioner's representative, however, did not dispute any of her household income amounts as used in the calculations by the Department.

9. The respondent argued that the above bills or costs for the petitioner's wife or community spouse are not considered by the Department, as per Department policy, in determining patient responsibility amount and community spouse diversion amounts. The Department representative also indicated the petitioner was receiving only $30 in SSI benefits previous to April 2015 and thus had no patient responsibility assigned at that time.

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. Fla. Admin. Code R. 65A-1.713 SSI-Related Medicaid Income Eligibility Criteria states in relevant part:

> 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.

....

(b) For institutional care, hospice, and HCBS waiver programs the department applies the following methodology in determining eligibility:

1. To determine if the individual meets the income eligibility standard the client's total gross income, excluding income placed in qualified income trusts, is counted in the month received. The total gross income must be less than the institutional care income standard for the individual to be eligible for that month.

2. If the individual's monthly income does not exceed the institutional care income standard in any month the department will prorate the income over the period it is intended to cover to compute patient responsibility, provided that it does not result in undue hardship to the client. If it causes undue hardship it will be counted for the anticipated month of receipt.

13. 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 themself 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 [emphasis added]**.** 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.

14. 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. The findings show that $867.23 of the petitioner's income is diverted to the community spouse, causing the patient responsibility to be $228.77. 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 (ICP) to the nursing facility.

15. A couple must present proof that an exceptional circumstance has caused unavoidable extreme financial duress for the community spouse. The petitioner's representative asserts the cost of her household expenses such as car payments, car insurance, and especially lawn maintenance should be considered for an increase in the spousal diversion amount. However, the undersigned concludes that a routine monthly expenses such as car payment, car insurance, and lawn maintenance does not meet the threshold of an exceptional or unavoidable circumstance. The petitioner's representative has not presented the undersigned with an exceptional circumstance, either temporary or long term, causing a significant financial inadequacy for her as the community spouse. Therefore, in accordance with the above controlling authority, the

undersigned concludes the petitioner does not meet the requirements for an increase in the spousal diversion amount. Petitioner has not met her burden of proof.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this 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 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 January, 2016, in Tallahassee, Florida.

Robert Akel

Robert Akel
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
Jan 05, 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.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 07 Volusia
UNIT: 88370

RESPONDENT.
_____/

APPEAL NO. 15F-07662

[redacted]

FINAL ORDER

Pursuant to notice, the undersigned reconvened an administrative hearing telephonically in the above-referenced matter on November 17, 2015 at 10:23 a.m.

APPEARANCES

For the Petitioner: The petitioner was present and represented herself.

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

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of October 21, 2015 to deny her application for SSI-Related Medicaid.

The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The hearing originally convened on October 15, 2015 at 10:16 a.m. The Department requested a continuance to allow time for the Division of Disability Determination (DDD) to make a disability determination on the petitioner's case. The petitioner did not object. The hearing was scheduled to reconvene on November 17, 2015 at 10:15 a.m.

The record was held open to allow the petitioner to submit additional evidence. Evidence was received and entered as the Petitioner Exhibit 4.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner (age 50) was receiving Family-Related Medicaid for herself and her now 18 year old son. The petitioner's coverage received under the Family-Related Medicaid program was terminated effective July 30, 2015 after her son turned 18 in June 2015.

2. The petitioner completed an application for SSI-Related Medicaid on September 22, 2015. The petitioner's disability information was submitted to DDD to review the petitioner's claim for disability.

3. The DDD did not make an independent disability determination because the SSA determined that the petitioner was not disabled in July 2014 and the denial is under appeal. The Department adopted the SSA unfavorable decision and denied the petitioner's application for SSI-Related Medicaid.

4. The petitioner argues that she was receiving Medicaid but was terminated. The petitioner believes she is entitled to Medicaid because her medical conditions

cause severe pain. The petitioner explained that she has to take several medications for her illnesses. The petitioner believes the Department does not understand all of her conditions. The petitioner lists her medical conditions as [redacted] and [redacted] The petitioner explained that her problems with her ankle are permanent. The petitioner has [redacted] in her joints and ligaments and does not have mobility. She has severe [redacted] and a [redacted] The Petitioner Exhibit 1, page 3, lists the medical conditions the petitioner believes were reviewed in the SSA disability determination. The petitioner did not have a copy of the SSA denial letter at the time of the hearing and one was not provided post-hearing.

5. The Department explained that the petitioner was no longer eligible for Medicaid as her eligibility was derived from a child under the age of 18. The Department explained that it explored other Medicaid programs for which the petitioner could be potentially eligible. The Department referred the petitioner's application for SSI-Related Medicaid to DDD to explore her potential eligibility for Medicaid due to a disability, as she has not yet reached age 65. The DDD denied the petitioner's claim for disability because her medical allegations are the same as the ones reviewed in the SSA determination of disability and that decision is under appeal (Respondent Exhibit 2).

6. The petitioner first applied for SSA disability on October 19, 2013 and was denied. The petitioner applied a second time for disability on March 3, 2014 and was denied on April 25, 2014. The petitioner appealed on June 6, 2014 and was denied on

July 16, 2014 (Petitioner Exhibit 4). The petitioner's denial is currently under appeal and is awaiting a hearing. The petitioner contends that she does not have any new medical conditions since the denial.

CONCLUSIONS OF LAW

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

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

9. Fla. Admin. Code R. Section 65A-1.705 Family-Related Medicaid General Eligibility Criteria states in part:

> (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.

10. The Department's Program Policy Manual, CFOP 165-22, passage 2230.0401 Definition of Terms (MFAM) states:

> 1. 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.

> 2. A child (for parents or other caretaker relatives who derive eligibility for themselves) is an individual under the age of 18, who has never been emancipated, is not married or whose marriage was annulled.
> 3. Parent or other caretaker relatives includes mother, father, adoptive mother and adoptive father, grandmother, grandfather, stepfather, stepmother, siblings (including natural, adopted, step, and half), uncle, aunt, first cousin (including first cousin once removed), nephew or niece and individuals of preceding generations as denoted by prefixes of, great, great-great, or great-great-great. Include the spouse of such parent or relative even after the marriage is terminated by death or divorce.

11. The Department's Program Policy Manual, CFOP 165-22, passage 2230.0402 Parents and Other Caretaker Relatives (MFAM) states:

> A parent or other caretaker relative must live with a child to derive their Medicaid eligibility. The child does not have to be a tax dependent of the adult parent or other caretaker relative to be potentially eligible. Include all countable income of the parent or other caretaker relative when they are a member of the SFU.

12. The above authorities explain that a parent seeking coverage under the Family-Related Medicaid program must be the caretaker of a deprived child under the age of 18 to be eligible for Medicaid herself. In this case, the petitioner was receiving Family-Related Medicaid for both herself and her son until her son turned 18 years of age in June 2015. Therefore, the undersigned concludes that the petitioner was no longer eligible for coverage under the Family-Related Medicaid as her son was no longer under the age of 18 at the time of the Department's termination action.

13. 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...

14. 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.

15. The Department's ACCESS Florida 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)

16. 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.

17. In this case, the petitioner is under age 65 and has several medical conditions such as [redacted] The findings show that these medical conditions were reviewed in the SSA disability determination. The findings show 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; the SSA denial is also currently under appeal. Therefore, the undersigned concludes that the petitioner did not meet her 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 petitioner meets the federal disability criteria (while under age 65) Medicaid cannot be approved.

DECISION

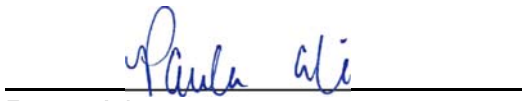
Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied.

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.

DONE and ORDERED this 05 day of January, 2016,

in Tallahassee, Florida.



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FILED
Jan 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. 15F-07747

PETITIONER,

Vs.

[redacted]

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 04 Duval
UNIT: 88323

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 23, 2015 at 9:13 a.m.

APPEARANCES

For the Petitioner: The petitioner was present and was represented by [redacted], designated Medicaid representative.

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

ISSUE

At issue is the Department's action to not approve the petitioner's request for Medicaid coverage for the months of October 2012 and October 2013.

The petitioner holds the burden of proof in this case.

PRELIMINARY STATEMENT

The record was held open until 5:00 p.m. on October 30, 2015 to allow time for the respondent to submit additional evidence; however, the deadline was extended until November 23, 2015 to allow the petitioner to submit additional evidence. Evidence was received and entered as the Petitioner Exhibits 2 through 4 and the Respondent Exhibits 2 through 3.

FINDINGS OF FACT

1. The petitioner's representative is requesting Medicaid coverage for the months of October 2012 and October 2013. The petitioner's representative believes the petitioner is eligible for those months because the petitioner was approved for Social Security disability income in October 2014 and was determined to be disabled beginning May 2012.

2. The petitioner's representative contends that the petitioner's Medicaid application was referred to the Department's Division of Disability Determination (DDD) in April 2012 and that he was determined to not be disabled due to a Hankerson decision; therefore, the Department denied his application for Medicaid. The petitioner filed another application for Medicaid in April 2014 and was denied. It is not known which medical conditions were reviewed.

3. The petitioner's representative explained that the petitioner received notification in October 2014 that he was deemed disabled by the Social Security Administration (SSA) retroactively to May 2012 and was approved for Social Security disability income (Petitioner Exhibit 1). The petitioner's representative believes the

Department's policy requires the DDD determinations made in May 2012, March 2013, and April 2014, to be overturned due to the petitioner's subsequent approval for Social Security disability and for the petitioner to be approved for Medicaid for the months of October 2012 and October 2013. The petitioner's representative completed an application on the petitioner's behalf for SSI-Related Medicaid on October 24, 2014.

4. The Department's representative contends that there was not an application filed for the months of October 2012 and October 2013; the petitioner's representative submitted medical bills for October 21, 2012 and October 13, 2013. Therefore, there were no Notices of Case Action sent to the petitioner to inform him of the Department's denial of the petitioner's requests for Medicaid coverage for October 2012 and October 2013. The Department mailed to the petitioner on April 14, 2014, the Notice of Case Action informing him of its denial of his application for SSI-Related Medicaid. The petitioner was mailed a Notice of Case Action on October 30, 2014 to inform him of his approval for the Medically Needy program with an estimated share of cost of $1068 (Respondent Exhibit 4).

5. The petitioner's representative explained that she is not requesting retroactive Medicaid for October 2012 and October 2013; she believes the Department's policy under passage 1440.1206 gives it the authority to re-evaluate the denials for the SSI-Related Medicaid applications submitted on May 21, 2012, March 25, 2013, and on April 9, 2014, and to approve those applications based on the subsequent and favorable disability determination completed in October 2014; the petitioner was determined to be disabled retroactively to May 2012. Therefore, the petitioner's representative believes

the petitioner is entitled to Medicaid coverage for October 2012 and October 2013 since he was determined to be disabled beginning May 2012 and because he has applications on file for those time periods.

6. The Department's representative explained that the passage 1440.1206 can only be applied to current situations according to its standard application processing policy and that it does not allow the Department to approve of Medicaid applications from years prior. The Department explained that its program specialist clarified its policy on the standard application processing to mean that it can review the petitioner's request for coverage for October 2012 and October 2013 only if there is a corresponding application for the months retroactive Medicaid is requested; there has to be an application for Medicaid for months requested (Respondent Exhibit 1, page 4). They can review months retroactively.

7. The Department explained that it was unable to review the retroactive months of October 2012 and October 2013 as there were no corresponding applications for Medicaid submitted for the months at issue. The Department's records indicate that there is not an application for Medicaid on file for the months of October 2012 and October 2013; the Department's records indicate that the applications on file for October 2012 and October 2013 are for Food Assistance Program benefits only (Respondent Exhibit 1, page 1).

8. The petitioner's representative believes the Department's standard application process is interpreted to mean that an unfavorable decision made by DDD may be overturned when a favorable SSA disability decision is made at a later date. The

petitioner's representative argues that the Department's policy regarding standard application processing requires a year's certification for a disabled person and makes no reference to retroactive Medicaid. The petitioner's representative argues that the Department must overturn its denial of the petitioner's applications for Medicaid submitted in May 2012, March 2013, and April 2014 and approve coverage for Medicaid for October 2012 and October 2013 by adopting the subsequent SSA disability decision.

9. It is an undisputed fact that the petitioner requested a hearing in September 2015; however, based on the evidence and testimony presented, the undersigned finds that the application submitted in October 2014 constitutes a request for a re-evaluation since the Department became aware of the petitioner's disability status at this point.

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 § 65-2.056.

12. Fla. Admin. Code 65A-1.702 Special Provisions states in part:

> (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:
…
3. New and Material Evidence – The department's determination was correct when made but new and material evidence that the department did not previously consider establishes that a different decision should be made.
(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.

13. The Department's Program Policy Manual, CPOF 165-22, passage

1440.1206 Change in Disability Determination by SSA (MSSI, SFP), states in part:

When the Social Security Administration (SSA) renders a disability decision that is different than that made by DCF, the SSA decision must be adopted unless the SSA decision was based on a condition different than that which the state reviewed.

If SSA renders a favorable disability decision on a case previously determined not disabled by the Department, the Department must adopt the SSA decision. Standard application processing policy applies.

14. The Department's Program Policy Manual, CPOF 165-22, passage

0440.0610 Reevaluating Medicaid Adverse Actions (MSSI, SFP) states:

The Department must reevaluate any Medicaid determination where there is evidence of good cause that the previous determination was incorrect. The request for reevaluation applies to the following situations:
1. benefits terminated or denied in error;
2. an overstated patient responsibility/share of cost; and
3. an error in the calculation of the level of benefits.

If a participant requests a reevaluation:
1. Within 90 days of the mailing date of the notice, follow hearing policy and continue to work on resolution.

2. After 90 days from the mailing date of the notice **but no more than 12 months following the effective date of the adverse action**, review the request to determine if good cause exists.

3. After 12 months from the effective date of the notice, deny the eligibility on FLORIDA and inform the individual of hearing rights on the electronic notice (emphasis added).

Good cause exists when:
1. The Department made mistakes in mathematical computations.
2. The Department made an error in the determination.
3. The participant presents new information that was not considered when the previous determination was completed and it may result in a different conclusion. The information must have been unavailable due to circumstances beyond the participant's control.
Once good cause is established, determine eligibility, authorize benefits as appropriate and send a new notice of case action. Notify the participant of the decision for all months as required below.
For applications: Review eligibility each month and authorize as appropriate back to the month of application, including any requested retroactive months.

15. The Department's Questions and Answers-Detail page, ID: 148, dated June 1, 2007, includes a question and answer regarding re-evaluation of a previous denial of an application for SSI-Related Medicaid and is listed below:

Question: If we deny Medicaid based on a SSA disability denial, and then the client contacts us within a year of our denial with evidence that they won their SSA appeal, must we go back to determine eligibility per 0440.0610, using our original application date? The client could not have provided us with the disability information at the time because it was under appeal. Must we treat this as a new application if they don't contact us within a year of DCF's denial of Medicaid?

Answer: You are correct on both accounts. Good cause for evaluating Medicaid adverse action exists when an individual wins an SSA appeal because it is information that was beyond their control when the Department initially denied Medicaid. If the individual presents the new evidence within a year of the Department's most recent denial, determine eligibility based on the application date associated with the denial, and three retro months if applicable. **If the SSA decision is presented over**

a year after the Department's most recent Medicaid denial, treat as a new application (emphasis added).

16. The above authorities explain that the Department must re-evaluate a previous adverse action related to the Medicaid program if the applicant shows good cause that a previous determination was incorrect and the request for a re-evaluation was made after 90 days but within 12 months of adverse action. A good cause example is when an applicant presents new information that was not previously considered at the time of the determination and which may reverse a previous decision. If the re-evaluation is requested as a result of a favorable SSA decision over one year after the Department's most recent Medicaid denial, the Department is instructed to treat the request as a new application.

17. In this case, the findings show that the petitioner requested a re-evaluation of his applications submitted in May 2012, March 2013, and April 2014. The above authorities limit requests for re-evaluations with good cause to a period of up to 12 months after the most recent denial action. Therefore, the undersigned concludes that the denials for the applications submitted in May 2012 and March 2013 cannot be included in the petitioner's request for a re-evaluation. The Department is to issue notice with appeal rights as directed in its policy, denying the petitioner's request for a re-evaluation of applications submitted in May 2012 and March 2013.

18. The findings also show that the petitioner submitted evidence verifying his disability when he submitted an application on October 24, 2014; this is within the 12 month re-evaluation timeframe to review his application submitted on April 9, 2014. The undersigned recognizes that the petitioner is seeking Medicaid coverage for the months

of October 2012 and October 2013; however, the exceptions in the above regulation restricts the Department to complete a re-evaluation only on requests made within 12 months from the date of the adverse action.

19. After considering the evidence and all of the appropriate authorities set forth above, the hearing officer concludes that the Department's action to deny the petitioner's request to re-evaluate the applications for the months of May 2012 and March 2013, which would have provided the requested Medicaid coverage months of October 2012 and October 2013, is correct. There is no evidence of a denial notice for these two months. Therefore, the Department is to issue a notice with appeal rights denying this request, as directed in its policy. However, the undersigned concludes that the Department will need to complete a Medicaid eligibility determination to re-evaluate the denial action that occurred during the month of April 2014 and to include a consideration of the three retroactive months prior to that application.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is both granted and denied.

The appeal is denied in that the Department's action to deny the petitioner's request for a re-evaluation for applications submitted in May 2012 and March 2013, which would provide Medicaid coverage for the months of October 2012 and October 2013, is affirmed.

The appeal is granted in that the appeal is remanded with instructions as set forth in the above Conclusions of Law for the re-evaluation of the application for April

2014 and the retroactive months. Once a determination is made, the Department is to issue a notice to both petitioner and the representative.

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 January, 2016, in Tallahassee, Florida.

Paula Ali
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency
[redacted]

FILED
Jan 14, 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-08008

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 18, 2015 at 1:12 p.m.

APPEARANCES

For the Petitioner: [redacted] Petitioner's Mother

For the Respondent: Stephanie Lang, R.N. Specialist, Fair Hearing Coordinator
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is the Respondent's action in reducing prescribed pediatric extended care services ("PPEC") beginning on September 23, 2015. The Agency held the burden of proof in this case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The Agency contracts with a Quality Improvement Organization ("QIO"), eQHealth Solutions, to perform medical utilization reviews for prescribed pediatric

extended care services through a prior authorization process for Medicaid beneficiaries. Through this contractual agreement, eQHealth Solutions is authorized to make determinations of medical necessity on behalf of the Agency and act as a witness in all related fair hearing proceedings.

A prior service authorization request is submitted by a provider along with information and documentation required to make a determination of medical necessity. Initial requests for prescribed pediatric extended care services will be authorized for up to 60 days (two-month period) to allow for reassessment of the recipient's condition. Thereafter, a medical necessity review is conducted every 180 days (six-month period). If necessary, a request for modification may be submitted by the provider.

Witness for the Respondent was [redacted]

Respondent's Exhibits 1 through 6 were admitted into evidence. Petitioner submitted no exhibits into evidence at the time of the hearing. The record was left open until November 27, 2015 for Petitioner to submit a copy of his doctor's notes supporting PPEC service. The doctor's note indicating persistent [redacted] and speech delay was received on November 30, 2015. As it was sent directly from the provider, although late, Petitioner will not be penalized and this will be included in the record as Petitioner's Exhibit 1. Respondent had until December 11, 2015 to issue any response to the new information, which it did on December 10, 2015. The response was marked and entered as Respondent's Exhibit 7. The record was closed on December 10, 2015.

The hearing officer took administrative notice of Section 409.905, Florida Statutes (2015), Florida Administrative Code Rules 59G-1.001, 59G-1.010, 59G-4.260,

and the Prescribed Pediatric Extended Care Coverage and Limitations Handbook (September 2013).

FINDINGS OF FACT

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

1. Petitioner is an approximately 3-year-old male diagnosed with [redacted] and [redacted]. He has speech difficulties and receives speech therapy at PPEC. He has two scheduled medications per day which his mother provides outside of PPEC. He is on as-needed nebulizer treatments but has not required any treatments at PPEC.

2. Petitioner was previously approved to attend PPEC, but needed to recertify to continue his attendance.

3. eQ Health Solutions (hereinafter referred to as eQ Health) is the entity which reviews service authorization requests for PPEC services. eQ Health denied Petitioner's request for continued PPEC services by notice dated September 14, 2015. The reason given for the denial decision is Petitioner's condition does not meet medical necessity for the PPEC service. The clinical rationale is as follows:

> The patient is a 2 year old with [redacted]
> The patient is on two scheduled medications. The patient requires as needed nebulizer treatments but has not needed any treatments while at PPEC. The patient receives speech therapy. The clinical information provided does not support the medical necessity of the requested services. The patient appears to no longer require skilled nursing as no skilled nursing interventions were provided while attending PPEC. Therapies can be provided as an outpatient. The requested services are denied.

4. eQ Health's decision was based on the information provided to it by the Petitioner's PPEC center and physician.

5. Currently, Petitioner is well-managed with medications. His scheduled medication is twice a day, which can be done, and is currently done, before and after PPEC. He does not require medical interventions. He is not on a special diet, and he is not on a ventilator or other medical device. He requires a nebulizer and other medications only on an as-needed basis, and has not needed any in the last 6 months at PPEC.

6. eQ Health concluded Petitioner does not have a need for skilled nursing services such as those offered at PPEC because there have been no recent medical interventions or hospitalizations required. He could receive speech therapy on an outpatient basis. eQ Health concluded Petitioner's request was not medically necessary.

7. PPEC nurses administer medications, monitor for signs and symptoms of aspiration, and check Petitioner's lungs to determine if he needs medication. The nurses educate the family as well. PPEC notes indicate discharge plans would be considered when the family can assume total care without skilled intervention. Petitioner has not required skilled intervention while at PPEC over the prior six month period.

8. Petitioner's problems are exacerbated in the fall and winter, and he usually requires additional albuterol treatments. This is common in patients with asthma. [redacted] alone does not require constant lung monitoring. There is no

documentation that such additional medication administrations have been required at PPEC.

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 120.80, Florida Statutes. The Office of Appeal Hearings provided the parties with adequate notice of the administrative hearing.

10. Florida Medicaid State Plan is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The program is administered by the Agency for Health Care Administration.

11. This hearing was held as a de novo proceeding pursuant to Rule 65-2.056, Florida Administrative Code.

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

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

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

13. Since 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. 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.

14. The United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in *Moore v. Reese*, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, which involved a dispute over private duty nursing:

> (1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.
> (2) A state Medicaid plan must include "reasonable standards … for determining eligibility for and the extent of medical assistance" … and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.
> (3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long

> as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."
>
> (4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."
>
> (5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to provide medically unnecessary, albeit desirable, EPSDT services. However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."
>
> (6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and my present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)).

15. 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.

16. The Prescribed Pediatric Extended Care Services Coverage and Limitations handbook (September 2013) ("Medicaid Handbook") has been incorporated by reference into Florida Administrative Code Rule 59G-4.260(2).

17. Page 2-1 of the Medicaid Handbook states that to receive PPEC services, the recipient must, among other criteria, "[r]equire short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care due to a medically complex condition."

18. According to Florida Administrative Code Rule 59G-1.010(164):

> "[m]edically 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.

The following section 165 explains that:

> "[m]edically 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 dependent, or is dependent on a heightened level of medical supervision to sustain life, and without such services is likely to expire without warning.

19. Petitioner does not require any continuous skilled nursing care. There is no evidence to suggest that Petitioner is dependent upon 24-hour per day medical or nursing care, or that he is dependent upon life-sustaining medical equipment, such that he would properly be deemed 'Medically Complex' or 'Medically Fragile.' His need for supervision, speech therapy, and/or medication administration does not support the authorization of PPEC, because there are alternative services that are better designed to meet those needs. As such, provision of PPEC would be convenience-based and excessive.

20. After careful review of the evidence submitted and the relevant laws set forth above, the undersigned concludes the Agency has met its burden of proof. Therefore, the Agency's action to reduce PPEC services was proper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is DENIED.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 14 day of January, 2016, in Tallahassee, Florida.

Danielle Murray
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Don Fuller, Area 6, AHCA Field Office Manager

FILED
Jan 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. 15F-08019

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 November 23, 2015 at 11:30 a.m.

APPEARANCES

For the Petitioner: [redacted] Petitioner

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

STATEMENT OF ISSUE

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

PRELIMINARY STATEMENT

The Petitioner did not submit any documents as evidence for the hearing.

Appearing as witnesses for the Respondent were [redacted]Dental Consultant, and [redacted], Grievance Specialist, from [redacted], which is the Petitioner's dental services organization. Also present as witnesses for the Respondent were Natalie Fernandez, Contracts Specialist, and Alice Quiroz, A.V.P. of Government Contracts, from Molina Healthcare, which is Petitioner's managed health care organization.

Respondent submitted several documents as evidence for the hearing, which were marked as follows: Exhibit 1 – Fair Hearing Summary; Exhibit 2 – x-rays; Exhibit 3 – Denial Notice; Exhibit 4 – Covered Services; and Exhibit 5 – Dental Fee Schedules.

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

FINDINGS OF FACT

1. The Petitioner is a fifty-five (55) 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 [redacted] which utilizes [redacted] for review and approval of dental services.

2. On or about September 9, 2015, the Petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from [redacted](and [redacted] to perform various dental procedures, including periodontal scaling and root

planing (deep cleaning) and a dental crown. [redacted] denied this request on September 10, 2015, stating that the requested services were not covered services under the Plan.

3. Petitioner testified that she has [redacted] and her [redacted] sent her to the dentist for tests so she could receive some type of injection in her bone. However, she was unsure of what treatment she will be undergoing or where the injections will be performed on her body.

4. The Respondent's witness, Ms. Fernandez from [redacted] Healthcare, testified that the services requested by the Petitioner – deep cleaning of four quadrants and one dental crown – are non-covered services under the Molina plan.

5. Dental 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

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, 7th Ed.).

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

11. 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.

12. Petitioner's requested dental services were not denied due to medical necessity considerations, but because the requested services are non-covered services according to the Plan.

13. 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.

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

15. Petitioner stated she believes the requested services should be approved because she was referred to the dentist by her [redacted] and the dental service is in some way related to her [redacted]

16. Respondent's witness did not address whether the services requested by Petitioner are medically necessary, but stated that the requested services are non-covered services.

17. After considering the evidence and testimony presented, the undersigned concludes that the Petitioner has not demonstrated that the requested services should have been approved by [redacted] or [redacted] Healthcare. The services requested (deep cleaning and dental crown) are non-covered services for adults under the Medicaid guidelines referenced above and under the Molina Healthcare dental plan

provisions. Therefore, the hearing officer cannot make a determination that these services must be covered by the Petitioner's plan.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is DENIED.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 20 day of January, 2016, in Tallahassee, Florida.

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

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

FILED
Feb 05, 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. 15F-08021

[redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 Palm Beach
UNIT: 02555

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on December 10, 2015 at 10:01a.m.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent Guillermo Carton, senior human service program specialist, Benefit Recovery Unit

ISSUE

The petitioner is appealing the Department's action to establish and collect an agency error overpayment of $200 in Food Assistance Program (FAP) benefits. The respondent carries the burden of proof by preponderance of evidence.

PRELIMINARY STATEMENT

The Department presented 12 exhibits which were accepted into evidence and marked as the Respondent's Exhibits 1-12. The petitioner did not present any exhibits

at the hearing. The record was held open until December 15, 2015, for the petitioner to provide verification of her Unemployment Compensation Benefit (UCB). The information was received, entered into evidence and marked as Petitioner's Exhibit 1. The record closed on December 15, 2015.

The respondent motioned for the appeal to be dismissed as the petitioner requested a hearing on September 22, 2014 for the same FAP claim.

FINDINGS OF FACT

1. The petitioner applied for FAP benefits on February 27, 2013. She completed the on-line application with an electronic signature and agreement to the Rights and Responsibilities. Her household consisted of herself only. No income was reported on the application or counted in the FAP budget. On March 1, 2013, the Department approved the petitioner for $200 FAP benefits.

2. In May of 2013, the petitioner began receiving UCB. The Department received an electronic alert informing the agency that the petitioner was receiving UCB. The Department did not take timely action to update the petitioner's case record with the UCB and as a result she received FAP benefits for August 2013 for which she was not eligible.

3. By notice dated June 25, 2014, the respondent informed the petitioner a review of her case showed that between August 1, 2013 and August 31, 2013, she received $200 more in Food Assistance benefits than she was eligible to receive. The reason given was that the agency did not take timely action on a reported change.

4. The overpayment amount was determined using the following methodology for August 2013. The Department added the petitioner's unemployment of $500 for August

6, 2013, $550 for August 14, 2013 and $550 for August 28, 2013, using information from Florida Department of Economic Opportunity, resulting total gross monthly income of $1,650. It was compared to the maximum gross income of $1,862 for a household size of one. A standard deduction of $149 was subtracted to get $1,501 as the petitioner's adjusted net income. The petitioner was ineligible for an excess shelter deduction as her total standard shelter (50% of adjusted net income) was less than the total shelters/utility cost ($338). Her adjusted net income remained $1,501. The maximum net income for a household size of one is $931.

FAP budget for August 2013

Unearned income (UCB)	$1,650
Total household income	$1,650
Standard deduction for a household of 1	($149)
Adjusted income after deductions	$1,501
Shelter costs	$0.00
Standard utility Allowance	$338
Total rent/utility cost	$0.00
Shelter standard (50% adjusted income)	$750.50
Excess shelter deduction	$0
Net Adjusted income	$1,501
Excess Shelter Deduction	0
Adjusted income after shelter deduction	$1,501

5. The respondent took 30% of $1,501 to calculate the benefit reduction of $451 (rounded up). The maximum FAP benefit amount for a household size of one was $200. As the benefit reduction was more than the FAP maximum allotment the

Department found that the petitioner was overpaid $200 in FAP benefits for August 2013.

6. The petitioner did not dispute the receiving UCB for August 2013. She disputed the amount of UCB the Department alleged she received. The petitioner confirmed she received $550 extra in August 2013 for payments owed in July 2013. She also provided a printout from Florida Department of Economic Opportunity indicating payment dates of August 6, 2013 for $550, August 14, 2013 for $550 and August 28, 2013 for $550.

7. The Department began recouping money towards repaying the overpayments. It has already recouped $137. The balance owed on the claim is $63.

CONCLUSIONS OF LAW

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

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

10. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the respondent. The party having the burden shall establish their position by a preponderance of evidence.

JURISDICTION:

11. It is necessary to establish if a hearing was requested timely. . Fla. Admin. Code Rule 65-2.046, sets forth time limits in which to request a hearing and states in part:

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

12. The findings show the petitioner made an initial request for hearing on September 22, 2014. She was notified of the overpayments on June 25, 2014. There was a hearing scheduled on October 20, 2014 which she missed. She claimed that she did not get the notice of hearing in time to attend the hearing as she moved four times. Her mail was forwarded to her but she received her notice of hearing after the hearing date. The respondent's Motion to Dismiss the hearing was denied since the petitioner's initial request for hearing was made on September 22, 2014, within the time period set forth in the controlling authority to request a hearing from the mailing date of the Notice of Case Action.

13. Fla. Admin. Code R. 65A-1.900 Overpayment and Benefit Recovery, defines the administrative policies applicable to the establishment and recovery of overpayment in the public assistance programs.

14. The FAP standards for gross income and net income and deductions appears in the Department's Program Policy Manual (The Policy Manual), CFOP 165-22, at Appendix A-1. Effective October 2012, the maximum gross income for a one person assistance group was $1,862. The maximum net income limit for a one-person

assistance group was $931. The standard deduction was $149. The standard utility was $338.

15. When determining over issuance in the Food Assistance Program, 7 C.F.R. § 273.18 states in part:

> (a) General.
> (1) A recipient claim is an amount owed because of: (i) Benefits that are overpaid or...
> (2) This claim is a Federal debt subject to this and other regulations governing Federal debts. The State agency must establish and collect any claim by following these regulations.
> (e) Initiating collection action and managing claims—(1) Applicability. State agencies must begin collection action on all claims unless the conditions under paragraph (g)(2) of this section apply…
> (a)(4) The following are responsible for paying a claim:
> (i) Each person who was an adult member of the household when the overpayment or trafficking occurred…
> (b) *Types of claims.*
> (2) Inadvertent household error: any claim for an overpayment resulting from a misunderstanding or unintended error on the part of the household.
> (3) Agency error (AE) claim: any claim for an overpayment caused by an action or failure to take action by the State agency...

16. The above authorities set forth the Department's legal obligation to initiate and collect any overpayment claims against any household who received a larger FAP benefit amount than they were eligible to receive. The above authority also states that each person who was an adult member of the household when the overpayment occurred is responsible for paying a claim.

17. Recovery of payments made due to mistake or fraud is set forth in § 414.41, Fla. Stat. It states:

> (1) Whenever it becomes apparent that any person or provider has received any public assistance under this chapter to which she or he is not entitled, through either simple mistake or fraud **on the part of the department or on the part of the recipient or participant**, the

department shall take all necessary steps to recover the overpayment… (emphasis added)

18. The above authorities provide the authority necessary for the Department to pursue and recover all overpayment claims from any liable individuals, caused either by an inadvertent household error, or by agency error. The Department's representative explained the overpayment occurred as the agency failed to take timely action to update the petitioner's UCB, and as a result she received $200 in FAP benefits which she was not eligible to receive.

19. The undersigned reviewed the overpayments budget did not find any mathematical errors with the calculation. The $200 FAP overpayment for the months of August 2013 is correct.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied. The Department's action is affirmed. The Department may seek repayment of FAP benefits for the period of August 2013 for $200.

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 05 day of February, 2016,

in Tallahassee, Florida.

Christiana Gopaul-Narine
Hearing Officer
Building 5, Room 255
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Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

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

FILED
Jan 14, 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-08071

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 09 Orange
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-styled matter on December 3, 2015, at approximately 2:09 p.m. in Orlando, Florida.

APPEARANCES

For Petitioner: [redacted]
Petitioner's mother

For Respondent: Doretha Rouse
Registered Nurse Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is whether or not Respondent's denial of Petitioner's request for a Rifton Activity Chair ("Rifton") is correct. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

Petitioner's mother represented him at the hearing. Respondent presented the following witnesses by telephone:

- [redacted]

Petitioner moved Exhibits 1 and 2 into evidence at the hearing. Respondent's Exhibits 1 through 8 were entered into evidence at the hearing. The undersigned took administrative notice of the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook, July 2010.

FINDINGS OF FACT

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

1. Petitioner is a 9-year-old male. At all times relevant to this proceeding, Petitioner was eligible to receive Medicaid services.

2. Petitioner is enrolled with Children's Medical Services ("Ped-I-Care") as his Managed Medical Assistance (MMA) plan.

3. Petitioner's primary diagnosis is Wolf-Hirshhorn Syndrome, which causes global developmental delay. Petitioner requires total assistance with all of his activities of daily living (ADLs).

4. Petitioner has a custom wheelchair, a Zippee TS ("Zippee"). It is designed to provide custom head, trunk, and pelvic support. It has a tilting function that is supposed to allow correct head alignment for safe feeding. It was provided to him when he lived in New York.

5. Ms. Gaines said if Petitioner's Zippee is not meeting his needs he can have it evaluated by a technician and modified as necessary. Petitioner's mother said it was evaluated and the technician told her that the Zippee and the Rifton tilt at different angles and the tilt angle is very minimal compared to the Rifton system. She said the Zippee gives him good trunk support and the headrest supports his head, but the headrests on the Zippee and Rifton are not the same.

6. The Zippee allows more movement of his head, making it more difficult to feed him. Ms. Gaines said the headrest can be changed or modified and that the angle that the Zippee tilts the seat-to-back angle can be modified. Ms. Gaines also testified the vendor that submitted the price quote for the Rifton is very experienced in making the adjustments and Ped-I-Care has not received anything regarding a need for customized adjustments. [redacted] said there is some missing information and that it would make sense for the Rifton vendor to communicate with Ped-I-Care's consultant because they don't understand why the Zippee is not meeting Petitioner's needs since it is customized for him.

7. Petitioner also has a Leckey positioning chair that was provided to him approximately seven (7) years ago when he lived in New York. Petitioner has outgrown the chair. Petitioner seeks to replace the Leckey with the Rifton. The Rifton has similar functionality to the Leckey as far as feeding is concerned. Petitioner's mother still continues to feed him in the Leckey because she is afraid he might aspirate if fed in the Zippee because he has a high risk for aspiration. She says he is steadier in the Leckey because of the tilt angle and she has more control

with feeding him in it. Petitioner eats three (3) to five (5) times per day, including both meals and snacks.

8. Petitioner was hospitalized two (2) years ago for almost three (3) months and was on a ventilator with pneumonia due to complications from a surgery. His mother testified his lungs are very weak.

9. Petitioner's mother said they use the Zippee primarily for transportation and the Leckey primarily for feeding. Respondent's position is that the Rifton would be duplicative of the functions of the Zippee and the Zippee should have the ability for safe feeding. Ms. Gaines testified the Zippee can be used for both transportation and positioning.

10. The Zippee requires tools to adjust its height and its seat-to-back angle. The Rifton does not require tools. The Rifton is not customized and is easy to adjust because it is designed for settings such as schools, where multiple children will use the same chair at different times. Ms. Gaines said the Rifton's height can be adjusted to drop almost all the way to the floor, but the Zippee cannot.

11. Ms. Gaines testified that as Petitioner grows the Zippee would need adjustment, which would require tools, but that it should be infrequent. Regarding the seat-to-back angle, she said it should not be adjusted frequently because Petitioner should not stay in the chair for extended periods of time. She said the seat-to-back angle can be adjusted on the Rifton without tools, but that it is still limited.

12. The Rifton can lean forward 15 degrees, which would allow Petitioner to wash his hands or reach something that requires leaning forward. The Zippee cannot lean forward. Ms. Gaines said Petitioner is documented to have extremely limited head

and trunk control, so leaning him forward could put him at increased risk of injury. She also said Petitioner is documented to have poor control of his hands and is unable to reach and manipulate objects, so it does not appear that he would be able to independently turn the water on and wash his hands at this time. She does not see any benefit to Petitioner from being able to lean forward.

13. Petitioner lives in a two-story home with his mother, brother, sister, and maternal grandparents. Petitioner's mother is unable to move the Zippee upstairs because it weighs around 85 pounds and is too heavy for her. His mother carries him upstairs at night to his bedroom.

CONCLUSIONS OF LAW

14. By agreement between AHCA and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction to conduct this hearing pursuant to § 120.80, Fla. Stat.

15. This 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. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

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

19. 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.

20. Page 2-5 of the DME Handbook states the service criteria for DME as follows:

> All DME, medical supplies, and orthotics and prosthetic devices must be:
>
> - Medically necessary, and
> - Functionally appropriate for the individual recipient, and
> - Adequate for the intended medical purpose, and
> - For conventional use, and
> - For the exclusive use of the recipient.
>
> **DME items requested or supplied must not duplicate or perform the same function as other DME equipment or medical supplies currently in the recipient's possession.** (emphasis added).

21. 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.

22. 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.

23. Under the above statute, the Agency must provide durable medical equipment that would correct or ameliorate Petitioner's condition.

24. The United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in *Moore v. Reese*, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, which involved a dispute over private duty nursing:

> (1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.
> (2) A state Medicaid plan must include "reasonable standards … for determining eligibility for and the extent of medical assistance" … and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.
> (3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and

> a treating physician is "required to operate within such reasonable limitations as the state may impose."
> (4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."
> (5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. **The state is not required to provide medically unnecessary, albeit desirable, EPSDT services.** However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."
> (6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and my present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)) (emphasis added).

25. Consistent with these requirements, the state is obligated to provide services to recipients under 21 years of age, but only to the extent such services are medically necessary. The definition of medical necessity for services provided under the EPSDT benefit is established by the state and the state is authorized to establish the amount, duration, and scope of such services.

26. In the instant matter, Petitioner has not met his burden of proof to show he requires the Rifton. The Zippee appears to be able to perform all of the medically necessary functions for Petitioner and the Rifton would be duplicative. Adjustments to the Zippee seems to be the appropriate solution. The fact that the adjustments require tools on the Zippee and do not on the Rifton is a matter of convenience, not necessity.

27. The undersigned notes Petitioner's mother is genuinely concerned for her son's safety. [redacted] emphasized that the ultimate goal is to ensure Petitioner's safety, only there isn't enough information as to why the Zippee cannot allow for safe feeding. The Zippee is designed to provide for safe feeding. Petitioner was using the Leckey for

feeding when he was hospitalized, so there is no guarantee the Rifton would be any safer for feeding than the Zippee.

28. Petitioner's mother is encouraged to work with the provider and Ped-I-Care to determine what adjustments to the Zippee are needed. In the event adjustments cannot provide for safe feeding, it may be appropriate for a new custom wheelchair or a Rifton to be provided at that time.

DECISION

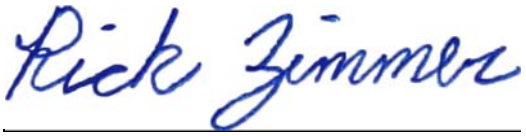
Based upon the foregoing, Petitioner's appeal is DENIED and the Agency's action is AFFIRMED.

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 14 day of January, 2016,

in Tallahassee, Florida.



Rick Zimmer
Hearing Officer
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FILED
Jan 12, 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.

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

RESPONDENT.
_____/

APPEAL NO. 15F-08155

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter on November 3, 2015 at 9:45 a.m. and reconvened on November 24, 2015.

APPEARANCES

For the petitioner: Designated representative [redacted] did not appear on November 24, 2015.

For the respondent: Susan Long, ACCESS Supervisor.

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny her application for Home and Community Based Services (HCBS) Medicaid Waiver Program. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

By notice dated September 21, 2015, the respondent notified the petitioner that her August 19, 2015 application for HCBS Medicaid Waiver Program was denied due to not receiving all the information necessary to determine eligibility. Petitioner timely requested a hearing to challenge the denial.

During the hearing on November 3, 2015, the respondent agreed to allow the petitioner's representative an opportunity to provide the missing verification needed to determine eligibility. The parties agreed to reconvene on November 24, 2015 at 9:45 a.m. During the hearing on November 3, 2015, the undersigned reviewed the documents submitted by the Department and determined additional evidence was needed to decide on the issues being raised. On record, the respondent was instructed to forward the following documents to both the undersigned and the petitioner prior to the November 24, 2015 hearing, so the documentation could be entered into evidence:

1. Notice of Case Action describing the action under appeal.
2. The Department's Running Comment Record (CLRC) notes from August 19, 2015 through September 24, 2015.
3. Document Viewing System (DVS) regarding verifications related to application dated August 19, 2015 (i.e., bank account statements).
4. The Department's Data Exchange Inquiry Asset Verification print outs.
5. Designated Representative form.

On November 24, 2015, the undersigned and respondent dialed in at the designated time to reconvene the hearing. The petitioner's representative did not dial in.

Additional evidence was received from the respondent prior to the November 24, 2015 hearing. However, the respondent did not submit the following documents: CLRC and DVS. The merits of the case were developed on November 3, 2015.

The petitioner did not submit any exhibits. Respondent submitted one exhibit, entered as Respondent Exhibit 1. The record closed on November 24, 2015.

FINDINGS OF FACT

1. Petitioner (94) submitted an application on August 19, 2015 for HCBS Waiver benefits. Petitioner reported on her application her mailing address as [redacted] in Orlando.

2. On September 2, 2015, the respondent mailed the petitioner a pending notice requesting proof of her bank account statements for [redacted] ending account number [redacted] and [redacted] ending account number [redacted] The requested information was due no later than September 14, 2015.

3. During the pending period, the representative provided [redacted] checking account bank statements. The respondent explained the bank statements provided indicated a "Secondary Bank account". The respondent electronically mailed the representative a request for clarification. The representative provided a copy of a second [redacted] bank account ending in [redacted] with a confirmation of closure on September 1, 2015.

4. On September 21, 2015, the respondent mailed the petitioner a Notice of Case Action informing her that the application was denied due to not providing all the information requested to determine eligibility.

5. The respondent explained the petitioner did not provide bank statements from Wells Fargo bank account number ending [redacted] The respondent presented documents from the Department's "Data Exchange Inquiry Asset Verification" as follow:

[redacted]

6. The data showed a balance in the [redacted] account of $0.00 since June 2014. The representative argued that the Wells Fargo account was a joint account the petitioner had with her son, [redacted] The representative explained the account is closed.

7. The petitioner's representative requested an opportunity to provide the bank statement for the [redacted] bank account ending in [redacted] The parties agree to reconvene on November 24, 2015. On November 24, 2015, the petitioner's representative did not dial in and no additional documents were provided.

CONCLUSIONS OF LAW

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

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

10. Fla. Admin. Code R. 65A-1.205 Eligibility Determination Process in part states:

> (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… the eligibility specialist must give the applicant written notice to provide the requested information or to comply, allowing ten calendar days from request or the interview, whichever is later. For all programs, verifications are due ten calendar days from the date of written request or the interview, or 60 days from the date of application, whichever is later. In cases where the applicant must provide medical information, the return due date is 30 calendar days following the written request or the interview, or 60 days from the date of application, whichever is later. If the due date falls on a holiday or weekend, the deadline is the next working day. If the applicant does not provide required verifications or information by the deadline date the application will be denied, unless the applicant requests an extension or there are extenuating circumstances justifying an additional extension.
> …
> **(5) The Department can substantiate, verify or document information provided by the applicant/recipient as part of each determination of eligibility. For any program, when there is a question about the validity of the information provided, the Department will ask for additional documentation or verification as required.** The term verification is used generically to represent this process. (emphasis added)
> (a) Substantiation establishes accuracy of information by obtaining consistent, supporting information from the individual.
> (b) Verification confirms the accuracy of information through a source(s) other than the individual. The Department can secure verification electronically, telephonically, in writing, or by personal contact.
> (c) Documentation establishes the accuracy of information by obtaining and including in the case record an official document, official paper or a photocopy of such document or paper or electronic source that supports the statement(s) made by the individual.
> **(6) The Department conducts data exchanges with other agencies and systems to obtain information on each applicant** and recipient. It uses data exchanges to validate or identify social security numbers, verify the receipt of benefits from other sources, verify reported information, and obtain previously unreported information. (emphasis added)
> (a) The Department conducts data exchanges with the Social Security Administration, Internal Revenue Service, Department of Economic Opportunity, federal and state personnel and retirement systems, other states' public assistance files and educational institutions.

11. Fla. Admin. Code R. 65A-1.712 SSI-Related Medicaid Resource Eligibility Criteria. states:

> (1) Resource Limits…
> (f) For the Home and Community Based Waiver Services (HCBS) Program, an individual cannot have countable resources that exceed $2,000. If the individual's income falls within the MEDS-AD Demonstration Waiver limit, the individual can have resources up to $5,000.
> (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…
> (g) An individual who is a beneficiary under a qualified state Long-Term Care Insurance Partnership Policy is given a resource disregard equal to the amount of the insurance benefit payments made to or on behalf of the individual for long term care services when determining if the individual's countable resources are within the program limits to qualify for Medicaid Institutional Care Program (ICP), HCBS…

12. Federal Regulations at 42 C.F.R. § 435.949 Verification of information through an electronic service in part states:

> (a) The Secretary will establish an electronic service through which States may verify certain information with, or obtain such information from, Federal agencies and other data sources, including SSA, the Department of Treasury, and the Department of Homeland Security.
>
> (b) To the extent that information related to eligibility for Medicaid is available through the electronic service established by the Secretary, States must obtain the information through such service, subject to the requirements in subpart C of part 433 of this chapter, except as provided for in §435.945(k) of this subpart.

13. The authorities above explain the eligibility determination process, application processing time standards and verification requirements. On September 2, 2015, the respondent mailed a pending notice to the address reported on the application to

request petitioner's bank account statements. This verification was needed to determine if the petitioner met the asset limit for the HCBS Waiver Program. The petitioner provided all information requested except the Wells Fargo bank account number ending [redacted] As of the November 24, 2015 hearing, the petitioner has not provided proof of the [redacted] bank checking account. However, the Data Exchange Inquiry Asset Verification showed a balance of $0.00 for said account since June 2014.

14. According to the authority above, information obtained through electronic data shall be considered a reasonable form of verification. If the information provided effects eligibility, the Department is to take proper action to notify the applicant. In this case, the electronic data showed an asset balance of $0.00 since June 2014 for the [redacted] bank account. This amount does not exceed the asset limit of $5,000.00.

15. In careful review of the cited authorities and evidence, the undersigned concludes the respondent erred by denying the petitioner's HCBS Medicaid Waiver application based on assets not verified.

16. Therefore, this matter is remanded back to the Department to inform the petitioner of the eligibility requirements and allow petitioner to submit the necessary documentation to have her eligibility for the HCBS Medicaid Waiver Program determined. The Department is to preserve the petitioner's original application date of August 19, 2015 and determine her HCBS Medicaid Waiver eligibility from that date. This remand does not guarantee benefits.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted and remanded back to the respondent in accordance with the above Conclusions of Law. Once an eligibility determination is completed, petitioner is to be notified of the outcome with a new notice that includes appeal rights.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 12 day of January, 2016, in Tallahassee, Florida.

Cassandra Perez

Cassandra Perez
Hearing Officer
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Office of Economic Self Sufficiency

FILED
Feb 24, 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-08244

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 19, 2015, at 1:20 p.m.

APPEARANCES

For the Petitioner: [redacted] the petitioner's daughter.

For the Respondent: Linda Latson, Registered Nurse Specialist, Agency for Health Care Administration (AHCA).

STATEMENT OF ISSUE

At issue is the Agency action, through Sunshine Health, in denying petitioner's request for bathroom modifications (walk-in shower with grab bars and widening of the bathroom door), a stair lift, and a shower chair. The petitioner carries the burden of proof in this matter.

PRELIMINARY STATEMENT

The petitioner was present as a witness. Present as witnesses for the respondent were India Smith, Grievance and Appeals Coordinator; Lynne Scullion, Case Manager; Dr. John M. Carter, Long-Term Care Medical Director; and Heather Ford, Long Term Care Supervisor, all from Sunshine Health. Present as an interpreter was [redacted]

The respondent submitted into evidence Respondent Exhibit 1 through 10. The petitioner submitted into evidence Petitioner Exhibit 1 and 2.

The record was left open for thirty days for the petitioner to submit additional information. The petitioner submitted additional information within the time frame allotted. The record was left open an additional fourteen days for the respondent to provide a response. No response was provided within the time frame allotted.

It was brought to this hearing official's attention that the information submitted by the petitioner may not have been provided to the respondent's witness. The undersigned issued an Order requiring the Agency to forward the additional information to Sunshine Health and for Sunshine Health to provide a response within fourteen days. A response was provided but after the deadline. This information was admitted after deadline, as it was needed to clarify the respondent's position on this issue.

FINDINGS OF FACT

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

1. The petitioner is a Long-Term Care (LTC) Medicaid recipient living in [redacted]. She is unable to ambulate on her own. She is seventy-seven years of

age and lives on the second floor of a two-story house. Sunshine Health is a Managed Care Organization authorized by AHCA to make prior service authorization decisions for individuals enrolled in Medicaid LTC Programs.

2. On July 31, 2015, the petitioner requested bathroom modifications (walk-in shower with grab bars and widening of the bathroom door), a stair lift, and a shower chair.

3. The petitioner lives in a two-story home where the full bathroom is on the second floor. She has numerous medical issues including [redacted] She was recently admitted to the hospital and was temporarily placed in a rehabilitation center before being sent home. The petitioner is approved for services that include personal care assistance on a weekly basis.

4. On August 12, 2015, Sunshine Health denied the petitioner's request and mailed a Notice of Action stating:

> …After our review, this service has been denied, as of 08/10/2015…
>
> We made this decision because:
>
> We determined that your requested services are not medically necessary because the services do not meet the reason(s) checked below:
>
> Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs.
>
> The requested service is not a covered benefit.
>
> Other authority-Lack of medical necessity.
>
> You asked for, Home modification (A service provided to make your home safe and handicap accessible), chair lift (A chair that allows you to move easily between floors of a house). Walk in shower with grab bars (The bar that is used to hold onto while in the shower or tub), and widening of the bathroom door. After review, this has been denied. The information given

> to Sunshine Health does not show that you cannot access the second floor. There is no Prescription (order written by your doctor) for shower chair (A chair you can sit on while you are in the shower) and in the picture provided to Sunshine Health you already have a shower chair. The chair lift is a non-covered benefit.

5. The respondent's witness, Dr. John Carter, Long-Term Care Medical Director, indicated the stair lift, as a home modification, is not a covered benefit under the plan. He indicated, however, that under certain circumstances, where there are no safety concerns, the stair lift may be provided as a covered service. For example, if an individual lives in a building with multiple housing units and there is no elevator and that person is quite mobile, has good posture, and is capable of using the lift safely to get to their home then it may be a covered service.

6. He indicated that the decision to deny was based on safety issues for the petitioner. He indicated he has concerns due to the petitioner's spinal problems, her mobility, and the fact that it is safer for her to be primarily on one floor. Subsequent to the issuance of the notice in this matter, petitioner was admitted to the hospital in October and November. Dr. Carter recommended a reassessment for the stair lift due to the change in petitioner's health status now that she has been discharged from rehab and the hospital.

7. Dr. Carter indicated, after hearing the petitioner's arguments on the stair lift, that he did not have or review any pictures of the petitioner's stairway. He indicated the petitioner should submit another request for the stair lift and provide more information such as pictures of the stairway. It was agreed that the record would be left open and information submitted by the petitioner would be reviewed and a response would be provided.

8. For the bathroom modifications, Dr. Carter indicated he agreed that other than shower chair, the modifications should be made for the petitioner's bathroom. The Case Manager testified she is familiar with petitioner's home and there is not enough space in the bathroom for petitioner or for any other individual to assist her.

9. The Grievance and Appeals Coordinator indicated that the petitioner's representative told the plan that the petitioner's house was in foreclosure. She indicated that based on this information, it would appear that the petitioner may not be living at her place of residence very long. She also indicated that this situation also played a role into the plan's decision not to approve any of the petitioner's request for home modification. She pointed out that according to the plan's contract as found on page 50 of Respondent Exhibit 8, under service limitations, it states: "The member has no plans to move either to another residence or institutional setting within the next three months." She indicated that the petitioner would need to present some type of documentation to show that she will continue to live at her current address.

10. Submitted as part of Petitioner Exhibit 2 were copies of pictures of the petitioner's stairway. It should be noted the pictures are not very clear. Petitioner submitted a copy of a price quote for the stair lift that equaled $11,766. She submitted a copy of a United States Bankruptcy Court document related to a request for Mortgage Modification Mediation filed on December 1, 2015.

11. The petitioner's representative argued that the petitioner cannot in anyway go up or down the stairway on her own. She argued that the petitioner's health has deteriorated recently increasing the need for a stair lift. She argued that the stairway in the home is suitable for the stair lift to be installed. She argued that the petitioner owns

her home and they have worked out the problems with the foreclosure. She argued the petitioner intends to continue living in her home.

12. Based on the additional information provided by the petitioner (pictures of the stairway, the price quote for the stair lift, and documentation regarding home modification), the undersigned left the record open for respondent to provide a response. That response is as follows:

> Based on further review of information about the stare lift and bathroom modification request the original denial should continue to stand. The information provided does not demonstrate a safe modification or alteration of a winding staircase. Sunshine Health continues to recommend that the member consider living on the ground floor, for safety reasons in case of need for emergency exit from the house plus the fact that the member should only safely be maintained on one level due to medical conditions regarding her spinal/musculoskeletal health.
>
> Member is currently receiving 14 hours of Personal Care weekly, 12 hours of Companion Care weekly, Respite Care 16 hours per week…

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

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

(166) “Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

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

17. The AHCA Long-Term Care Program contract, page 50 of the Respondent’s evidence packet, states in part:

The criteria for home accessibility adaptation services include the following:

Physical adaptations to the home must be based on each of the three (3) below criteria:

Adaptation to the home is necessary for the health, welfare and safety of the member.

The adaptation to the home will enable the member to function with greater independence in the home.

Without the adaptation to the home, the member would be institutionalized.

18. As shown in the Findings of Fact, the Agency, through Sunshine Health, denied the petitioner's request for bathroom modifications (walk-in shower with grab bars, widening of the bathroom door), a stair lift, and a shower chair.

19. Regarding the bathroom modifications (widening of the bathroom door and walk-in shower with grab bars), both the Long-Term Medical Director and Case Manager were in agreement at hearing that the bathroom indeed warranted modification. The evidence shows petitioner requires these adaptions to her home to maintain a safe living environment.

20. Regarding the stair lift, the Agency argued safety is a primary concern as petitioner has spinal problems, issues with mobility, and would be primarily safer staying on one floor. Subsequent to the issuance of the notice in this matter, petitioner had several admissions to the hospital and an admission to a rehab facility. The Agency's position would be in line with the above medical necessity rule "[b]e 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." In view of the evidence, the undersigned concludes petitioner did not meet her burden in showing that the denial of the stair lift was incorrect.

21. Petitioner's condition may change in the future. If the petitioner's needs increase or her condition changes, a new request may be submitted at that time. Her family is encouraged to work with her caseworker and the plan regarding future assessments.

22. Regarding the shower chair, the Agency denied this request because no physician prescription was submitted and petitioner already had a shower chair. No

evidence was submitted to rebut these assertions. The controlling legal authorities make clear that Medicaid services cannot be in excess of the patient's needs. Therefore, the undersigned concludes petitioner did not meet her burden in showing that the denial of the shower chair was incorrect.

23. After careful review of the evidence submitted and the relevant laws set forth above, the undersigned concludes the petitioner failed to meet her burden in showing that the denial of the stair lift and shower chair was incorrect.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal is GRANTED in part and DENIED in part as follows:

- The request for bathroom modification (widening of the bathroom door and walk-in shower with grab bars) is granted.
- The request for a stair lift and shower chair 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 24 day of February, 2015,

in Tallahassee, Florida.

Robert Akel

Robert Akel
Hearing Officer
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FILED
Feb 26, 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-08247

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 20 Lee
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on January 11, 2016 at approximately 3:30 p.m.

APPEARANCES

For Petitioner: [redacted]
Petitioner's mother

For Respondent: Suzanne Chillari
Medical/Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is whether or not Respondent's denial of Petitioner's request for 25 additional hours per week of Companion Care, 84 additional hours per week of Personal Care, and 168 hours per week of Homemaker services through the Participant Directed Option ("PDO") was correct. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

Petitioner's mother represented him at the hearing. Respondent presented the following witnesses:

- Katrina Hill – Long-Term Care Supervisor – Sunshine Health
- Dr. John Carter – Long Term Care Medical Director – Sunshine Health
- Natalee Wright – Case Manager – Sunshine Health
- Paula Daley – Grievance and Appeals Coordinator – Sunshine Health

Erica Colon, Director of Case Management, Long-Term Care Plan, Sunshine Health and James Van Landingham, Associate Attorney with Hogan Lovells, attorneys for Sunshine Health, observed the hearing. Mr. Van Landingham did not participate in the hearing in any way and Petitioner's mother consented to his presence. Petitioner did not move any exhibits into evidence. Respondent's Exhibits 1 through 7 were entered into evidence.

FINDINGS OF FACT

1. Petitioner is a 37-year-old male. Petitioner is enrolled with Sunshine Health ("Sunshine") as his Long-Term Care ("LTC") plan.

2. Petitioner's medical conditions include:

- [redacted]

3. Petitioner lives in the family home, consisting of himself, his mother, his father, his sister, and his sister's two (2) children. Petitioner's mother sometimes pays his sister to watch him when she runs errands.

4. The current level of services Petitioner is receiving through PDO are 10 hours per week of Companion Care, 25 hours per week of Homemaker services, and 25 hours per week of Personal Care. At the time of the hearing, Petitioner was receiving seven (7) hours per week of Skilled Nursing Care [redacted] and one (1) hour bi-weekly of Skilled Nursing Care [redacted]. Petitioner can allocate the PDO hours however desired, including overlapping services at the same time, as long as he does not exceed the total number of approved hours.

5. On February 16, 2016, Petitioner's mother spoke to the Hearing Officer, at Ms. Wright's direction, to inform him that Petitioner no longer receives the Skilled Nursing Care. The record in this proceeding had closed at the time of this communication. Any subsequent termination of services is not at issue in this appeal and will not be addressed.

6. Petitioner's mother testified that he is [redacted] from the waist down, but only has small movement in his hands. His 701B Comprehensive Assessment ("701B") lists him as having [redacted] (Respondent's Exhibit 2).

7. Petitioner requires total assistance with all of his activities of daily living ("ADLs") and instrumental activities of daily living ("IADLs"). Because of this he requires care 24 hours per day, seven (7) days per week. Petitioner's mother works outside of the home eight (8) hours per day as a special education teacher. Petitioner receives services

from an outside provider, [redacted] while his mother is at work. Sixteen (16) hours of the home health services are provided by Petitioner's mother.

8. Petitioner needs to be repositioned every 30 minutes. His family members assist with this task. [redacted] also comes once or twice a week to bathe him. This takes between one (1) and two (2) hours. Petitioner's family also assists with this task. He also requires catheter care and care for changing his ostomy bag.

9. Petitioner has visited a hospital approximately 25 times within the last year, and an emergency room approximately 50 times within the last year.

10. On July 24, 2015, Sunshine received the request for the increase in services. On August 5, 2015, Sunshine issued a Notice of Action denying the request as not being medically necessary, specifically because it "Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs." (Respondent's Composite Exhibit 4). The Notice of Action stated:

> You requested additional PDO/Participant [redacted] (The person you choose to take care of you) service hours of 25 hours per week of Companion Care (The person that helps assist and watch over you), 84 hours per week of Personal care (The person who helps care for you), and 168 hours per week of Homemaking (The person who helps with cleaning and chores).
>
> Sunshine Health has also looked at your care needs and services. The care you are now getting, 32 hours per week of Personal Care (The person who helps care for you), 10 hours per week of Companion Care (The person that helps assist and watch over you) plus 25 hours per week of Homemaker Services (The person who helps with meals/cleans/chores), can meet your care needs. Your request for the additional hours of Companion Care, Personal care, and Homemaking services is denied. Your Case Manager will continue to assess your care needs.
>
> The facts that we used to make our decision are: This decision was made with Sunshine Health Policy LT.UM.09 Long Term Care Ancillary Service Criteria.

11. Petitioner requested an internal appeal with Sunshine. On September 17, 2015, Sunshine issued a letter advising that the denial had been upheld (Respondent's Composite Exhibit 4). The letter states, in pertinent part:

> This case was reviewed by Sunshine Health's Medical Director, who is Dual Board Certified in Emergency Medicine and Internal Medicine. Our decision is based upon the conclusion of our review of the additional medical documentation, clinical judgment, standards of practice and Sunshine Health Guideline. The appeal is denied and the denial is upheld for additional personal care, companion care, and homemaking hours. The member requires total assistance with all activities and instrumental activities of daily living. He is currently receiving 67 combined hours with and an additional 7 hours of skilled nursing. The request for an additional 25 hours of companion care per week, 84 hours of personal care hours per week, and homemaking of 168 hours per week is excessive. If there is a need for that many hours, consideration of placement into a nursing home for 24-hour care should be entertained.
>
> The LT.UM.09 LTC (Long Term Care) Ancillary Services was used in making the decision.

12. Per Sunshine's Policy and Procedure, LT.UM.09, (Respondent's Exhibit 6), Adult Companion Care includes:

> Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discreet services. The provision of companion services does not entail hands-on nursing care. The service includes light housekeeping tasks incidental to the care and supervision of the member. The provision of services may be provided at the member's residence or anywhere in the community where supervision and care is necessary. The services cannot be provided by a family member.

13. Homemaker Services are defined as:

> General household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these services is temporarily absent or unable to manage these activities, Chore services, including heavy chore services and pest control may be included in this service.

14. Personal Care Services are defined as:

> A service that provides assistance with eating, bathing, dressing and personal hygiene and other activities of daily living. The service includes assistance with preparation of meals, but does not include the cost of meals. The 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 member, rather than the member's family. Personal care services include the following:
>
> - Providing assistance to the member to complete personal hygiene (bathing, grooming, mouth care, etc.)
> - Assistance with bladder and bowel requirements that include assisting the member to and from the bathroom or with bedpan routines.
> - Assisting the member in following through with physician orders. The Personal Care provider cannot administer medications, but may bring medications to the member and remind the member to take the medicine at specific times.
> - Assisting with food, nutrition, and diet activities, including preparing meals, when required and other incidental services, (i.e. housekeeping chores) essential to the health and welfare of the member.
> - Performing household services (changing bed linen or arranging furniture), when such services are essential to the member's health and comfort.
>
> Personal Care workers must be supervised by a registered nurse, licensed to practice nursing in Florida and who conducts a supervisory home visit every 60 days to observe the personal care worker. The services may be provided in the member's home or other location. Family members cannot be paid for Personal Care Services.

15. Companion Care, Homemaker Services, and Personal Care Services are all ancillary home health services under Sunshine's Policy and Procedure. Sunshine considers the level of support needed when determining the amount of services needed. The services are intended to "augment and support the existing informal care and community services being provided to allow the member to remain safely in their home."

16. One of the level of support considerations is the recipient's living situation. Sunshine considers whether or not someone lives alone or with family. [redacted] said someone who lives alone would need more care than someone who lives with family. Sunshine also considers whether the recipient requires Minimum, Moderate, or Maximum support to complete their daily tasks. Petitioner requires Maximum support since he requires total assistance with all ADLs and IADLs and Sunshine defines Maximum support as support need for 75% of the task or more. Sunshine does not dispute that Petitioner requires total care. The only dispute regards the total number of hours required to meet his needs.

17. The Policy and Procedure includes time guidelines for the services, based upon the recipient's level of support needs. One unit of time is 15 minutes. Because Petitioner requires total care, he needs assistance with all services. The following paraphrased list contains the maximum amount of time for each service for Petitioner's living situation, per the guidelines:

> 1. Supervision and Socialization Support:
> Lives with family who provide a minimum or moderate amount of supervision of the member's daily needs and/or socialization: 75 minutes per week.
>
> 2. Meal Preparation Assistance: breakfast, lunch, dinner, and additional meal alone (assuming no family member is in the home at his meal times): 75 minutes per day, 7 days per week = 525 minutes per week.
>
> 3. Shopping Criteria:
> Lives with family who provide a minimum or moderate amount of the member's shopping: 75 minutes per week.
>
> 4. Housekeeping and Chore Services:
> Lives with family who provide a minimum or moderate amount of the member's housekeeping or chores: 90 minutes per week.

5. Laundry Criteria:
Lives with family who provide a minimum or moderate amount for the member's laundry: 90 minutes per week.

6. Bathing Criteria:
Maximum assistance needed, full bath, once per day: 45 minutes per bath, 7 days per week = 315 minutes per week. Petitioner's mother testified he only bathes once or twice per week, however, this guideline assumes he could bathe once per day if desired.

7. Dressing and Grooming Criteria:
Maximum assistance: 20 minutes per task. Number of tasks (6): dressing, undressing, hair care, shaving, oral hygiene, nail care, for a total of 120 minutes per day, 7 days per week = 840 minutes per week.

8. Toileting Criteria:
Maximum assistance: 15 minutes per day of emptying urine from catheter bag, and 15 minutes per day of caring for ostomy bag: 30 minutes per day, 7 days per week = 210 minutes per week.

9. Mobility Criteria:
Maximum assistance: 30 minutes per task. The number of tasks is inherently variable depending upon how much mobility Petitioner needs on a given day. Assuming he leaves and returns to his home once a day, 30 minutes leaving and 30 minutes returning is 60 minutes per day, 7 days per week = 420 minutes per week.

10. Transferring Criteria:
Maximum assistance with one or more persons or totally dependent on other for transferring: 30 minutes per task. Petitioner's mother testified he needs to be repositioned every 30 minutes. Allowing 30 minutes per task would mean he is constantly being transferred every second of the day. The guideline for someone who is bed-bound and requires frequent turning and repositioning is up to 90 minutes per day, 7 days per week = 630 minutes per week.

11. Eating and Feeding Criteria:
Maximum assistance: 30 minutes per meal, 4 meals per day: 120 minutes per day, 7 days per week = 840 minutes per week.

12. Nutritional Assessment/Risk Reduction Services:
Two (2) one (1) hour visits within 2 weeks = 60 minutes per week.

13.Respite Services Criteria:

> Care of the member for periods of time when the caregiver is absent. Petitioner's mother is absent eight (8) hours per day, five (5) days per week due to working outside of the home. Assuming there is no other caregiver in the home during the eight (8) hour period, even though other family members live in the home: 480 minutes per day, 5 days per week = 2,400 minutes per week.

18. The sum total of the maximum time guidelines for all services is 6,570 minutes per week, which is 109.5 hours per week. Petitioner's mother testified the services provided by [redacted] occur when she is at work, which is when Respite Care would be appropriate. Further, Respite Care was not requested. Removing Respite Care from the calculation yields 4,170 minutes per week, which is 69.5 hours per week.

CONCLUSIONS OF LAW

19. By agreement between AHCA and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction to conduct this hearing pursuant to § 120.80, Fla. Stat.

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

21. This is a Final Order, pursuant to Sections 120.569 and 120.57, Fla. Stat.

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

23. Legal authority governing the Florida Medicaid Program is found in 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.

24. Section 409.978 (2) of the Florida Statutes states, in pertinent part: "[AHCA] shall make payments for long-term care, including home and community based services, using a managed care model…."

25. Section 409.98 of the Florida Statutes requires that LTC plans include, among other services, personal care, home-delivered meals, case management, medication administration, and nutritional assessment and risk reduction.

26. The October 2014 Florida Medicaid Home Health Services Coverage and Limitations Handbook ("Home Health Handbook") is promulgated into law by Chapter 59G of the Florida Administrative Code.

27. Page 1-2 of the Home Health Handbook defines "Home Health Services," stating:

> Home health services are medically necessary services, which can be effectively and efficiently provided in the place of residence of a recipient. Services include home health visits (nurse and home health aide), private duty nursing and personal care services for children, therapy services, medical supplies, and durable medical equipment.

28. 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.

29. Sunshine concluded the request for the additional hours is in excess of Petitioner's needs. The undersigned agrees. The total number of hours requested per week for each service is 109 hours of Personal Care and Skilled Nursing Care (25 existing plus 84 additional requested), 35 hours per week of Companion Care (10 existing plus 25 additional requested) and 193 hours of Homemaking Services (25 existing plus 168 additional requested), which totals 337 hours per week of services. The undersigned notes that there are 168 hours in a week, therefore Petitioner's request for Homemaker Services exceeds 24/7 service. This does not include the 7.5 hours per week of skilled nursing care, which has apparently been terminated subsequent to the hearing.

30. It is undisputed that Petitioner requires total care. His level of services at the time of the hearing was 67.5 hours per week, including the skilled nursing care. He has 60 hours per week of combined Personal Care, Companion Care, and Homemaker Services. The calculated maximum amount of home health services under Sunshine's LTC plan is 69.5 hours, under the assumption that Petitioner does not have any family member with him to assist with meal preparation and feeding.

31. Because the calculated maximum amount of the requested services is 69.5 hours per week, and Petitioner was receiving 67.5 hours per week at the time of the hearing, the undersigned concludes Petitioner has not shown, by preponderance of the evidence, that he requires the requested additional hours of services.

32. The 337 requested hours of services is clearly excessive. However, the undersigned has based this decision on the calculated maximum number of hours according to Sunshine's guidelines and the evidence presented. As noted above, Sunshine considers a number of factors when determining the level of support required for a member. Petitioner is encouraged to work with his Case Manager to re-evaluate his needs. When considering all factors, he may be able to receive additional home health services that are not in excess of his needs. In the event his needs cannot be met through home health services, Petitioner and his mother may wish to consider placement in a nursing home, as suggested by [redacted]

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 26 day of February, 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
Dietra Cole, Area 8, AHCA Field Office Manager

FILED
Jan 29, 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-08249

PETITIONER,

Vs.

[redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 04 Clay
UNIT: 03DDD

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an in-person administrative hearing in the above-referenced matter on December 11, 2015 at 10:15 a.m. at the respondent's facility located in Jacksonville, Florida.

APPEARANCES

For the Petitioner: The petitioner was present and represented herself.

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 September 9, 2015 to terminate her SSI-Related Medicaid benefits effective September 30, 2015 as she no longer met the disability requirement.

The respondent holds the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The hearing originally convened on November 5, 2015 at 10:15 a.m. The petitioner did not appear. On November 6, 2015, the petitioner contacted the undersigned and requested to reschedule as she was confused as to when the hearing was scheduled to take place. Her request was granted and the hearing was scheduled for December 11, 2015. On December 2, 2015, the petitioner contacted the undersigned to request an in-person hearing. Her request was granted and the hearing location was changed to an in-person hearing, same date and time.

The record was held open until 5:00 p.m. on December 15, 2015 to allow time for the petitioner to submit additional evidence. Evidence was submitted and entered as the Petitioner Exhibit 2.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner (age 44) was determined disabled by the Division of Disability Determination (DDD) in February 2015 and was approved for SSI-Related Medicaid. A review was set for July 2015. The petitioner completed an application to recertify for SSI-Related Medicaid on July 24, 2015. The petitioner completed an application for Supplemental Security Income (SSI) on July 30, 2015.

2. The petitioner's SSI-Related Medicaid application was forwarded to the DDD on August 21, 2015. The Respondent Exhibit 2 includes the "Disability Determination and Transmittal" (Transmittal), signed on September 8, 2015. The Transmittal

completed by the DDD lists the petitioner's primary diagnosis as [redacted] with a code in Part II, section 11a. The secondary diagnosis is listed as [redacted] under section 11b. On September 8, 2015, the Social Security Administration (SSA) determined the petitioner to not be disabled and denied her application for SSI with a denial code of "N32." The Department explained that the denial code of "N32" means the petitioner is "not disabled". Therefore, the Department adopted the SSA decision and terminated the petitioner's SSI-Related Medicaid benefits effective September 30, 2015.

3. The petitioner timely appealed the Department's action on September 29, 2015.

4. The petitioner does not agree with the Department's action to terminate her SSI-Related Medicaid benefits as she had foot surgery on September 30, 2015. The petitioner argues that the SSA had already denied her disability claim by the time she had her surgery. The petitioner argues that she needs follow-up treatment to give her a better prognosis as a result of the surgery. The petitioner argues that the surgical procedure would have been done in vain if she does not receive the follow-up treatment. The petitioner explained that she needs the recommended therapy and corrective boots to get the optimal results from the surgery. The petitioner would like Medicaid for an additional three or four months to assist her.

5. The petitioner does not understand why she was granted Medicaid before without having the new medical conditions on file. The petitioner filed an appeal for the SSA denial on November 9, 2015.

6. The petitioner contends that she falls a lot, which could stem from her brain injury. She also has [redacted] from a car accident in 1994, which caused a "drop foot" medical condition. The petitioner's other medical conditions include a [redacted], [redacted] and [redacted] The petitioner believes these conditions were reviewed in the SSA disability determination. The petitioner believes her [redacted] diagnosed in 2002 is a new medical condition it was not included in the review completed by the SSA to determine her claim for disability.

7. The Petitioner Exhibit 1 includes the report dated February 15, 2002 from physician, Dennis Dewey, M.D. The report is labeled: [redacted] and [redacted] The report includes in its notes the following statements: [redacted] and [redacted] The "Impression" section of the report states: [redacted]

8. The Petitioner Exhibit 2 includes the "Explanation of Determination" from the SSA. The "Explanation of Determination" states:

> You state that you are disabled and unable to work due to chronic pain, [redacted], a history of a [redacted] and [redacted]. We realize that you may feel that you are disabled at this time. However, we were unable to obtain sufficient evidence to show that your condition was disabling as of 09/30/2011…

9. The Department's position is that the petitioner received a favorable DDD disability decision in February 2015 since her SSA application had not been filed yet. Once the SSA made its disability decision, the Department had to adopt the SSA decision. The Department explained that the petitioner reported on her application the same conditions reviewed by the SSA and did not include the new conditions. The Department contends that the petitioner may complete another application for SSI-Related Medicaid in order for it to submit the medical records for SSA to review her new medical condition of a brain injury.

CONCLUSIONS OF LAW

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

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

12. Florida Administrative 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, 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...

13. Federal Medicaid Regulations at 42 C.F.R. § 435.541 Determinations of disability states in relevant part:

> (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 and 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. (emphasis added)

14. The Department's Program Policy Manual (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.

15. The above authority explains that a disability application must be sent to the DDD 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.

16. In this case, the petitioner is under age 65 and alleges that she has a new medical condition of a [redacted] that was not reviewed by SSA. The petitioner provided evidence of [redacted] through an MRI report dated February 15, 2002. The petitioner's evidence shows that the [redacted] was not included as one of the medical conditions reviewed by the SSA.

17. The Policy Manual, passage 0440.0604 Continuation of Benefits (MSSI, SFP) states:

> If an individual requests a hearing by the end of the last day of the month prior to the effective date of the adverse action, reinstate the benefits to the prior level within 10 calendar days, unless the individual makes a written request to have the benefits terminated or reduced. If the last day of the month falls on a weekend or holiday, allow until the next working day for the request.
> Inform recipients that they are liable for any overpayment caused by the continuation of benefits, pending the hearing decision

18. The Department's ACCESS Florida Program Policy Manual, 165-22 section 1440.1206 Change in Disability Determination by SSA (MSSI, SFP)

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

19. The above authorities explain that the Department is directed to continue SSI-Related Medicaid benefits if the fair hearing is requested prior to the date of the adverse action, unless the petitioner requests to have the benefits terminated. In this case, the findings show that the petitioner requested a hearing on September 29, 2015, which is prior to the effective date of September 30, 2015. Therefore, the undersigned concludes that the petitioner's SSI-Related Medicaid benefits should have been continued as she requested a fair hearing prior to the effective date of the adverse action.

20. The above authorities also explain that the Department is to continue SSI-Related Medicaid benefits if the SSA renders a decision different from the DDD determination if the individual files a timely appeal (within 60 days) with the SSA; the SSI-Related Medicaid benefits are to continue until the outcome of the SSA appeal. The findings show that the SSA denied the petitioner's claim for disability on September 8, 2015. The findings also show that the petitioner filed an appeal on November 9, 2015. Since the 60th day fell on November 7, 2015, which was a Saturday, the undersigned concludes that the petitioner timely appealed with the SSA.

21. Based on the above findings and authorities, the undersigned concludes that the Department was premature in its termination of the petitioner's SSI-Related Medicaid benefits. The Department is remanded with instructions to reinstate the petitioner's SSI-Related Medicaid. The Department must continue the petitioner's SSI-Related Medicaid benefits while it waits on the disability decision from the SSA. Once the SSA makes its determination, the Department is to issue notice with appeal rights.

22. Should the SSA decision be unfavorable, the petitioner may reapply for SSI-Related Medicaid and include her new medical conditions not previously reviewed by the SSA.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted and remanded to the Department with instructions to reinstate petitioner's Medicaid coverage pending the disability decision from the SSA. Once that decision is made, the Department is to issue a written notice to include appeal rights.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 29 day of January, 2016,

in Tallahassee, Florida.

Paula Ali

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

FILED
Feb 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. 15F-08311

PETITIONER,

Vs.

[redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 20 Collier
UNIT: 88287

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on January 12, 2016 at 9:03 a.m., at 2295 Victoria Avenue in Fort Myers, Florida.

APPEARANCES

For Petitioner: Petitioner

For Respondent: Signe Jacobson, Economic Self-sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the department took correct action regarding petitioner's current and past health insurance premiums and dental cost as related to his enrollment in the Medically Needy (MN) program, including the three months prior to the month of application. Also, as he stated that the department has sent several Notices of Case Actions (NOCA) with different amounts for his monthly share of cost (SOC) due to his enrollment in MN program, the petitioner wants to ensure that the correct SOC is being

considered. The petitioner is asserting the affirmative and bears the burden of proving his case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing was originally scheduled to convene on November 13, 2015 at 1:00 p.m. On October 7, 2015, the undersigned was contacted by the petitioner to request the hearing be rescheduled as a face-to-face hearing. The petitioner's request was granted and the hearing was rescheduled to be heard in [redacted] on the same day, November 13, 2015 at 10:30 a.m.

On November 4, 2015, the petitioner contacted the undersigned requesting a continuance due to being out of state and would like to be rescheduled in December 2015. The petitioner's request was granted and the hearing rescheduled to December 14, 2015 at 10:30 a.m. In December 14, 2015, the petitioner requested a continuance as he requested a larger room to include witnesses and members of the media. The petitioner's request was granted and the hearing was rescheduled to be reconvened in Fort Myers, Florida on January 12, 2016.

The petitioner submitted 10 exhibits that were accepted into evidence and marked as Petitioner's Exhibits "1" through "10" respectively.

The respondent submitted 17 exhibits that were accepted into evidence and marked as Respondent's Exhibits "1" through "17" respectively. The record was held open until the close of business on January 22, 2016 for the respondent to supplement the record and for the petitioner to review and provide a response, if necessary. The respondent timely provided the additional documentation, which were accepted into evidence and marked as Respondent's Exhibits "18" through "24". On January 28,

2016, the petitioner requested an additional week to provide a response. The additional time was granted. The record closed on February 8, 2016 as the petitioner did not submit any additional evidence.

FINDINGS OF FACT

1. The petitioner (age 72) is a single-person household. In July 2015, the petitioner's sole source of income was his Social Security benefits (SSA) in the monthly gross amount of $1,429. The petitioner has Medicare Part B with a $104.90 monthly premium.

2. A paper application for Medicaid benefits was submitted, by the petitioner, on July 13, 2015. The application noted that the petitioner's SSA gross income was $1,325 and that the health insurance premiums that were paid monthly was his Medicare and a United Healthcare Supplemental (United Healthcare) of $233.15. The petitioner has been paying another health insurance premium: SilverScript Medicare Supplement (SilverScript).

3. The department calculated the MN budget by including the petitioner's gross monthly SSA income in the amount of $1,429 as the gross total income. The total gross income was subtracted by the unearned income disregard of $20 to result in $1,409 total countable income. The total countable income was subtracted by the Medically Needy income limit (MNIL) of $180, for one person, to result in a monthly SOC of $1,229.

4. As the petitioner is requesting a review of his paid health insurance premium expenses for the 3-month period prior to his application, the department considered the health insurance premiums that the petitioner is obligated to pay monthly

in the determination of the Remaining SOC. For the period of April 2015 through August 2015, the department considered the Medicare and the [redacted] premiums for a total amount of $338.05, which was subtracted from the SOC for a Remaining SOC of $890. For the period of September 2015 and ongoing, the department considered the Medicare [redacted] and the [redacted] (unverified) health insurance premiums for a total amount of $348.45, which was subtracted from the SOC for a Remaining SOC of $880.

5. The petitioner's Medicare premiums were paid by the State of Florida, as a third-party payer, effective July 2015. The department also noted that the Medicaid program that paid the Medicare premium was incorrectly approved for the petitioner and provided a NOCA, dated December 15, 2015, indicating that the program would end effective December 31, 2015.

6. The petitioner must meet his SOC on a monthly basis in order to be Medicaid eligible. The SOC is met by having the total allowable medical expenses meet or exceed the SOC and that the Medicaid eligibility begins from the date that the SOC is met until the end of the month.

7. The petitioner submitted bills for bill-tracking consideration and the department states that the medical bills have not met or exceeded the SOC for any of the petitioner's enrolled months. The petitioner submitted into evidence the following paid bills: $29 (April 29, 2015 - [redacted], $155.80 (June 8, 2015 – [redacted] shoes), $40 (July 14, 2015 – [redacted]), $20 (August 6, 2015 – [redacted], $181 (August 25, 2016 – [redacted], $10.60 (September 3, 2015 – [redacted], $0.96 (September 3, 2015 – [redacted], $155.80 (September 11, 2015 –

[redacted], $75 (September 14, 2015 – [redacted]), and $229.98 (September 14, 2016 – [redacted]). The petitioner states that the shoes from [redacted] were not acquired through a prescription from nor provided by a medical provider. The petitioner is unsure of the amount paid monthly for his [redacted] premiums. The petitioner also stated that the insurance premium for [redacted] has changed to $187; however, he was unable to state what month this was effective. Verification of the monthly [redacted] health insurance premiums have not been provided to the department. No unpaid medical bills or dental bills were provided.

8. The department states that they would consider the petitioner's enrollment in the Medically Needy program for the three months prior to the month of application as the petitioner stated during the appeal that he had medical expenses in those months.

9. Though the petitioner has been provided a Medicaid identification number, the petitioner states that he is unable to find a Medicaid dental provider who will accept him as a patient. The petitioner also states that he has made numerous requests for a supervisor to call him back regarding the concerns he has for his case and he has not received any call backs.

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

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

12. 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.

13. The above controlling authorities 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 petitioner does not qualify for full coverage Medicaid.

14. Fla. Admin. Code. R. 65A-1.710(5), SSI-Related Medicaid coverage Groups, states in part that the "Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. §§ 1396a and 1396d, for aged … individuals … who do not qualify for categorical assistance…"

15. The above authority explains that the Medically Needy Program is a coverage group for aged individuals who do not qualify for full Medicaid.

16. Fla. Admin. Code R. 65A-1.713 (2) explains that the Department follows the SSI policy specified in 20 C.F.R. 416.1100 for included and excluded income. Federal Regulations at 20 C.F.R. 416.1124 (c)(12) sets forth income that is not counted

in this program and states, "(t)he first $20 of any unearned income in a month other than …income based on need."

17. The Fla. Admin. Code R. 65A-1.716 sets forth the Medically Needy income levels and states :

> (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…

18. As the petitioner is not eligible for full Medicaid, the Department enrolled him in the MN program and assigned a SOC based on his gross income of $1,429. Prior to any consideration of medical expenses (including health insurance premiums) and after the deductions of the $20 general exclusion and the MNIL for one of $180, the SOC was determined to be $1,229.

19. The undersigned concludes that the respondent's action to enroll him in the Medically Needy Program with a monthly share of cost in the amount of $1,229 was a correct action.

20. The Code of Federal Regulations, 42 C.F.R. § 435.915, states in part that "(t)he agency must make eligibility for Medicaid effective no later than the third month before the month of application…

21. Fla. Admin. Code. R. 65A-1.701, Definitions, states in part:

> (30) Share of Cost (SOC): SOC represents the amount of recognized medical expenses that a Medically Needy enrolled individual or family must incur each month before becoming eligible to receive Medicaid benefits for medical expenses incurred during the remainder of the month.

22. The Fla. Admin. Code R. 65A-1.713 sets forth the Medically Needy budgeting process regarding SOC and states:

> (4) Income Budgeting Methodologies.
> (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. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 2640.0508, Proof of Medical Expenses, states in part that:

> The following are verification requirements for allowable medical expenses to be counted toward share of cost.
> For Medicare premiums the individual's statement may be accepted (including coinsurance charges).
> For other health insurance premiums proof is needed of the amount and frequency of the premium. Acceptable evidence is the insurance policy, canceled check, receipt, pay stub or verbal verification from the agent.
> For paid medical services bills (includes coinsurance payments) proof is needed of the date of the payment, amount of payment and an estimate of

> third party liability/TPP, if applicable. Acceptable evidence is the paid bill, receipt, canceled check, written statement from doctor or verbal verification from the provider. (For TPP, verbal verification is not acceptable.)

24. For the period of April 2015 to August 2015, the department considered the total amount of health insurance premiums (verified and unverified) equaling $338.05, which was subtracted from the SOC of $1,229 to reduce the SOC to $890. For the period of September 2015 and ongoing, the department considered the total amount of health insurance premiums (verified and unverified) equaling $348.45, which was subtracted from the SOC of $1229 to reduce the SOC to $880. The reoccurring health insurance premiums have been considered, prior to bill-tracking any other paid and/or unpaid medical bills for each of the months enrolled in the Medically Needy program. As the effective date of the reduced United Healthcare premium and the amount of the SilverScript premium have not been verified, these premiums cannot be used to meet the SOC, on a monthly basis, until they have been verified. Though [redacted] and [redacted] have not been verified and that the Medicare premiums for the months from July 2015 to December 2015 were paid by a third party, the undersigned concludes that the department has considered the reoccurring health insurance premiums in the SOC determination, particularly in the bill-tracking phase of the enrollment, which included the three-month period prior to the month of application.

25. As the total reported monthly health insurance premiums do not meet or exceed the SOC for each of the months that the expenses were incurred by the petitioner, the SOC will not be met without additional paid and/or unpaid medical expenses included in the bill-tracking process. The petitioner presented paid medical

receipts totaling the following for each month: $29 (April 2015), $40 (July 2015), $201 (August 2015), and $316.54 (September 2015). The totals listed do not include the monthly health insurance premiums as the Medicare premiums were paid by the state during the above months and the amount paid for the other health insurance premiums have not been verified. The undersigned concludes that the paid expenses for each month do not meet or exceed the SOC for any of the bill-tracked months. Also when reviewing the three months prior to the month that a bill is being tracked, the total amount of carried-over medical expenses do not meet or exceed the SOC. For example, while bill-tracking the month of September, paid bills for June, July and August (three prior months to the month of bill-tracking) that have not been used to meet the share of cost in another month, can be used in determining whether or not the SOC is met in September. The total amount of paid bills in July, August and September equal $557.54, which does not meet the SOC for September of $1,229. Again, the Medicare premiums were paid by the state and the other health insurance premiums have not been verified. If the health insurance premiums were verified, the potential to meet the SOC improves as they would be incurred in each of the four months considered. The Snydermann shoes were not included in the calculation as it was not provided or prescribed by a recognized member of the medical community.

26. The undersigned concludes that the department was correct in not including any dental expenses in the bill-tracking process as the petitioner has stated that the dental expenses have not been incurred. If the petitioner incurs any medical expenses, including dental, the undersigned encourages him to submit verification of his medical expenses, paid or unpaid, to the department for bill-tracking purposes.

27. In terms of the petitioner's concern regarding his phone calls not returned by supervisors within the Department of Children and Families, he may contact Krystalee Salgado, Client Relations Coordinator, at (239) 895-0231 or toll-free at (877) 595-0384.

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 19 day of February, 2016, in Tallahassee, Florida.

Raymond Muraida

Raymond Muraida
Hearing Officer
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Copies Furnished To: [redacted] 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

[redacted]

APPEAL NO. 15F-08379

PETITIONER,

Vs.

[redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 01 Escambia
UNIT: 88113

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on December 10, 2015 at 1:36 p.m.

APPEARANCES

For the Petitioner: [redacted] petitioner's son
[redacted] petitioner's daughter

For the Respondent: Julie Mount, ACCESS Supervisor
Christine Frier,
Northwest Region ACCESS Program Office

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of September 17, 2015 denying the petitioner's application for Institutional Care Program (ICP) Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

Raymond Muraida, hearing officer, appeared as an observer with no objections from either party.

The petitioner submitted evidence prior to the hearing, which was entered as Petitioner Exhibit 1. The Department submitted evidence prior to hearing, which was entered as 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 submitted an application for Institutional Care Program (ICP) Medicaid on August 17, 2015.

2. The petitioner separated from his wife in 1991.

3. [redacted] entered an Order Enforcing Agreement of Separation and for Separate Maintenance on January 30, 2009. In the Order, the petitioner is required to pay his estranged wife $1,702.00 per month as Separate Maintenance beginning February 1, 2009 as well as pay for her health and life insurance policies in existence as of November 1, 2008. In addition, the petitioner was prohibited from "any conduct calculate and/or designed to harass, threaten, intimidate, or otherwise interfere with" estranged wife's peace and dignity.

4. A Qualifying Income Trust (QIT) was set up on the petitioner's behalf on September 28, 2015. This was submitted to the Department on September 30, 2015.

5. The petitioner believes due to the court order of separate maintenance that he should be considered an impoverished spouse.

6. The petitioner does not believe the Department has considered the court ordered separation of income correctly.

7. The petitioner believes the income and assets of the spouse should not be considered, as the petitioner and his spouse have remained separated since 1991.

8. The petitioner maintains he did not separate from his wife with the intent of becoming eligible for benefits as it occurred long before the petitioner applied for assistance with the Department.

9. The Department explained the policy requires the income and assets of a legally married couple are included in eligibility determination. In addition, the petitioner's income must be counted unless irrevocably assigned at the source. The Department does not view the court order of income to the spouse as irrevocably reassigned at the source as when the spouse dies, the income would revert to the petitioner.

10. The petitioner believes there is a Mississippi case (Goodwin) which should be considered in this case as the estranged spouse resides in Mississippi.

11. The Department explained Federal rules and regulations supersedes another state's ruling in a matter. The Department does not recognize the Mississippi ruling as law in the state of Florida.

12. The Department explained the assets of the spouse must be verified in order to determine eligibility. Federal law allows the Department to exclude those assets only if the spouse's assets make the petitioner ineligible.

13. The petitioner questioned if the state was compelling the petitioner to become divorced in order to become eligible for Medicaid.

14. The Department does not view a legal separation, no matter the length of time separated, the same as divorced.

15. The petitioner provided a statement from the petitioner's estranged wife informing she does not maintain health insurance on the petitioner. She further declares in the statement "she refuses to make her income and/or resources available for the cost of any necessary medical care for the Applicant." (Petitioner Exhibit 1, page 7)

16. The Department advised the court ordered spousal support is not a division of an asset, but a division of income.

17. The petitioner believes when the federal government, payee of the petitioner's pension, followed the court ordered support to redirect the prescribed amount to the spouse; the Department should also honor the Mississippi ruling.

18. The petitioner maintains if the spouse is already refusing to make any of her income or assets available to the spouse; the Department should accept it and move forward.

19. The petitioner maintains because his spouse refuses to provide for his care or any additional information regarding her income or assets, it is placing an undue hardship on the petitioner for obtaining Medicaid eligibility.

CONCLUSIONS OF LAW

20. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to 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.

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

22. 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:
> …
> (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.

23. The ICP Medicaid Program covers the institutional provider payment for skilled nursing home care. The petitioner applied for this coverage on August 17, 2015.

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

> (a) Resources; defined. For purposes of this subpart L, resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance.
>
> (1) If the individual has the right, authority or power to liquidate the property or his or her share of the property, it is considered a resource. If a property right cannot be liquidated, the property will not be considered a resource of the individual (or spouse).

25. Fla. Admin. Code R. 65A-1.712 "SSI-Related Medicaid Resource Eligibility Criteria" states in relevant 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.

26. The above controlling authority sets forth the requirement that resources (assets) be equal to or below the resource limit at some point during each month, that ICP Medicaid eligibility is sought.

27. Fla. Admin. Code R. 65A-1.716 Income and Resource Criteria states:

> (5) SSI-Related Program Standards.
> (a) SSI (42 U.S.C. §§ 1382 – 1383c) Resource Limits:
> 1. $2000 per individual.
> 2. $3000 per eligible couple or eligible individual with an ineligible spouse who are living together.

28. The applicable resource limit for petitioner under the ICP program is $2000.

29. Fla. Admin. Code R. 65A-1.303 "Assets" states in relevant part:

> (1) Specific policies concerning assets vary by program and are found in federal statutes and regulations and Florida Statutes.
> (2) Any individual who has the legal ability to dispose of an interest in an asset owns the asset.
> (3) Once the individual's ownership interest of an asset(s) is established, the availability of that asset must be determined. Asset(s) determined not to be available are not considered in determining eligibility. Assets are considered available to an individual when the individual has unrestricted access to it. Accessibility depends on the legal structure of the account or property. An asset is countable, if the asset is available to a representative possessing the legal ability to make the asset available for another's support or maintenance, even though the representative chooses not to do so. Assets not available due to legal restrictions are not considered in determining total available assets unless the legal restrictions were caused or requested by the individual or another acting at their request or on their behalf.

30. The above authority identifies that an individual's ownership interest in an asset must be established before the availability of the asset can be determined.

31. 42 U.S.C. § 1396r-5 (c)(2) "Attribution of resources at time of initial eligibility determination" states in relevant part:

> In determining the resources of an institutionalized spouse at the time of application for benefits under this subchapter, regardless of any State laws relating to community property or the division of marital property—
>
> (A) except as provided in subparagraph (B), all the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse, and
>
> (B) resources shall be considered to be available to an institutionalized spouse, but only to the extent that the amount of such resources exceeds the amount computed under subsection (f)(2)(A) of this section (as of the time of application for benefits).
>
> (C) the State determines that denial of eligibility would work an undue hardship.

32. The Department's Program Policy Manual, CFOP 165-22, passage 1640.0314.01 "Assets Available to Spouse (MSSI)" states in relevant part:

> The following policy applies to ICP, ICP-MEDS, and ICP-Hospice individuals admitted to institutions on or after September 30, 1989. This includes SSI recipients applying for institutional services. (If the individual was institutionalized prior to September 30, 1989, refer to Chapter 2200).
> Although the assets of a Medicaid recipient's spouse may not have been considered available to the individual in the community (e.g., when the couple is separated), when the individual applies for institutional services, the assets of both spouses must be considered in determining the individual's eligibility for institutional services.
> The portion of a couple's assets available to the institutional spouse is the amount remaining after the community spouse's asset allowance is subtracted from the couple's total included assets. If this figure is over the program's allowable asset limit, the individual is ineligible until the assets are reduced to within the program's standard.
> If after declaring and verifying his assets, the community spouse refuses to make them available to the individual, the institutionalized spouse may assign his rights of support to the state and obtain institutional care benefits (refer to passages 1640.0314.03 and 1640.0314.04 for policy). Community spouses who refuse to make their assets available to the institutionalized spouse are not entitled to a community spouse income allowance.
> **If the couple has been separated for a long time and the community spouse cannot be located, there is no "community spouse" and the**

> **applicant must be considered an individual when applying income and asset standards.**
> If either spouse can verify that the community spouse asset allowance determined by the agency is inadequate to generate income to raise the community spouse's income to the minimum monthly maintenance needs allowance, the asset allowance may be revised through the fair hearing process. (emphasis added)

33. The findings show the petitioner and his wife separated in September 1991. The findings also show the petitioner or his representatives know where or how to contact his spouse. The above controlling authority states if the community spouse cannot be located, there is no "community spouse". In this case, the spouse is located. The undersigned concludes although the community spouse provided a statement explaining she will not supply her income or assets to assist with the care of the petitioner, the controlling authorities require that her assets be declared in order to determine the petitioner's eligibility for ICP Medicaid.

34. The Department's Policy Manual section 1640.0314.03 "Assignment of Support Rights (MSSI)" states

> If the community spouse refuses to make available assets attributed to the institutionalized spouse, the institutionalized spouse may assign his rights of support to the state and obtain institutional care benefits. This situation may arise when assets allocated to the individual actually solely belong to the community spouse who, in turn, refuses to make them available to the individual.
> The institutionalized spouse may complete CF-ES Form 2504, Assignment of Support Rights, which allows the state to pursue recovery from the community spouse. The original copy of this form is to be sent to Headquarters Program Policy, in Tallahassee, Attention: SSI-Related Medicaid Program staff. This form is not an option that an eligibility specialist suggests to an ineligible couple, but rather a solution to an existing situation which is brought to the eligibility specialist's attention. **When all conditions in passage 1640.0314.04 are met, the allocated assets being withheld by the community spouse will no longer be considered available to the institutionalized spouse.**

> If the institutionalized spouse does not assign the rights of support to the state, continue to consider the assets available to the institutionalized individual. (emphasis added)

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

> (4) Spousal Impoverishment
> …
> (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:
> 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, CF-ES 2504, 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.

36. The Department's Policy Manual section 1640.0314.04 "Undue Hardship (MSSI) states:

> The institutionalized spouse will not be determined ineligible based on a community spouse's assets if all of the following conditions are found to exist:
> 1. The institutionalized individual is not eligible due to the community spouse's assets and the community spouse refuses to use the assets for the institutionalized spouse; and
> 2. The Assignment of Support Rights form (CF-ES Form 2504) is signed; and
> 3. The institutionalized spouse would be eligible if only those assets to which he has access were counted; and
> 4. The institutionalized spouse has no other means to pay for the nursing home care.

37. The findings show the community spouse's assets have not been verified. The undersigned concludes without verifying the community spouse's assets, the Department cannot determine if the petitioner is ineligible for ICP Medicaid due to her assets. As a result, the undersigned further concludes not ALL of the conditions required for undue hardship as detailed in the above controlling authority are met.

38. In a Department Question and Answer clarification in its Knowledge Bank, ID number 87, the question is asked if the whereabouts of the community spouse (CS) is unknown, is there a length of time they must be separated before we treat them as individuals and not count the assets of the community spouse. The answer from the Headquarters' program is:

> As long as a couple are legally married, we must look at the CS' assets in determining the institutionalized spouse's (IS) eligibility for Medicaid. If the whereabouts of the CS are unknown, we can determine the IS as an individual. We recognize that sometimes the CS may be uncooperative and this can be problematic. If the IS is ineligible for ICP solely due to the CS's assets, the IS can sign the Assignment of Support Rights form. Of course, this requires that the CS first disclose their assets to DCF. We would not divert income to a CS if the IS does not want to divert income to them, which would be true in cases of separation.

39. The above further clarifies the ICP requirement of a married couple when the spouse refuses to cooperate and make her assets known for an ICP Medicaid eligibility determination of the spouse in the facility. The findings clearly show the petitioner and his wife are separated but not divorced which requires them to be considered as married according to the above controlling authority. Based on this policy, since the spouse's location is known and she stated she will not cooperate with the eligibility determination, the ICP is denied as eligibility cannot be determined. Therefore, the undersigned concludes that once the spouse refuses to cooperate, the

Department would have been unable to determine eligibility and the Department's denial action was correct.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 29 day of February, 2016, in Tallahassee, Florida.

Melissa Roedel

Melissa Roedel
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency
Donald Eicher III

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

[redacted]

APPEAL NO. 15F-08406

PETITIONER,

Vs.

[redacted]

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 17 Broward
UNIT: 88595

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on November 24, 2015 at 9:58 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Luisa Soto, acting-supervisor.

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of denying her full Medicaid benefit and enrolling her in the Medically Needy Program with a high estimated share of cost (SOC). The petitioner is seeking full Medicaid coverage. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

[redacted] petitioner's father, appeared as a witness of her behalf.

During the hearing, the petitioner submitted one exhibit which was accepted and marked as Petitioner's Composite Exhibit 1. The Department submitted seven (7) exhibits which were accepted into evidence and marked as Respondent's Exhibits 1 through 7 respectively.

The record was left open through December 22, 2015 for the petitioner to submit additional information for the respondent to consider. Petitioner's evidence was received and marked as Petitioner's Composite Exhibit 2. The Department did not respond. The record was closed on December 22, 2015.

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 54 years old with neurological and physical limitations. She underwent spine surgeries in July 2013 and ended up in a coma a few hours later. She has been determined disabled by Social Security Administration (SSA) and received Supplemental Security Income (SSI) for a short while.

2. Petitioner's monthly gross Social Security Disability (SSD) benefit is $887. The SSD income amount is not in dispute, *see* Petitioner's Composite Exhibit 1. Petitioner is not yet eligible for Medicare benefits.

3. On May 26, 2015, the petitioner submitted an application to continue her Medicaid benefits and did not report any recurring medically related expenses, *see* Respondent's Exhibit 1.

4. The Department's representative explained its action to enroll the petitioner in the Medically Needy Program with a share of cost. She explained that the petitioner gross income exceeds the SSI-Related Medicaid Program income limit ($864). She explained that petitioner was evaluated under the Medically Needy (MN) Program and that her share of cost amount is directly dependent on her income.

5. To begin the budgeting process for Medically Needy Program, the Department counted monthly income of $887, minus a $20 standard income disregard followed by a $180 Medically Needy Income Level (MNIL) deduction for one person, from her income. After these deductions, the share of cost was determined to be $687, *see* Respondent's Exhibit 3.

6. On June 3, 2015, the Department sent a notice to the petitioner informing her that she was approved for the Medically Needy Program with an $867 share of cost effective July 2015, *see* Respondent's Exhibit 2. On October 5, 2015, the petitioner requested an appeal challenging her enrollment in the Medically Needy (MN) Program.

7. The petitioner did not dispute the income amount used by the Department in the eligibility process, but asserted as follows: That she has serious health issues that require constant monitoring, resulting in recurring medical expenses. That her SOC is too high and that she cannot afford that much monthly expense on a fixed income. During the hearing, the petitioner's witness reported the following expenses: $625 for rent, $32 for telephone, $102 for electricity, $50 for car insurance and $30 for gas. Petitioner argued after paying for her household expenses, she has no money left and cannot afford any deductibles. The petitioner mentioned recurring medical expenses not previously reported to and verified by the Department.

8. The Department's representative explained that household expenses are not considered in the Medicaid eligibility determination and that the petitioner does not have to spend out of pocket if she has recurring medical expenses that exceed her SOC, and explained how the share of cost was determined and how it could be met. Petitioner was advised to submit all outstanding medical bills to the Department so that it can be determined when the share of cost is met and when Medicaid coverage could begin. The respondent agreed to give petitioner the opportunity to submit verification of recurring medical expenses to determine if the SOC could be lowered, however no response was received.

9. On December 15, 2015, the petitioner submitted additional information for the respondent to consider and respond. Petitioner's Composite Exhibit 2 is a print out of her recurring medical expenses. It indicates that the petitioner incurred $133.06 in expenses for prescribed medications, $52.31 for prescribed over-the-counter supplements and $180 for specialist referrals between July 2015 and December 2015.

CONCLUSIONS OF LAW

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

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

12. The Department determines Medicaid eligibility based on the household circumstances. When the household consists of parents and children, Medicaid

eligibility is determined under Family-Related Medicaid policy. When the household consists of an elderly or disabled individual or couple, Medicaid eligibility is determined under Adult-Related Medicaid policy (also referred to as SSI-Related Medicaid or Medically Needy). Medicaid eligibility is based on federal regulations. Petitioner was evaluated under the SSI-Related Medicaid coverage group.

13. Federal Regulations at 45 C.F.R. §435.500 sets forth the regulations for requirements for determining the eligibility of both categorically and medically needy individuals. 45 C.F.R. §435.520 states, "The agency must not impose an age requirement of more than 65 years." The regulation continues at 45 C.F.R. §435.541 to define disability as either determined by the Social Security Administration (SSA) or the Medicaid agency.

14. In this case, petitioner has been determined disabled by the SSA. For the SSI-Related Medicaid Programs, an individual must either be aged 65 or older or determined disabled by the SSA or the Department. Based on this regulation, the Department determined Medicaid eligibility for petitioner and approved her for SSI-Related Medically Needy Program benefits.

15. Federal Regulations at 20 C.F.R. §416.1123 defines how unearned income is counted and states in relevant part:

> (b) Amount considered as income. We may include more or less of your unearned income than you actually receive.
> (1) We include more than you actually receive where another benefit payment (such as a social security insurance benefit) (see Sec. 416.1121) has been reduced to recover a previous overpayment. You are repaying a legal obligation through the withholding of portions of your benefit amount, and the amount of the debt reduction is also part of your unearned income. Exception: We do not include more than you actually receive if you received both SSI benefits and the other benefit

> at the time the overpayment of the other benefit occurred and the overpaid amount was included in figuring your SSI benefit at that time.

16. Fla. Admin. Code R. 65A-1.701, Definitions, states:

> (20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services…

17. 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.

18. The Eligibility Standards for SSI-Related Programs appear in the Department's Program Policy Manual CFOP 165-22 (the Policy Manual), at Appendix A-9. Effective July 2015, 88% of FPL for a one member household is $864. Petitioner is not receiving Medicare but her income is in excess of the Program limit to receive full Medicaid benefits.

19. The Medically Needy Program provides coverage for individuals who meet the technical requirements for Medicaid but whose income or assets exceed the income limits.

20. Fla. Admin. Code R. 65A-1.710, SSI-Related Medicaid Coverage Groups, states in part:

> The department covers all mandatory coverage groups and the following optional coverage groups:
> (1) MEDS-AD Demonstration Waiver. A coverage group for aged and disabled individuals (or couples), as provided in 42 U.S.C. § 1396a(m)…(5) Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. §§ 1396a and 1396d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance due to their level of income or resources. The program does not cover nursing

> facility care, intermediate care for the developmentally disabled services, or other long-term care services…
> (30) Share of Cost (SOC): SOC represents the amount of recognized medical expenses that a Medically Needy enrolled individual or family must incur each month before becoming eligible to receive Medicaid benefits for medical expenses incurred during the remainder of the month.

21. The above authorities also define Medically Needy and Share of Cost (SOC). SOC represents the amount of recognized medical expenses that a Medically Needy enrolled individual or family must incur each month before becoming eligible to receive Medicaid benefits. This program is available for aged or disabled individuals or eligible couples who do not qualify for the MEDS-AD Program.

22. Federal regulations at 20 C.F.R. § 416.1124, Unearned income we do not count, "(c) (12). The first $20 of any unearned income in a month…"

23. Fla. Admin. Code R. 65A-1.716 (2), Income and Resource Criteria, sets forth the MNIL for an individual at $180.

24. The above cited rules explain the budgeting procedure to determine the share of cost. The gross income is reduced by a standard deduction ($20) and the MNIL for the assistance group size of one at $180. The Department followed this procedure and determined the share of cost at $867 effective July 2015 as petitioner's income is greater than the income limit to receive full Medicaid benefits. Rent and other personal expenses are not allowable deductions under the SSI-Related Medicaid Program.

25. Based on the evidence, testimony, and the controlling authorities, the undersigned concludes that the Department correctly determined that the petitioner is not eligible for full Medicaid benefits and should be enrolled in the Medically Needy Program. No errors were found in the calculation of the amount of the share of cost.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal is denied. The Department's action is upheld.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this _____ day of _____, 2016,

in Tallahassee, Florida.

Roosevelt Reveil
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
Office of Economic Self Sufficiency
Michael Connolly

FILED
Jan 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. 15F-08528

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 09 Orange
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on November 30, 2015 at approximately 3:30 p.m.

APPEARANCES

For Petitioner: [redacted]
Petitioner's daughter

For Respondent: Lisa Sanchez
Senior Human Services Program Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is whether or not Respondent's denial of Petitioner's request for one (1) additional hour of companion care in the evening, seven (7) days per week, was correct. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

Petitioner's daughter, [redacted] ("Petitioner's representative") represented her at the hearing. The following witnesses were present for Petitioner:

- [redacted] – Petitioner's daughter
- [redacted] – Petitioner's son

Respondent presented the following witnesses:

- India Smith – Grievance and Appeals Coordinator – Sunshine Health
- Dr. John Carter – Long Term Care Medical Director – Sunshine Health
- Emily Fry – Case Manager – Sunshine Health
- Kritzia Torres – Supervisor of Case Management – Sunshine Health
- Tonya James – Clinical Manager - Cenpatico
- Mary Stoker – Service Care Coordinator – Cenpatico

Petitioner's Exhibits 1 and 2 were entered into evidence. Respondent's Exhibits 1 through 9 were entered into evidence. The Hearing Officer inadvertently marked two of Respondent's exhibits as Exhibit 9. The Exhibits are now marked for identification as Exhibit 9A and Exhibit 9B. The record was held open for both parties to submit additional evidence. Petitioner submitted additional evidence, entered as Exhibits 3 through 5. Respondent submitted additional evidence, entered as Exhibits 10 through 15. The undersigned took administrative notice of Fla. Stat. § 409.978.

FINDINGS OF FACT

1. Petitioner is an 82-year-old female. Petitioner is a dual-enrolled Medicare/Medicaid recipient with Sunshine Health ("Sunshine") as her Long Term Care ("LTC") plan.

2. Petitioner's medical conditions include:

- [redacted]

- [redacted]

3. Petitioner lives in her home with her husband. Petitioner's representative said he is starting to get [redacted]. Petitioner's current services are 15.5 hours per week of companion care, 15.5 hours per week of homemaker services, two (2) home-delivered meals per day, five (5) days per week, and three (3) times per day of medication administration.

4. On September 4, 2015, Sunshine received a request from Petitioner's representative requesting an extra hour per day of companion care in order for someone to supervise her during dinner. On September 11, 2015, Sunshine issued a Notice of Action denying the request as not being medically necessary, specifically because it "Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs." (Respondent's Exhibit 3). The Notice of Action stated:

> You asked for 7 more hours per week of Companion Care (The person that helps assist and watch over you), this [is] denied. Your case manager looked at your care needs and your current care plan of 15 hours and 30 minutes per week of Companion Care (The person that helps assist and watch over you), 15 hour 30 [minutes] per week of Homemaker Service (The person that cleans for you), 10 Home Delivered Meals (Meals that are sent to your home) per week and Skilled Nursing (The nurse that helps you with your medication) meets your needs. Your case manager will continue to assess your needs.
>
> The facts that we used to make our decision are: Sunshine Health Policy LT.UM.09 Ancillary Service Criteria.

5. Petitioner's physician, [redacted] wrote a prescription for the extra hour of companion care on November 13, 2015 (after the hearing request date of October 9,

2015) on the basis of her [redacted] and [redacted] (Petitioner's Exhibit 1). After the hearing, in support of this request, he submitted a letter dated December 7, 2015, stating he felt she would benefit from the extra hour due to her mental status. He did not include any clinical documentation. (Petitioner's Exhibit 4).

6. Per Sunshine's Policy and Procedure (Respondent's Exhibit 9B), Adult Companion Care includes:

> Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discreet services. The provision of companion services does not entail hands-on nursing care. The service includes light housekeeping tasks incidental to the care and supervision of the member. The provision of services may be provided at the member's residence or anywhere in the community where supervision and care is necessary. The services cannot be provided by a family member.

7. Companion care does not include hands-on care. The companion can prompt Petitioner to eat and observe her eating, but cannot force her to eat.

8. Companion care and homemaker services are provided by a home health aide. In Petitioner's case, the services are provided by [redacted] with [redacted] ([redacted]

9. Sunshine's Medicaid Fair Hearing Summary (Respondent's Exhibit 2) states:

> On 9/10/2015, the assigned CM received call from [redacted], staffing coordinator at [redacted] with the following information: the aide that is there around dinner time can and has been encouraging the member to eat her dinner. As per the member's assessment findings, there is no indication for the need of additional hours at this time; therefore, a notice of action letter (NOA) was sent to the member's listed address on 9/11/2015.

10. According to her timesheets and the testimony provided by Petitioner's representative [redacted] typically arrives at Petitioner's home between 6:30 a.m. and 7:00

a.m. and leaves between 10:30 a.m. and 11:00 a.m. Petitioner's children are concerned that their mother does not have someone to remind her to eat dinner. The timesheets indicate Ivonne occasionally (less than once a week) visits Petitioner in the late afternoon or early evening. (Respondent's Exhibit 14). The timesheets, therefore do not match the information communicated by [redacted] with [redacted] on September 10, 2015. Petitioner's family is correct that Ivonne is usually not with her at dinner time.

11. After the hearing, Respondent submitted Exhibit 15, which states a call was placed to [redacted] on December 2, 2015 requesting the timesheets. It also says she was asked if Petitioner was only being seen in the morning and that she indicated yes. Another telephone call was placed on December 4, 2015 inquiring whether the hours could be split in the morning and the afternoon and that [redacted] said yes.

12. Respondent's Exhibit 15 indicates Petitioner's Case Manager, Ms. Fry, spoke directly with Petitioner on December 3, 2015. The note regarding the call states:

13. On September 3, 2015, Ms. Fry conducted a 701B Comprehensive Assessment on Petitioner. (Respondent's Exhibit 7). Petitioner's representative was present during the assessment. She stated this is when she requested the extra hour of companion care.

14. In the Memory Section, Ms. Fry concluded Petitioner has cognitive problems, noting she has a diagnosis of [redacted] with behavioral disturbances. At hearing, Petitioner's representative said her mother still has legal capacity, despite her diagnoses.

15. Petitioner can feed herself, but needs assistance with meal preparation and needs reminders to eat. In the Notes & Summary portion of the Instrumental Activities of Daily Living Section, Ms. Fry wrote "Member receives formal assistance with homemaking. Member is able to use telephone to make and receive calls. Member's son is POA and manages finances. Member's homemaker and husband provide meal preparation, assistance with shopping, and transportation…." (Respondent's Exhibit 7).

16. In the Nutrition Section, Petitioner responded she does not typically eat at least two meals per day. She said on a typical day she says she has eggs and toast for breakfast, soup for lunch, a sandwich for dinner, and cookies, chocolate, and ice cream for snacks. These inconsistent statements are likely due to her cognitive problems. Petitioner did not know her height or weight. She was listed as being 5'0'' and 140lbs, which was taken from her previous annual assessment. No changes were reported to Ms. Fry. Petitioner's weight is in the normal range for her height.

17. On November 20, 2015, Ms. Fry visited Petitioner for her quarterly assessment. Petitioner's husband was home at the time. According to her notes: "Member reports she feels she is currently having enough oversight of her health care through [Sunshine] and reports and with her caregiver [redacted]…She states she is eating [home delivered

meals] and caregiver providers supervision and occasional meal preparation."

(Respondent's Exhibit 12).

CONCLUSIONS OF LAW

18. By agreement between AHCA and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction to conduct this hearing pursuant to § 120.80, Fla. Stat.

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

20. This is a Final Order, pursuant to Sections 120.569 and 120.57, Fla. Stat.

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

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

23. Section 409.978 (2) of the Florida Statutes states, in pertinent part: "[AHCA] shall make payments for long-term care, including home and community based services, using a managed care model…."

24. Fla. Stat. 409.98 requires that LTC plans include, among other services, personal care, home-delivered meals, case management, medication administration, and nutritional assessment and risk reduction.

25. The October 2014 Florida Medicaid Home Health Services Coverage and Limitations Handbook ("Home Health Handbook") is promulgated into law by Chapter 59G of the Florida Administrative Code.

26. Page 1-2 of the Home Health Handbook defines "Home Health Services," stating:

> Home health services are medically necessary services, which can be effectively and efficiently provided in the place of residence of a recipient. Services include home health visits (nurse and home health aide), private duty nursing and personal care services for children, therapy services, medical supplies, and durable medical equipment.

27. 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.

28. Sunshine concluded the request for the additional hour per day of companion care in order to supervise Petitioner at dinner time is in excess of her needs. The undersigned agrees.

29. It is undisputed that Petitioner is able to feed herself, but that she needs to be reminded to eat. Ms. Fry included this in her 701B Assessment, and Petitioner's representative was present during the assessment and testified to this at hearing.

30. There is no evidence that Petitioner is malnourished. She may be confused as to how much she eats and how often, but she is at a normal weight for her height and no evidence was presented to indicate she has any nutritional deficiencies.

31. Sunshine provided Petitioner with an alternative where she could reallocate her hours so that she would have a caregiver present both in the morning and at dinner time. Petitioner has capacity and rejected this alternative saying she doesn't want any changes.

32. While it may be desirable for Petitioner to have companion care at dinner time, it is not medically necessary because it is in excess of her needs. There are multiple alternative ways for Petitioner to be reminded to eat dinner. One alternative was to reallocate the service hours. Petitioner rejected this alternative.

33. Petitioner lives with her husband. Petitioner's representative said he is starting to get [redacted] however, when Ms. Fry first called to inquire about reallocating the service hours, he informed her that Petitioner was at a doctor appointment. It appears that he has enough control of his mental faculties to have the ability to remind Petitioner to eat at least some of the time.

34. Even if her husband does not have the ability to remind her to eat, she has the ability to make and receive telephone calls. One of Petitioner's family members could call her at dinner time to remind her. Or, an alarm clock or other device, such as a cell phone, could be used to signal to Petitioner that it is time for dinner.

35. The level of concern for her health and safety expressed by Petitioner's children is admirable. There is no dispute that she is quite ill and requires significant care. However, the undersigned concludes Petitioner's current services are sufficient to meet her needs at the present time.

36. Petitioner's condition may change in the future. This Order is based on Petitioner's current circumstances. Her family is encouraged to monitor her condition and stay in communication with her case manager regarding future assessments. In the event Petitioner's needs increase, a new request can be submitted 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 20 day of January, 2016,

in Tallahassee, Florida.

Rick Zimmer

Rick Zimmer
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
Judy Jacobs, Area 7, AHCA Field Office
JoAnn Chase

FILED
Jan 27, 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-08555

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 09 Orange
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on December 4, 2015, at approximately 10:30 a.m.

APPEARANCES

For Petitioner: [redacted]
Petitioner's mother

For Respondent: Doretha Rouse
Registered Nurse Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is whether or not Respondent's termination of Petitioner's Dexcom Continuous Glucose Monitor ("CGM") is correct. The burden of proof is assigned to Respondent.

PRELIMINARY STATEMENT

Petitioner's mother represented him at the hearing. Petitioner presented the following witness:

- [redacted]

Respondent presented the following witnesses:

- Carlene Brock, Quality Operations Nurse, Amerigroup
- Dr. Amy Zitiello, Lead Medical Director, Amerigroup

Petitioner moved Exhibits 1 through 9 into evidence at the hearing. Respondent's Exhibits 1 through 10 were entered into evidence at the hearing. The record was held open for Respondent to submit additional evidence and for Petitioner to submit a response, if desired. Respondent submitted additional evidence, entered as Exhibits 11 through 14. Petitioner did not submit a response. The undersigned took administrative notice of the Florida Medicaid Provider General Handbook, July 2012.

FINDINGS OF FACT

1. Petitioner is a 10-year-old male.

2. Petitioner is enrolled with Amerigroup as his Managed Medical Assistance (MMA) plan.

3. Petitioner was diagnosed with [redacted] in June of 2011. Petitioner has [redacted] particularly at night.

4. On September 30, 2015, Petitioner's endocrinologist, [redacted] submitted a Detailed Written Order to Amerigroup for the CGM and associated accessories, CPT codes A9276, A9277, and A9278. He indicated Petitioner was running low on supplies for the CGM. (Respondent's Composite Exhibit 4).

5. Initially, Amerigroup denied the request as not being medically necessary, via a Notice of Action dated October 5, 2015 signed by [redacted] Associate Medical Director. (Respondent's Exhibit 5). On October 7, 2015, [redacted] had a peer-to-peer conference, where Mr. Leach was told the CGM is not a covered benefit, per Medicaid rules. (Respondent's Exhibit 6). On October 9, 2015, Amerigroup issued a letter upholding the denial of the CGM as not a covered benefit.

6. Dr. Zitiello testified Amerigroup's vendor was incorrectly providing Petitioner with the CGM without Amerigroup's authorization. She testified the CGM was denied as not being a covered benefit pursuant to the Florida Medicaid Durable Medical Equipment Fee Schedule. Codes A9276, A9277, and A9278 are not on the Fee Schedule. (Respondent's Exhibit 14).

7. Dr. Zitiello also said it is not medically necessary because it is a convenience item and in excess of Petitioner's needs. She said it has not been proven in the medical literature that a CGM reduces [redacted] events in the middle of the night. It is Amerigroup's position that Petitioner only needs to perform finger sticks to check his blood glucose and does not need a second way to monitor it.

8. A CGM does not measure blood glucose levels. It continuously measures interstitial glucose. A finger stick is a more accurate measure of blood glucose. However, a finger stick only measures blood glucose at that exact moment in time. CGMs are approved for use in individuals ages seven (7) to eighteen (18) years of age as of 2007. CGMs were approved for use in adults prior to being approved for use in children.

9. [redacted] testified the CGM does 288 readings per day. He further stated that using a CGM does not preclude the use of a finger stick. The CGM warns the patient via an alarm when they are becoming [redacted] or [redacted] He stated the CGM in not experimental in nature. He said that in Europe, CGMs are approved to be used for administering doses of insulin. In the United States, the CGM warns the patient, but a finger stick is still required to determine appropriate insulin dose.

10. [redacted] said CGMs are not provided to every patient. He said the patient must maintain a consistent hemoglobin A1c level over a two (2) to three (3) month period before it will be provided. He said Petitioner and his mother have done a terrific job at maintaining his A1c level. Dr. Zitiello agreed. The target for children in Petitioner's age group is 7.5% according to the American Diabetes Association ("ADA"), and Petitioner has averaged 7.6% over a three (3) month period. He referenced Petitioner's Exhibit 3, which concludes that even with excellent A1c levels, children often experience nocturnal hypoglycemia and hyperglycemia and that a CGM can provide a means of maintaining optimal blood glucose levels.

11. Dr. Zitiello said the ADA only recommends CGMs for Petitioner's age group if they have A1c levels below 7.0%. Respondent submitted Exhibit 12, which is an article from the New England Journal of Medicine that concludes "Continuous glucose monitoring can be associated with improved glycemic control in adults with type 1 diabetes. Further work is needed to identify barriers to effectiveness of continuous monitoring in children and adolescents." The article is dated October 2, 2008.

12. Respondent also submitted Exhibit 11, which is a Clinical Practice Guideline from the Endocrine Society, published in October of 2011. In support of Dr. Zitiello's assertion, the article states: "2.1 We recommend that RT-CGM with currently approved devices be used by children and adolescents with T1DM who have achieved HbA1c levels below 7.0% because it will assist in maintaining target HbA1c levels while limiting the risk of [redacted]." However, the article also states: "2.2 We recommend RT-CGM devices be used with children and adolescents with T1DM who have HbA1c levels [greater than or equal to] 7.0% who are able to use these devices on a nearly daily basis." Petitioner was using the device on a daily basis prior to termination.

13. [redacted] testified that an A1c level of 7.0% is ideal, but that 7.5% is the current target for children, per the ADA. Further, [redacted] submitted a letter stating: "The internationally recognized standard of care in pediatric [redacted], for [redacted] is 7.5% as established by the [ADA] and the International Society for Pediatric and [redacted] (ISPAD)." (Petitioner's Exhibit 1).

14. Petitioner's Exhibits 5 through 8 are logs of his CGM reports and finger sticks using different meters. A blood glucose level below 70 is considered [redacted] In Petitioner's Exhibit 7, [redacted] showed where Petitioner had a blood glucose level below 70 at three (3) different times during the short period of October 10, 2015 through October 23, 2015.

15. Petitioner's mother testified that prior to using the CGM, he would have frequent episodes of [redacted]. She said he would become faint and discolored, couldn't

eat or drink, and was weak. She testified that he did not have any [redacted] episodes when he was using the CGM. She said she is able to prevent the episodes because the CGM will alarm her when he becomes [redacted] and she can take appropriate action prior to him experiencing problems.

16. Petitioner also experiences benefits from the CGM beyond monitoring his blood sugar levels at night while sleeping. Petitioner's primary care physician, [redacted] drafted a letter dated October 8, 2015 (Respondent's Exhibit 7), which states, in pertinent part:

> [Petitioner's] mother contacted me informing me that Amerigroup would no longer cover his Dexcom machine. My understanding and experience with this child tells me that his lifestyle has so dramatically improved with this device that I find it hard to understand why it would not be covered.
>
> Before utilizing this device, it was my advice along with his endocrinologist, to check his blood sugar levels every few hours with test strips. His sleep, school and daily routines were constantly interrupted and inhibited with this type of monitoring, albeit necessary. The Dexcom machine allowed him to have a more routine, normal daily life…The exhaustion he previously experienced, which affected his attitude, behavior and focus in school, was relieved using this device.

CONCLUSIONS OF LAW

17. By agreement between AHCA and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction to conduct this hearing pursuant to § 120.80, Fla. Stat.

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

19. This is a Final Order, pursuant to Sections 120.569 and 120.57, Fla. Stat.

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

21. 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.

22. 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.

23. Page 2-5 of the DME Handbook states the service criteria for DME as follows:

> All DME, medical supplies, and orthotics and prosthetic devices must be:
>
> - Medically necessary, and
> - Functionally appropriate for the individual recipient, and
> - Adequate for the intended medical purpose, and
> - For conventional use, and
> - For the exclusive use of the recipient.
>
> **DME items requested or supplied must not duplicate or perform the same function as other DME equipment or medical supplies currently in the recipient's possession.** (emphasis added).

24. It is Amerigroup's position that the CGM is not a covered benefit. It is also their position that, even if it is a covered benefit, it is not medically necessary because it is a convenience item and in excess of his needs. They contend finger sticks are sufficient to monitor his blood glucose, and that the CGM duplicates this function.

25. 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.

26. 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:

> 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. Under the above statute, the Agency must provide durable medical equipment that would correct or ameliorate Petitioner's condition.

28. 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).

29. 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.

30. In the instant matter, Amerigroup is incorrect that the CGM is not a covered benefit. Pursuant to EPSDT, Medicaid is required to pay for durable medical equipment that would correct or ameliorate Petitioner's condition. The totality of evidence shows the CGM is clearly helping to ameliorate Petitioner's condition. His mother testified he would have frequent [redacted] episodes while not using the CGM, and he did not have a single episode while using it. [redacted] indicated the CGM has improved Petitioner's attitude, behavior, and focus in school, among other benefits.

31. Amerigroup's next argument is that the CGM is not medically necessary because it is a convenience item, and that it is in excess of his needs because it duplicates the function of finger sticks. The DME Handbook prohibits providing equipment that duplicates the function of DME already in Petitioner's possession, and EPSDT does not require Medicaid to pay for medically unnecessary equipment, even if it is desirable. The states can review medical necessity on a case-by-case basis.

32. Regarding Petitioner's case, the greater weight of the evidence shows the CGM is not duplicating the function of the finger sticks, but is complementing it. Petitioner is unaware if he is [redacted] at night. The CGM alerts his mother that he is becoming hypoglycemic. A finger stick is then performed to determine his exact blood glucose level and the appropriate course of action.

33. The notion that the CGM is a convenience item is without merit in this case. The Florida Administrative Code prohibits items that are *primarily* intended for the convenience of the recipient, caretaker, or provider. It is true that not having to set

alarms at night, waking both Petitioner and his mother, in order to perform a finger stick just to make sure he's OK is more convenient than only having to wake up if the CGM sounds an alarm. But that is not the *primary* purpose of the CGM. The primary purpose of the CGM is to help optimize Petitioner's A1c levels and avoid hypoglycemic episodes like he has experienced in the past.

34. Respondent has not met its burden of proof that it was proper to terminate providing Petitioner's CGM and supplies.

DECISION

Based upon the foregoing, Petitioner's appeal is GRANTED. The Agency is directed to provide Petitioner with the Dexcom Continuous Glucose Monitor and associated supplies, CPT codes A9276, A9277, and A9278, consistent with [redacted] Detailed Written Order.

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 January, 2016,

in Tallahassee, Florida.

Rick Zimmer

Rick Zimmer
Hearing Officer
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Tallahassee, FL 32399-0700
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Copies Furnished To: [redacted] Petitioner
Judy Jacobs, Area 7, AHCA Field Office

FILED
Feb 01, 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-8557

PETITIONER,

VS.

[redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 DADE
UNIT: 88693

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on December 29th, 2015 at 8:30 a.m.

APPEARANCES

For the Petitioner: The petitioner was not present but was represented by [redacted]

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

STATEMENT OF ISSUE

The petitioner is appealing the respondent's actions to terminate his son's Medicaid, and enroll him in the Medically Needy program with an assigned share of cost. The respondent carries the burden of proving its position by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing was originally scheduled for on December 7th, 2015. The petitioner then requested that the hearing be rescheduled, and a continuance was granted for December 15th, 2015. On that date, the respondent did not appear and the hearing was necessarily rescheduled. The hearing convened as described above.

Petitioner's Composite Exhibit 1 was marked into evidence.

Respondent's Exhibits 1 through 4 were marked into evidence.

By way of a Notice of Case Action dated October 2nd, 2015, the respondent informed the petitioner that his son would be enrolled in the Medically Needy program with an estimated share of cost (SOC) of $4,533 effective October 2015. On October 7th, 2015, the petitioner filed a timely appeal to challenge the respondent's action.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner's son (born in [redacted]) received full Medicaid (no SOC assigned) through September 2015.

2. The petitioner submitted an application to recertify on August 27th, 2015. The recertification was to be effective October 2015. As part of the recertification process, the respondent is required to explore all factors of eligibility which include, but are not limited to, all sources of countable income.

3. The petitioner is self-employed as an independent contractor for [redacted]. He reported his self-employment earnings as $3,000 twice a month, or $6,000 per month. The petitioner also incurs self-employment expenses which come to $981. These amounts are not in dispute.

4. The respondent took the petitioner's self-employment gross earnings of $6,000, subtracted $981 in business expenses, and considered the balance of $5,019 as income to be used in determining eligibility for his son's Medicaid.

5. The petitioner's son is [redacted] and requires round-the-clock care from his mother, who is unable to work due to such. The petitioner's son also requires multiple therapy sessions which the petitioner cannot afford on his own. He contends that his share of cost is too high, and he cannot afford to incur out-of-pocket expenses for his son's medical care if his share of cost is not met. The petitioner explored KidCare, and has also searched for options under the Affordable Health Care Act through the Fair Market Place, but has been unsuccessful in finding anything to suit his son's needs.

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

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

8. Fla. Admin. Code R. 65A-1.707 and 65A-1.716 list the Family-Related Medicaid Income and Resource Criteria. These authorities set forth full Medicaid coverage groups available for the household member.

9. 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.

10. Fla. Admin. Code R. 65A-1.716 Income and Resource Criteria continues:

> (2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows:

Family Size	Income Level
1	$180
2	$241
3	**$303** *[emphasis added]*…

11. The authority cited sets forth the income limits for full Medicaid. The undersigned concludes petitioner's total countable income of $5,019 exceeds the income standard for a household size of three of $303. Therefore, the petitioner is not eligible for full Medicaid.

12. The Code of Federal Regulations 42 C.F.R. § 435.310 discusses Medically Needy coverage of specified relatives:

(a) If the agency provides for the medically needy, it may provide Medicaid to specified relatives, as defined in paragraph (b) of this section, who meet the income and resource requirements of subpart I of this part.

(b) Specified relatives means individuals who:

(1) Are listed under section 406(b)(1) of the Act and 45 CFR 233.90(c)(1)(v)(A); and

(2) Have in their care an individual who is determined to be (or would, if needy, be) dependent, as specified in §435.510…

13. Federal Regulation 42 C.F.R. § 435.831 Income eligibility, explains:

The agency must determine income eligibility of medically needy individuals in accordance with this section.

..

(b) Determining countable income. The agency must deduct the following amounts from income to determine the individual's countable income.

(1) For individuals under age 21 and caretaker relatives, the agency must deduct amounts that would be deducted in determining eligibility under the State's AFDC plan.

(c) Eligibility based on countable income. If countable income determined under paragraph (b) of this section is equal to or less than the applicable income standard under §435.814, the individual or family is eligible for Medicaid…

14. The above authority explains Medically Needy provides coverage for individuals who do not qualify for full Medicaid due to income.

15. The ACCESS Florida Program Policy Manual Appendix A-7, Family-Related Medicaid Income Limits chart sets forth a $486 MNIL for a household size of three.

16. The respondent subtracted the $486 MNIL from $5019 to arrive at the $4,533 share of cost for the petitioner.

17. The ACCESS Florida Program Manual at 2030.1400, Medically Needy Coverage (MFAM) sets forth:

> The Medical Needy Program coverage is for individuals who meet the technical requirements of the above coverage groups but whose income exceeds the income limit. If the household's income is great than the income limit, the exceeding amount is determined as the share of cost. The individual is enrolled but is not eligible until the share of cost is met. Medically Needy provides month-to-month coverage when individuals have incurred medical bills that meet their share of cost.

18. A review of the rules and regulations did not find any exception to this formula. Based on a review of the evidence in its totality, the hearing officer concludes that the respondent's action to enroll the petitioner in a Medicaid Medically Needy Program and determine a share of cost of $4,533 was within the rules of the program.

DECISION

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

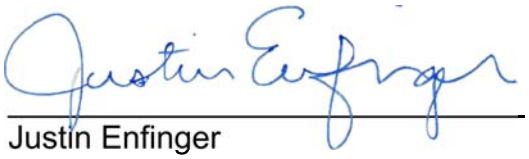
NOTICE OF RIGHT TO APPEAL

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 February, 2016,

in Tallahassee, Florida.



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

FILED
Jan 07, 2016
Office of Appeal Hearings
Dept. of Children and Families

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

[redacted]

PETITIONER,

APPEAL NO. 15F-08624

Vs.

CASE NO.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 18, 2015 at 1:12 p.m.

APPEARANCES

For the Petitioner: [redacted] Petitioner's Mother

For the Respondent: Stephanie Lang, R.N. Specialist, Fair Hearing Coordinator
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is the Respondent's action in reducing prescribed pediatric extended care services ("PPEC") beginning on September 23, 2015. The Agency held the burden of proof in this case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The Agency contracts with a Quality Improvement Organization ("QIO"), eQHealth Solutions, to perform medical utilization reviews for prescribed pediatric

extended care services through a prior authorization process for medicaid beneficiaries. Through this contractual agreement, eQHealth Solutions is authorized to make determinations of medical necessity on behalf of the Agency and act as a witness in all related fair hearing proceedings.

A prior service authorization request is submitted by a provider along with information and documentation required to make a determination of medical necessity. Initial requests for prescribed pediatric extended care services will be authorized for up to 60 days (two-month period) to allow for reassessment of the recipient's condition. Thereafter, a medical necessity review is conducted every 180 days (six-month period). If necessary, a request for modification may be submitted by the provider.

Witness for the Respondent was Rakesh Mittal, M.D., Physician Consultant with eQHealth Solutions.

Respondent's Exhibits 1 through 6 were admitted into evidence. Petitioner submitted no exhibits into evidence. The hearing officer took administrative notice of Section 409.905, Florida Statutes (2015), Florida Administrative Code Rules 59G-1.001, 59G-1.010, 59G-4.260, and the Prescribed Pediatric Extended Care Coverage and Limitations Handbook (September 2013).

Petitioner's benefits were continued at their prior level pending the outcome of the fair hearing process.

FINDINGS OF FACT

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

1. Petitioner is an approximately 4-year-old male diagnosed with [redacted], and [redacted].

2. Petitioner was previously approved to attend PPEC, but needed to recertify to continue his attendance. He attends a pre-K program and would attend PPEC after school, on school holidays, or when he is too ill for school.

3. eQ Health Solutions (hereinafter referred to as eQ Health) is the entity which reviews service authorization requests for PPEC services. eQ Health denied Petitioner's request for continued PPEC services by notice dated September 29, 2015. The reason for the denial decision is Petitioner's condition does not meet medical necessity for the PPEC service. The clinical rationale is as follows:

> The patient is a 4 year old with [redacted] and developmental delay. The patient is attending a pre K program and receives speech therapy as an outpatient. The patient is on an age-appropriate diet. The patient has reactive airway disease but has not required [any] nebulizer treatments. The clinical information provided does not support the medical necessity of the requested services. The patient does not appear to require skilled nursing. The remainder of the requested services are denied.

4. eQ Health's decision was based on the information provided to it by the Petitioner's PPEC center and physician.

5. Currently, Petitioner shows no symptoms of congestive heart failure. He is well-managed with medications. He does not require medical interventions. He is not on a special diet and he is not on a ventilator or other medical device.

6. eQ Health concluded Petitioner does not have a need for skilled nursing services such as those offered at PPEC because there have been no recent medical interventions or hospitalizations required. eQ Health concluded Petitioner's request was

not medically necessary. Petitioner has gone to the emergency room only once in the past year for a breathing issue. He was not admitted. His other visits in the past year to the emergency room were due to falls and fever, unrelated to his diagnoses.

7. PPEC nurses monitor Petitioner for signs and symptoms of fluid overloads, medication interactions, and respiratory assessments. The nurses educate the family as well. PPEC notes indicate discharge plans would be considered when the family can assume total care without skilled intervention. Petitioner has not required skilled intervention while at PPEC over the prior six month period.

8. Petitioner's mother is generally able to pick him up after school or have a relative watch him if she is unavailable. However, the relatives are scared of watching him due to the possibility of a medical incident. His mother wants him to attend PPEC so she has peace of mind that he is cared for, especially in case of a medical incident. He did not attend PPEC for three months because his mother was not aware of after school transportation options to PPEC. He did not suffer from any significant medical problems during the time away from PPEC.

9. If Petitioner needs care on non-school days or holidays, Petitioner's mother can submit a request for PPEC care on those days on an as-needed basis.

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 120.80, Florida Statutes. The Office of Appeal Hearings provided the parties with adequate notice of the administrative hearing.

11. Florida Medicaid State Plan 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 hearing was held as a de novo proceeding pursuant to Rule 65-2.056, Florida Administrative Code.

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

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

14. Since 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. 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.

15. The United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in *Moore v. Reese*, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, which involved a dispute over private duty nursing:

> (1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.
> (2) A state Medicaid plan must include "reasonable standards … for determining eligibility for and the extent of medical assistance" … and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.
> (3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."
> (4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."
> (5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to provide medically unnecessary, albeit desirable, EPSDT services. However, a state's provision of a required EPSDT benefit, such

> as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."
> (6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and my present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)).

16. 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.

17. The Prescribed Pediatric Extended Care Services Coverage and Limitations handbook (September 2013) ("Medicaid Handbook") has been incorporated by reference into Florida Administrative Code Rule 59G-4.260(2).

18. Page 2-1 of the Medicaid Handbook states that to receive PPEC services, the recipient must, among other criteria, "[r]equire short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care due to a medically complex condition."

19. Skilled nursing services are defined by Florida Administrative Code Rule 59G-4.290(3)(b). These are services that must be:

> 1. Ordered by and remain under the supervision of a physician;
> 2. Sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse.
> 3. Required to be performed by, or under the direct supervision of, a registered nurse or other health care professionals for safe and effective performance;
> 4. Required on a daily basis;
> 5. Reasonable and necessary to the treatment of a specific documented illness or injury; and

> 6. Consistent with the nature and severity of the individual's condition or the disease state or stage.

Examples of services that qualify as "skilled nursing services" include intravenous medications or fluids, injections, daily medication management, catheter care, wound care, tracheotomy care, colostomy care and ulcer care. Fla. Admin. Code R. 59G-4.290(3)(c). Petitioner does not require any skilled nursing care as defined above.

20. According to Florida Administrative Code Rule 59G-1.010(164):

> "[m]edically 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.

The following section 165 explains that:

> "[m]edically 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 dependent, or is dependent on a heightened level of medical supervision to sustain life, and without such services is likely to expire without warning.

21. Petitioner does not require any continuous skilled nursing care. There is no evidence to suggest that Petitioner is dependent upon 24-hour per day medical or nursing care, or that he is dependent upon life-sustaining medical equipment, such that he would properly be deemed 'Medically Complex' or 'Medically Fragile.' His need for supervision and/or medication administration does not support the authorization of PPEC, because there are alternative services that are better designed to meet those needs. As such, provision of PPEC would be convenience-based and excessive.

22. After careful review of the evidence submitted and the relevant laws set forth above, the undersigned concludes the Agency has met its burden of proof. Therefore, the Agency's action to reduce PPEC services was proper.

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 07 day of January, 2016, in Tallahassee, Florida.

Danielle Murray
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
Don Fuller, Area 6, AHCA Field Office Manager

FILED
Feb 05, 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-08633

PETITIONER,

vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice and agreement, an administrative hearing convened before Hearing Officer Patricia C. Antonucci on December 9, 2015 at 1:00 p.m. All parties and witnesses appeared via teleconference.

APPEARANCES

For the Petitioner: [redacted] Petitioner's mother

For the Respondent: Sheila Broderick, Registered Nurse Specialist,
Agency for Health Care Administration

STATEMENT OF THE ISSUE

At issue is a decision by Respondent, the Agency for Health Care Administration (AHCA), through its contracted health plan, Ped-I-Care, to reduce Petitioner's previously authorized Occupational Therapy (OT) service from three, 60-minute sessions per week to three, 45-minute sessions per week. Respondent bears the burden of proving, by a preponderance of the evidence, that this proposed reduction is proper.

PRELIMINARY STATEMENT

This matter was originally scheduled to convene on two prior occasions, but was continued and reset by agreement of the parties, to allow for exchange and review of proposed documentary evidence. Although Petitioner did not have all evidence packets in front of her when the final hearing convened, Petitioner opted to proceed with hearing, noting that she had copies of the same documentation within her own files.

At hearing on December 9, 2015, the minor Petitioner was not present, but was represented by her mother, [redacted] Additional testimony on Petitioner's behalf was provided by [redacted] Petitioner's Occupational Therapist, and [redacted], Petitioner's Speech Therapist. The Respondent was represented by Sheila Broderick, RN Specialist and Fair Hearing Liaison with AHCA. Respondent presented several witnesses from Ped-I-Care: John Nackashi, Ph.D., M.D., Medical Director; Justin Breton, OT Consultant; Holly Estep, Assistant Director of Utilization Management; and Laura Monday, Utilization Management Manager.

Petitioner's Exhibits 1, 2, and 3, and Respondent's Exhibits 1 through 9, inclusive, were accepted into evidence. Administrative Notice was taken of pertinent legal authority, including relevant portions of the Florida Medicaid Therapy Services Coverage and Limitations Handbook (August 2013).

FINDINGS OF FACT

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

1. The Petitioner is an 8-year old female, born November 22, 2007. At all times relevant to this proceeding, Petitioner has been eligible for and receiving Medicaid.

2. Petitioner has several diagnoses, including [redacted]

3. The Petitioner's scores on standardized assessments show improvement since Petitioner began receiving OT in September of 2013, but still reflect low percentiles of development. Per Petitioner's therapist, Petitioner has yet to plateau and continues to progress.

4. The Petitioner attends school, and receives assistance from a classroom aide; however, the aide is assigned to Petitioner's entire class, and does not provide individual assistance to Petitioner, beyond walking her to the bathroom every 30 minutes in accordance with a toileting schedule.

5. Prior to the action at issue, from approximately November of 2013 through October of 2015, Petitioner was authorized to receive three, hour-long sessions of OT service per week via her provider, O. T. 4 Kids.

6. On or about September 11, 2015, O. T. 4 Kids submitted to Ped-I-Care a request on behalf of the Petitioner to continue OT services of three hours per week, for the certification period spanning September 11, 2015 through March 8, 2016. Petitioner's OT Plan of Care was included along with this request.

7. On or about September 14, 2015, Ped-I-Care received the request and supporting documentation, and conducted a medical necessity review. Intake notes from Ped-I-Care's reviewing nurse note that Petitioner has a weak grasp, cannot write, is showing increased stimming behaviors and emotional sensitivity, difficulty sleeping ("likely indicative of poor self-regulation/modulation"), poor oral motor control and poor

sensory awareness. She is noted as unable to manipulate buttons or fasteners and to be working on potty training. Petitioner's request for OT was then forwarded to the medical director, as it exceeded "nurse approvable limits (greater than 2hr/wk for age)."

8. Via Notice of Action dated September 16, 2015, Ped-I-Care notified Petitioner of its intent to reduce her weekly OT. Said Notice stated, in pertinent part:

> Children's Medical Services Managed Care Plan (Ped-I-Care Title XIX Program) has reviewed your request for Occupational Therapy (OT)…. After our review, this service has been:
> REDUCED to 3 times a week for 45 minutes for 6 months as of October 1, 2015.
> We made our decision 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 able to be the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.
> …
> Progress toward new skills will require daily exposure and repetition. Documentation shows a strong family participation and practice of the Home Education Program. This will help improve member's growth towards functional outcomes. The member is now receiving support from a personal care assistant (PCA) in school to facilitate progress and meet individual needs. The PCA can take a leadership role in implementation of handwriting curriculum at school. Some goals are educationally-relevant and should be worked on by the educators and caregivers. The child's condition is ongoing and considered chronic. Ped-I-Care guidelines recommend moderate therapy for chronic conditions which is defined as up to 9 units (1 unit equals 15 minutes) per week.
>
> 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.

9. Via facsimile cover sheet sent to Petitioner's OT provider and physician, Ped-I-Care noted:

> Member has been receiving intensive therapy for more than 12 months with this provider, and continues to work on goals that are developmental in nature. Acquisition of new skills will require daily exposure and repetition due to member's medical condition and global developmental delays…. [long term goals] #7 and #12 are educationally-relevant abilities that should be emphasized by the educators and caregivers, not clinical OT. However, we recognize the need for ongoing therapy due to member's age and positive response to intervention. For these reasons, an authorization for up to 9 units a week is provided, which reflects that maximum amount of therapy for chronic conditions based on established therapy guidelines (please refer to the Ped-I-Care XIX Provider Manual). Thank you.

10. Via letter dated September 18, 2015, [redacted] Petitioner's OT at O. T. 4 Kids, requested reconsideration of the proposed reduction. [redacted] noted, in part:

> … [Petitioner] is currently participating in intensive sensory and therapeutic home programs in addition to therapy services to address sensory processing issues and developmental delays….These programs are recommend[ed] in addition to, not in place of, intensive therapy services.
>
> Although [Petitioner's] condition is considered "chronic" she is making steady and significant therapeutic gains with intensive therapy services including improved gross motor and fine motor skills, increased independence with daily living skills including grooming, dressing, and toileting. However, she continues to demonstrate global developmental delays and [it] is medically necessary that [she] continue to receive intensive therapy services to address all areas of need so that she will continue to make progress towards functional independence. Reduction of services at this time may result in regression.
>
> The medical necessity guidelines according to EPSDT standards require appropriate level of service not just minimal services because a child with a chronic condition cannot be expected to progress with limited intervention. Our request is appropriate to meet this level of service.

11. Via Notice of Appeal Determination dated October 12, 2015, Ped-I-Sure upheld its decision to reduce Petitioner's weekly OT.

12. On or about October 12, 2015, Petitioner requested a hearing to challenge this reduction.

13. At hearing, [redacted] reviewed Petitioner's Plan of Care, her evaluations, and her progress [redacted] is a licensed occupational therapist, who obtained her Master's in OT from the University of Florida. She is trained in sensory processing disorders, Handwriting without Tears, Interactive Metronome, and other treatment modalities. Ms. Messier has worked primarily in pediatric OT since 2008, and has experience with neurodevelopmental delays. It is [redacted] opinion that at this point in Petitioner's development, mere practice and repetition via a home program and in school will not lead to improvement in handwriting or activities of daily living-based goals, as Petitioner lacks the fundamental spatial and body awareness to know such basics as top/bottom/left/right orientation, and does not have the grasp strength or motor skills to hold a pencil. As such, hand-over-hand assistance will not be sufficient is to meet her therapy goals. The Petitioner does not currently have bilateral skills/motor planning to facilitate non-OT intervention, and still requires sensory system regulation by a skilled OT provider.

14. Per [redacted] when Petitioner arrives for an OT session, she is "low-end lethargic," and begins by stimming/hitting herself in her face. [redacted] starts the OT session by getting Petitioner alert and engaged, addressing her body via deep pressure touch protocol in preparation for working on other skills, such as toileting, posture, grasp strengthening, gross motor, bilateral integration, motor planning, and vestibular systems. If Petitioner is not prepared at a foundational level for skill training, she is unable to fully engage and benefit from skill practice. As such, it is [redacted]

opinion that educators and a general classroom aide will not be able to implement the OT curriculum utilized in intensive OT sessions, and cannot take the place of skilled OT intervention.

15. Over the course of Petitioner's weekly OT, she works on each program within her Plan of Care. [redacted] does not know what would be cut from the program, were Petitioner reduced from 60-minute sessions to 45-minute sessions, but believes Petitioner would regress if this were to occur. This is particularly true given that Petitioner has already regressed, following hospitalization and surgery in June of 2015, during which she could not attend OT. Following hospitalization [redacted] noted a regression in toileting, and increased balance issues. While Petitioner is regaining these skills, she is still not where she was prior to hospital admission. Although the aide at school takes Petitioner to the bathroom on a schedule, so as to avoid accidents, this does not assist in self-regulation. Petitioner still lacks the body awareness to know when she has to go to the bathroom, and the aide does not assist in teaching Petitioner how to move her body onto/off of the toilet, or to unfasten and/or reposition her clothes, as needed. Petitioner is still progressing toward independence in this regard.

16. Petitioner's Speech Language Pathologist, [redacted], also works with the Petitioner relative to the motor planning aspect of her dyspraxia [redacted] has noticed that Petitioner responds positively to OT, which has assisted in the development of gestures and queueing, related to oral-motor processing and planning for speech. Prior to OT, Petitioner could not manage simple sign language, because she couldn't motor plan her body to accomplish signing. Now, she is integrating motor planning and her speech is developing, as well. She can follow along with gesture systems which

she could not before, due to lack of coordinatio [redacted] works closely with Ms. [redacted] in providing interdisciplinary therapies to the Petitioner. It is [redacted] position that under EPSDT, Petitioner requires intensive, one-on-one services, and that reducing OT would be detrimental to development of her gross and fine motor skills, and sensory growth.

17. It is Ped-I-Care's position that the generally accepted standard of care for OT is intensive therapy (2-3 hours per week) for younger children, followed by transition to maintenance therapy (1-2 hours per week) in combination with a home program and school attendance. [redacted] who has 33 years of experience in pediatrics and has been Ped-I-Care's Medical Director since 2003, the intervention model guidelines utilized by Ped-I-Care recommend this coaching-based approach, combining therapy sessions with home and educational programs [redacted] Statement of Matters, "Three hours a week of OT is not indicated in the treatment of [Petitioner's] developmental disability. A total package of OT, speech therapy, home educational program and school is recommended and meets best practices."

18. [redacted] Ped-I-Care's OT Consultant, is a licensed Occupational Therapist, who has been practicing since 1995, and working in Florida, primarily in pediatric OT, since 1999. He graduated from McGill University, which is accredited in OT. It is Mr. [redacted] opinion that the Petitioner needs skilled interventions and observation, mainly to relay and teach interventions to caregivers for daily implementation. His recommendation for OT at 45-minute sessions is based on Petitioner's diagnoses and age, and the need to improve performance. However, he believes that the best practice is family-centered intervention, and testified that the proposed reduction is based on

generally accepted practice to reduce OT intensity as child ages and is exposed to additional supports, i.e., interventions in school and a comprehensive home program. Per [redacted] Petitioner's progress is steady but slow, which suggests the skilled intervention needs to continue, but that daily interventions must be provided at home and in the natural environment. Petitioner has met some of her goals, continues to work on others, and is still developing goals that were initiated when OT began in 2013. Mr. [redacted] does not believe that any of the interventions in Petitioner's plan of care are inappropriate, and agrees that they are geared toward meeting Petitioner's needs. Per [redacted] three, 45-minute sessions of OT per week is still considered intensive therapy.

19. [redacted] disagrees with the plan to reduce OT, at this time, noting that Petitioner has yet to plateau, and is thus not ready for mere maintenance therapy. She is still progressing, such that reduction is premature and may prohibit Petitioner from reaching her potential. In [redacted] opinion, the Petitioner will be ready for reduced OT once she achieves her therapy goals and gains independence, or if she does plateau, such that maintenance is appropriate. However, so long as Petitioner is progressing, [redacted] believes she needs to continue with three hours of OT per week, to obtain foundational skills that will allow for the type of practice and repetition that can be accomplished through home programs and in school.

CONCLUSIONS OF LAW

20. 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.

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

22. The Florida Medicaid Therapy Services Coverage and Limitations Handbook, August 2013 ("The Handbook") has been incorporated, by reference, into Fla. Admin. Code 59G-4.320(2).

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

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

25. The burden of proof in the instant case is assigned to the Respondent, who seeks to reduce a previously authorized service. The standard of proof in an administrative hearing is preponderance of the evidence. (See Fla. Admin. Code R. 65-2.060(1).)

26. Fla. Stat. § 409.905 addresses mandatory Medicaid services under the State Medicaid Plan:

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

(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.—The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

27. The Handbook describes the services covered under the Florida Medicaid Home Health Services Program, including OT.

28. Page 1-3 of The Handbook defines Occupational Therapy 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.

29. Similarly, per Fla. Stat. § 468.203(4):

> "Occupational therapy" means the use of purposeful activity or interventions to achieve functional outcomes.
> (a) For the purposes of this subsection:
> 1. "Achieving functional outcomes" means to maximize the independence and the maintenance of health of any individual who is limited by a physical injury or illness, a cognitive impairment, a psychosocial dysfunction, a mental illness, a developmental or a learning disability, or an adverse environmental condition.
> 2. "Assessment" means the use of skilled observation or the administration and interpretation of standardized or nonstandardized tests and measurements to identify areas for occupational therapy services.
> (b) Occupational therapy services include, but are not limited to:
> 1. The assessment, treatment, and education of or consultation with the individual, family, or other persons.
> 2. Interventions directed toward developing daily living skills, work readiness or work performance, play skills or leisure capacities, or enhancing educational performance skills.

> 3. Providing for the development of: sensory-motor, perceptual, or neuromuscular functioning; range of motion; or emotional, motivational, cognitive, or psychosocial components of performance.
> (emphasis added)

30. Consistent with the law, Ped-I-Care performs service authorization reviews under the Prior Authorization Program for certain Medicaid recipients in the state of Florida. Once Ped-I-Care receives an OT service request, its medical personnel conduct file reviews to determine the medical necessity of requested services, pursuant to the authorization requirements and limitations of the Florida Medicaid Program.

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

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

32. As the Petitioner is under 21, a broader definition of medically necessary applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) requirements. The undersigned must, therefore, consider both EPSDT and standard Medical Necessity requirements when developing a decision.

33. 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.

34. United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in Moore v. Reese, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, (which involved a dispute over private duty nursing):

> (1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.
> (2) A state Medicaid plan must include "reasonable standards … for determining eligibility for and the extent of medical assistance" … and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.
> (3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."
> (4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."
> (5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to

> provide medically unnecessary, albeit desirable, EPSDT services. However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."
> (6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and my present its own evidence of medical necessity in disputes between the state and Medicaid patients (citations omitted).

35. In terms of being specific and individualized, in keeping with Fla. Admin. Code R. 59G-1.010(166)(2), Petitioner's POC is based upon her therapist's evaluation, via standardized tests *and* professional observation of the petitioner, such that said POC is "an individualized and specific written program…designed to meet the medical, health and rehabilitative needs of the recipient." (See page 2-11 of the Handbook).

36. Fla. Admin. Code R. 59G-1.010(166)(2) also bears the requirement that any provided service not be in excess of the patient's needs. Although the Respondent suggests that provision of three hours per week of OT is excessive, nothing within the OT definitions or relevant legal authority excludes the treatment which Petitioner's provider recommends, nor does Ped-I-Care deny that such protocols are consistent with the provision of OT. Indeed, Respondent previously authorized O. T. 4 Kids' treatment protocol, at the frequency requested. Ped-I-Care now contends that this frequency is too intensive, as Petitioner has aged, and "best practice" suggests reduction of intensity to moderate OT based upon her age and developmental delays.

37. Similarly, with regard to Fla. Admin. Code R. 59G-1.010(166)(3)'s requirement that a service be consistent with generally accepted professional medical standards as determined by the Medicaid program, Ped-I-Care suggests that moderate OT is appropriate for Petitioner's diagnoses and that 9 units per week (which it defines as

moderate) is "the maximum amount of therapy for chronic conditions based on established therapy guidelines." Ped-I-Care's approach seems slightly inconsistent in this regard, as it suggests moderate or maintenance therapy is appropriate, but then contends that 45-minutes per week is still considered intensive. The fact that the recommendation of service relies, in part, upon Petitioner's diagnosis and age, is itself, inconsistent with the case-by-case review required under EPSDT.

38. With regard to Fla. Admin. Code R. 59G-1.010(166)(1), ST services were initially approved to treat and ameliorate the developmental delay and resultant deficits which Petitioner's situation present. Respondent contends that Petitioner can continue to progress with a reduced frequency of skilled OT, while Petitioner argues that without three weekly hours, Petitioner risks regression.

39. The undersigned finds that, absent competent and substantial evidence to the contrary, continuation of three weekly OT hours is appropriate until such time as Petitioner's deficits are ameliorated and prolonged progress (beyond the fundamental level) is maintained. (Fla. Admin. Code. R. 59G-1.010(166)(1). This is particularly important given that Petitioner has experienced some regression due to hospitalization, and must be given opportunity to regain skills previously obtained, as she continues to progress in her overall development.

40. After examining all testimony and evidence, it is determined that Petitioner requires OT to address the effects of her developmental delays on activities of daily living and communication. These needs and the therapeutic plan for addressing same substantiate the provision of OT at 60-minute sessions, three times per week, through a treatment protocol that address all of Petitioner's deficits.

41. When jointly considering the requirements of both ESPDT and Medical Necessity, along with a review of the totality of the evidence and legal authority, Respondent has not met its burden of proof to show that reduction of OT is appropriate, at this time.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 05 day of February, 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
Debbie Stokes, Area 4, AHCA Field Office Manager

FILED
Jan 06, 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-08660

PETITIONER,

Vs.

[redacted]

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 18 Brevard
UNIT: 88999

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 10:40 a.m. on November 9, 2015.

APPEARANCES

For the Petitioner: [redacted] pro se

For the Respondent: Susan Long, ACCESS Supervisor

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny the petitioner's application for Home and Community Based Services (HCBS) Medicaid Waiver is proper. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

By notice dated October 1, 2015, the respondent (or the Department) notified the petitioner her Medicaid application, dated August 31, 2015, was denied. Petitioner timely requested a hearing to challenge the denial.

Petitioner did not submit exhibits. Respondent submitted four exhibits, entered as Respondent Exhibits "1" through "4". The record was closed on November 9, 2015.

FINDINGS OF FACT

1. On August 31, 2015, petitioner submitted an HCBS application for herself.

2. Petitioner's income includes $1,658.97 from [redacted] retirement pension and $1,400.90 from Social Security (SS) retirement, totaling her monthly gross income at $3,059.87.

3. The gross monthly income limit to be eligible for HCBS, for a household size of one, cannot exceed $2,199.

4. Petitioner's monthly gross income ($3,059.87) exceeds the $2,199 HCBS income limit. However, petitioner could qualify if she establishes a Qualified Income Trust (QIT) fund and deposits at least $860.87 ($3,059.87 - $2,199) monthly into the fund.

5. On September 14, 2015, the Department mailed petitioner a Notice requesting: 1) medical waiver packet with level of care, 2) direct deposit bank statement on bank letter head indicating SS income deposits, 3) qualified income trust and bank statements indicating proper funding and 4) a financial release form. The Notice requested the petitioner submit the documents by September 24, 2015.

6. Petitioner did not submit the requested documents to the Department.

7. On October 1, 2015, the Department mailed the petitioner a Notice of Case Action, notifying her the August 31, 2015 application was denied; due to not receiving the requested information to determine eligibility.

8. Petitioner did not dispute that she did not provide the requested documents to the Department. Petitioner said that she uses every penny of her monthly income to pay

bills and for her care. And she cannot afford to pay $350/$400 to an attorney to set up a QIT fund; nor can she afford to fund the QIT monthly.

9. Petitioner stated that she understands what is required to qualify for HCBS Medicaid Waiver and will "try" to establish a QIT fund and provide the required documents.

10. Respondent's representative requested that petitioner submit another application when she has the requested documents.

CONCLUSIONS OF LAW

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

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

13. Fla. Admin. Code R. 65A-1.713 SSI-Related Medicaid Income Eligibility Criteria in part states:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows…
> (e) For HCBS, gross income cannot exceed 300 percent of the SSI federal benefit rate…
> (2) (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.
> (4) Income Budgeting Methodologies. To determine eligibility SSI budgeting methodologies are applied except where expressly prohibited by 42 U.S.C. § 1396…
> (b) For institutional care, hospice, and HCBS waiver programs the department applies the following methodology in determining eligibility:
> 1. To determine if the individual meets the income eligibility standard the client's total gross income, excluding income placed in qualified income

> trusts, is counted in the month received. The total gross income must be less than the institutional care income standard for the individual to be eligible for that month…

14. The qualified income trust is a legal document that meets criteria in 42 U.S.C. §1396 (p)(d), which in part states:

> (B) A trust established in a State for the benefit of an individual if—
> (i) the trust is composed only of pension, Social Security, and other income to the individual (and accumulated income in the trust)…

15. In accordance with the above authorities, for petitioner to be eligible for HCBS, her monthly income cannot exceed 300 percent of the SSI federal benefit rate. And income placed into a QIT is not considered in determining HCBS eligibility.

16. The Department's Program Policy Manual, CFOP 165-22, Appendix A-9, sets forth the HCBS income limit for an individual at $2,199.

17. The evidence establishes that petitioner receives $1,658.97 from Pfizer, Inc. retirement pension and $1,400.90 from SS retirement, totaling her monthly gross income at $3,059.87. Therefore, petitioner is not eligible for HCBS Medicaid Waiver.

18. Fla. Admin. Code R. 65A-1.205, Eligibility Determination Process in part explains:

> (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…. 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 30 days from the date of application, whichever is later… If the applicant does not provide required verifications or information by the deadline date the application will be denied, unless the applicant requests an extension or there are extenuating circumstances justifying an additional extension…** (emphasis added)

19. In accordance with the above authority, the Department mailed petitioner a notice requesting that the petitioner provided the appropriate documents to determine eligibility. The notice was sent on September 14, 2015 and requested that petitioner provide the documents by September 24, 2015. Petitioner did not provide the requested documents.

20. The above authority also explains the requested verification is due ten days from the date of the notice, or 30 days from the date of application. And if the verification is not received by the deadline date, the application will be denied; unless an extension is requested.

21. The evidence establishes that petitioner did not provide the requested documents by the deadline date of October 1, 2015 (30 days from the date of application) and did not request an extension.

22. In careful review of the cited authorities and evidence, the undersigned concludes the Department followed Rule in denying petitioner HCBS; due to not providing the required verification to determine eligibility.

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 06 day of January, 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

FILED
Jan 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. 15F-08757

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 24, 2015 at 1:05 p.m.

APPEARANCES

For the Petitioner: [redacted]
Pro Se

For the Respondent: Lisa Sanchez
Senior Human Services Program Specialist

ISSUE

Whether a dental bill for $5400.00 should be paid by the Florida Medicaid Program. The burden of proof was assigned to the petitioner.

PRELIMINARY STATEMENT

Petitioner entered no exhibits into evidence.

Ms. Sanchez appears as both the representative and witness for the respondent. Respondent's exhibit "1" was entered into evidence.

Due to jurisdictional concerns, the record was held open through December 3, 2015 for petitioner to provide a notice which denies; terminates; reduces; or suspends a Medicaid service. The record was also held open for petitioner to provide dental bills. Dental bills were timely provided and entered as petitioner's exhibit "1". A notice which denies; terminates; reduces; or suspends a Medicaid service was not provided.

The record was also held open through December 3, 2015 for respondent to provide a summary of any conversation with the treating provider. A response was not received.

On December 2, 2015 petitioner's Request for Extension of Time (90 days) and Appointment of Counsel was received. On December 4, 2015 the request for additional time was partially granted. Petitioner was allowed an additional 30 days to respond to jurisdictional concerns (through January 4, 2016). Petitioner's request for appointment of counsel was denied.

A response to jurisdiction concerns was not received.

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's date of birth is [redacted] He is dually enrolled in Medicare and Medicaid.

2. The Department of Children and Families (DCF) determines Medicaid eligibility.

3. Petitioner was determined eligible for Medicaid's Medically Needy Program. He has a monthly share of cost (SOC) of $1248.00.

4. For those in the Medically Needy Program, Medicaid eligibility is determined on a monthly basis. The individual must submit medical bills to DCF. The individual becomes Medicaid eligible on the day when allowable medical expenses equal the designated SOC. The individual is then Medicaid eligible from that date until the end of the month. The entire process starts over the following month.

5. DCF determined petitioner Medicaid eligible for the following timeframes:

- January 13, 2015 to January 31, 2015
- March 5, 2015 through March 31, 2015
- May 29, 2015 through May 31, 2015

6. No claims were submitted for the above timeframes.

7. Petitioner has a dental plan with Humana for which he pays $25.00 per month.

8. At an unspecified date in January 2015 petitioner incurred dental expenses related to a root canal; extractions and dentures.

9. The treating dentist completed all dental procedures and sent petitioner a bill for $5400.00. Petitioner has paid the dentist approximately $500.00.

10. Petitioner asserts the dentist told him some of the work would not be covered by Humana. The dentist inquired if there was any other insurance. The petitioner's response was Medicaid.

11. It is not known if the treating dentist is an enrolled provider in the Medicaid Program.

12. It is not known if Humana was billed for the dental procedures. It is also not known if Humana thereafter denied or paid any portion of the claim.

13. Ms. Sanchez has attempted to contact the treating physician several times. Messages have been left but the calls have not been returned.

14. Respondent has issued no denial notices to the petitioner for any dental procedure.

CONCLUSIONS OF LAW

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

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

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

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

19. Regarding the Medically Needy Program, Fla. Admin. Code R. 65A-1.701, Definitions, states in part:

> (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.

20. The Florida Medicaid Provider General Handbook (Provider Handbook) continues by providing the following clarification on page 3-31

> A Medically Needy recipient is an individual who would qualify for Medicaid, except that the individual's income or resources exceed Medicaid's income or resource limits.
>
> On a month-by-month basis, the individual's medical expenses are subtracted from the individual's income, and if the remainder falls below

> Medicaid's income limits, the individual may qualify for Medicaid from the day he became eligible until the end of the month.
>
> A Medically Needy recipient may be eligible for a full month or part of a month. The provider must check the recipient's eligibility before providing services.
>
> A Medically Needy recipient becomes eligible on the day that the recipient incurs allowable medical expenses that equal the amount by which his income exceeds the Medicaid income standard (share of cost). The recipient must submit his medical bills to DCF, and DCF makes the eligibility determination. The recipient will be eligible through the end of the month.

21. The undersigned was not able to make a Finding of Fact that claims for the dental procedures were submitted to DCF for processing. If claims had been submitted and either not processed or processed incorrectly, an appealable issue would exist with DCF.

22. The undersigned was also not able to make a Finding of Fact that the treating dentist was an enrolled provider in the Medicaid Program. It is noted that the Provider Handbook addresses certain considerations regarding billing the recipient (see pages 1-6 through 1-7). As the Medicaid status of the treating dentist is unknown, it is not possible for this provision to be evaluated.

23. Regarding petitioner's dental coverage with Humana and his eligibility for Medicare, The Provider Handbook continues by stating, in part:

> Page 1-12:
>
> Third Party Liability (TPL) is the obligation of any entity other than Medicaid or the recipient to pay for all or part of the cost of the recipient's medical care. If the recipient has other coverage though a TPL source, the provider must bill the TPL source prior to billing Medicaid.
> …

> Medicaid is the payer of last resort. If a recipient has other insurance coverage through a third party source, such as Medicare … the provider must bill the primary insure prior to billing Medicaid.
>
> Page 1-16:
>
> Recipients who are 65 years or older … can have full major medical coverage through Medicare.
> …
>
> Dually-eligible recipients (eligible for Medicaid and Medicare) may receive Medicare services from a Medicare Advantage Plan (Medicare HMO). A Medicare Advantage Plan is considered to be a TPL source.

24. The undersigned was not able to make a Finding of Fact that Humana was first billed for the dental expenses at issue. Additionally, it is not clear if petitioner is enrolled in a Medicare Advantage Plan that might cover the dental expense.

25. Analysis is next directed to jurisdictional concerns.

26. 42 C.F.R. address fair hearings for applicants and beneficiaries.

27. 42 C.F.R. §431.20 states, in part:

> 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 beneficiary who requests it because he or she believes the agency has taken an action erroneously.

28. 42 C.F.R. §431.201 provides the following definition: "Action means a termination, suspension, or reduction of Medicaid eligibility or covered services …"

29. Documentary evidence does not establish a Medicaid service has been denied; terminated; suspended; or reduced. As such, the undersigned lacks jurisdiction

regarding the identified issue. When jurisdiction does not exist, the matter must be dismissed.

30. Petitioner can further pursue billing with the dental provider. If the provider is enrolled in the Medicaid Program, the claims can be submitted to DCF for consideration and processing.

31. The Medically Needy Program can be confusing for both a recipient and a provider. A brochure, which was downloaded from the DCF website, is attached to this order. This information was found at:

http://www.myflfamilies.com/service-programs/access-florida-food-medical-assistance-cash/medicaid

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, due to the lack of jurisdiction, petitioner's 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 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 January, 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
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Judy Jacobs, Area 7, AHCA Field Office

Helpful Websites:

Information on Public Assistance Benefits

If you have questions about the Medically Needy Program or other Public Assistance benefits, want to see a list of our service centers, fax numbers or apply for benefits, visit our website:
www.myflorida.com/accessflorida

Medical Coverage for Children under age 19:
www.Floridakidcare.org
OR
www.healthykids.org

The following websites provide information on various programs for free or low cost prescriptions for certain medications:

www.benefitscheckup.org
www.medicare.gov
www.pparx.org
www.needymeds.com
www.rxassist.org
www.aarp.org/fl
www.togetherrxaccess.com
www.nacds.org

You may contact the Elder Helpline at (800) 963-5337.

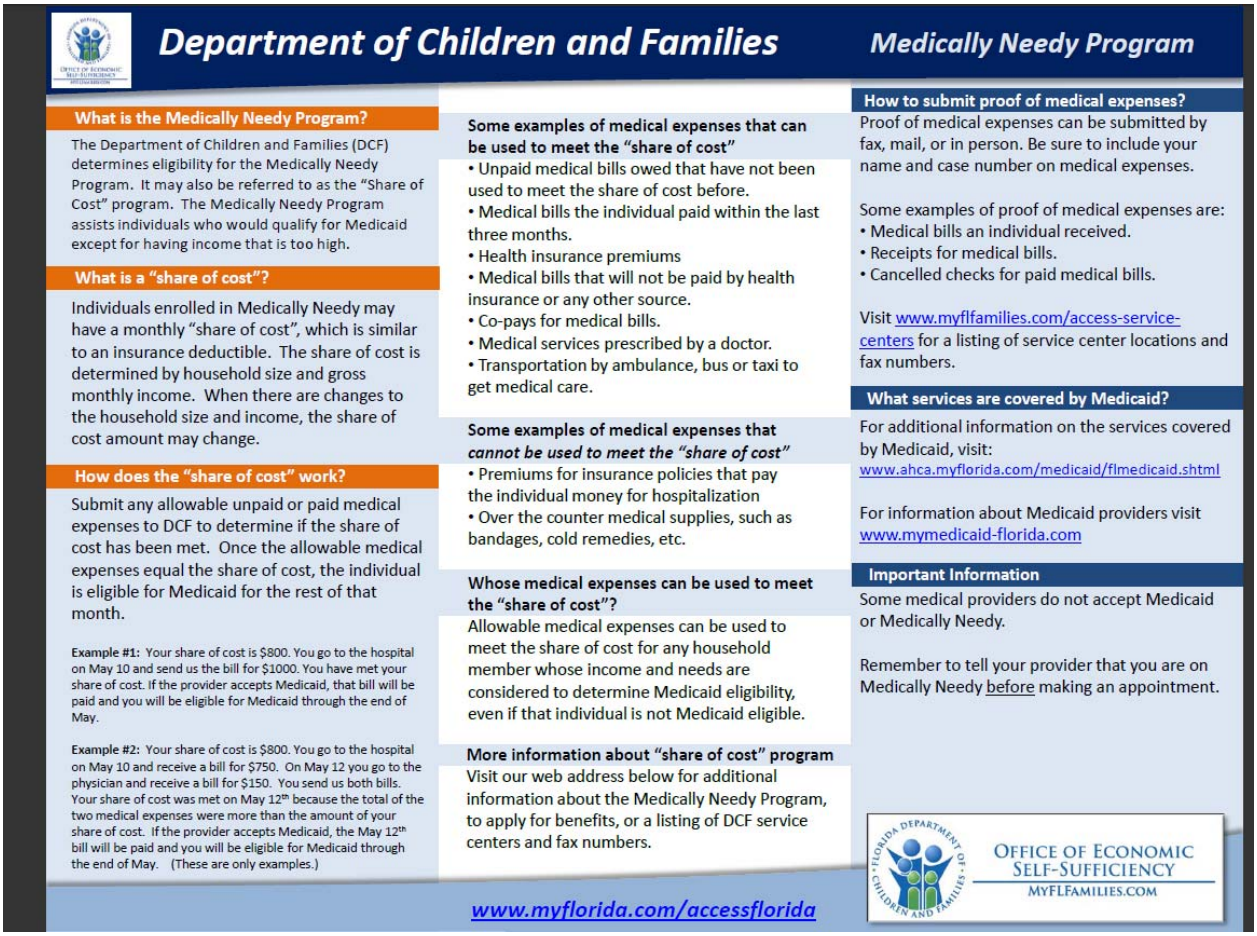
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF ECONOMIC SELF-SUFFICIENCY
MYFLFAMILIES.COM

CF/PI 165-70, Sep 2014

Department of Children and Families

Medically Needy Program

An Explanation of "Share of Cost"



Department of Children and Families

Medically Needy Program

What is the Medically Needy Program?

The Department of Children and Families (DCF) determines eligibility for the Medically Needy Program. It may also be referred to as the "Share of Cost" program. The Medically Needy Program assists individuals who would qualify for Medicaid except for having income that is too high.

What is a "share of cost"?

Individuals enrolled in Medically Needy may have a monthly "share of cost", which is similar to an insurance deductible. The share of cost is determined by household size and gross monthly income. When there are changes to the household size and income, the share of cost amount may change.

How does the "share of cost" work?

Submit any allowable unpaid or paid medical expenses to DCF to determine if the share of cost has been met. Once the allowable medical expenses equal the share of cost, the individual is eligible for Medicaid for the rest of that month.

Example #1: Your share of cost is $800. You go to the hospital on May 10 and send us the bill for $1000. You have met your share of cost. If the provider accepts Medicaid, that bill will be paid and you will be eligible for Medicaid through the end of May.

Example #2: Your share of cost is $800. You go to the hospital on May 10 and receive a bill for $750. On May 12 you go to the physician and receive a bill for $150. You send us both bills. Your share of cost was met on May 12th because the total of the two medical expenses were more than the amount of your share of cost. If the provider accepts Medicaid, the May 12th bill will be paid and you will be eligible for Medicaid through the end of May. (These are only examples.)

Some examples of medical expenses that can be used to meet the "share of cost"

- Unpaid medical bills owed that have not been used to meet the share of cost before.
- Medical bills the individual paid within the last three months.
- Health insurance premiums
- Medical bills that will not be paid by health insurance or any other source.
- Co-pays for medical bills.
- Medical services prescribed by a doctor.
- Transportation by ambulance, bus or taxi to get medical care.

Some examples of medical expenses that *cannot be used to meet the "share of cost"*

- Premiums for insurance policies that pay the individual money for hospitalization
- Over the counter medical supplies, such as bandages, cold remedies, etc.

Whose medical expenses can be used to meet the "share of cost"?

Allowable medical expenses can be used to meet the share of cost for any household member whose income and needs are considered to determine Medicaid eligibility, even if that individual is not Medicaid eligible.

More information about "share of cost" program

Visit our web address below for additional information about the Medically Needy Program, to apply for benefits, or a listing of DCF service centers and fax numbers.

How to submit proof of medical expenses?

Proof of medical expenses can be submitted by fax, mail, or in person. Be sure to include your name and case number on medical expenses.

Some examples of proof of medical expenses are:
- Medical bills an individual received.
- Receipts for medical bills.
- Cancelled checks for paid medical bills.

Visit www.myflfamilies.com/access-service-centers for a listing of service center locations and fax numbers.

What services are covered by Medicaid?

For additional information on the services covered by Medicaid, visit:
www.ahca.myflorida.com/medicaid/flmedicaid.shtml

For information about Medicaid providers visit www.mymedicaid-florida.com

Important Information

Some medical providers do not accept Medicaid or Medically Needy.

Remember to tell your provider that you are on Medically Needy before making an appointment.

www.myflorida.com/accessflorida

Office of Economic Self-Sufficiency
MyFLFamilies.com

FILED
Jan 26, 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-08793

PETITIONER,

Vs.

[redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 04 Duval
UNIT: 88781

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned reconvened an administrative hearing telephonically in the above-referenced matter on December 15, 2015 at 1:33 p.m.

APPEARANCES

For the Petitioner: The petitioner was present and represented himself.

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

STATEMENT OF ISSUE

The petitioner is appealing the Department's action on September 24, 2015 to deny his application for SSI-Related Medicaid.

The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The hearing originally convened on December 3, 2015 at 9:00 a.m. The petitioner was present but requested to reschedule to allow additional time for him to prepare for the hearing. The petitioner's request was granted and rescheduled for December 15, 2015 at 1:30 p.m.

Appearing as an observer for the respondent was Ernestine Bethune, ESSS II for DCF.

Pamela Vance, hearing officer, appeared as an observer.

The record was held open until 5:00 p.m. on December 18, 2015 to allow the petitioner to submit additional evidence. Evidence was not received.

FINDINGS OF FACT

1. On August 27, 2015, the petitioner (age 43) applied for SSI-Related Medicaid for self only. The petitioner's disability information was submitted to the Division of Disability Determination (DDD) to review the petitioner's claim for disability.

2. The DDD did not make an independent disability determination because the Social Security Administration (SSA) determined that the petitioner was not disabled in September 2015. The DDD determined that the petitioner was not disabled and denied his claim for disability using code "N39." The *Respondent Exhibit 2* includes the "State On-line Query (SOLQ) User Guide", which defines code "N39" as "Non-pay-Applicant willfully fails to follow prescribed treatment." The Department adopted the SSA unfavorable decision and denied the petitioner's application for SSI-Related Medicaid.

3. The petitioner disputes the Department's denial because he needs Medicaid to obtain the medications needed to treat his medical conditions. The petitioner argues

that his Supplemental Security Income (SSI) was denied because he was not adhering to his treatment plan. The petitioner argues that he is not able to adhere to his treatment plan because he does not have Medicaid to obtain the prescriptions he needs. The petitioner argues that he admits himself into the hospital in order to receive the necessary medications to treat his mental health condition.

4. The petitioner believes SSA reviewed his medical conditions of [redacted] issues. The petitioner contends that he has no new medical conditions but that his conditions have gotten worse.

5. The petitioner applied for SSI on March 30, 2015 and was denied on September 9, 2015.

CONCLUSIONS OF LAW

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

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

8. 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, 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...

9. 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
(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 –
(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.

10. 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.

11. The above authorities indicate that the Department may not make an independent determination of disability if SSA has made a disability determination on the same issues presented in the Medicaid application (within 12 months of the date of the Medicaid application). The regulation also states that the Department must make a determination of disability if the individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA and alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination or alleges more than 12 months after the most recent SSA determination. The Department is bound by the federal agency's decision unless there is evidence of a new disabling condition not reviewed in its unfavorable determination.

12. In this case, the Department adopted the unfavorable disability determination made by the SSA.

13. In this case, the petitioner is under 65 and has medical conditions of seizures, high blood pressure, blood clots, and mental health issues. The findings show that the petitioner's medical conditions have been reviewed by the SSA but have worsened. 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 disability denial from September 2015. Until petitioner meets the federal disability criteria (while under age 65) Medicaid cannot be approved.

DECISION

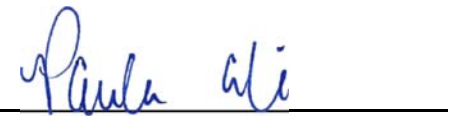
Based upon the foregoing Findings of Fact and Conclusions of Law, appeal is denied.

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 26 day of January, 2016,

in Tallahassee, Florida.



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

FILED
Feb 11, 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-08799

PETITIONER,

Vs.

[redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 Brevard
UNIT: 55207

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 2:30 p.m. on December 30, 2015. The recorder incorrectly states the time as 12:30 p.m.

APPEARANCES

For the Petitioner: [redacted] petitioner's partner

For the Respondent: Jill Dike, ACCESS Supervisor

STATEMENT OF ISSUE

At issue is whether the respondent's action to enroll the petitioner in the Medically Needy (MN) Program with a Share of Cost (SOC) is proper. The respondent carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

By notice dated September 18, 2015, the respondent (or the Department) notified the petitioner his August 24, 2015, application was approved and he was enrolled in MN

with a $768 SOC. Petitioner timely requested a hearing to challenge enrollment in the MN Program.

Petitioner was present and provided testimony. Emily Fuoco, ACCESS Economic Self-Sufficiency Specialist, appeared as an observer. Petitioner did not submit exhibits. Respondent submitted five exhibits, entered as Respondent Exhibits "1" through "5". The record was held open until December 31, 2015, for the respondent and petitioner to submit exhibits. The exhibits were received timely and entered as Petitioner Exhibit "1" and Respondent Exhibit "6". The record was closed on December 31, 2015.

FINDINGS OF FACT

1. On August 24, 2015, petitioner submitted a recertification application for Food Assistance and Medicaid benefits for himself and his partner. Medicaid for the petitioner is the only issue.

2. Petitioner received Supplemental Security Income (SSI) until August 31, 2015. Therefore, petitioner received full Medicaid through the Social Security Administration (SSA).

3. In November 2015, the SSA changed petitioner's SSI to $968 Social Security Disability Income (SSDI), which terminated his full Medicaid through the SSA.

4. For petitioner to be eligible for full Medicaid, his income cannot exceed the income limit of $864. Petitioner's $968 SSDI exceeds the $864 income limit. The next available program is MN with a SOC.

5. The Department calculated petitioner's SOC as follows:

$968	SSDI
-$ 20	unearned income disregard
-$180	MN income level (MNIL) for a household size of one
$768	SOC

6. On September 18, 2015, the Department mailed petitioner a Notice of Case Action, notifying his August 24, 2015, application was approved and he was enrolled in MN with a $768 SOC.

7. Petitioner's representative stated petitioner exceeds his SOC every month. And petitioner prefers to have full Medicaid rather than MN with a SOC.

CONCLUSIONS OF LAW

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

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

10. 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.

11. The Department's Policy Manual, CFOP 165-22, Appendix A-9, sets forth 88 percent of the federal poverty level (FPL) for a household size of one at $864.

12. In accordance with the above authority (#10), petitioner's income cannot exceed 88% of the FPL. Petitioner $968 SSDI exceeds the $864 FPL for a household size of one. Therefore, petitioner is not eligible for full Medicaid.

13. 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"…

14. The above authority explains MN provides coverage for individuals who do not qualify for full Medicaid due to income.

15. Federal Regulations 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…"

16. The Fla. Admin. Code R. 65A-1.716 sets forth the MNIL at $180 for a family size of one.

17. In accordance with the authorities, respondent deducted $20 unearned income and $180 MNIL from petitioner's $968 SSDI to arrive at $768 SOC.

18. In careful review of the cited authorities and evidence, the undersigned concludes the respondent is correct in approving petitioner in the MN Program with a $768 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 11 day of February, 2016,

in Tallahassee, Florida.

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

FILED
Jan 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. 15F-08821

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 18 Seminole
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on December 14, 2015, at approximately 10:30 a.m.

APPEARANCES

Petitioner: [redacted]

For Respondent: Lisa Sanchez
Senior Human Services Program Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is whether or not Respondent's denial of Petitioner's request for a second set of dentures is correct. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

Petitioner represented himself at the hearing. Petitioner presented one witness, [redacted]

The following individuals were present as witnesses for Respondent:

- Diana Andia – Grievance & Appeals Supervisor – Clear Health Alliance
- Dr. Merlin Osorio – Medical Director – Clear Health Alliance
- Haydee Penaranda – Complaints & Grievance Specialist - DentaQuest
- Dr. Daniel Dorrego – Dental Consultant – DentaQuest

Respondent's Exhibits 1 through 10 were entered into evidence at the hearing. Petitioner did not move any exhibits into evidence at the hearing. The undersigned took administrative notice of the Florida Medicaid Provider General Handbook (July 2012).

FINDINGS OF FACT

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

1. Petitioner is a 65-year-old male. At all times relevant to this proceeding, Petitioner was eligible to receive Medicaid services.

2. Petitioner was enrolled with Clear Health Alliance ("Clear Health") as his Managed Medical Assistance (MMA) program until September 30, 2015. He is currently enrolled with Staywell as his MMA program.

3. Petitioner's issue regards a full set of dentures that he says do not fit properly. Petitioner's issue arose when he was a member of Clear Health.

4. On June 8, 2015, Petitioner visited [redacted] to get both a mandibular and maxillary impression taken. Petitioner signed an agreement that he was satisfied with the impressions.

5. On June 16, 2015, Petitioner visited [redacted] for an adjustment. He indicated he was satisfied with the adjustment.

6. On June 18, 2015, Petitioner contacted Clear Health's Grievance & Appeals Department and stated the dentures never fit properly and after the adjustment they

were worse. He testified the adjustment was so significant that he can see through them. He says they scrape his mouth, causing pain and difficulty eating.

7. On June 23, 2015, Clear Health authorized Petitioner to seek a second opinion from a different dental provider to determine whether or not the dentures were made correctly and fit properly. A second set of dentures was not approved at this time, only the evaluation.

8. Petitioner visited [redacted] The treatment plan indicates the dentures are loose and causing pain. Petitioner was informed the denture process can require multiple adjustments over a two (2) to three (3) month period of time. He was also informed that a new set of dentures cannot be guaranteed to fit any better than the current ones.

9. On August 17, 2015, [redacted] submitted a request for a new full set of dentures, both mandibular and maxillary. The request was denied the same day. The reason given for the denial was that the new set of dentures is not a covered benefit since Medicaid will only provide one (1) set of dentures per lifetime.

10. Petitioner requested a Fair Hearing on October 15, 2015. DentaQuest reviewed the hearing request on October 24, 2015 and said Petitioner only went for one (1) adjustment, and that they would consider approving new dentures if after three (3) or (4) visits there was still no improvement.

11. Petitioner has a full set of dentures that were fabricated six (6) years ago. They were not provided by Medicaid. They have wear and tear and are discolored because Petitioner drinks a lot of grape juice. Petitioner testified they fit well, but do cause sores in his mouth.

12. Dr. Dorrego stated the old dentures could be relined and repaired, but nothing could be done about the discoloration because to do so would leave the dentures weak. Petitioner said he would be satisfied with this and Dr. Dorrego said he would approve repairing the old dentures if Clear Health would agree. The parties conferred outside of the presence of the undersigned and no agreement was reached.

13. Dr. Dorrego analogized a new set of dentures to a new pair of shoes. They have to be broken in and sometimes they fit like the old pair and sometimes they do not. He said there is roughly a 50/50 chance of achieving a comparable fit. A new set of dentures could be better or they could be worse. He said a new set of dentures will not fit exactly like the old ones because Petitioner has little bone left in his mouth.

CONCLUSIONS OF LAW

14. 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.

15. This 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. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

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

19. The November 2011 Florida Medicaid Dental Services Coverage and Limitations Handbook ("Dental Handbook") is promulgated into law by Chapter 59G of the Florida Administrative Code.

20. Page 2-2 of the Dental Handbook states:

> 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 reimburseable if the patient is to receive dentures. Procedures relating to dentures such as repairs, relines and adjustments are reimbursable.

21. Page 2-32 states:

> Full and removable partial dentures may be reimbursed once for an upper, a lower or a complete set of per the lifetime of the recipient
> ….
>
> Relines may be reimbursed once per denture per 366 days.

22. Page 2-32 also states:

> 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 function, because of the physical condition of the recipient; or
> - Full or partial dentures are no longer functional, because of the condition of the denture.

23. Regarding relining of the old dentures, page 2-32 states: "Relines may be reimbursable regardless of whether Medicaid paid for the dentures."

24. In the instant matter, Petitioner has failed to meet his burden to prove he qualifies for an exception to the once per lifetime rule. Petitioner only went for one (1)

adjustment of his dentures. DentaQuest and [redacted] are in agreement that dentures can require multiple adjustments in order to get a proper fit. DentaQuest indicated they would consider approving a new set of dentures if Petitioner went for three (3) to four (4) adjustments and they still did not fit. In order to meet his burden, Petitioner would need to show he tried multiple times to adjust the dentures before requesting a new set.

25. Dr. Dorrego said he would approve a relining and repair of Petitioner's old dentures that were not provided by Medicaid. Petitioner found this option acceptable, but Clear Health did not approve it. This issue is not under appeal at this time and therefore will not be addressed. Petitioner may want to consider requesting this as an alternative, in the event multiple adjustments of his Medicaid-provided dentures proves unsuccessful.

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 13 day of January, 2016,

in Tallahassee, Florida.

Rick Zimmer

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

FILED
Jan 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. 15F-08823

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 09 Osceola
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on December 8, 2015, 2015, at approximately 4:00 p.m.

APPEARANCES

Petitioner: [redacted]

For Respondent: Doretha Rouse
Registered Nurse Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is whether or not Respondent's denial of Petitioner's request for the drug [redacted] was correct. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

Petitioner represented herself at the hearing. Respondent presented the following witnesses:

- Stephanie Shupe – Regulatory Research Coordinator - Staywell
- Lisa Hogan – Clinical Pharmacist, Senior Manager, Medicaid Appeals Department - Staywell
- Erika Hatchman – Pharmacy Appeals Manager - Staywell

Petitioner's Exhibits 1 and 2 were entered into evidence. Respondent's Exhibits 1 through 13 were entered into evidence. The record was held open for Respondent to submit additional evidence. Respondent submitted additional evidence, entered as Exhibit 14. The undersigned took administrative notice of the July 2012 Florida Medicaid Provider General Handbook.

FINDINGS OF FACT

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

1. Petitioner is a 57-year-old female. At all times relevant to this proceeding, Petitioner was eligible to receive Medicaid services.

2. Petitioner is enrolled with Staywell as her Managed Medical Assistance (MMA) plan.

3. Petitioner's medical conditions include:

- [redacted]

4. Petitioner currently takes approximately 20 different medications to treat her conditions. She stated the medications ruin her appetite and she doesn't eat, which makes her vomit because she can't take them on an empty stomach, but forces herself

to do so. She currently does not take any medication for nausea, although she sometimes drinks Alka-Seltzer. She said nothing works to treat the nausea, only [redacted].

5. Petitioner previously took [redacted] by paying for it herself and says she can no longer afford it. Petitioner claims [redacted] helps with several of her conditions and would allow her to take fewer medications, along with treating the nausea.

6. Petitioner is largely homebound due to her condition. She testified she only leaves her house for doctor appointments and to buy food, and it can take her several hours to get out of the house.

7. On September 25, 2015, Petitioner's physician submitted a request for the [redacted] in order to treat her nausea.

8. In a Notice of Action dated September 28, 2015, Staywell informed Petitioner of the denial of the prescription. The Notice of Action (Respondent's Exhibit 5) states:

> The request could not be approved. This drug is not approved by the Food and Drug Administration (FDA) to treat NAUSEA. It is only FDA approved for the treatment of anorexia associated with weight loss in patients with AIDS; and nausea and vomiting associated with cancer chemotherapy in patients who have failed to respond adequately to conventional antiemetic treatments in patients 18 years of age and older.
>
> The facts we used to make our decision are: The criteria are the Food and Drug Administration (FDA) manufacturer package insert for [redacted] 5 MG CAPSULE, AND Policy & Procedure C20RX150 which states WellCare only covers FDA approved indication(s).

9. Petitioner filed an appeal with Staywell on October 20, 2015. Staywell sent Petitioner an Appeal Denial Upheld Notice, dated November 4, 2015, stating the request was reviewed by a board-certified doctor who was not part of the original review. It further stated the doctor's findings were given to Staywell's Appeal Review Committee,

consisting of Medical Director(s) specializing in Internal Medicine, and Pharmacist(s). (Respondent's Exhibit 11). The denial of the [redacted] was upheld and Staywell said they would not pay for the medication.

10. AHCA maintains a Preferred Drug List ("PDL"). [redacted] is not on the PDL. Medications not on the PDL require prior authorization. AHCA requires specific criteria be met for approval of [redacted] (Marinol). AHCA posts the criteria for approval of [redacted] on the Internet at the address: ahca.myflorida.com/Medicaid/Prescribed_Drug/drug_criteria_pdf/Marinol_Criteria.pdf.

11. The review criteria lists two conditions for which [redacted] can be prescribed: (A) Anorexia due to AIDS, and (B) Treatment of refractory chemotherapy-induced nausea and vomiting. (Respondent's Exhibit 14). Petitioner does not have either of these conditions.

12. Pursuant to Staywell's contract with AHCA (Respondent's Exhibit 12), they are permitted, but are not required, to cover prescriptions when the Medicaid State Plan would not. Specifically, the contract states:

> The Managed Care Plan shall make available those drugs not on the PDL, when requested and approved, if the drugs on the PDL have been used in a step therapy sequence or when other medical documentation is provided. The Managed Care Plan may adopt the Medicaid prior authorization criteria posted on the Agency website, or develop its own criteria. Prior authorization, step-edit therapy protocols for PDL drugs may not be more restrictive than that used by the Agency as indicated in the Florida Statutes, the Florida Administrative Code, the Medicaid State Plan and those posted on the Agency website.

13. Ms. Hogan testified that Staywell looked in the drug compendia known as [redacted] to make an informed decision as to whether or not [redacted] is appropriate for treating

any of Petitioner's conditions. [redacted] lists labeled and off-labeled uses, dosing, age requirements, administration, and the effects on the body with a particular drug.

14. Ms. Hogan testified the off-label indications for [redacted] are spasticity related to [redacted], diagnosis of [redacted] and before or after a patient receives surgery. Petitioner does not meet any of these criteria. She recommended that Petitioner take a copy of the PDL with her to her doctor to discuss if there are any options available to her.

CONCLUSIONS OF LAW

15. By agreement between AHCA and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction to conduct this hearing pursuant to § 120.80, Fla. Stat.

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

17. This is a Final Order, pursuant to Sections 120.569 and 120.57, Fla. Stat.

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

19. 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.

20. Section 409.912 of the Florida Statutes, entitled "Cost-effective purchasing of health care", states, in pertinent part:

> [AHCA] shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care.
> ....
>
> (8)(a) The agency shall implement a Medicaid prescribed-drug spending-control program that includes the following components:
> 1. A Medicaid preferred drug list, which shall be a listing of cost-effective therapeutic options recommended by the Medicaid Pharmacy and Therapeutics Committee established pursuant to s. 409.91195 and adopted by the agency for each therapeutic class on the preferred drug list. At the discretion of the committee, and when feasible, the preferred drug list should include at least two products in a therapeutic class. The agency may post the preferred drug list and updates to the list on an Internet website without following the rulemaking procedures of chapter 120.
> ....
>
> 14. The agency may require prior authorization for Medicaid-covered prescribed drugs. The agency may prior-authorize the use of a product:
> a. For an indication not approved in labeling;
> b. To comply with certain clinical guidelines; or
> c. If the product has the potential for overuse, misuse, or abuse.
>
> The agency may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug. The agency shall post prior authorization, step-edit criteria and protocol, and updates to the list of drugs that are subject to prior authorization on the agency's Internet website within 21 days after the prior authorization and step-edit criteria and protocol and updates are approved by the agency. For purposes of this subparagraph, the term "step-edit" means an automatic electronic review of certain medications subject to prior authorization.

21. The Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook, July 2014 ("Drug Handbook") is promulgated into law by Chapter 59G of the Florida Administrative Code.

22. Page 2-4 of the Drug Handbook states, in relevant part:

> The Preferred Drug List (PDL) is a listing of prescription products recommended by the Pharmaceutical and Therapeutics (P&T) Committee for consideration by AHCA as efficacious, safe, and cost effective choices when prescribing for Medicaid patients.
> ....

> Products included on the PDL must be prescribed first unless the patient has previously used these products unsuccessfully or the prescriber submits documentation justifying the use of a non-PDL product.
> ....
>
> Non-PDL drugs may be approved for reimbursement upon prior authorization.

23. Page 2-2 of the Drug Handbook provides:

> To be reimbursed by Medicaid, a drug must be medically necessary and either (a) prescribed for **medically accepted indications and dosages found in the drug labeling or drug compendia**...or (b) prior authorized by a qualified clinical specialist approved by the Agency.... (emphasis added).

24. 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.

25. Section 409.912 of the Florida Statutes requires AHCA to create a PDL. [redacted] is not on the PDL and therefore requires prior authorization. AHCA's criteria for [redacted] are available on its website.

26. Petitioner does not meet the criteria fo[redacted] listed on AHCA's website, contained in Respondent's Exhibit 14. Staywell is allowed to approve a medication even if AHCA's review criteria are not met, per its contract, so long as it meets the medically accepted indications and dosages found in the drug labeling or drug compendia. Staywell researched Drugdex and found that [redacted] is not indicated for any of Petitioner's conditions.

27. Petitioner is encouraged to work with her physician and research the Preferred Drug List and AHCA drug criteria to see if a different medication can meet her needs.

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 15 day of January, 2016,

in Tallahassee, Florida.

Rick Zimmer

Rick Zimmer
Hearing Officer
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Judy Jacobs, Area 7, AHCA Field Office

FILED
Jan 12, 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.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 Seminole
UNIT: 55207

RESPONDENT.
_____/

APPEAL NO. 15F-08868

[redacted]

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 11:00 a.m. on November 20, 2015.

APPEARANCES

For the Petitioner: [redacted] pro se

For the Respondent: Jill Dike, ACCESS Supervisor

STATEMENT OF ISSUE

At issue is whether the respondent's action to terminate petitioner's child [redacted] full Medicaid and instead enroll her in the Medically Needy (MN) program with a Share of Cost (SOC) is proper. The respondent carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

By notice dated August 13, 2015, the respondent (or the Department) notified the petitioner that full Medicaid for [redacted] would end on August 31, 2015 and [redacted] was enrolled in

the MN with a $2,573 SOC, effective September 2015. Petitioner timely requested a hearing to challenge JT's full Medicaid termination and enrollment in the MN program.

Petitioner did not submit exhibits. Respondent submitted five exhibits, entered as Respondent Exhibits "1" through "5". Petitioner did not receive the respondent's exhibits and elected to proceed with the hearing without the respondent's exhibits. The record was held open through end of business day on November 20, 2015, for the respondent to submit an additional exhibit. The exhibit was received timely and entered as Respondent Exhibit "6". The record was closed on November 20, 2015.

FINDINGS OF FACT

1. Prior to the action under appeal, JT received full Medicaid benefits.

2. On July 27, 2015, petitioner submitted a web application for Food Assistance and Medicaid benefits for herself, her boyfriend [redacted], their mutual child [redacted], age two and petitioner's other minor child. All household members are in the same tax filing unit. Medicaid for [redacted] is the only issue.

3. Petitioner is employed at [redacted] and is paid weekly. CT is employed at [redacted] and is paid biweekly.

4. The respondent determined the household income using paystubs provided by the petitioner. The income is as follows:

[redacted]	Date	Gross amount
	07/02/15	$163.28
	07/09/15	$224.54
	07/16/15	$163.61
	08/05/15	$138.10
		$689.53

[redacted]	Date	Gross amount
	07/20/15	$1,144.50
	08/05/15	$1,324.65
		$2,469.15

$ 689.53	[redacted]
+$2,469.15	
$3,158.68	total household income

5. For [redacted] to be eligible for full Medicaid, the household income for a household size of four cannot exceed $2,688. Petitioner's $3,158.68 household income exceeds $2,688; therefore, [redacted] is not eligible for full Medicaid. The next available program is MN with a SOC.

6. The Department subtracted $585, the MN income level for a household size of four, from $3,158.68 (total household income) to arrive at [redacted] $2,573 SOC.

7. On August 13, 2015, the respondent mailed petitioner a Notice of Case Action, notifying petitioner that Medicaid for [redacted] would end on August 31, 2015 and [redacted] was enrolled in the MN program with a $2,573 SOC, effective September 2015.

8. Petitioner stated that the household income has not changed and she does not understand the reason [redacted] is now in the MN program.

9. Respondent's representative explained that [redacted] received 12 months of continuous Medicaid from September 2014 through August 2015. Therefore, [redacted] is no longer eligible for full Medicaid, due to income.

CONCLUSIONS OF LAW

10. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla.

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

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

12. Federal Regulations at 42 C.F.R. § 435.603 "Application of modified adjusted gross income (MAGI)" states:

> (a) Basis, scope, and implementation. (1) This section implements section 1902(e)(14) of the Act.
> (2) Effective January 1, 2014, the agency must apply the financial methodologies set forth in this section in determining the financial eligibility of all individuals for Medicaid, except for individuals identified in paragraph (j) of this section and as provided in paragraph (a)(3) of this section.
> (b) Definitions. For purposes of this section—
> *Child* means a natural or biological, adopted or step child.
> *Code* means the Internal Revenue Code.
> *Family size* means the number of persons counted as members of an individual's household.…
> *Parent* means a natural or biological, adopted or step parent.
> *Sibling* means natural or biological, adopted, half, or step sibling….
> (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…

13. The above authority explains all household members and their income are counted in the Medicaid eligibility determination.

14. 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…

15. In accordance with the above authorities, the Department included petitioner's income from [redacted] ($689.53) and [redacted]'s income from [redacted] ($2,469.15), in determining [redacted]'s Medicaid eligibility.

16. Fla. Admin. Code R. 65A-1.703 Family-Related Medicaid Coverage Groups, states in part:

> (3) Medicaid for children not yet age 19. To be eligible for this coverage group the child must meet the general requirements specified in Rule 65A-1.705, F.A.C. The following additional criteria apply…
> (b) 2. Age one to age six is less than or equal to 133 percent of the federal poverty level…

17. In accordance with the above authority, for [redacted] to be eligible for full Medicaid the household income must be less than or equal to 133 percent of the federal poverty level (FPL).

18. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, Appendix A-7, sets forth 133 percent of the FPL at $2,688 for a child age one through 5, with a household size of four. Petitioner's $3,158.68 household income exceeds $2,688; therefore, [redacted] is not eligible for full Medicaid.

19. The Department's Policy Manual, Appendix A-7, sets forth the MN income level at $585 for a household size of four.

20. Fla. Admin. Code R. 65A-1.707 Family-Related Medicaid explains:

> (a)...For Medically Needy coverage groups, the amount by which the gross income exceeds the applicable payment standard income level is a share of cost…

21. In accordance with the above authority, the Department subtracted $585 (MN income level for a household size of four) from $3,158.68 (petitioner's household income) to arrive at $2,573 SOC for JT.

22. Fla. Stat. § 409.904 Optional payments for eligible persons, explains Continuous Medicaid and in part states:

> (6)A child who has not attained the age of 19 who has been determined eligible for the Medicaid program is deemed to be eligible for a total of 6 months, regardless of changes in circumstances other than attainment of the maximum age. **Effective January 1, 1999, a child who has not attained the age of 5 and who has been determined eligible for the Medicaid program is deemed to be eligible for a total of 12 months regardless of changes in circumstances other than attainment of the maximum age.** (emphasis added)

23. Additionally, the Department's Policy Manual section 0830.0800 CONTINUOUS MEDICAID ELIGIBILITY (MFAM) states:

> After Medicaid eligibility has been established, children who become ineligible for Medicaid for any reason may remain on Medicaid for up to twelve months from the last application, eligibility review or addition to Medicaid coverage. **Children up to age 5 receive a minimum of twelve months of continuous Medicaid coverage.** (emphasis added) Children age five up to 19 receive a minimum of six months of continuous Medicaid coverage.
> If it is later discovered that the child was not eligible at the point eligibility was determined, continuous Medicaid does not apply. An ex parte review must be completed to explore eligibility in other categories.
> Note: A child determined eligible for Medicaid any day prior to turning age five continues to receive Medicaid for twelve months without redetermination or verification of eligibility. Months of Medicaid received since the most recent application or eligibility review count toward the six or twelve months of continuous Medicaid eligibility. Count the first month of eligibility as month one if the last action is an application. If the last action is an eligibility review, count as month one the month following the date the eligibility review was completed. Retroactive Medicaid does not count as a month of continuous Medicaid coverage.

24. The above authority and Department's Policy Manual explain children up to age 5 receive 12 months of continuous Medicaid after Medicaid eligibility has been established. In this case, [redacted] received full Medicaid from September 2014 through August 2015.

25. In careful review of the cited authorities and evidence, the undersigned concludes that the Department was correct in terminating [redacted]s full Medicaid and enrolling [redacted] in the MN program with a $2,573 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 __12__ day of __January_____, 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

FILED
Jan 08, 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-08886
15F-08887

PETITIONER,

Vs.

[redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 17 Broward
UNIT: 88597

RESPONDENT. _____/

ORDER TO DISMISS

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on December 2, 2015 at 9:02 a.m. The petitioner was present and represented himself. Marilyn Newton, supervisor, represented the Department. The hearing was reconvened on December 18, 2015 at 2:03 pm with the same parties. All parties appeared telephonically from different locations.

At issue, the petitioner is appealing the Food Assistance Program (FAP) benefits $16, stating he believes he was entitled to more. The petitioner is also seeking retroactive coverage of the Qualifying Individual 1 (QI 1) benefits for the months of June, July, and August of 2015.

During the initial hearing, the merits of the case were discussed. The petitioner did not agree with the FAP of $16 and he believed that he is entitled to retroactive QI 1 benefits for the months of June, July, and August of 2015. The record remained open

until December 7, 2015 for further evidence to be submitted by both the petitioner and the respondent. The following was requested from the respondent: the budgets for the FAP and QI 1, FAP and QI 1 Income Limits, the Notice of Case Action (NOCA) for the QI 1 benefit, Medicare Coverage screen updates, and the running record comments beginning April 1, 2015 to the present. The respondent provided the budget screens for both benefits, the income limits for both benefits, the NOCA for the QI 1 benefit and the Medicare coverage screen. There was no evidence submitted by the petitioner.

Upon review of the additional evidence submitted by the respondent, it was determined that the hearing needed to be reconvened. As the merits of the case were being discussed, the petitioner requested to withdraw his FAP appeal and the QI 1 eligibility appeal. The petitioner had no other issues that needed to be addressed.

Based on the petitioner's request, both appeals are hereby dismissed.

DONE and ORDERED this 08 day of January, 2016, in Tallahassee, Florida.

Pamela B. Vance

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FILED
Jan 12, 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.

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 01 Okaloosa
UNIT: 88630

RESPONDENT.
_____/

APPEAL NO. 15F-08941

[redacted]

FINAL ORDER

Pursuant to notice, an administrative hearing in the above captioned matter was convened before Hearing Officer Gregory Watson on December 1, 2015, at approximately 2:00 PM. All participants appeared via teleconference.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Theresa Nadeau, Economic Self-Sufficiency Specialist II, Department of Children and Families

PRELIMINARY STATEMENT

Petitioner submitted additional evidence while the record was held open on December 2, 2015. It was entered as Petitioner's Exhibit 2.

Sheila Rushing, Operations Management Consultant with the Department of Children and Families appeared as a witness. Lauren Coe, Program Operations Administrator with Division of Disability Determinations also appeared as a witness. Susan Dixon, Hearing Officer, observed the proceeding.

ISSUE

Petitioner is appealing the Department's action to deny her Medicaid benefits through the Department's SSI-Related Medicaid Program on the basis that she did not meet the disability criteria. The petitioner carries the burden of proof by the preponderance of evidence that this denial was improper.

FINDINGS OF FACT

1.) The Petitioner is a 51-year-old woman, born [redacted] She has a 12th grade education and work history as a waitress and in retail. She has not worked since September 27, 2015.

2.) On October 2, 2015, a Medicaid application was submitted for the Petitioner by her designated representative, [redacted] A disability application with the Social Security Administration was also submitted on this day; as of the date of the hearing, it was in a pending status.

3.) On September 27, 2015, Petitioner presented at [redacted] reporting dizziness and left leg weakness. She was admitted. Radiologist interpretation states: [redacted]

4.) On September 28, 2015 Petitioner suffered a Transient Ischemic Attack (TIA) with continued left leg weakness. An MRI was consistent with an ischemic event and Petitioner has significant family history of the same. [redacted] Transfer was recommended and Petitioner moved to [redacted].

5.) The medical record dated October 5, 2015 states:

[redacted]

6.) From October 7 through 18, Petitioner was moved from FWBMC to Inpatient Rehabilitation. Petitioner suffered another stroke and was transferred back to [redacted] on October 19, 2015 where she remains.

7.) On October 23, 2015, the Department denied the Medicaid application, sending a Notice of Case Action on October 26, 2015 that states:

> Your Medicaid application/review dated October 02, 2015 is denied…
> Reason: You or a member(s) of your household do not meet the disability requirement. No household members are eligible for this program. The law

that supports this actions is: (FL Admin. Code = R) (FL Statute = S), R65A-1.711 R65A-1.205

8.) The Department does not itself make disability determinations. These are contracted out to the Division of Disability Determinations (DDD).

9.) This denial is subsequent to receipt from the DDD of its findings. On October 22, 2015, a CF-ES 2909 was received by the Department stating that the primary diagnosis of [redacted] and the secondary diagnosis of [redacted] were reviewed and disability denied with code N31 (Non-pay – Capacity for substantial gainful activity – customary past work, no visual impairment [page 38 of DCF State On-line Query (SOLQ) User's Guide]). This document was stamped as reviewed by Master Adjudicator, [redacted] on October 22, 2015.

10.) [redacted] is not a physician or nurse; however, she is highly trained in disability examination by her employer.

11.) Medical documentation of Petitioner's worsening condition was submitted to the Social Security ERE Portal for disability consideration by her representative (RN case manager). This portal is accessed by DDD for receipt of information for the Social Security Administration's disability determinations. The information therein was not considered by [redacted] when making her Medicaid disability determination for the Department. In addition, the RN case manager provided that discharge plans are being made for petitioner to enter an in-field nursing home facility as she is not ambulatory, paralyzed on the left side and has slurred speech. As part of the discharge plan, a nursing home level of care has already been determined by the Department of Elder Affairs

(DOEA) which means she is medically appropriate to be admitted to a nursing home upon discharge from the rehabilitation facility.

12.) DDD determined the Petitioner's residual functional capacity (RFC) as light and that she had the capacity to return to her prior work as a waitress and retail work.

13.) On October 22, 2015, the medical record states [redacted]

14.) Subsequently, on November 17, 2015, the medical record states: [redacted]

CONCLUSIONS OF LAW

15.) Fla. Admin Code R. 65A-1.710 et seq., set forth the rules of eligibility for Elderly and Disabled Individuals Who Have Income of Less Than the Federal Poverty Level. For an individual less than 65 years of age to receive benefits, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. The regulations state, in part:

> 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 which makes you unable to do your previous work or any other substantial gainful activity which 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.) This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056. Medical evidence was presented at the hearing which was not submitted to DDD. DDD declined to review the new evidence and stood by its denial determination during the hearing. However, the undersigned has reviewed and considered all new relevant medical evidence in making this decision.

17.) The hearing officer evaluated the Petitioner's claim of disability using the sequential evaluation as set forth in 20 C.F.R. § 416.920.

18.) The first step is to determine whether or not the individual is working. The Petitioner has not worked since September 27, 2015 and therefore meets the first step.

19.) The second step is to determine whether or not an individual has a severe impairment. The Petitioner suffers with slightly slurred speech, intermittent muscle spasms and left side paralysis. Petitioner's treating physician concludes the disability is permanent. Therefore, petitioner meets step two of the analysis.

20.) The third step is to determine whether or not the individual's impairment(s) meets or equals a listed impairment in Appendix 1 of the Social Security Act. It was not found that petitioner meets a listing.

21.) The fourth step is to determine whether or not the individual's impairment(s) prevents her from doing past relevant work. Petitioner's past work was in retail and waitressing. For prior jobs as a waitress and [redacted] Sales Representative, the Dictionary of Occupational Titles lists the functional

capacity as light. Considering the medical evidence and testimony, the undersigned has concluded the Petitioner does not even meet sedentary RFC. Petitioner's paralysis on the left side and her not being ambulatory would prevent her from working in a restaurant or store. In addition there is an altered mental status. Her discharge plans are to enter a nursing facility and she has been assigned a level of care by DOEA. In addition, her physician concluded she is totally and permanently disabled. There was no rebuttal evidence from respondent. Therefore, the undersigned concludes petitioner passes step four of the sequential analysis.

22.) The fifth step is to determine whether or not the individual's impairment prevents her from performing other work in the national economy. Based on the treating physician's opinion, the undersigned concludes petitioner does not have the mental or physical capacity remaining to do any job in the national economy and is therefore determined to meet the disability criteria for SSI-related Medicaid.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, the appeal is granted. The Department's denial action is reversed. The Department is ordered to determine eligibility from the application of October 2, 2015 to include the retroactive month of September 2015. The Department is to consider the petitioner disabled beginning September 2015 and issue a written notice once the determination is complete. A copy is to be provided to the representative.

A disability review is to be completed one year from this decision. In the event the Social Security Administration decides otherwise, the Department is to follow its policy concerning adoption of SSA decisions.

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 12 day of January, 2016,

in Tallahassee, Florida.

Gregory Watson

Gregory Watson
Hearing Officer
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Office of Economic Self Sufficiency
MICHELLE CASTRO

FILED
Jan 14, 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-08957

PETITIONER,

Vs.

[redacted]

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 15 Palm Beach
UNIT: 88701

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on December 9, 2015 at 11:34am.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Mary Triplett, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of August 24, 2015 denying Medicaid eligibility for the petitioner for February 2015. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

[redacted] appeared as an observer with no objection. The petitioner submitted evidence on December 8, 2015, which was entered as Petitioner Exhibit 1.

The Department submitted evidence on November 23, 2015, which was entered as 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. An application for SSI-Related Medicaid for the petitioner was filed on June 25, 2015 by [redacted]

2. The petitioner is a 54-year-old man who resides alone.

3. The Department submitted the disability report to the Division of Disability Determinations (DDD) on July 31, 2015.

4. DDD approved the petitioner's disability beginning with March 2015, which included three months of retroactive coverage prior to the date of application.

5. The Department issued a Notice of Case Action on August 24, 2015 approving the petitioner for Medicaid beginning June 2015 and ongoing. The Department also approved the retroactive months of March through May 2015.

6. The petitioner was admitted to the hospital on February 9, 2015 due to having a stroke. The petitioner had a previous stroke in February 2014.

7. The petitioner had a Supplemental Security Income (SSI) application that was denied on May 8, 2014. The SSI application was denied with a reason code "N30:

Slight impairment; medical consideration alone, no visual impairment." The SSI decision was appealed. A decision on the appeal has not been rendered.

8. The Department submitted a 2931 Disability Report to DDD inquiring for disability approval for February 2015. DDD responded to this request by informing the Department the petitioner has a pending appeal with Social Security. DDD further advised month of eligibility in question cannot be reviewed by DDD while the appeal with Social Security is pending.

9. Applications for SSI-Related Medicaid were also filed on February 23, 2015 and April 2, 2015.

10. The Department reported no disability report was received with either the February 23, 2015 or April 2, 2015 application. Each of these applications were denied for failure to return the necessary information.

11. The Department confirmed the petitioner's applications filed in February 2015 and April 2015 protect the petitioner's potential eligibility for February 2015 once disability has been established.

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. The definition of MEDS-AD Demonstration Waiver is found in Fla. Admin. Code § 65A-1.701 and 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. Fla. Admin. Code R. 65A-1.711 "SSI-Related Medicaid Non-Financial Eligibility Criteria" states in 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).

16. 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;** (emphasis added)

17. Fla. Admin. Code R. 65A-1.702 "Special Provisions" states in relevant 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. The date of eligibility includes the three months immediately preceding the month of application (called the retroactive period).

18. The petitioner is 54 years old. As he is under age 65, a disability determination is required for the SSI-related Medicaid program.

19. The petitioner applied for Medicaid with the Department on February 23, 2015 and April 2, 2015. The findings also show the applications from February and April 2015 did not include a disability report to have disability established by the DDD office. The findings show SSA made a determination the petitioner was not disabled on May 8, 2014. The petitioner asserted that he had a second stroke on February 9, 2015

causing additional problems. DDD determined the petitioner's onset of disability beginning March 2015, as it was the first month retroactive to the June 2015 application. However, the petitioner has an application dated April 2, 2015. Three months of retroactive coverage to the April 2, 2015 application includes February 2015, which is the month for which the petitioner is seeking eligibility. In accordance with the above controlling authorities, the undersigned concludes the petitioner's eligibility for February 2015 is a retroactive month to an application.

20. Based on the evidence and testimony presented, the above-cited rules and regulations, the undersigned concludes the Department's action to deny Medicaid under the SSI-Related (Adult) Medicaid Program without considering February 2015 a retroactive month from a prior application was an oversight. The undersigned remands the case to the Department for a determination of eligibility for the month of February 2015.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted and remanded to the Department for a determination of eligibility. The Department is to determine eligibility for the month of February 2015 following its policy on retroactive Medicaid and issue written notice to include appeal rights, to both petitioner and the representative.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 14 day of January, 2016,

in Tallahassee, Florida.

Melissa Roedel

Melissa Roedel
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FILED
Jan 26, 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-08960

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on December 18, 2015, at 10:30 a.m.

APPEARANCES

For the Petitioner: [redacted], the petitioner's daughter.

For the Respondent: Linda Latson, Registered Nurse Specialist, Agency for Health Care Administration (AHCA).

STATEMENT OF ISSUE

At issue is the Agency action's, through Humana, in denying the petitioner's request for five additional hours per day, Monday through Friday, of Personal Care Services (PCS) based on not meeting the medical necessity requirements. The petitioner carries the burden of proof.

PRELIMINARY STATEMENT

Present as witnesses for the respondent were Mindy Aikman, Grievance and Appeals Specialist, Linda Robinson, Care Manager, and Dr. Teresita Hernandez, Medical Director, all from Humana Health Plan.

Present as an observer was LaToya Stevenson from Humana.

The respondent submitted into evidence Respondent Exhibit 1 and 2.

The petitioner submitted into evidence Petitioner Exhibit 1.

FINDINGS OF FACT

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

1. The petitioner is a Long Term Care Medicaid recipient living in Broward County, Florida. She is eighty-seven years of age and has multiple medical problems.

2. The petitioner receives Medicaid services through Humana. The petitioner receives five hours per day, Monday through Friday, of PCS services. She requested five additional hours per day, Monday through Friday, of PCS services. She also receives three hours of respite care on Saturdays and four hours per month of companion services.

3. On September 9, 2015, 2015, Humana denied the petitioner's request for the above and mailed the petitioner a Notice of Action stating:

> Humana American Eldercare has reviewed your request for personal care, 40 units, requested 10 hours daily, approved 5 hours weekly, 5 hours weekly denied…
>
> We determined that your requested services are not medically necessary because…

Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs.

It should be noted that even though this "notice" indicates approval of five hours weekly, it actually is five hours daily as indicated by the respondent witness.

4. The physician witness indicated the petitioner receives the PCS for help with all of her Activities of Daily Living (ADL's), which includes meal preparation. She indicated the petitioner can eat food by herself, if placed next to her. The petitioner's daughter is the caretaker for the petitioner. This witness also indicated the petitioner's daughter leaves to go to work at seven in the morning and arrives home at four in the afternoon. She also indicated that through "Medicare wound care," the petitioner can receive up to two hours a day of wound care from a nurse.

5. The petitioner was receiving the PCS service from nine in the morning to noon. The respondent physician witness indicated Humana added two hours of the PCS in the afternoon between two in the afternoon to four in the afternoon. She indicated that the petitioner can be left alone for short periods of time and that any more hours of PCS would be in excess of her needs and would be in excess of medical necessity.

6. The petitioner's representative argued that her mother is a rather large person and needs a lot of turning and lifting as part of her ADL care. She argued that her mother takes pain medication and is rather confused, thus needing more care. She argued that the PCS aide arrives at 9:30 a.m. until 2:30 p.m. She also argued that she herself leaves to go to work 6:00 a.m. and comes home about 4:30 to 4:45 p.m. She argued that she is very tired from her job and could use some help with the petitioner at

the time she comes from work. She argued that the "wound nurse" only comes for one visit per day.

7. The respondent's witness, the Care Manager, indicated that Humana can still provide split care for the petitioner in the morning and then afternoon, even if it is not from the same service agency. Additionally, she indicated that Medicare can provide an aide along with the wound nurse for the petitioner for another visit and provide bathing for the petitioner. She indicated that she can help the petitioner's representative with Medicare in getting this service.

CONCLUSIONS OF LAW

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

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

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

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

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

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

12. As shown in the Findings of Fact, the Agency, through Humana, denied the petitioner's request for five additional hours per day, Monday through Friday, of Personal Care Services (PCS), based on the request not meeting the medical necessity requirements.

13. For the case at hand, the respondent argued that the petitioner can be alone for a short period of time and with the PCS aide working a split shift, the petitioner's ADL needs can be sufficiently met. Additionally, the respondent argued that any additional hours requested is in excess of the petitioner's medical needs as the service must be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs. The hearing officer agrees with the above respondent argument.

14. After careful review of the evidence submitted and the relevant laws set forth above, the undersigned concludes the Agency's action to deny the request for the additional five hours per day of PCS is proper, and the Petitioner's burden was not met.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 26 day of January, 2016, in Tallahassee, Florida.

Robert Akel

Robert Akel
Hearing Officer
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Rhea Gray, Area 11, AHCA Field Office Manager

FILED
Feb 01, 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-9029

PETITIONER,

VS.

[redacted]

FLORIDA DEPT 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 November 30th, 2015 at 9:15 a.m. in Miami, Florida.

APPEARANCES

For the Petitioner: [redacted] the petitioner's wife.

For the Respondent: John Roche, Operations Management Consultant for the Economic Self-Sufficiency program.

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to terminate her Medicaid (Medically Needy) and Qualified Medicare Beneficiary (QMB) benefits. The respondent carries the burden of proving its position by a preponderance of the evidence.

PRELIMINARY STATEMENT

Appearing as a witness for the petitioner was [redacted], the petitioner's daughter.

Serving as a translator was Oneida Gamboa of ESS.

Petitioner's Exhibit 1 was moved into evidence.

Respondent's Exhibits 1 through 6 were moved into evidence. Additionally, the respondent submitted pages of policies from the Department's Policy Manual. The hearing officer made administrative note of these, but did not move them into evidence.

By way of a Notice of Case Action (Spanish version) dated October 16th, 2015, the respondent informed the petitioner that her September 24th, 2015 application for Medically Needy and QMB benefits was denied. The reason stated on the notice is that the value of the assets was too high to qualify for the programs. On October 28th, 2015, the petitioner filed a timely appeal to challenge the respondent's action.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner was a recipient of both benefits. This fact was undisputed.

2. The petitioner submitted an application to recertify for his benefits on September 24th, 2015. As part of the recertification process, the respondent is required to explore, and if deemed necessary, verify certain factors of eligibility which include the value of all assets.

3. Upon securing the appropriate signed authorization from the petitioner, the respondent placed an inquiry of assets ownership through its Data Exchange system. The Data Exchange system collects information from various sources, to be used in determining an individual's eligibility for ESS benefits.

4. On October 15th, 2015, the respondent received a response from the Data Exchange system indicating that the petitioner was the owner of five (5) accounts as follows: a [redacted] at Bank of America with a balance of $41,549.14; a [redacted] at Bank of America with a balance of $374,792.68; a [redacted] at Bank of America with a balance of $1,523.46, and a [redacted] with a balance of $30.63. The respondent did not submit any viable verification of these balances; however, the petitioner did not dispute either the existence or the balances of these accounts.

5. The respondent explained that the Medically Needy program has an asset limit of $6,000, and the QMB program has an asset limit of $10,930. As the total of the balances of the petitioner's accounts, $411,116.43 exceeds these amounts, the petitioner is no longer eligible for either of these benefits.

6. The petitioner asserted that the money in the accounts was left for the petitioner's minor granddaughter (who is not part of the petitioner's household) by the latter's mother (petitioner's daughter) who passed away in November 2012. The monies, originally a life insurance policy, were converted into trust funds purportedly titled in the petitioner's (and the petitioner's other daughter present who was present at the hearing) in trust for the petitioner's granddaughter. The petitioner alleges that she neither owns these funds nor has access to them.

7. The respondent acknowledged that policy does allow the petitioner the opportunity to rebut ownership of these accounts, but had no evidence that this procedure was followed prior to terminating benefits. The respondent agreed to be in

touch with the petitioner following the hearing, and to allow the petitioner the opportunity to verify that she does not own or have access to these funds. Should the petitioner prevail in her rebuttal, the respondent will establish eligibility for both the Medicaid (or Medically Needy, whichever is applicable) and the Qualified Medicare Beneficiary (QMB) programs, preserving the application date of September 24th, 2015.

CONCLUSIONS OF LAW

8. The Department of Children and Families Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to §120.80, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

9. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056, which states in part, "(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."

10. Fla. Admin. Code R. 65A-1.701, defines resources:

> (28) Resources: Cash or other liquid assets, or any real or personal property that an individual owns and could convert to cash to be used for their support and maintenance. Resources is synonymous with assets.

11. Fla. Admin. Code R. 65A-1.712, SSI-Related Medicaid Resource Eligibility Criteria, states in relevant 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., with the following exceptions:
(a) For Medicaid for the Aged or Disabled Demonstration Waiver (MEDS-AD), an individual whose income is equal to or below 88 percent of the federal poverty level must not have resources exceeding the current Medically Needy resource limit specified in Rule 65A-1.716, F.A.C.

12. Fla. Admin. Code R. 65A-1.303, Assets, states in part:

(1) Specific policies concerning assets vary by program and are found in federal statutes and regulations and Florida Statutes.

(2) Any individual who has the legal ability to dispose of an interest in an asset owns the asset.

(3) Once the individual's ownership interest of an asset(s) is established, the availability of that asset must be determined. Asset(s) determined not to be available are not considered in determining eligibility. Assets are considered available to an individual when the individual has unrestricted access to it. Accessibility depends on the legal structure of the account or property. An asset is countable, if the asset is available to a representative possessing the legal ability to make the asset available for another's support or maintenance, even though the representative chooses not to do so. Assets not available due to legal restrictions are not considered in determining total available assets unless the legal restrictions were caused or requested by the individual or another acting at their request or on their behalf.

13. The Department's Public Assistance Policy Manual, Passage 1640.0302.04, Proof Needed to Rebut Ownership states as follows:

When an individual has unrestricted access to the funds in a joint account but does not consider himself an owner of part or all of the account funds, you must advise the individual that:
1. the funds are presumed to be his; and
2. he may rebut the presumption of ownership by presenting proof the funds belong to someone else.

> To rebut the presumption of ownership, the individual must provide the following information:
> **First** *[emphasis in original]*, the individual must provide a written statement and corroborating evidence from the financial institution(s) and other sources to substantiate:
> 1. any claims about ownership of the funds or interest from the funds;
> 2. the reasons for establishing the joint account;
> 3. whose funds were deposited into the account;
> 4. who made withdrawals from the account; and
> 5. information on how withdrawals were spent.
>
> **Second** *[emphasis in original]*, the individual must provide a written statement from the joint owner(s) explaining their understanding of the ownership of the account(s); that is, claims of ownership, why the account was set up, who deposited funds, withdrew funds and used the account. When an individual is a co-owner of an account with someone who is incompetent or a minor, the corroborating co-owner statement is not necessary. You must obtain a corroborating statement from a third party who has knowledge of the circumstances.
>
> If there is no third party or the individual is unable to provide all bank verification, you must make a rebuttal determination based on the evidence submitted. Enter an explanation on CLRC why no written corroborating statement was obtained from the joint owner.
> To successfully rebut ownership of a joint account, the evidence must clearly support that the individual is not a joint owner of the funds.

14. The above-cited authority defines the owner of an asset as "any individual who has the legal ability to dispose of an interest in an asset." In the instant case, as the petitioner's name appeared on the assets in question, the respondent presumed that the petitioner owned the assets, and therefore, considered the assets available to the petitioner.

15. However, as established in the Findings of Fact, the petitioner asserted that she has no access to the funds in the accounts in question. According to the above guidelines, when such a situation is alleged, the

respondent must allow the petitioner to challenge the respondent's presumption. The respondent, by its own admission, was unable to determine whether or not the petitioner was afforded this opportunity, and agreed to allow the petitioner this opportunity following the hearing.

16. Therefore, the case is hereby remanded to the respondent for corrective action. If it has not already done so, the respondent will, within ten days from the date of this order, issue written notice to the petitioner, allowing her at least ten days to prove that the funds in the accounts in question are inaccessible to the petitioner. The petitioner will need to cooperate in this process. If the petitioner successfully proves this allegation, the respondent will exclude the assets from consideration and re-evaluate the petitioner's eligibility accordingly. The respondent will issue new notice informing the petitioner of the outcome of this procedure, and the notice must include appeal rights should the petitioner disagree with the outcome.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is remanded to the respondent for corrective action as described above, to be taken within ten days from the date of this order.

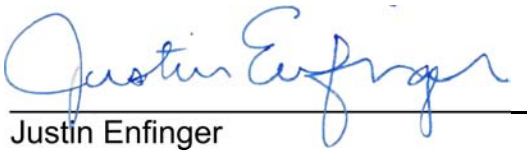
NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with

the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of 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 February, 2016,

in Tallahassee, Florida.



Justin Enfinger
Hearing Officer
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Copies Furnished To [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

APPEAL NO. 15F-09066

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened telephonically in this matter before the undersigned hearing officer on December 14, 2015, at 3:05 p.m.

APPEARANCES

For the Petitioner: [redacted]
Petitioner's mother

For the Respondent: Stephanie Lang, R.N.
Registered Nurse Specialist/Fair Hearing Coordinator
Agency for Health Care Administration

STATEMENT OF ISSUE

Did the respondent prove by a preponderance of the evidence that it correctly terminated the petitioner's Prescribed Pediatric Extended Care ("PPEC") Services?

PRELIMINARY STATEMENT

[redacted], the petitioner's mother, appeared on behalf of the petitioner, [redacted] ("petitioner"), who was not present. [redacted] may sometimes hereinafter be referred to as the petitioner's "representative".

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. Darlene Calhoun, D.O., Physician Reviewer with eQHealth Solutions, appeared as a witness on behalf of the Agency.

The respondent introduced Exhibits "1" through "6", inclusive, at the hearing, all of which were accepted into evidence and marked accordingly. The petitioner did not introduce any exhibits.

At the request of the respondent, the hearing officer took administrative notice of the following:

- Section 409.905, Florida Statutes.
- Florida Administrative Code Rules 59G-1.001, 59G-1.010, and 59G-4.260.
- The Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook, September 2013.

FINDINGS OF FACT

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

1. The petitioner was a 22-month-old infant at the time of application for the services that are the subject of this appeal.

2. Petitioner was eligible to receive Medicaid services at all times relevant to this proceeding.

3. The petitioner was born prematurely; he was estimated to be a 26-week gestational newborn.

4. The petitioner's medical history is remarkable for the following: [redacted]

5. Because the petitioner was born prematurely, he is more prone to illness than other children.

6. The petitioner's medications include: [redacted]

7. The petitioner's medication regimen is not complex. A skilled nurse is not required to administer the petitioner's medications. His inhalation treatments may be administered at home by his parents.

8. A PPEC is a non-residential center that serves three or more medically dependent or technologically dependent recipients under the age of 21 who require short, long-term, or intermittent medical care due to medically-complex conditions. A PPEC offers services that meet the recipients' physiological, developmental, nutritional, and social needs.

9. The petitioner was approved to receive PPEC Services for the certification period directly prior to the present request for services. The prior certification period was April 9, 2015 through October 5, 2015.

10. The petitioner was approved to receive PPEC Services Monday through Saturday for up to and including 12 hours per day in the prior certification period. In terms of units, the petitioner was approved to receive 624 partial-day PPEC units and 156 full-day PPEC units for the period. Partial-day units may be used to secure services for up to five hours per day, whereas full-day units may be used for services up to 12 hours per day.

11. On September 22, 2015, Pediatric Health Choice, the petitioner's PPEC provider, submitted a request to eQHealth Solutions for PPEC services to be approved for the following certification period, October 6, 2015 through April 2, 2016. The services were to be provided Monday through Saturday for up to and including 12 hours per day. The provider requested 620 partial-day units and 155 full-day units for the period.

12. eQHealth Solutions is the Quality Improvement Organization contracted by the Agency for Health Care Administration to review requests by Medicaid recipients in the State of Florida for PPEC Services.

13. eQHealth Solutions is delegated the responsibility of determining whether a requested service is medically necessary under the terms of the Florida Medicaid Program. eQHealth Solutions has the authority to act as a witness for AHCA.

14. A request for PPEC Services is submitted directly to eQHealth Solutions by a petitioner's PPEC provider. Once eQHealth Solutions receives the information, it completes a prior authorization review – it reviews the written request to determine if the services requested are medically necessary.

15. The petitioner's request was reviewed by an eQHealth Solutions Physician Reviewer on September 28, 2015. The Physician Reviewer approved a 30-day

extension of PPEC services to allow the petitioner time to transition to different services but denied all other requested PPEC Services. In terms of units, the Physician Reviewer approved 104 units of partial-day PPEC Services and 26 units of full-day PPEC Services for the period October 6, 2015 through November 4, 2015. The Physician Reviewer denied 516 units of partial-day PPEC Services and 129 units of full-day PPEC Services for the period November 5, 2015 through April 2, 2016.

16. The Physician Reviewer provided the following approval rationale for the decision:

> The patient is a 22 month old with [redacted] The patient is on twice per day inhalers and as needed nebulizer treatments. The patient has developmentally made progress. The clinical information provided does not support the medical necessity of the requested services; however, 1 month will be approved to allow time to transition the patient out of PPEC.

17. The Physician Reviewer also supplied the following clinical rationale for the decision:

> The clinical information provided does not support the medical necessity of the requested services. The patient does not appear to require skilled nursing. The remainder of the requested services are denied.

18. The petitioner did not request an internal review of the eQHealth Solutions decision. This case proceeded directly to the administrative hearing process.

19. The Agency for Health Care Administration administratively approved the continuation of petitioner's PPEC Services at the previous level pending the resolution of this appeal.

20. The respondent's witness testified that Prescribed Pediatric Extended Care is designed for children that are medically fragile and who require skilled nursing

care. She also testified the petitioner in the present case does not require skilled nursing services. His medication regimen is not complex and, although he requires monitoring for respiratory distress, monitoring alone is not supportive of an approval of PPEC Services. Although the petitioner has a shunt to drain the fluid from his brain, the fluid from the shunt drains into his abdomen and not externally. He does not have any supplemental oxygen needs.

CONCLUSIONS OF LAW

21. 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.

22. The Florida Medicaid Program is authorized by Chapter 409, Fla. Stat., and Chapter 59G, Florida Administrative Code. The Program is administered by AHCA.

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

24. The respondent in the present case is proposing to terminate services the petitioner was previously approved to receive. Therefore, in accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof is assigned to the respondent.

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

26. 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…

27. 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.

28. 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.

29. The United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in *Moore v. Reese*, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, which involved a dispute over private duty nursing:

> [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.
>
> (2) A state Medicaid plan must include "reasonable standards … for determining eligibility for and the extent of medical assistance" … and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.
>
> (3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."
>
> (4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients."

> Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."
>
> (5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. **The state is not required to provide medically unnecessary, albeit desirable, EPSDT services.** However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."
>
> (6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and my present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)) (emphasis added).

30. 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.

31. 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.

32. 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.

33. The Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook, September 2013 ("PPEC Handbook") is promulgated into law by Florida Administrative Code Rule 59G-4.260.

34. 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.

35. 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.

36. The testimony and documentary evidence in the instant matter fails to establish the medical necessity of PPEC Services for the petitioner. Although the petitioner requires monitoring for potential respiratory distress, monitoring alone is not supportive of an approval for PPEC Services. Furthermore, the petitioner is not on a complex medication regimen, nor does she require the provision of skilled nursing services for any other purpose. The petitioner's level of illness does not reach the level of "medically complex" or "medically fragile," as defined in the Florida Administrative Code.

37. After carefully reviewing the EPSDT and medical necessity requirements set forth above, the hearing officer concludes the respondent has met its burden of proof, by the greater weight of the evidence, in terminating petitioner's PPEC services.

DECISION

Based upon the foregoing, the petitioner's appeal is DENIED and the decision of the Agency for Health Care Administration 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 January, 2016,

in Tallahassee, Florida.

Peter J. Tsamis

Peter J. Tsamis
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Don Fuller, Area 6, AHCA Field Office Manager

FILED
Feb 10, 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-09071
15F-09818

PETITIONER,

Vs.

CASE NO. [redacted]

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in West Palm Beach, Florida on January 28, 2016 at 11:01 a.m.

APPEARANCES

For the Petitioner: [redacted]
Petitioner's Son

For the Respondent: Linda Latson
Registered Nurse Specialist

ISSUE

15F-09071: Whether the termination of disposable liners was proper. The burden of proof was assigned to the respondent.

15F-09818: Whether respondent's denial of 24 hours per day of Personal Care Services (PCS) was proper. The burden of proof was assigned to the petitioner.

PRELIMINARY STATEMENT

Telephonic hearings were first scheduled for December 18, 2015. After scheduling, petitioner's request for face to face hearings was received. The hearings were thereafter rescheduled for January 28, 2016.

The hearings were scheduled to commence at 10:00 a.m. Respondent's representative contacted the Office of Appeal Hearings stating a transportation issue had arisen. The expected time of arrival was 11:00 a.m. Petitioner agreed to wait until 11:00 a.m. At 11:00 the representative for the respondent had not arrived. The hearing commenced at 11:01 a.m. Respondent's representative arrived at approximately 11:30 a.m.

Petitioner was not present. Petitioner entered the following exhibits into evidence:

15F-09071: No exhibits
15F-09818: Petitioner's exhibit "1"

Present by telephone from Sunshine Health were Jennifer Arteaga, Grievance and Appeals Coordinator; Dr. David Gilchrist, Medical Director; Lisa Simshauser, Long Term Care Supervisor; and Marsha Santana, Case Manager.

Respondent entered the following exhibits into evidence:

15F-09071: Respondent's Exhibit "1"
15F-09818: 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's date of birth is [redacted]

2. In 1998 petitioner was diagnosed with [redacted]

3. Petitioner resides with her son, who is her primary caregiver. He is not currently employed outside the household.

4. Petitioner is enrolled in respondent's Long Term Managed Care Program (LTMC Program).

5. Respondent administers Florida's Medicaid Program and contracts with Health Maintenance Organizations (HMOs) to provide comprehensive, cost-effective medical services to Medicaid recipients enrolled in the LTMC Program.

6. Respondent does not have a promulgated Coverage and Limitations Handbook for the LTMC Program. LTMC services descriptions are defined by contract.

7. Petitioner's LTMC services are provided by Sunshine Health.

8. Through the LTMC Program, petitioner is approved to receive 14 hours per week of PCS and 14 hours of homemaker services. The designated service hours are 9:00 a.m. to 1:00 p.m.; Sunday through Saturday.

9. Petitioner also receives disposable pull-up briefs; gloves; disposable liner pads; and underpads.

10. Petitioner is also enrolled in respondent's Patient Directed Option (PDO). The program allows family members to be paid for caregiver services.

11. Since December 2015 PCS and homemaker services have been provided by petitioner's representative.

12. On May 11, 2015 a Sunshine Health case manager completed a 701 B Comprehensive Assessment. Regarding the petitioner, the assessment provides the following information:

- Unable to speak.
- Unable to walk. A wheelchair is utilized.
- Incontinent.
- Has difficulty swallowing.
- At risk for aspiration.
- Total assistance required with toileting; dressing; and bathing.

13. The above assessment contained, in part, the following narrative:

> The member is able to answer yes/no questions by moving her head. Member appears to be alert and is aware of her surroundings; however, due to [redacted] Son denied any history or diagnosis of [redacted]
> …
>
> The member is mainly total care with ADL's (Activities of Daily Living). Member is w/c hound. However, the member is still weight bearing and able to stand for at least 3-5 minutes with extensive assist. Member is able to hold on grab bars but balance is unsteady as per observation. Member is able to transfer with extensive assist of 1 …

15F-09071 – Disposable Liners

14. For additional protection, liner pads were placed in petitioner's disposable underwear.

15. The type of disposable underwear approved for the petitioner was changed from regular to extra absorbent.

16. On October 6, 2015 Sunshine Health issued a Notice of Action denying ongoing funding for the disposable liner pads. The notice states, in part: "You asked to stop getting Disposable liners (Pad you place in your underwear that can be thrown away after use). You request to terminate (stop) this service has been approved. Please let your case manager know if your needs change."

17. On October 28, 2015 the Office of Appeal Hearings timely received petitioner's request for a fair hearing.

18. Petitioner's representative does not refute agreeing to the termination of the disposable liners. He now believes, however, both the extra absorbent disposable underwear and the disposable liner are now needed.

15F-09818 – Personal Care Services

19. On September 30, 2015 Sunshine Health received a request for 24 hours per day of care. The request was based on an order from petitioner's neurologist that 24 hour care was needed.

20. A Sunshine Health physician thereafter reviewed petitioner's 701 B Comprehensive Assessment and Plan of Care.

21. On October 29, 2015 Sunshine Health issued a Notice of Action which denied petitioner's request as not being medically necessary.

22. On November 24, 2015 the Office of Appeal Hearings timely received petitioner's request for a fair hearing.

23. Petitioner's representative argues:

- The assessment was copied from a prior assessment.
- Petitioner's disease is progressive.
- Payment has not been received for services provided through the PDO Program.
- The representative has no private time due to the needs of the petitioner.

24. Respondent notes a caretaker is present in the household. Should the representative find employment outside the household, the service hours could be re-evaluated. Additionally, the request for 24 hours of PCS is in excess of the petitioner's need.

CONCLUSIONS OF LAW

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

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

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

28. Regarding the LTMC Program, § 409.978, Fla. Stat. states:

> (1) … the agency shall administer the long-term care managed care program …
>
> (2) The agency shall make payments for long-term care, including home and community-based services, using a managed care model.

29. Sunshine Health and the respondent entered into a contractual relationship. The contract identifies 26 services to be offered through the LTMC Program.

30. Contract service definitions relevant to this proceeding are:

> (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.
>
> (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.
>
> (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. Florida Medicaid, which includes the LTMC Program, only covers those services determined to be medically necessary. See § 409.905 (4) (c), Fla. Stat.

32. 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.

15F-09071 – Disposable Liners

33. The Findings of Fact establish petitioner's representative agreed to the termination of disposable liner pads. This agreement also appears in the Notice of Action issued by Sunshine Health on October 6, 2015. That notice also advised that if conditions change, the case manager should be contacted.

34. Petitioner is afforded the opportunity to once again request disposable liner pads. If denied, hearing rights would be associated with that action.

35. Sunshine Health's Notice of Action dated October 6, 2015 formalized a mutually accepted agreement. The fair hearing process is not the appropriate forum to request a new service. Until a new request for disposable liners is made through Sunshine Health's prior authorization process, the matter is not yet ripe for appeal.

36. Based on petitioner's initial agreement that disposable liners should be terminated, respondent's action in this matter was proper.

15F-09818 – Personal Care Services

37. Petitioner's need for assistance with all activities of daily living is not disputed. The issue, however, focuses on whether 24 hours of personal care is medically necessary.

38. To warrant 24 hours of personal care, it must be demonstrated the service is medically necessary for the entire timeframe. It is noted the definitions for personal care and homemaker do not include supervision. Rather, each service is task oriented.

39. The undersigned notes a neurologist ordered 24 hours of care. Fla. Admin. Code R. 59G-1.010, however, is clear that a prescription alone does not make the requested service medically necessary.

40. A service need must match a service description. As such, it has not been demonstrated that the tasks associated with PCS is medically necessary on a continuous 24 hour basis.

41 The role of a hearing officer is not to determine the actual number of medically necessary PCS hours. In this matter, the issue solely focuses on whether medical necessity has been demonstrated for 24 hours of PCS.

42. If desired, petitioner can ask the case manager whether the LTMC Program covers services that include 24 hours supervision. This might include either assisted living or nursing facility services.

43. The petitioner has not established, by the greater weight of the evidence, that respondent's action in this matter was improper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law:

- Petitioner's appeal regarding the termination of disposable liners (15F-09071) is denied.
- Petitioner's appeal concerning the denial of 24 hours of PCS (15F-09818) is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days

of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 10 day of February, 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
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Judy Jacobs, Area 7, AHCA Field Office

State of Florida
Department of Children and Families

Rick Scott
Governor

Mike Carroll
Secretary

Date: 01/13/2016

To: Debbie Stokes, Area 4, AHCA Field Office Manager

From: Nathan Koch, Chief
Office of Appeals Hearings

Subject: Final Order

RE: [redacted]

The hearing request for the above individual has been completed and the final order is attached.

Please send correspondence to:
Office of Appeal Hearings
Building 5, Room 255
1317 Winewood Blvd.
Tallahassee, FL 32399-0700

The office telephone number is 850-488-1429, SC 278-1429.
The fax number is 850-487-0662, SC 277-0662.

FILED
Jan 13, 2016
Office of Appeal Hearings
Dept. of Children and Families

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

[redacted]
28945 SE 175 ST
UMATILLA, FL 32784

APPEAL NO. 15F-09074

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on November 25, 2015, at approximately 1:30 p.m.

APPEARANCES

Petitioner: [redacted]

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

STATEMENT OF ISSUE

At issue is whether or not Respondent's denial of Petitioner's request for the prescription drug Harvoni was correct. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

Petitioner represented himself at the hearing. The following individuals were present as witnesses for Respondent:

- Dr. Marc Kaprow – Medical Director, Long Term Care Plan Florida – United Healthcare
- Christian Laos – Senior Compliance Analyst – United Healthcare
- Shana Bush – Pharmacy Director – United Healthcare

Bonnie Taylor, Program Administrator with the Agency for Health Care Administration ("AHCA" or "Agency") observed the hearing. Respondent's Exhibits 1 through 11 were entered into evidence at the hearing. Petitioner did not move any exhibits into evidence at the hearing.

FINDINGS OF FACT

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

1. Petitioner is a 63-year-old male. At all times relevant to this proceeding, Petitioner was eligible to receive Medicaid services.

2. Petitioner is enrolled with United Healthcare ("United") as his Managed Medical Assistance (MMA) plan.

3. Petitioner has a diagnosis of [redacted]. He previously tried [redacted] and [redacted] but they were unsuccessful in treating his condition.

4. Petitioner's physician submitted a request to United for a 12-week course of the drug [redacted] on July 13, 2015. According to Petitioner's physician, multiple trials of a 12-week course of [redacted] have shown it to be highly effective at treating [redacted]

5. On July 14, 2015, United denied the prescription as not being medically necessary. The Notice of Action (Respondent's Exhibit 3) states:

> The facts that we used to make our decision:
>
> The requested medication is used for a virus when you have more severe [redacted]. The facts given to us do not show that you have [redacted]. This decision was made per the United Healthcare Community and State [redacted] medication guideline.

6. Petitioner filed an appeal with United, which was received on August 5, 2015. United issued a letter upholding the denial on September 4, 2015.

7. Petitioner's [redacted] which translates to [redacted] (Respondent's Exhibit 7). The fibrosis score range for [redacted] In order for the condition to be at [redacted] the fibrosis score needs to be [redacted]

8. AHCA maintains a Preferred Drug List ("PDL"). [redacted] is not on the PDL. Medications not on the PDL require prior authorization. AHCA requires specific criteria be met for approval of [redacted]. AHCA posts the criteria for approval of [redacted] on the Internet at the address:

ahca.myflorida.com/Medicaid/Prescribed_Drug/drug_criteria_pdf/Harvoni_Criteria.pdf

9. The specific criteria for Petitioner's condition are contained in the box titled "[redacted]" (Respondent's Exhibit 4). Dr. Kaprow testified this is the most common type of [redacted] in the United States. The criteria requires evidence of [redacted] including one of the following:

[redacted]

- Petitioner did not submit any evidence regarding this criterion.

10. Petitioner is currently asymptomatic. Petitioner said it didn't make any sense to him to wait for his condition to worsen before treating it. In a letter contained in Respondent's Exhibit 8, Petitioner's physician, a board certified gastroenterologist, stated: "recent reports [show] initiating therapy in patients with [redacted] may extend the benefits of sustained [redacted] (SVR)." He included medical literature with the letter to support this opinion, showing the [redacted] of [redacted]

11. Dr. Kaprow testified an individual only needs a portion of thei[redacted] in order for it to function and that Petitioner's [redacted] is currently functioning. He also testified there is no guarantee that Petitioner's condition will worsen and that his lifestyle might keep it from worsening. He said [redacted] changes are seen before changes in liver function, so in the event Petitioner's condition increases to [redacted], he can likely treat the condition before he loses [redacted]. He further stated that [redacted] may or may not go away after treatment.

CONCLUSIONS OF LAW

12. By agreement between AHCA and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction to conduct this hearing pursuant to § 120.80, Fla. Stat.

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

14. This is a Final Order, pursuant to Sections 120.569 and 120.57, Fla. Stat.

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, 7th Ed.).

16. 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.

17. Section 409.912 of the Florida Statutes, entitled "Cost-effective purchasing of health care", states, in pertinent part:

> [AHCA] shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care.
> ….
>
> (8)(a) The agency shall implement a Medicaid prescribed-drug spending-control program that includes the following components:
> 1. A Medicaid preferred drug list, which shall be a listing of cost-effective therapeutic options recommended by the Medicaid Pharmacy and Therapeutics Committee established pursuant to s. 409.91195 and adopted by the agency for each therapeutic class on the preferred drug list. At the discretion of the committee, and when feasible, the preferred drug list should include at least two products in a therapeutic class. The agency may post the preferred drug list and updates to the list on an Internet website without following the rulemaking procedures of chapter 120.
> ….
>
> 14. The agency may require prior authorization for Medicaid-covered prescribed drugs. The agency may prior-authorize the use of a product:
> a. For an indication not approved in labeling;
> b. To comply with certain clinical guidelines; or
> c. If the product has the potential for overuse, misuse, or abuse.
>
> The agency may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug. The agency shall post prior authorization, step-edit criteria and protocol, and updates to the list of drugs that are subject to prior authorization on the agency's Internet website within 21 days after the prior authorization and step-edit criteria and protocol and updates are approved by the agency. For purposes of this subparagraph, the term "step-edit" means an automatic electronic review of certain medications subject to prior authorization.

18. The Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook, July 2014 ("Drug Handbook") is promulgated into law by Chapter 59G of the Florida Administrative Code.

19. Page 2-4 of the Drug Handbook states, in relevant part:

> The Preferred Drug List (PDL) is a listing of prescription products recommended by the Pharmaceutical and Therapeutics (P&T) Committee for consideration by AHCA as efficacious, safe, and cost effective choices when prescribing for Medicaid patients.
> ….
>
> Products included on the PDL must be prescribed first unless the patient has previously used these products unsuccessfully or the prescriber submits documentation justifying the use of a non-PDL product.
> ….
>
> Non-PDL drugs may be approved for reimbursement upon prior authorization.

20. Page 2-2 of the Drug Handbook provides:

> To be reimbursed by Medicaid, a drug must be medically necessary and either (a) prescribed for medically accepted indications and dosages found in the drug labeling or drug compendia…or (b) prior authorized by a qualified clinical specialist approved by the Agency….

21. 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.

22. Section 409.912 of the Florida Statutes requires AHCA to create a PDL. [redacted] is not on the PDL and therefore requires prior authorization. Respondent can publish the PDL and drug criteria on an Internet website and make changes without going through the rulemaking process, and has done so. Therefore, the undersigned is bound by the drug criteria for [redacted] listed in Respondent's Exhibit 4, as addressed above.

23. The evidence presented by Petitioner shows he has a [redacted] The drug criteria for [redacted] is clear that [redacted] with a [redacted] is required in order for [redacted] to be approved.

24. It may be desirable to provide Petitioner with the [redacted] sooner, rather than later. Doing so might result in a significantly better outcome, as stated by Petitioner's board certified gastroenterologist, and supported by the supplied medical literature. However, the undersigned concludes Respondent properly applied the drug criteria for [redacted] in this matter, and the drug criteria has the force of law. Desirability does not equate with necessity, and it must be medically necessary, as defined in the Florida Administrative Code, in order for Petitioner to receive the [redacted]

25. Petitioner is encouraged to closely monitor his condition. In the event his condition worsens, he may wish to submit a new request for [redacted] 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 13 day of January, 2016, in Tallahassee, Florida.

Rick Zimmer

Rick Zimmer
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

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

FILED
Feb 03, 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-09101
15F-09102

PETITIONER,

Vs.

[redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 14 Bay
UNIT: 55143

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matters on December 3, 2015 at 9:38 a.m. The petitioner was present. Amy Sumner, ACCESS Supervisor, Antoinette Santillo, ACCESS supervisor and Michelle McDonald, Public Benefits Integrity Investigator, represented the Department.

Petitioner filed these appeals due to the Department's action of closing her Food Assistance and Medicaid effective November 30, 2015. The Department explained the petitioner's benefits were closed at the instruction of the Public Benefits Integrity Investigator. The petitioner also requested a letter clearing the names of herself and her husband of any wrongdoing in this investigation.

The petitioner and Department worked subsequent to the hearing to review the petitioner's case documentation and reopen the petitioner's Food Assistance and

Medicaid benefits. The petitioner has notified the undersigned that she is satisfied with the Department's action in relation to reestablishing her eligibility for benefits.

The petitioner informed the undersigned, as of January 28, 2016, that she has not received a statement from the Public Benefits Integrity investigator or the investigator's supervisor that the names of herself and her husband are cleared of any wrongdoing in this matter.

Fla. Admin. Code R. 65-2.044 "Right to Request a Hearing"

> Any applicant/recipient dissatisfied with the Department's action or failure to act has a right to request a Hearing. He/she may do so when it is believed that:
> (1) Opportunity to make application has been denied.
> (2) The application has been rejected.
> (3) The application has not been acted upon within a reasonable length of time.
> (4) The benefits have been modified or discontinued.
> (5) Reconsideration of the assistance/service benefits is refused or delayed.
> (6) Opportunity has not been given to make a choice of service.
> (7) Any other DCF action (or inaction) is incorrect.

Fla. Admin. Code R. 65-2.046 "Basis of Hearings" states:

> 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.

The above controlling authority establishes the basis of hearings. Specifically, the Department action must affect the petitioner's ability to participate in the program(s). The Department reestablished the petitioner's eligibility for Food Assistance and Medicaid. The petitioner has acknowledged the Department has taken action and no benefits have been lost. The undersigned concludes the matters are resolved and dismisses the appeals as moot.

The undersigned acknowledges the petitioner's desire to have a letter from the Public Benefits Integrity office clearing the name of herself and her husband. The undersigned lacks jurisdiction to require such a letter. The petitioner may contact the Office of Client Relations at 850-747-5453 for assistance receiving the requested letter.

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 Februarv, 2016,

in Tallahassee, Florida.

Melissa Roedel

Melissa Roedel
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard

Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

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

FILED
Feb 01, 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-9104

PETITIONER,

Vs.

[redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 16 MONROE
UNIT: 66302

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on December 28th, 2015 at 8:37 a.m.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Odalys Perez, Economic Self-Sufficiency Specialist.

STATEMENT OF ISSUE

The petitioner is appealing the respondent's denial of Institutionalized Care Program (ICP) Medicaid for the months of April 2015 through July 2015. The petitioner carries the burden of proving his position by a preponderance of the evidence.

PRELIMINARY STATEMENT

Petitioner's Exhibits 1 through 4 were moved into evidence.

Respondent's Exhibits 1 through 3 were moved into evidence. The respondent submitted additional documents from June and July 2015, but was unable to develop these on the record; therefore, the documents could not be moved into evidence or considered.

No Notice of Case Action addressing the matter under appeal was submitted into evidence. The petitioner filed an appeal to challenge the respondent's position in the matter on October 30th, 2015. Absent evidence to the contrary, the appeal is considered to have been filed timely.

FINDINGS OF FACT

1. The petitioner (born in 1953) has been a resident of [redacted] since August 2013.

2. The petitioner had been a recipient of Institutionalized Care Program Medicaid benefits since the time of admission. ICP Medicaid covers the cost of nursing home residence. The respondent contends that these benefits were erroneously authorized (and subsequently terminated) during 2014 due to underreported income on the petitioner's application. The respondent asserts that the petitioner's total income of $2,504 exceeded the ICP Medicaid income limit for one person of $2,199. Therefore, in order to remain eligible for ICP Medicaid, the petitioner would have been required to establish a Qualified Income Trust account, to be funded monthly in an amount to be determined by the respondent.

3. There was no dispute from either party that the petitioner's income exceeded the limit for ICP Medicaid.

4. On April 30th, 2015, the petitioner submitted a new application for Institutionalized Care Program (ICP) Medicaid benefits.

5. On May 12th, 2015, the respondent issued a Notice of Case Action to the petitioner informing him that in order to complete the application process, the following information, in full and verbatim, was necessary:

> Please complete and sign the Authorization to Disclose Information Form
> Please complete and sign the Informed Consent Form
> Please complete and sign the Affidavit for Designated Representative Form
>
> Please send the verifications of the gross civil services received during 2014 (never provided before) and for 2015.
> We requested a new Income trust legal instrument since Dept 2014, never provided neither *[Sic].* The last 3 months of the PTF acct 1212 and the income trust acct properly funded. Due date: 05/21/15. *[Sic.]* Thanks.

The notice provides a deadline of May 22nd, 2015 (contrary to May 21st, 2015, as indicated above.) The notice also provides the various means available by which to provide the requested information. The notice further advises that failure to provide the information would result in the respondent's inability to determine the petitioner's eligibility, and that his application could be denied or benefits could end.

6. The respondent asserted that during the time that the application was in pending status, the petitioner did not supply the information requested, but instead, sent a copy of a letter from an attorney explaining how to establish a QIT account.

7. The petitioner submitted into evidence as Petitioner's Exhibit 2 a Consumer Account Application from [redacted] indicating that the petitioner applied for a Qualified Income Trust on April 30th, 2015. How the petitioner applied for this QIT prior to the respondent's date of request on the same date of his application for ICP benefits, and prior to the respondent's May 22nd, 2015 request, was not clear.

8. The respondent contends that over the next two months, the requested information in the above-cited notice was received only in pieces, and no action could be taken until July 2015, at which time the QIT paperwork was forwarded to the Department's Office of Legal Counsel for final approval. The paperwork was approved; however, the final page of the paperwork, which included all signatures necessary to execute the trust, was not received until August 3rd, 2015. (See Respondent's Exhibit 3, final page.) Therefore, August 2015 was the first month that ICP benefits could be approved.

9. The petitioner explained that he only assumed his current position as administrator for the facility in July 2015, and therefore, could not address any events that took place prior to that time. The petitioner also explained that the facility has seen a heavy turnover of social workers, business managers, and administrators over the past several months and as a result, many unresolved issues, including this one, "slipped through the cracks." The petitioner asserts that despite the circumstances, the facility provided its services, and is now seeking payment for the months in question.

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

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

12. Fla. Admin. Code Rule 65A-1.025, "Eligibility Determination Process" 1(a) states as follows:

> The Department must determine an applicant's eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter. It is the applicant's responsibility to keep appointments with the eligibility specialist and furnish information, documentation and verification needed to establish eligibility.

13. Fla. Admin. Code Rule 65A-1.205, "Eligibility Determination Process" 1(c) sets forth the time frame for an applicant to provide additional information:

> If the eligibility specialist determines during the interview or at any time during the application process that the applicant must provide additional information...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… If the applicant does not provide required verifications or information by the deadline date the application will be denied, unless the applicant requests an extension or there are extenuating circumstances justifying an additional extension.

14. The above citations explain that it is the petitioner's responsibility to provide requested verification to the Department.

15. Fla. Admin. Code Rule 65A-1.713, "SSI-Related Medicaid Income Eligibility Criteria" in part states:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
>
> …
>
> (d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in subsection 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional care services by establishing an income trust which meets criteria set forth in subsection 65A-1.702(15), F.A.C…
>
> (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 …

> (b) For institutional care, hospice, and HCBS waiver programs the department applies the following methodology in determining eligibility:
>
> 1. To determine if the individual meets the income eligibility standard the client's total gross income, excluding income placed in qualified income trusts, is counted in the month received. The total gross income must be less than the institutional care income standard for the individual to be eligible for that month.

16. The above authority explains that in order to be eligible for the ICP Medicaid, an applicant's gross income cannot exceed 300% of the federal benefit rate. However, if applicant's income exceeds the limit, he/she is able to establish and fund a QIT to qualify for ICP Medicaid benefits. Total gross income outside of the qualified income trust must be counted in the month received and must be less than the ICP income standard for the individual to be eligible for that month.

17. The Department's ACCESS Florida Program Policy Manual, 165-22, Appendix A-9 sets forth the ICP income limit for an individual at $2,199 (effective April 2015.)

18. The ACCESS Florida Program Policy Manual, 165-22, Section 1840.0110 "Income Trusts (MSSI, SFP)" 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. …

19. As established in the Findings of Fact, there was no dispute from either party that the petitioner's total income of $2,504 exceeded the limit of $2,199 and that therefore, establishment of a QIT was necessary in order to remain eligible for this benefit. The evidence shows that the respondent requested that the petitioner provide verification of said QIT on May 12th, 2015, but was not provided in full until August 3rd, 2015. Therefore, the hearing officer affirms the respondent's position that eligibility for ICP Medicaid benefits cannot be established for April 2015 through July 2015.

DECISION

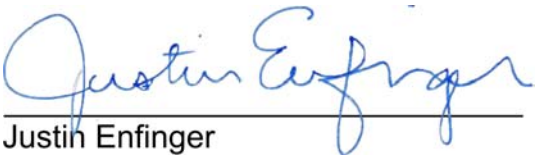
Based on the foregoing Findings of Fact and Conclusions of Law, this appeal is denied. The respondent's action is affirmed.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 01 day of February, 2016,

in Tallahassee, Florida.



Justin Enfinger
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency
[redacted]

FILED
Feb 11, 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.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 Palm Beach
UNIT: 88701

RESPONDENT.
_____/

APPEAL NO. 15F-09106

[redacted]

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter on December 22, 2015 at 1:00 p.m.

APPEARANCES

For the petitioner: [redacted] Registered Nurse, Care Manager represented the petitioner as her designated representative.

For the respondent: Cynthia Haynes, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action to deny petitioner's application for SSI-Related Medicaid benefits on the basis that she did not meet the disability Program requirement. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

By notice dated August 18, 2015, the Department notified the petitioner that her application was denied for Medicaid disability because she did not meet the disability requirement. Petitioner timely requested this appeal to challenge the denial.

Lauren Coe, Program Operations Administrator with the Division of Disability Determination (DDD), appeared telephonically, as a witness for the respondent.

Petitioner did not present any exhibits. Respondent submitted four exhibits, entered as Respondent Exhibits “1” through “4”.

FINDINGS OF FACT

1. On June 16, 2015, the petitioner (51) applied for SSI-Related Medicaid benefits for herself. Petitioner had applied for disability benefits through the Social Security Administration (SSA) and was denied in 2013. Petitioner was not over age 65 or blind and does not have any minor children. The petitioner declared her disabling conditions to be [redacted] resulting from a head injury sustained on March 11, 2004 and June 23, 2008. Her disabling conditions also include [redacted]

2. The petitioner graduated from college. Petitioner was last employed in 2002. However, petitioner has volunteered in the last seven to eight years in various organizations including a consignment store. The most recent volunteer work the petitioner did was at a hospital.

3. The respondent reviewed the petitioner’s eligibility for SSI-Related Medicaid for the blind, aged or disabled. The respondent sent petitioner’s medical information to DDD on July 16, 2015 for a disability determination.

4. The respondent explained DDD completed an independent medical evaluation of disability and determined that the petitioner did not meet the criteria of aged, blind or disabled to be eligible for SSI-Related Medicaid benefits.

5. On August 14, 2015, DDD completed a disability review, which resulted in an unfavorable (N32) decision. DDD lists the petitioner's primary diagnosis as [redacted] There was nothing listed under secondary diagnosis. However, according to the witness's testimony, the secondary diagnosis considered was [redacted] Decision code N32 signifies "Impairment of insufficient severity to preclude individual's engaging in all SGA".

6. DDD Case Analysis Form, SSA-416, dated August 14, 2015 states in part:

1. Is claimant engaging in SGA? DDD did not address
2. Is impairment severe? YES
3. Does impairment meet or equal a Listing? NO
   Listings considered- 11.02, 11.03 and 11.04
4. Can claimant perform PRW? NO
5. Can claimant perform other work? YES

7. DDD determined petitioner not disabled at step five. DDD determined that the petitioner's impairments did not meet or medically equal a listing according to Vocational Rule 202.13. The petitioner was found not be disabled and is capable of light work such as a street sweeper, silver wrapper or stickers.

8. On August 18, 2015, the respondent sent the petitioner a Notice of Case Action denying her June 16, 2015 application for SSI-Related Medicaid benefits. The reason stated was that she did not meet the disability requirement.

9. The petitioner's representative believes the petitioner's condition continues to get worse and explained that the petitioner has a medical history of multiple traumatic brain

injury because of constant falls, subsequently due to [redacted]. Petitioner demonstrates behavioral functional limitations in concentrating, difficulties in organization and in thoughts.

10. The evidence shows petitioner is able to perform her personal care independently, her household chores, cooks, grocery shops, climbs, balances and stoops. Petitioner volunteers at the hospital 20-25 hours per week.

11. The evidence also shows a recent medical record dated June 4, 2015 from petitioner's outpatient visit with [redacted] Petitioner was treated and prescribed the medication [redacted] Petitioner was also prescribed [redacted] According to testimony, the petitioner's last seizure episode was in 2007. During the visit, no acute back pain or localize joint pain was found under the musculoskeletal system.

12. Petitioner went to Quest Diagnostics on June 4, 2015 for blood test to determine her TSH level. Her [redacted] is being treated adequately as well as the seizures with medication. No changes were reported in the dosage.

CONCLUSIONS OF LAW

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

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

15. Federal Regulation 42 C.F.R. § 435.541 sets standards for when it is appropriate for the state Medicaid agency to make a determination of disability for individuals who apply for Medicaid. The regulation states in relevant part:

> (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.

16. 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. § 1396 a(m). For an individual less than 65 years of age to receive benefits, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. 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.

17. 42 C.F.R. § 435.541 indicates that a state Medicaid agency's determination of disability must be in accordance with the requirements for evaluating evidence under the SSI program specified in 20 C.F.R. §§ 416.901 through 416.998.

18. 20 C.F.R. § 416.920, Evaluation of Disability of Adults, explains the five-step sequential evaluation process used in determining disability. The regulation states in part:

> (a) General—(1) Purpose of this section. This section explains the five-step sequential evaluation process we use to decide whether you are disabled, as defined in § 416.905.
>
> (2) Applicability of these rules. These rules apply to you if you are age 18 or older and you file an application for Supplemental Security Income disability benefits.
>
> (3) Evidence considered. We will consider all evidence in your case record when we make a determination or decision whether you are disabled.
> (4) The five-step sequential evaluation process. The sequential evaluation process is a series of five "steps" that we follow in a set order. If we can find that you are disabled or not disabled at a step, we make our determination or decision and we do not go on to the next step. If we cannot find that you are disabled or not disabled at a step, we go on to the next step. Before we go from step three to step four, we assess your residual functional capacity. (See paragraph (e) of this section.) We use this residual functional capacity assessment at both step four and at step five when we evaluate your claim at these steps. These are the five steps we follow:
> (i) At the first step, we consider your work activity, if any. If you are doing substantial gainful activity, we will find that you are not disabled. (See paragraph (b) of this section.)
> (ii) At the second step, we consider the medical severity of your impairment(s). If you do not have a severe medically determinable physical or mental impairment that meets the duration requirement in § 416.909, or a combination of impairments that is severe and meets the duration requirement, we will find that you are not disabled. (See paragraph (c) of this section.)
> (iii) At the third step, we also consider the medical severity of your impairment(s). If you have an impairment (s) that meets or equals one of our listings in appendix 1 to subpart P of part 404 of this chapter and meets the duration requirement, we will find that you are disabled. (See paragraph (d) of this section.)
> (iv) At the fourth step, we consider our assessment of your residual functional capacity and your past relevant work. If you can still do your past relevant work, we will find that you are not disabled. (See paragraph (f) of this section and § 416.960(b).)

> (v) At the fifth and last step, we consider our assessment of your residual functional capacity and your age, education, and work experience to see if you can make an adjustment to other work. If you can make an adjustment to other work, we will find that you are not disabled. If you cannot make an adjustment to other work, we will find that you are disabled. (See paragraph (g) of this section and § 416.960(c).

19. 20 C.F.R. § 404.1567 "Physical exertion requirements" states:

> To determine the physical exertion requirements of work in the national economy, we classify jobs as sedentary, light, medium, heavy, and very heavy…In making disability determinations under this subpart, we use the following definitions:
> (a) Sedentary work. Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.
> (b) Light work. Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, you must have the ability to do substantially all of these activities. If someone can do light work, we determine that he or she can also do sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time.

20. In evaluating the first step, the petitioner is not engaging in substantial gainful activity. Therefore, the first step is met.

21. In evaluating the second step, the impairments must last or be expected to last for a continuous period of at least 12 months to meet durational requirements. The petitioner has a diagnosis of Seizures, which is considered severe. The second step is met.

22. In evaluating the third step, the impairment(s) would have to meet or equal one of the listings in Appendix 1 to Subpart P of Part 404 of the Social Security Act (Adult

listings-Part A). As it relates to listing, [redacted] The undersigned reviewed the impairment 11.00 Category of impairments, neurological, including 11.18 [redacted] The listing indicates that the required level of severity demonstrates loss of consciousness and convulsive seizures or episodes manifesting which interfere significantly with activity during the day. The report also indicates typical seizure pattern, including occurring more frequently than once a month. According to the evidence on the Physical Residual Functional Capacity Assessment (SSA-416), petitioner is able to perform her personal care independently, her household chores, cooks and volunteers at the hospital 20-25 hours a week. According to testimony and evidence, petitioner's last seizure episode was in 2007. There is no indication or evidence of convulsive seizure patterns, loss of conscious or reoccurrence episode which interfere with the petitioner's daily activities. Based on a combination of the medical evidence submitted into the record and petitioner's testimony, the petitioner does not meet a relevant Social Security listing. Petitioner does not meet this step. The analysis continues on to step 4.

23. The fourth step is an assessment of the petitioner's residual functional capacity and past relevant work. Petitioner was last employed in 2002. DDD did not review petitioner's previous employment. Therefore, it would be appropriate for DDD to move forward. The analysis continues on to step 5.

24. The fifth step is to determine if the petitioner's impairments prevent the petitioner from performing any other work in the national economy. Based on the petitioner's age, educational grade level, employment history and her impairments; the DDD assessment shows petitioner would be capable of light work. According to DDD's analysis and the

objective medical evidence, petitioner should be capable of performing light and sedentary duty jobs in the national economy.

25. Based on the evidence submitted, the hearing officer must conclude that the petitioner does have the ability to perform work in the national economy. The petitioner does not meet the disability criteria and does not meet the definition of disability as set forth in the Social Security Act. It is concluded that the respondent's denial of the petitioner's SSI-Related Medicaid application is 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 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 _February_____, 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
[redacted]

FILED
Feb 01, 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-09107

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 16 MONROE
UNIT: 66302

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on December 28th, 2015 at approximately 9:35 a.m.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Odalys Perez, Economic Self-Sufficiency Specialist.

STATEMENT OF ISSUE

The petitioner is seeking approval of Institutionalized Care Program Medicaid benefits for October 2014 through July 2015. The petitioner carries the burden of proving his position by a preponderance of the evidence in this appeal.

PRELIMINARY STATEMENT

Petitioner's Exhibits 1 through 4 were submitted into evidence.

Respondent's Exhibits 1 through 10 were moved into evidence. (Several other exhibits submitted by the respondent were not moved into evidence as they were duplicative of the petitioner's exhibits, or otherwise either irrelevant or not developed on record.)

No Notice of Case Action addressing the matter under appeal was submitted. The petitioner filed a request to challenge the respondent's action (or lack thereof) on October 15th, 2015. Absent evidence to the contrary, the request must be considered timely.

FINDINGS OF FACT

1. The petitioner alleged that he applied for ICP Medicaid benefits on October 27th, 2014, upon admittance to the facility. (ICP Medicaid covers the cost of nursing home residence.) No evidence of this application was received. The respondent countered that the first application for ICP benefits was received on May 14th, 2015.

2. On May 18th, 2015, the respondent issued a Notice of Case Action to the petitioner requesting, in full and verbatim:

> Please read the disability pamphlet
> Please complete and sign the Authorization To Disclose Information Form
> Please complete and sign the Informed Consent Form
> Please complete and sign the Affidavit for Designated Representative Form
> Please provide Income *[Sic]* Trust documents.

The notice advised the petitioner that if he needed assistance with these verifications, he should advise the respondent “right away”. The notice provided a deadline of May 28th, 2015, and further advised the petitioner that failure to provide the requested information would result in the respondent’s inability to approve the application and therefore, benefits may be denied or terminated.

3. On May 27th, 2015, the respondent issued a second Notice of Case Action requesting that the following, in full and verbatim, be provided:

> We need the following information by June 08, 2015.
>
> Please Complete and sign the "Financial Information Release" form
> Other - please see comments below
> 2nd Pending letter: Please send the verification of the gross pension of 2015. The new Income trust legal document prepared by a lawyer (includes his/her name, address & ph#) The last 3 months of the bank statements of the bank accts and the income trust account initial deposit. Due date: 06/02/15.

Notably, there is a conflict on the notice regarding the deadline.

4. The petitioner’s income (undisputed) exceeded the limit for ICP Medicaid. Therefore, a properly established and executed Qualifying Income Trust fund was necessary in order for the petitioner to remain eligible for ICP Medicaid. The account was to be properly funded on a monthly basis in the assigned amount.

5. On October 27th, 2014, under legal advisement, the petitioner established an Irrevocable Qualified Income Trust Fund. However, the necessity of such a trust fund had not yet been established, as the respondent did not receive an application for benefits until May 2015.

6. During the application process, the respondent determined that the petitioner's income, which consisted of Social Security benefits in the monthly amount of $1,228, and a monthly pension of $1,950.84 (totaling $3,178.84) exceeded the income limit of $2,199, and therefore, provided all other eligibility factors were met, a Qualified Income Trust would indeed need to be executed. The petitioner's income was not in dispute.

7. The respondent asserts that none of the requested information was ever received, and action was taken to deny the petitioner's May 15th, 2015 application. The respondent submitted no evidence to this effect.

8. The petitioner submitted another application for ICP benefits on July 15th, 2015.

9. On July 21st, 2015, the respondent issued a Notice of Case Action to the petitioner requesting, in full and verbatim, the following:

> We need the following information by July 31, 2015.
> Other - please see comments below
> The case was reopened but we need the new income trust legal document prepared by a lawyer. An income trust bank acct should be opened and properly funded every month. The proof of the initial deposit in it. Please also send the Social Security letter of 2015 and the Florida retirement pension of 2014-2015 (it change each July).The last 3 months of the bank statements of any active bank acct. Due date: 7/30/15.

Again, there is a notable discrepancy on the notice regarding the deadline.

10. On July 29th, 2015, the respondent issued a Notice of Case Action to the petitioner requesting, in full and verbatim, the following:

> We need the following information by August 10, 2015.

> Other - please see comments below
> As per our phone conversation we still need the Income trust legal instrument document to be reviewed by the DCF Legal Department. The verification of the gross pension from Illinois received in 2014 & 2015. The last months of the bank statements of the [redacted] checking acct ending [redacted] and the deposits made in the income trust acct during 11/2014 & 12/2014 as well as 04/2015, 05/2015, 06/2015 & 07/2015. Due date: 08/06/15.

Again, there is a notable discrepancy on the notice regarding the deadline.

11. The petitioner submitted an application for ICP benefits on August 19th, 2015. The reason for this application was not clear, as the respondent provided no testimony or evidence regarding the disposition of the July 15th application.

12. On August 25th, 2015, the respondent issued a Notice of Action to the petitioner requesting, in full and verbatim, the following:

> We need the following information by September 04, 2015.
> Other - please see comments below The Income trust document & POA were sent to the DCF Legal Dept. We still need to verify the pension from Illinois of 2015 & the SSA of 2015. Also the copies of her social security card, her Medicare card and proof of citizenship.
> Last 3 months of the bank statements of her checking acct at WF bank.
> Due date: 09/03/15.

13. The respondent explained that a qualified income trust account must be established through a lawyer, and if applicable, accompanied by a Power of Attorney. The documents are then forwarded to Department's District Legal Counsel Office for final approval. The respondent asserted that during at least the last application process, partial documents were received and therefore, nothing could be sent for approval. Specifically, the final page of the qualified income trust fund that would have consisted of the necessary signatures

attesting to the terms of the account was not received until August 3rd, 2015, at which time ICP benefits were approved.

14. The petitioner explained that over the past several months the facility has seen a heavy turnover of social workers, business managers, and administrators, and as a result, many unresolved issues, including this one, "slipped through the cracks." The petitioner asserts that despite these circumstances, the facility provided its service to the petitioner and is now seeking payment for the months in question.

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

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

17. Fla. Admin. Code Rule 65A-1.025, "Eligibility Determination Process" 1(a) states as follows:

> The Department must determine an applicant's eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter. It is the applicant's responsibility to keep appointments with the eligibility specialist and furnish information, documentation and verification needed to establish eligibility.

18. Fla. Admin. Code Rule 65A-1.205, "Eligibility Determination Process" 1(c) sets forth the time frame for an applicant to provide additional information:

> If the eligibility specialist determines during the interview or at any time during the application process that the applicant must provide additional information...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… If the applicant does not provide required verifications or information by the deadline date the application will be denied, unless the applicant requests an extension or there are extenuating circumstances justifying an additional extension.

19. The above citations explain that it is the petitioner's responsibility to provide requested verification to the Department.

20. Fla. Admin. Code Rule 65A-1.713, "SSI-Related Medicaid Income Eligibility Criteria" in part states:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
>
> …
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> (d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in subsection 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional care services by establishing an income trust which meets criteria set forth in subsection 65A-1.702(15), F.A.C…
>
> (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.
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> (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.
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> (b) For institutional care, hospice, and HCBS waiver programs the department applies the following methodology in determining eligibility:
>
> 1. To determine if the individual meets the income eligibility standard the client's total gross income, excluding income placed in qualified income trusts, is counted in the month received. The total gross income must be less than the institutional care income standard for the individual to be eligible for that month.

21. The above authority explains that in order to be eligible for the ICP Medicaid, an applicant's gross income cannot exceed 300% of the federal benefit rate. However, if applicant's income exceeds the limit, he/she is able to establish and fund a QIT to qualify for ICP Medicaid benefits. Total gross income outside of the qualified income trust must be counted in the month received and must be less than the ICP income standard for the individual to be eligible for that month.

22. The ACCESS Florida Program Policy Manual, 165-22, Section 1840.0110 "Income Trusts (MSSI, SFP)" states:

> 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. …

23. The evidence shows that on May 18th, 2015, the respondent requested that the petitioner provide verification of a Qualified Income Trust fund, but such verification was not received in full until August 3rd, 2015. Therefore, the hearing officer affirms that eligibility for ICP Medicaid benefits cannot be established for the October 2014 through July 2015.

DECISION

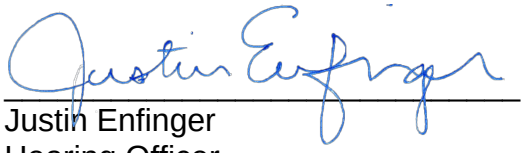
Based on the foregoing Findings of Fact and Conclusions of Law, this appeal is denied. The respondent's action is affirmed.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this __01___ day of __February_____, 2016,

in Tallahassee, Florida.



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Chet Malanowski

FILED
Jan 20, 2016
Office of Appeal Hearings
Dept. of Children and Families

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

[redacted]

PETITIONER,

APPEAL NO. 15F-09113

VS.

[redacted]

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 15 PALM BEACH
UNIT: 88238

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on December 8, 2015 at 1:42 p.m.

APPEARANCES

For the Petitioner: [redacted] supervisor

For the Respondent: [redacted]

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to enroll him in the Medically Needy Program. He is seeking full Medicaid. The petitioner carries the burden of proof by a preponderance of evidence.

PRELIMINARY STATEMENT

The respondent presented five exhibits, which were accepted and entered into evidence as Respondent's Exhibits 1 to 5. The record was held open until December

15, 2015, for the petitioner to provide his evidence. The petitioner presented one exhibit which was accepted and entered into evidence and marked as Petitioner's Exhibit 1.

FINDINGS OF FACT

1. On September 1, 2015, the petitioner submitted an application for Medicaid benefits. The petitioner's household consists of only himself (age 57). He was determined disabled and is receiving Social Security Disability Income (SSDI) of $1,499. The petitioner is not currently receiving Medicare benefits.

2. The respondent determined the petitioner's household income exceeded the income limit of $864 for full Medicaid benefits and enrolled him in the Medically Needy Program with a share of cost (SOC).

3. The respondent performed the following budget calculations when it determined the petitioner's estimated SOC. A $20 unearned income disregard was subtracted from the petitioner's SSDI of $1,499 and resulted in countable unearned income of $1,479. The Medically Needy Income Level for one person, $180 was subtracted resulting in the petitioner's final SOC of $1,299 in the SSI-Related Medically Needy Program.

4. By notice dated September 3, 2015, the respondent notified the petitioner he was eligible for Medically Needy Medicaid coverage.

5. On October 27, 2015, the petitioner requested an administrative hearing to challenge the decision.

6. At the hearing, the Department explained that in the prior certification no income was counted thus the reason the petitioner had full Medicaid benefits. When the Department updated the petitioner's case file at recertification he was no longer eligible for full Medicaid therefore he was enrolled in the Medically Needy Program

7. The petitioner explained that if he is enrolled in the Medically Needy Program with an estimated SOC he will not be able to pay for medication and also pay for living expenses. He emphasized that he is disabled and needs his medication.

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 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 petitioner has been determined disabled by Social Security. His Medicaid eligibility was determined under the SSI-Related Medicaid Program.

11. 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…"

12. Income budgeting for MEDS-AD is set forth in Fla. Admin. Code R. 65A-1.713. It states:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
> (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. (2) Included and Excluded Income. For all SSI-related coverage groups the department follows the SSI policy specified in 20 C.F.R. 416.1100, et seq.,…
> (4) Income Budgeting Methodologies. To determine eligibility SSI budgeting methodologies are applied except where expressly prohibited

> by 42 U.S.C. §1396, or another less restrictive option is elected by the state under 42 U.S.C. §1396(2000 Ed., Sup. IV)...

13. 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…"

14. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, Appendix A-9, identifies 88 % of the federal poverty level for SSI-Related Medicaid under the MEDS-AD Program at $864 effective July 2015. The petitioner's total countable income of $1,479 (after $20 disregard) exceeds the income standard for full MEDS-AD as listed above. The respondent's action to deny full Medicaid Program benefits for the petitioner was within the rules and regulation of the Program. The petitioner is not eligible for full coverage Medicaid.

15. A review of the rules and regulations did not find any exception to meeting the income limits for the Program.

16. 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.

17. The above authority explains the Medically Needy Program is a coverage group for aged, blind or disabled individuals who do not qualify for full Medicaid due to their level of income.

18. 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.

19. 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.”

20. 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…

21. 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.”

22. The Policy Manual at passage 2440.0102, Medically Needy Income Limits (MSSI) states:

> When the assistance group has met the technical eligibility criteria and the asset limits, it is enrolled. There is no income limit for enrollment. The assistance group is income eligible (entitled to Medicaid) once income is less than or equal to the Medically Needy Income Level (MNIL) or medical bills equal the amount by which his income exceeds the MNIL. Once medical bills are equal to this surplus income, referred to as share of cost, the assistance group is eligible.
> The eligibility specialist must determine eligibility for Medically Needy any time the assistance group's income exceeds the income limits for another full Medicaid Program.

23. 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. Eligibility for full Medicaid is not found.

24. 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 $1,299 is within the rules of the Program.

DECISION

Based upon the 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 20 day of January, 2016,

in Tallahassee, Florida.

Christiana Gopaul Narine

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

FILED
Jan 27, 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-09145

PETITIONER,

Vs.

[redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pinellas
UNIT: 88287

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on December 3, 2015 at 1:00 p.m. All parties appeared telephonically from different locations.

APPEARANCES

For the petitioner: [redacted] pro se.

For the respondent: Signe Jacobson, Economic Self Sufficiency Specialist II.

STATEMENT OF ISSUE

Petitioner is appealing the Department's action to close her full Medicaid coverage. At the hearing the burden of proof was assigned to the petitioner but after further review it is determined that the burden falls to the Department by the preponderance of evidence.

PRELIMINARY STATEMENT

On October 9, 2015, the Department sent the petitioner a Notice of Case Action (NOCA) informing her that her Medicaid would end as of October 31, 2015 because" a household member has left the home and can no longer be included in this program." On October 27, 2015, the Department sent the petitioner a subsequent NOCA informing her that her application for Medicaid dated October 7, 2015 was denied. The petitioner timely appealed this action on October 30, 2015.

The petitioner presented no evidence for the undersigned to consider. The Department presented a total of 94 pages of evidence for the undersigned to consider, which was entered into the record as Respondent's Composite Exhibit 1. The record was closed on December 3, 2015.

FINDINGS OF FACT

1. The Department explained during the hearing that the petitioner lost her full Medicaid eligibility once her eldest child turned 18 years old. The petitioner did not contest this action.

2. On October 7, 2015, the petitioner applied for full Medicaid for herself. She is 40 years old and has no other children under the age of 18 in her home. She claimed to be disabled. On October 19, 2015, the Department sent a Disability Determination and Transmittal form to the Division of Disability Determination (DDD) to make a disability determination.

3. The petitioner filed a disability application with the Social Security Administration (SSA) which was denied on December 24, 2014. The petitioner appealed the SSA's decision on January 5, 2015 and that appeal is currently pending.

4. On October 23, 2015, DDD returned the transmittal to the Department informing it that an adoption of the SSA's decision was made. DDD did not conduct an independent review; instead, it denied the petitioner's disability claim by adopting the SSA denial.

5. The code used to deny was N32, which is non-pay-capacity for substantial gainful activity-other work. The primary diagnosis was [redacted] and the secondary diagnosis was [redacted] from the SSA Blue Book. During the hearing, the petitioner reported her disabling conditions to be: knee pain, bone condition, obesity, high blood pressure, joint pain and mental conditions. All of these conditions were considered by the SSA as indicated in its "Explanation of Determination" denying the petitioner's claim. The petitioner reports that her knee pain and bone condition have worsened. She reported no new disabling conditions, only worsening of her existing conditions.

6. On October 27, 2015, the Department sent the petitioner a NOCA informing her that she was ineligible for Medicaid. The Department explained that the petitioner did not meet the disability requirement to be eligible for Medicaid. The petitioner did not agree with the Department's action to adopt SSA's disability denial.

7. On October 30, 2015, the petitioner submitted additional medical documentation to the Department. She provided this to show worsening of her conditions. The petitioner was concerned that the Department did not consider this additional documentation as the timeframe from when she returned it to when it was denied was too short. The Department did not resend the DDD transmittal and new documentation as no new disabling conditions were reported. The Department testified

that it cannot make an independent disability determination if the petitioner was previously denied by the SSA within one year, unless a new disabling condition(s) occurred and medical documentation supporting that is returned.

8. In the additional medical evidence provided by the petitioner on October 30, 2015, only two items were found that had not been previously submitted to DDD. The first was dated just "October" and was a prescription written by [redacted] It states, "due to ongoing medical conditions, [redacted] is disabled and unable to work for 2 months." There is no year listed on this prescription. The second page was signed by [redacted] on October 27, 2015 and states, "[redacted] has been under my care on 10/27/2015 and pt is restricted from work due to joint dysfunction in her lower extremities." Neither of these doctor notes report or verify a new disabling condition.

9. No other medical evidence was provided by the petitioner to support a new disabling condition. The petitioner testified that her conditions have worsened. The Department cannot re-submit to DDD as no evidence of a new disabling condition has been reported and verified.

CONCLUSIONS OF LAW

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

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

12. Fla. Admin. Code, Section 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. For an individual to receive Medicaid who are less than 65 years of age, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. The regulation states, in part:

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

13. The Code of Federal Regulations at 42 C.F.R. § 435.541 Determinations of Disability states:

> (a) *Determinations made by SSA*. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.
> (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under § 435.909.
> (b) *Effect of SSA determinations*.
> (1) Except in the circumstances specified in paragraph (c)(3) of this section-
> (i) **An SSA disability determination is binding on an agency until the determination is changed by SSA**. [emphasis added]
> (ii) If the SSA determination is changed, the new determination is also binding on the agency.
> (2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.
> (c) *Determinations made by the Medicaid agency*. The agency must make a determination of disability in accordance with the requirements of this section if any of following circumstances exist…

> (4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and-
> (i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or
> (ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.
> (iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—
> (A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or
> (B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

14. The above federal regulation explains that the respondent may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.912 on the same issues presented in the Medicaid application. The respondent is bound by the federal agency's decision unless there is evidence of a new disabling condition not reviewed by SSA. The petitioner confirmed all of her medical conditions have been reported to SSA to the best of her knowledge. SSA denied the petitioner's disability claim on December 24, 2014 because it determined she was not disabled under their rules. The petitioner disagreed with SSA's disability denial and has filed an appeal with SSA, which is still pending. The respondent adopted SSA's decision and denied the petitioner's Medicaid application.

15. In careful review of the evidence and controlling legal authorities, the undersigned concludes that the respondent followed rule in adopting the SSA disability denial from December 24, 2014 and denying the petitioner's Medicaid disability application.

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 27 day of January, 2016, in Tallahassee, Florida.

Brandy Ricklefs

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Office of Economic Self Sufficiency

FILED
Jan 25, 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.

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

RESPONDENT.
_____/

APPEAL NO. 15F-09146

CASE NO.

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above referenced matter telephonically on January 5, 2016, at 10:45 a.m.

APPEARANCES

For the petitioner: [redacted]
Petitioner's Mother

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 orthodontic treatment in the form of braces?

PRELIMINARY STATEMENT

[redacted] the petitioner's mother, appeared on behalf of the petitioner, [redacted] ("petitioner"), who was not present. [redacted] may sometimes hereinafter be referred to as the petitioner's "representative".

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. The following individuals appeared as witnesses on behalf of the Agency: Carlene Brock, L.P.N., Quality Operations Nurse with Amerigroup Florida; Jackelyn Salcedo, Complaints and Grievances Specialist with DentaQuest; and Susan Hudson, D.M.D., Dental Consultant with DentaQuest.

The respondent introduced Exhibits "1" through "12", inclusive, at the hearing, all of which were accepted into evidence and marked accordingly. The petitioner did not introduce any 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 is a 13-year-old female.

2. Petitioner was eligible to receive Medicaid services at all times relevant to this proceeding.

3. Petitioner is an enrolled member of Amerigroup Florida ("Amerigroup"). Amerigroup is a health maintenance organization ("HMO") contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in Florida.

4. Amerigroup provides certain dental and orthodontic benefits to its members. Amerigroup has contracted DentaQuest to review prior authorization requests for dental and orthodontic services.

5. On or about October 8, 2015, petitioner's orthodontist submitted a prior authorization request for a pre-orthodontic treatment examination to monitor growth and development, comprehensive orthodontic treatment of the adolescent dentition (braces), fixed appliance therapy, and subsequent periodic orthodontic treatment visits.

6. In a Notice of Action dated October 12, 2015, DentaQuest informed the petitioner it denied her request for orthodontic treatment. The Notice of Action states, in part:

> We determined that your requested services are **not medically necessary** because the services do not meet the reason(s) checked below: *(See Rule 59G-1.010)*
>
> X Must be needed to protect life, prevent significant illness or disability, or alleviate severe pain.
> X Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs.
> X Must meet accepted medical standards and not be experimental or investigational.

7. Both the Agency for Health Care Administration and DentaQuest use the Medicaid Orthodontic Initial Assessment Form (IAF) to evaluate an individual's need for orthodontic treatment.

8. To be considered for orthodontic treatment by the Agency for Health Care Administration or DentaQuest, an individual must attain a score of at least 26 on the Initial Assessment Form.

9. The petitioner's orthodontist completed an Initial Assessment Form on the petitioner and submitted this information to DentaQuest. The Initial Assessment Form submitted by the petitioner's orthodontist has a score of 27 at the bottom.

10. The petitioner's orthodontist did not complete the Initial Assessment Form correctly. He did not complete and score the individual sections of the form; he simply listed a total score of 27 at the bottom.

11. The narrative submitted by the petitioner's orthodontist along with the request for services states the petitioner has an [redacted]

12. The respondent's dentist testified that the documentation submitted by the petitioner's orthodontist does not reveal an [redacted]

13. The petitioner has pain and overcrowding in her mouth. Pain alone is not a sufficient justification for the approval of braces.

14. Based on the information submitted to it by the petitioner's orthodontist, DentaQuest completed its own Initial Assessment Form on the petitioner. DentaQuest arrived at a score of 18 when it completed the form.

15. On November 12, 2015, DentaQuest re-reviewed the petitioner's request for orthodontic treatment. DentaQuest upheld the denial at that time.

CONCLUSIONS OF LAW

16. 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.

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

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

19. 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.

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

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

22. 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…

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

> (166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

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

24. 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.

25. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Chapter 59G-4. In accordance with the above Statute, the Handbook states on page 1-27:

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.

> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.
>
> Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

26. Page 1-28 of the Florida Medicaid Provider General Handbook provides a list of HMO covered services. Page 1-30 of the Handbook explains "Other services that plans may provide include dental services, transportation, nursing facility and home and community-based services."

27. 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."

28. Rule 59G-4.060, Florida Administrative Code, addresses dental services and states, in part:

> (2) All dental services providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Dental Services Coverage and Limitations Handbook, November 2011, … and the Florida Medicaid Provider Reimbursement Handbook, ADA Dental Claim Form, July 2008, which are incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which is incorporated by reference in Rule 59G-4.001, F.A.C.
>
> (3) The following forms that are included in the Florida Medicaid Dental Services Coverage and Limitations Handbook are incorporated by reference: Medicaid Orthodontic Initial Assessment Form (IAF), …

29. The Dental Services Coverage and Limitations Handbook, on Page 2-17, discusses the Initial Assessment Form. It states, in part:

> 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 the Medicaid's orthodontic consultant all the distinctive details pertaining to an individual's case.

30. Page 2-18 of the Dental Services Coverage and Limitations Handbook discusses the index score attained on an Initial Assessment Form and states, in part:

> 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.

31. Amerigroup's rules governing the approval of orthodontic services for children under age 21 are similar to those of the Agency for Health Care Administration.

32. In the present case, the Initial Assessment Form submitted by petitioner's orthodontist was not completed properly. The orthodontist did not score the individual sections of the form; he only listed a total score of 27 at the bottom. Additionally, the documentation submitted along with the form does not show an [redacted]

[redacted] The Initial Assessment Form completed by DentaQuest pursuant to the information submitted by the petitioner's orthodontist reflects a score of 18, which is insufficient to support approval of orthodontic treatment. Furthermore, overcrowding and pain alone are not sufficient to demonstrate the necessity of orthodontic treatment.

33. Pursuant to the above, the petitioner has not met her burden of proof to show the respondent incorrectly denied her request for orthodontic treatment.

34. Should the petitioner's situation worsen, or should the petitioner be able to secure additional documentation from her dental provider tending to show orthodontic treatment is medically necessary, the petitioner is encouraged to re-submit her request to DentaQuest for further evaluation.

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 25 day of January, 2016,

in Tallahassee, Florida.

Peter J. Tsamis

Peter J. Tsamis
Hearing Officer
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Don Fuller, Area 5, AHCA Field Office Manager

FILED
Jan 27, 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-09153

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 December 7, 2015 at 10:00 a.m.

APPEARANCES

For the Petitioner: [redacted] Petitioner

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

STATEMENT OF ISSUE

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

PRELIMINARY STATEMENT

The Petitioner submitted a photograph of her teeth as evidence for the hearing, which was marked as Petitioner Exhibit 1.

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

Respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Exhibits: Exhibit 1 – Summary and Member Information; Exhibit 2 – Claim Form; Exhibit 3 – Denial notice; Exhibit 4 – Dental Services Criteria; Exhibit 5 – Dental Director Review Form.

FINDINGS OF FACT

1. The Petitioner is an adult Medicaid recipient over twenty-one years of age who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. She receives services under the plan from Humana, which utilizes DentaQuest for review and approval of dental services.

2. On or about August 27, 2015, the Petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from DentaQuest to perform dental

services, including deep gum and root cleaning on four quadrants. DentaQuest denied this request on August 31, 2015.

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

> Your teeth must have noticeable bone loss or show on an x-ray that there is a hard substance built up on the root of the tooth. Our dentist looked at the information sent by your dentist. This service is not needed. We have told your dentist this also. Please talk to your dentist about other options to treat your teeth.

4. Petitioner testified that she needs the requested services because her gums bleed and her teeth have hard plaque. She also stated a regular cleaning will not resolve the problems with her teeth.

5. The Respondent's expert witness, Dr. Hudson, testified that the denial of the Petitioner's request for the deep cleaning was appropriate because there must be moderate bone loss on four or more teeth in each quadrant and this was not demonstrated in the Petitioner's case. Dr. Hudson also stated there is a different dental procedure code which would be applicable where there is moderate bone loss demonstrated on one or two teeth.

6. Dental 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, 7th Ed.).

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

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

> "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide;
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
> . . .
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

13. The Florida Medicaid Program provides limited dental services for adults. The Dental Handbook describes the covered services for adults as follows:

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

14. Managed care plans, such as Humana, may provide more generous benefits but cannot be more restrictive than the Medicaid guidelines contained in the Dental Handbook. The dental services requested by the Petitioner are covered services under Humana's dental plan provisions, but the services were denied due to medical necessity considerations.

15. After considering the evidence and testimony presented, the undersigned concludes the Respondent correctly denied Petitioner's request for deep cleaning. The evidence demonstrates there is a more appropriate dental procedure code which can be

utilized, and Petitioner should explore this option with her provider. In order to justify the approval of the requested services, there must be moderate bone loss in four or more teeth per quadrant and that criterion was not met in this case.

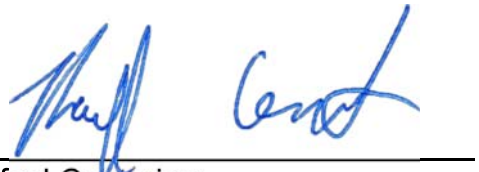
DECISION

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 27 day of January, 2016, in Tallahassee, Florida.



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FILED
Jan 29, 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-09164

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on December 17, 2015, at 9:10 a.m.

APPEARANCES

For the Petitioner: [redacted] Senior Program Specialist, Agency for Health Care Administration (AHCA).

For the Respondent: [redacted], the petitioner's mother.

STATEMENT OF ISSUE

At issue is whether the Agency's denial of a dental procedure was correct. The petitioner carries the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

Present as witnesses for the respondent were Mindy Aikman, Grievance and Appeals Coordinator with Humana; Jacqueline Salcedo, Complaints and Grievances

Representative with DentaQuest; and Dr. Susan Hudson, Dental Director with DentaQuest.

[redacted] provided interpreter services for petitioner who is Spanish-speaking.

The respondent submitted into evidence Respondent Exhibit 1 through 3.

FINDINGS OF FACT

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

1. The petitioner is seventeen years of age and is a Medicaid recipient living in Miami-Dade County, Florida. She is enrolled in the Medicaid MMA (Managed Medical Assistance) Program with Humana. Humana is a Managed Care Organization that has been authorized by AHCA to make certain prior service authorization decisions for individuals enrolled in Medicaid MMA Programs. [redacted] is contracted by Humana to provide dental services and perform prior authorization reviews.

2. [redacted] received a prior service authorization request from the petitioner's treating dental surgeon on June 26, 2015 for the removal of her four wisdom teeth, tooth numbers 1, 16, 17 and 32. [redacted] reviewed this request and provided an Authorization Determination notice to the petitioner's dental provider on June 30, 2015.

3. The above referenced notice indicated that the request for procedure code D7220 was denied. The determination reason provided indicated "there is no sign of

infection or other medical reasons for tooth removal." Additional procedure codes were also denied, but those codes are directly related to the D7220 code procedure and are not stand alone requests.

4. [redacted] sent the petitioner a "Notice of Action" on June 30, 2015 regarding the above noted decision which states in part:

> We made our decision 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 necessary to protect life, prevent significant illness or disability or significant disability, or alleviate severe pain
>
> Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not in excess of the patient's needs
>
> Must meet accepted medical standards and not be experimental or investigational

5. The respondent's dental physician witness indicated that [redacted] had two to three dentist review the information presented by the petitioner's treating dental surgeon, which included the X rays, and found no evidence of infection, pathology or enough space between the teeth that would meet the criteria for the service request to be approved. She reiterated that the removal of the wisdom teeth request does not meet the medical necessity criteria to be approved.

6. The petitioner's representative argued that the petitioner has complained to her of pain in her lower mouth and that she has a hard time eating. She indicated that the petitioner's mouth is swollen. She also indicated that the petitioner does not take

any prescribed medication for pain except occasionally she will give her over the counter Advil.

7. The respondent witness indicated that it is normal for individuals to have some pain associated with wisdom teeth.

CONCLUSIONS OF LAW

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

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

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

11. The Dental Services Coverage and Limitations Handbook, dated November 2011, has been incorporated by reference into Chapter 59G-4, Fla. Admin. Code and states on page 2-15:

> Extractions of all erupted teeth or exposed roots within a quadrant, same recipient and same date of service, are reimbursable with procedure code D7140, using D7140's reimbursement rate for each applicable extraction. This rule does not apply if an extraction within the quadrant is a surgical removal of an erupted tooth or the removal of an impacted tooth, which will be identified by the appropriate extraction procedure code.

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

(166) “Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

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

12. As shown in the Findings of Fact, [redacted] denied the petitioner’s request for dental procedure code D7220, which is oral surgery to remove or extract four wisdom teeth, tooth numbers 1, 16, 17 and 32.

13. For the case at hand, the respondent indicated and argued that after review of the information submitted for the request including the X rays, [redacted] found no evidence of infection or pathology. However, the petitioner testified she is in constant pain to the point where she needs medications.

14. After considering the evidence and Early and Periodic Screening, Diagnosis, and Treatment Services (EPDST) requirements all of the appropriate authorities set forth in the findings above, the hearing officer concludes that the petitioner has met her

burden of proof and the Agency's action denying the petitioner's request for the dental procedures is incorrect.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is GRANTED.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 29 day of January, 2016, in Tallahassee, Florida.

Robert Akel

Robert Akel
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

FILED
Jan 29, 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-09219

PETITIONER,

Vs.

[redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 17 Broward
UNIT: 88249

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on December 17, 2015 at 11:40 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Luisa Soto, acting supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of denying him full Medicaid benefit and enrolling him in the Medically Needy Program with a high estimated share of cost (SOC). The petitioner is seeking full Medicaid coverage or a lower SOC. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

As of the date of the hearing, the petitioner did not receive the evidence packet, but agreed to go forward without it.

During the hearing, the petitioner did not submit any exhibits for the undersigned to consider. The Department submitted seven (7) exhibits which were accepted into evidence and marked as Respondent's Exhibits 1 through 7 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. The petitioner, [redacted] is 44 years old and has been determined disabled by Social Security Administration (SSA) effective December 2014. Petitioner is not yet eligible for Medicare benefits.

2. Petitioner's monthly gross Social Security Disability (SSD) benefit is $1,956. The SSD income amount is not in dispute, *see* Respondent's Exhibit 4.

3. On January 14, 2015, the petitioner applied for Medicaid benefits for himself. He reported a past medical bill for hospitalization from [redacted], but did not report any recurring medically related expenses, *see* Respondent's Exhibit 1.

4. The Department's representative explained its action to enroll the petitioner in the Medically Needy Program with a share of cost. The share of cost amount is directly dependent on the petitioner's income.

5. To begin the budgeting process for the petitioner's Medically Needy Program, the Department counted monthly income of $1,956, minus a $20 standard income disregard followed by a $180 Medically Needy Income Level (MNIL) deduction for one person,

from his resulting income. After these deductions, the share of cost was determined to be $1,756, *see* Respondent's Exhibit 3.

6. On March 11, 2015, the Department sent a notice to the petitioner informing him he was approved for the Medically Needy Medicaid with a $3,278 estimated share of cost. In October 2015, the SOC was adjusted to $1,756. A notice of that action was not provided to the undersigned. On November 4, 2015, the petitioner requested an appeal challenging his enrollment in the Medically Needy (MN) Program.

7. The petitioner did not dispute the income amount used by the Department in the eligibility process, but asserted as follows: That he has serious health issues that require constant monitoring, but less than his SOC. That his SOC is too high and that he cannot afford that much monthly expense on a fixed income. That the Medically Needy Program is only good for hospitalization. Petitioner argued after paying for his household expenses, he has no money left and cannot afford any deductibles. During the hearing, the petitioner mentioned that he has no recurring medical expenses for the moment, but is expecting monthly bills of $240 for his bed and $700 for catheters in addition to bills for his physical and respiratory therapy sessions.

8. The Department's representative explained that petitioner does not have to spend out of pocket if he has recurring medical expenses that exceed his SOC, and explained how the share of cost was determined and how it could be met. Petitioner was advised to submit all outstanding medical bills to the Department so that it can be determined when the share of cost is met and when Medicaid coverage could begin. The Department's representative explained that all unpaid medical bills not previously used can be used during any future months for which eligibility is needed.

CONCLUSIONS OF LAW

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. The Department determines Medicaid eligibility based on the household circumstances. When the household consists of parents and children, Medicaid eligibility is determined under Family-Related Medicaid policy. When the household consists of an elderly or disabled individual or couple, Medicaid eligibility is determined under Adult-Related Medicaid policy (also referred to as SSI-Related Medicaid or Medically Needy). Medicaid eligibility is based on federal regulations. Petitioner was evaluated under the SSI-Related Medicaid coverage group.

12. Federal Regulations at 45 C.F.R. §435.500 sets forth the regulations for requirements for determining the eligibility of both categorically and medically needy individuals. 45 C.F.R. §435.520 states, “The agency must not impose an age requirement of more than 65 years.” The regulation continues at 45 C.F.R. §435.541 to define disability as either determined by the Social Security Administration (SSA) or the Medicaid agency.

13. In this case, petitioner has been determined disabled by the SSA. For the SSI-Related Medicaid Programs, an individual must either be aged 65 or older or determined disabled by the SSA or the Department. Based on this regulation, the

Department determined Medicaid eligibility for petitioner and approved him for SSI-Related Medically Needy Program benefits.

14. Federal Regulations at 20 C.F.R. §416.1123 defines how unearned income is counted and states in relevant part:

> (b) Amount considered as income. We may include more or less of your unearned income than you actually receive.
> (1) We include more than you actually receive where another benefit payment (such as a social security insurance benefit) (see Sec. 416.1121) has been reduced to recover a previous overpayment. You are repaying a legal obligation through the withholding of portions of your benefit amount, and the amount of the debt reduction is also part of your unearned income. Exception: We do not include more than you actually receive if you received both SSI benefits and the other benefit at the time the overpayment of the other benefit occurred and the overpaid amount was included in figuring your SSI benefit at that time.

15. Fla. Admin. Code R. 65A-1.701, Definitions, states:

> (20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services…

16. 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.

17. The Eligibility Standards for SSI-Related Programs appear in the Department's Program Policy Manual CFOP 165-22 (the Policy Manual) at Appendix A-9. Effective July 2015, 88% of FPL for a one member household is $864. The petitioner's countable income after the $20 deduction is $1,936, which exceeds the standard for full Medicaid benefits. Petitioner is not receiving Medicare but his income is in excess of the Program

limit to receive full Medicaid benefits. The respondent explored petitioner's eligibility for the Medically Needy Program.

18. The Medically Needy Program provides coverage for individuals who meet the technical requirements for Medicaid but whose income or assets exceed the income limits.

19. Fla. Admin. Code R. 65A-1.710, SSI-Related Medicaid Coverage Groups, states in part:

> The department covers all mandatory coverage groups and the following optional coverage groups:
> (1) MEDS-AD Demonstration Waiver. A coverage group for aged and disabled individuals (or couples), as provided in 42 U.S.C. § 1396a(m)…(5) Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. §§ 1396a and 1396d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance due to their level of income or resources. The program does not cover nursing facility care, intermediate care for the developmentally disabled services, or other long-term care services…
> (30) Share of Cost (SOC): SOC represents the amount of recognized medical expenses that a Medically Needy enrolled individual or family must incur each month before becoming eligible to receive Medicaid benefits for medical expenses incurred during the remainder of the month.

20. The above authorities also define Medically Needy and Share of Cost (SOC). SOC represents the amount of recognized medical expenses that a Medically Needy enrolled individual or family must incur each month before becoming eligible to receive Medicaid benefits. This program is available for aged or disabled individuals or eligible couples who do not qualify for the MEDS-AD Program.

21. Federal regulations at 20 C.F.R. § 416.1124, Unearned income we do not count, "(c) (12). The first $20 of any unearned income in a month…"

22. Fla. Admin. Code R. 65A-1.716 (2), Income and Resource Criteria, sets forth the MNIL for an individual at $180.

23. The above cited rules explain the budgeting procedure to determine the share of cost. The gross income is reduced by a standard deduction ($20) and the MNIL for the assistance group size of one at $180. The Department followed this procedure and determined the share of cost at $1,756.

24. Based on the evidence, testimony, and the controlling authorities, the undersigned concludes that the Department correctly determined that the petitioner is not eligible for full Medicaid benefits and should be enrolled in the Medically Needy Program. No errors were found in the calculation of the amount of the share of cost.

25. Petitioner is encouraged to submit all medical bills to the Department for tracking so that it can be determined when the share of cost is met and when Medicaid coverage could begin.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal is denied. The Department's action is upheld.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 29 day of January, 2016,

in Tallahassee, Florida.

Roosevelt Reveil

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

FILED
Feb 01, 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-09241

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in this matter on December 16, 2015 at 1:29 p.m. and reconvened on December 22, 2015 at 10:00 a.m.

APPEARANCES

For the Petitioner: [redacted] Pro se

For the Respondent: Dianna Chirino,
Senior Human Services Program Specialist,
Agency for Health Care Administration

STATEMENT OF ISSUE

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

- D4260-osseous surgery;
- D4910-periodontal maintenance; and
- D4341-periodontal scaling and root planing.

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

PRELIMINARY STATEMENT

For the December 22, 2015 proceeding, Donald Sinclair, Compliance Manager, appeared as Respondent's witness from Petitioner's managed care plan Magellan Complete Care (Magellan). Appearing as Respondent's witnesses from DentaQuest were Dr. Neil Williams, Dental Consultant, and Nicholas Calderon, Complaints and Grievance Supervisor.

Respondent submitted a 103-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. Petitioner is a 59 year-old Medicaid recipient enrolled with Magellan Complete Care (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 the prior authorization requests.

3. Petitioner's dentist submitted a prior authorization on September 21, 2015 for D4341-periodontal scaling and root planning; D4910-periodontal maintenance; and D4260-osseous surgery.

4. DentaQuest sent a Notice of Action to the Petitioner on October 19, 2015 explaining its denial of Petitioner's requests. For D4341-periodontal scaling and root planning the notice states: "This service is allowed one time every 36 months. Our records show that you received this service less than 36 months ago." For D4910-periodontal maintenance and D4260-osseous surgery the notice states: "This is not a covered service."

5. Petitioner filed a timely request for a fair hearing on November 4, 2015.

6. Petitioner asserted she is very sick from swallowing the blood from her bleeding gums and the dental procedures are medically necessary for her medical health. She further stated that without the dental services she would lose more of her teeth.

7. DentaQuest's dentist explained that procedure D4341-periodontal scaling and root planning has a service limitation of once every 36 months. He noted she received this service on October 5, 2015.

8. The dentist also advised that D4910-periodontal maintenance and D4260-osseous surgery are not covered services. He suggested that Petitioner's dentist call DentaQuest for a peer-to-peer consultation to explore alternatives that could meet the Petitioner's needs.

CONCLUSIONS OF LAW

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

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

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

12. 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.

13. Section 409.912, Florida Statutes also provides that the Agency may mandate prior authorization for Medicaid services.

14. 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.

15. 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.

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

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

> The adult dental program provides for the reimbursement of full and removable partial dentures. Extractions and other surgical procedures essential to the preparation of the mouth for dentures are reimbursable if the patient is to receive dentures. Procedures relating to dentures such as repairs, relines and adjustments are reimbursable.
>
> Medicaid will reimburse for medically-necessary emergency dental procedures to alleviate pain and or infection for eligible adult Medicaid

recipients 21 years of age or older. Emergency dental care shall be limited to emergency problem-focused evaluations, necessary radiographs to make a diagnosis, extraction, and incision and drainage of abscess.

18. In addition to the Handbook, the Dental General Fee Schedule published by the Agency for Health Care Administration dated January 1, 2014 indicates what dental procedure codes are covered by Medicaid. Medicaid does not cover procedure code D4260 for adults (over 20 years old) and does not cover procedure code D4910 regardless of age.

19. While the Petitioner asserted she needs the deep gum and root cleaning and the surgery, Medicaid does not cover these services for adults.

20. Respondent provided sufficient testimony that the requested procedures are not covered by Medicaid and suggested Petitioner's dentist call DentaQuest for a peer-to-peer review to explore alternatives to meet her medical needs. Petitioner failed to meet her burden of proof.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Agency for Health Care Administration acted correctly in denying service procedure codes D4260 and D4910 for the Petitioner. Therefore Petitioner's appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the Petitioner disagrees with this decision, the Petitioner may seek a judicial review. To begin the judicial review, the Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The Petitioner must also file another copy of the "Notice of Appeal" with

the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The Petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 01 day of February, 2016,

in Tallahassee, Florida.

Warren Hunter
Hearing Officer
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Rhea Gray, Area 11, AHCA Field Office Manager

FILED
Feb 02, 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-09253

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 January 7, 2016, at 1:15 p.m.

APPEARANCES

For the Petitioner: [redacted]
Petitioner's mother

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 his request for a custom cranial remolding helmet?

PRELIMINARY STATEMENT

[redacted] the petitioner's mother, appeared on behalf of the petitioner, [redacted] ("petitioner"), who was not present. [redacted] may sometimes hereinafter be referred to as the petitioner's "representative".

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. The following individuals appeared as witnesses on behalf of the Agency: Erik Stumpf, M.D., Medical Director of Prestige Health Choice; Rachelle Narcisse, Grievance and Appeals Coordinator with Prestige Health Choice; and Sharon Burgher, Grievance and Appeals Coordinator for Prestige Health Choice.

The petitioner introduced Composite Exhibit 1, inclusive, at the hearing. The respondent introduced Exhibits "1" through "9", inclusive, at the hearing.

FINDINGS OF FACT

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

1. The petitioner is an 11-month-old infant. His date of birth is [redacted]

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

3. Petitioner is enrolled in Prestige Health Choice ("Prestige"). Prestige 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 is diagnosed with [redacted] of the [redacted]

5. On or about August 27, 2015, the petitioner's provider submitted a prior authorization request to Prestige Health choice for a [redacted] in the form of a [redacted] The letter accompanying the request states, in part:

> [redacted]
>
> The purpose of the [redacted] will be to address the [redacted] as repositioning efforts have failed to produce results. [Petitioner] has significant flattening of the left frontal and right occipital areas. [redacted]

6. In a Notice of Action dated September 17, 2015, Prestige Health Choice informed the petitioner it was denying his request for a [redacted]. The Notice states, in part:

> *We determined that your requested services are not medically necessary because the services do not meet the reason(s) below: (See Rule 59G-1.010)*
>
> *Must meet accepted medical standards and not be experimental or investigational.*

7. The Notice of Action goes on to state:

> The facts that we used to make our decision are: The request for a [redacted] is not approved as the supplied request does not comply with the requirements contained in the FL Medicaid DME Benefits and Limitations Handbook (p:2-48) which are as follows: Supporting documentation, at a minimum, must include: Clinical evidence, including measurements, indicating the infants current [redacted], taken from the following views: Superior; Frontal; Posterior; Right and left

lateral; and A statement from a treating orthopedic or [redacted]urgeon, stating that treatment using a [redacted]orthosis is recommended due to poor improvement in the infants CIS, after a documented six (6) months trial period of active counter positioning has been completed; and Six (6) months worth of documentation regarding daily counter positioning therapy.

8. The Prestige Health Choice Medical Director re-reviewed the petitioner's request on or about October 15, 2015 and upheld the denial.

9. The petitioner was informed of this denial in a Resolution of Appeal letter dated October 15, 2015. The letter explains, in part: "…the authorization request for a [redacted]s not approved as the supplied request continues to not comply with the requirements contained in the FL Medicaid DME Benefits and Limitations Handbook…."

10. Prestige Health Choice follows the Agency for Health Care Administration Medicaid guidelines for the approval of cranial orthotics.

11. The petitioner's [redacted]

CONCLUSIONS OF LAW

12. 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.

13. 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.

14. All goods and services requested under the Florida Medicaid Program must be shown to be medically necessary in order to be approved.

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

16. 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.

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

18. Section 409.905, Fla. Stat. addresses mandatory Medicaid services under the State Medicaid Plan:

> Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law…
> ….
> (4) HOME HEALTH CARE SERVICES.--The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home…
> (a) The agency shall require prior authorization of home health services….
> (c) The agency may not pay for home health services unless the services are medically necessary …

19. The Florida Medicaid Home Health Services Coverage and Limitations Handbook October 2014 is incorporated by reference and promulgated into Rule by Rule 59G-4.130, Florida Administrative Code.

20. Rule 59G-4.130, Florida Administrative Code states in part:

> (2) All providers of home health services must be in compliance with provisions of the Florida Medicaid Home Health Services Coverage and Limitations Handbook, October 2014....

21. The Florida Medicaid Home Health Services Coverage and Limitations Handbook, on Page 2-27, states as follows

> Home health agencies that provide DME must comply with the policies and procedures contained in this handbook and in the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook.

22. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Chapter 59G-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.

23. Pages 1-28 of the Florida Medicaid Provider General Handbook provide a list of HMO covered services. These services include durable medical equipment.

24. Page 1-30 of the Florida Medicaid Provider General Handbook states: “An HMO’s services cannot be more restrictive than those provided under Medicaid fee-for-service.”

25. In order for durable medical equipment and supplies to be approved, the equipment and supplies must not only be medically necessary but must also meet all

requirements set forth in the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook.

26. 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.

27. 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.

28. The United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in *Moore v. Reese*, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, which involved a dispute over private duty nursing:

> [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.
>
> (2) A state Medicaid plan must include "reasonable standards … for determining eligibility for and the extent of medical assistance" … and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.
>
> (3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."
>
> (4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients."

> Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."
>
> (5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. **The state is not required to provide medically unnecessary, albeit desirable, EPSDT services.** However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."
>
> (6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and my present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)) (emphasis added).

29. 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.

30. 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.

31. 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.

32. The Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook July 2010 ("DME Handbook") is promulgated into rule by Fla. Admin. Code R. 59G-4.070. The Handbook describes the covered services, limitations, and exclusions associated with the acquisition and reimbursement of durable medical equipment and medical supplies obtained through the Medicaid program.

33. The DME Handbook, on Page 2-48, describes a custom cranial remolding orthosis as "a non-invasive device used to correct the symmetry of an infant's skull."

34. The DME Handbook, also on Page 2-48, sets forth the eligibility and reimbursement requirements for a custom [redacted] It states as follows:

> Custom [redacted] require prior authorization (PA). PA requests must be submitted using the appropriate DME procedure code, to ensure proper routing for physician review.
>
> Custom [redacted] devices are covered by Medicaid when it is determined medically necessary to correct a moderate to severe [redacted] Supporting documentation, at a minimum, must include:
>
> - A prescription from an orthopedic or craniofacial surgeon; and

- Clinical evidence, including measurements, indicating the infant's current [redacted] and

- Current color photographs of the infant's head, taken from the following views:
  - Superior;
  - Frontal;
  - Posterior;
  - Right and left lateral; and

- A statement from a treating orthopedic or [redacted] stating that treatment using a [redacted] is recommended due to poor improvement in the infant's [redacted] after a documented six (6) month trial period of active counter positioning has been completed; and

- Six (6) month's worth of documentation regarding daily counter positioning therapy.

35. The AHCA rules definitively state that a custom [redacted] will be reimbursed by Medicaid only if the [redacted] is less than [redacted] In the present case, petitioner's [redacted] Therefore, Prestige Health Choice correctly denied the petitioner's request for the device.

36. In rendering this decision, the undersigned hearing officer considered all of the testimony and documentary evidence presented during the hearing process and reviewed all conditions of "medical necessity" set forth in the Florida Administrative Code and the rules governing the Florida Medicaid program.

37. This Order is not intended to state that the petitioner will not benefit from the use of a [redacted] only that he does not currently meet the Medicaid requirements for such a device.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, 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 02 day of February, 2016, in Tallahassee, Florida.

Peter J. Tsamis

Peter J. Tsamis
Hearing Officer
Building 5, Room 255
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Don Fuller, Area 5, AHCA Field Office Manager

FILED
Feb 01, 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-09267

PETITIONER,

Vs.

[redacted]

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter on December 1, 2015 at 10:45 a.m.

APPEARANCES

For the petitioner: [redacted] petitioner's designated representative

For the respondent: Susan Long, ACCESS Supervisor

STATEMENT OF ISSUE

The petitioner's representative is appealing the respondent's action to deny the petitioner's applications for Adult-Related Medicaid benefits. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

No Notice of Case Action describing the action under appeal was issued to the petitioner by the respondent. The respondent explained no notices were issued to the petitioner regarding applications submitted on May 21, 2015 and July 14, 2015.

On November 3, 2015, petitioner's representative filed an appeal to challenge the respondent's denial of petitioner's applications. The appeal is considered to be timely filed for the May 21, 2015 and July 14, 2015 applications since the respondent failed to properly notify the petitioner that these applications were denied.

Petitioner did not submit any exhibits. Respondent submitted seven exhibits, entered as Respondent Exhibits "1" through "7". The record was held open until close of business on December 14, 2015 for submission of additional evidence from the respondent. On December 3, 2015, additional evidence was received and entered as Respondent Exhibit "8. The record closed on December 3, 2015.

FINDINGS OF FACT

1. On May 21, 2015 and July 14, 2015, the petitioner's representative submitted applications for Adult-Related Medicaid benefits for the petitioner (60). The petitioner was not aged or blind and did not have any minor children.

2. On the applications, the petitioner is reported to be disabled and born in Cuba. Petitioner arrived under an order of supervision on June 9, 2011, petitioner did not have an immigration status. This was documented by the respondent's use of the Department of Homeland Security's SAVE Program; it was further corroborated by the petitioner's copy of his form I-220B. The petitioner had been battling with bone cancer

since 2014. Petitioner's condition had worsened and he was placed in Hospice care on May 11, 2015. He passed away on July 27, 2015.

3. The respondent reviewed the State of Florida Social Security Administration (SSA) State on-line query screen. The system showed that the petitioner applied for disability benefits with SSA on January 26, 2015. On March 2, 2015, SSA denied the petitioner's disability claim with a decision code N-13. Decision code N-13 indicates the petitioner was denied due not being a citizen or eligible alien. No disability determination was made by SSA.

4. The Department's Division of Disability (DDD) is responsible for making a State disability determination on behalf of the respondent when an applicant applies for Medicaid disability. The respondent did not complete a Medicaid disability interview or refer the petitioner's applications to DDD to complete a disability determination.

5. The petitioner's representative did not understand why the petitioner's applications were not referred to DDD in order to have a disability determination completed. The representative requested posthumous benefits because petitioner was alive when she submitted an application on July 14, 2015 (he passed away on July 27, 2015). The petitioner's representative is seeking Adult-Related Medicaid benefits for the petitioner for three calendar months preceding the month of the May 21, 2015 and July 14, 2015 applications. According to the submitted applications, the petitioner's representative is seeking retroactive Medicaid benefits for the months of February, March, April, May and June 2015.

6. The respondent explained the Department's Policy on "qualified noncitizen" Medicaid Assistance Program and who qualifies. Petitioner did not have citizenship

status; therefore; the respondent was to determine if the petitioner qualified for Emergency Medicaid Assistance for Aliens (EMA).

7. The respondent's position is that the petitioner's applications were forwarded to DDD for a disability determination because it must adopt SSA's March 2, 2015 denial decision.

CONCLUSIONS OF LAW

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

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

10. Fla. Admin. Code. 65A-1.711 et seq. sets forth the rules of eligibility for elderly and disabled individuals. For an individual under 65 years of age to receive benefits, he or she must meet the disability criteria of Title XVI of the Social Security Act (SSA) appearing in 20 C.F.R. §416.905. The regulations state, in part:

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

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

> (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 issue presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility…
> (b) Effect of SSA determinations. (1)(i) **An SSA disability determination is binding on an agency until the determination is changed by SSA.** (emphasis added)
> …
> (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:
> …
> (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.

12. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 1440.0116, Assistance for Ineligible Noncitizens (MSSI, SFP):

> 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.

13. The Policy Manual at 1440.1203, Blind/Disability Requirement (MSSI, SFP) explains:

> If an individual is not aged, he must meet the factor of blindness and/or disability.
> Blindness is defined as central visual acuity of 20/200 or less in the better eye with the use of a corrective lens.

> Note: Blindness does not apply to the MEDS-AD Program.
> Disability is defined as:
> 1. the inability to engage in any substantial activity due to any medically determinable physical or mental impairment, and
> 2. a disability which has lasted or can be expected to last for a period of at least 12 consecutive months or **result in death.** (emphasis added)

14. The Policy Manual at 0640.0104, Expedited Service for Disability-Related Medicaid (MSSI, SFP) explains:

> Screen applications for disability related Medicaid to see if an expedited interview is necessary. Provide eligible AGs expedited services regardless of whether or not they are requested.
> Individuals or families are entitled to expedited services if an AG member is:
> 1. under age 65 and claiming a disability; and
> 2. not currently receiving SSI or SSDI benefits from the Social Security Administration (SSA),…
> Provide the individual a copy of the Screening for Expedited Medicaid Appointments form. Inform the individual that the Department uses all recorded information to determine eligibility for an expedited interview.
> Provide individuals eligible for expedited services with a notice of the time and date of the scheduled interview.
> Schedule an interview for an expedited applicant within three working days; conduct an interview and complete the disability packet within seven calendar days of the date of application. If the application is dropped off or mailed, contact the household by phone to tell them of the scheduled appointment, and mail a follow-up appointment notice. If unable to reach the applicant by phone, schedule the appointment five to seven calendar days from the application date.
> Provide individuals with a brochure titled Notice of Disability Information and Request Form. The brochure includes a list of the information the individual will need to bring to the interview to complete the disability forms used by the Division of Disability Determinations to determine whether the applicant is disabled. The date of the scheduled interview is the verification due date for these households. The notice/brochure will also advise the individual that failure to show for the interview or to bring the requested information to the interview may delay application processing.
> Document the date the applicant receives the notice/brochure.

15. The cited authorities explain an independent decision cannot be made on a SSA disability denial decision. However, SSA did not make a disability determination in this case, it denied petitioner's disability claim due to his non-citizenship status.

16. The above-cited authorities set forth the rules for processing applications and determining eligibility in the Adult-Related Medicaid Program. The respondent should have addressed the petitioner's request for disability Medicaid within the required 90-days time standard from the date of the applications.

17. The undersigned concludes that a State disability determination should have been completed. However, a favorable disability determination by DDD cannot be guaranteed. Delay by the respondent does not create automatic eligibility as the State must follow the Social Security disability standards in accordance with federal regulations found at 42 C.F.R. § 435.540: "Definition of disability. (a) Definition. The agency must use the same definition of disability as used under Supplemental Security Income (SSI)…"

18. While a final determination of disability cannot be guaranteed because of federal definitions, the respondent's processing delay needs to be remedied as quickly as possible. Therefore, this matter is remanded back to the Department to obtain the necessary information and forward all the required documentation to DDD to complete a disability determination. The respondent is to preserve and honor the petitioner's applications dated May 21, 2015 and July 14, 2015, including the retroactive months of February, March, April, May and June 2015. The respondent is to issue a written Notice of Case Action (NOCA) to the petitioner and his representative as soon as possible,

including his appeal rights, upon competition of the Adult-Related Medicaid eligibility determination.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted and remanded back to the Department to take correction 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 01 day of February, 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

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

FILED
Feb 24, 2016
Office of Appeal Hearings
Dept. of Children and Families

[redacted]

APPEAL NO. 15F-09284

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.
_____/

FINAL ORDER

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

APPEARANCES

For the Petitioner: [redacted] the petitioner's mother.

For the Respondent: Linda Latson, Registered Nurse Specialist, Agency for Health Care Administration (AHCA).

STATEMENT OF ISSUE

At issue is whether the Agency's denial of a dental procedure was correct. The petitioner carries the burden of proving his case by a preponderance of the evidence.

PRELIMINARY STATEMENT

Present as witnesses for the respondent were Stacey Larson, Clinical Guidance Analyst, with Humana; Jacqueline Salcedo, Complaints and Grievances Representative with DentaQuest; and Dr. Susan Hudson, Dental Director with DentaQuest.

[redacted]

The respondent submitted into evidence Respondent Exhibit 1 and 2.

FINDINGS OF FACT

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

1. The petitioner is nineteen years of age and is a Medicaid recipient living in Broward County, Florida. He is enrolled in the Medicaid MMA (Managed Medical Assistance) Program with Humana. Humana is a Managed Care Organization that is authorized by AHCA to make certain prior service authorization decisions for individuals enrolled in Medicaid MMA Programs. DentaQuest is contracted by Humana to provide dental services and perform prior authorization reviews.

2. DentaQuest received a prior service authorization request from the petitioner's treating dental surgeon on October 22, 2015 for periodontal scaling and root planning, also known as a deep cleaning, for all four quadrants of the petitioner's mouth. DentaQuest reviewed this request and provided an Authorization Determination notice to the petitioner's dental provider on October 26, 2015. The determination indicated "periodontal scaling and root planning is denied due to no evidence of bone loss." The

above referenced notice indicated procedure code D4341 was denied for each quadrant.

3. DentaQuest sent the petitioner a Notice of Action on October 26, 2015 regarding the above noted decision which states in part:

> We made our decision because:
>
> Must be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain
>
> Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not in excess of the patient's needs
>
> Must meet accepted medical standards not be experimental or investigational;

4. The respondent's dental physician witness indicated several dentist from DentaQuest reviewed the information presented by the petitioner's treating dentist, including the X-rays, and found no evidence of bone loss that would meet the criteria for the service request to be approved. She also indicated that there was no evidence of buildup of root surface deposits on the petitioner's gums for this request, plus there was no evidence of gum disease for the petitioner to meet the medical necessity criteria. She indicated that the procedure requested is a procedure that would be done for an individual with gum disease.

5. The petitioner's representative argued that two of the petitioner's dentist agreed that the deep cleaning is necessary for the petitioner. She argued that she understood that the petitioner may not have gum disease at this time, but why wait until it was too late to have this procedure done for the petitioner.

6. The dental witness for the respondent indicated that the provisions of the EPSDT Program were reviewed for this decision. She also indicated that normal daily tooth brushing twice a day along with flossing will be sufficient preventive measures for future tooth problems for the petitioner.

CONCLUSIONS OF LAW

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

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

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

10. The Dental Services Coverage and Limitations Handbook (November 2011) which has been incorporated by reference into Chapter 59G-4, Fla. Admin. Code states on page 2-15,:

> Scaling and Root Planing
>
> Scaling and root planing involves instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus and stains. **It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature** [emphasis added].
>
> This is a definitive, meticulous treatment procedure designed to remove cementum or dentin that is rough, and may be permeated by calculus, or

contaminated with toxins or microorganisms. It may be used as a definitive treatment in some stages of periodontal disease or a part of pre-surgical procedures in others.

Scaling and root planing procedures are limited to beneficiaries under 21 years of age who exhibit generalized periodontal pocket depths in the 4-5 mm range. Significant periodontal pockets must be indicated in the patient's dental record. The provider may use Appendix E, Sample Periodontal Chart, or the tooth chart in the patient's record for charting periodontal pockets.

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

(166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

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

12. The State Medicaid Manual in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services section states in part:

5010. Overview

A. Early and Periodic Screening, Diagnostic and Treatment Benefit.-- Early and periodic screening, diagnostic and treatment services (EPSDT)

is a required service under the Medicaid program for categorically needy individuals under age 21…

5110. Basic Requirements

OBRA 89 amended §§1902(a)(43) and 1905(a)(4)(B) and created §1905(r) of the Social Security Act (the Act) which set forth the basic requirements for the program. Under the EPSDT benefit, you[1] must provide for screening, vision, hearing and dental services at intervals which meet reasonable standards of medical and dental practice established after consultation with recognized medical and dental organizations involved in child health care. You must also provide for medically necessary screening, vision, hearing and dental services regardless of whether such services coincide with your established periodicity schedules for these services. Additionally, the Act requires that any service which you are permitted to cover under Medicaid that is necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be provided to EPSDT participants regardless of whether the service or item is otherwise included in your Medicaid plan.

13. Section 409.913, Florida Statutes addresses "Oversight of the integrity of the Medicaid program," with (1)(d) describing "medical necessity or medically necessary" standards and stating in relevant part: "For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity." As indicated 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.

14. As shown in the Findings of Fact, DentaQuest denied the petitioner's request for dental procedure codes D4341, which is periodontal scaling and root planning for all quadrants of the petitioner's mouth and also known as deep cleaning.

[1] "You" in this manual context refers to the state Medicaid agency.

15. For the case at hand, the respondent argued that after review of the information submitted for the request, including the X-rays, DentaQuest found no evidence of bone loss, buildup of root surface deposits on the petitioner's gums, or any evidence of gum disease that would meet the medical necessity criteria to be approved. The hearing officer agrees with the respondent's arguments. Before the Agency can approve treatment for periodontal disease, the petitioner must show he indeed has periodontal disease, which is not the case.

16. After considering the evidence and all of the appropriate authorities set forth in the findings above, the hearing officer concludes that the petitioner has not met his burden of proof and the Agency's action denying the petitioner's request for the above noted dental procedure is correct.

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 24 day of February, 2016,

in Tallahassee, Florida.

Robert Akel

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

FILED
Feb 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,

APPEAL NO. 15F-09304

Vs.

[redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 Brevard
UNIT: 55207

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 9:30 a.m. on December 11, 2015.

APPEARANCES

For the Petitioner: [redacted] pro se

For the Respondent: Anthony Barresi, ACCESS Supervisor

STATEMENT OF ISSUE

At issue is whether the respondent's action to enroll petitioner in the Medically Needy (MN) Program with a Share of Cost (SOC) is proper. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

By notice dated October 16, 2015, the respondent (or the Department) notified the petitioner her September 18, 2015 application was approved for MN with a $659 SOC. Petitioner timely requested a hearing to challenge enrollment in the MN program.

Petitioner did not submit exhibits. Respondent submitted five exhibits, entered as Respondent Exhibits "1" through "5". The record was held open through end of business day on December 11, 2015, for the respondent to submit an additional exhibit. The exhibit was received timely and entered as Respondent Exhibit "6". The record was closed on December 11, 2015.

FINDINGS OF FACT

1. On September 18, 2015, petitioner (age 50) submitted a Medicaid application for herself. The application indicates petitioner is disabled and receives $859 Social Security Disability Income (SSDI).

2. Petitioner receives Medicare part "B". Therefore, she is not eligible for full Medicaid benefits. The next available program is the MN with a SOC.

3. The Department determined petitioner's SOC as follows:

$859.00	SSDI
-$ 20.00	unearned income disregard
-$180.00	MN Income Limit (MNIL) for a household size of one
$659.00	SOC

4. October 16, 2015, the Department notified the petitioner her September 18, 2015 application was approved and she was enrolled in MN with a $659 SOC.

5. Petitioner asserts that the 2015 Florida Poverty Line Guidelines list $980.83 as the income limit for a family size of one; therefore, she is eligible for full Medicaid. Petitioner did not submit evidence to support her assertion.

6. Respondent's representative responded that the State of Florida has two different Medicaid programs; Family-Related Medicaid and SSI-Related Medicaid. And petitioner is considered in the SSI-Related Medicaid due to receiving SSDI.

7. Petitioner responded that she understands the reason she is not eligible for full Medicaid. And would like something in writing stating she is not eligible for full Medicaid.

CONCLUSIONS OF LAW

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

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

10. 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.

11. Petitioner does not have minor children and is not pregnant; therefore, she is not eligible for Family-Related Medicaid. Petitioner is a disabled adult; therefore, her eligibility is determined under SSI-Related Medicaid.

12. 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

13. Fla. Stat. § 409.904 Optional payments for eligible persons in part states:

> (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.

14. In accordance with the above authority petitioner is not eligible for full Medicaid because she is Medicare eligible and is not receiving "Medicaid-covered institutional care services, hospice services, or home and community-based services".

15. 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"…

16. The above authority explains MN provides coverage for individuals who do not qualify for full Medicaid due to income.

17. Federal Regulations at 20 C.F.R. § 416.1124 explain unearned income not counted and states in part "(c) Other unearned income we do not count… (12) The first $20.00 of any unearned income in a month…"

18. The Fla. Admin. Code R. 65A-1.716 sets forth the MNIL at $180 for a family size of one.

19. In accordance with the authorities, respondent deducted $20 unearned income and $180 MNIL from petitioner's $859 SSDI to arrive at $659 SOC.

20. In careful review of the cited authorities and evidence, the undersigned concludes the respondent is correct in approving petitioner in the MN program with a $659 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 02 day of February, 2016,

in Tallahassee, Florida.

Priscilla Peterson

Priscilla Peterson
Hearing Officer
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Copies Furnished To [redacted] Petitioner
Office of Economic Self Sufficiency

FILED
Jan 14, 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-09325

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above matter on January 5, 2016 at 1:04 p.m.

APPEARANCES

For the Petitioner: [redacted]
Petitioner's Husband

For the Respondent: Doretha Rouse
Registered Nurse Specialist

ISSUE

Whether respondent's denial of petitioner's request for the following services through the Statewide Long Term Managed Care Program (LTMC Program) was proper:

- 31.5 hours per week of additional personal care services
- 25.0 hours per week of additional respite services
- 2.0 hours per week of homemaker services
- 24.5 hours per week of companion services

The burden of proof for each service was assigned to the petitioner.

PRELIMINARY STATEMENT

Petitioner was not present. The representative provided a Durable Power of Attorney appointing him as petitioner's attorney-in-fact. The document was admitted as petitioner's exhibit "1".

Ms. Rouse appeared as both a representative and witness for the respondent. Present from Humana/American Eldercare were: Mindy Aikman, Grievance and Appeals Specialist; Etzer Thomas, Clinical Front Line Leader; Stacey Larsen, Clinical Guidance Analyst; Sounedy Amedee, Care Manager; and Dr. Teresita Hernandez, Medical Director. Respondent's exhibits "1" and "2" were entered into evidence. Administrative notice was taken of the Florida Medicaid Provider General Handbook.

The record was held open through January 12, 2016 for respondent to provide contract service definitions; an assessment; and a Plan of Care. Information was timely received and entered as respondent's exhibit "3". Petitioner did not wish to provide a written response to the post hearing submissions.

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 79 years of age and resides with her husband.

2. At all times relevant to this proceeding, petitioner was Medicaid eligible.

3. 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.

4. Respondent does not have a promulgated Coverage and Limitations Handbook for the LTMC Program. LTMC services descriptions are defined by contract.

5. Effective November 1, 2015 Petitioner's LTMC services have been provided by Humana/American Eldercare. Prior to that date, petitioner was not eligible for the LTMC Program.

6. Upon becoming eligible for the LTMC Program, Humana/American Eldercare conducted an assessment. The purpose was to determine medically necessary services.

7. Based on petitioner's assessment, the following Finding of Facts are made:

- Diagnosed with early [redacted]
- Assistance is required with bathing and dressing
- No assistance need with eating
- Incontinent of bladder
- Frequent incontinence of bowel
- Easily confused
- Recent back surgery resulted in paralysis in the lower extremities
- Uses a wheelchair

8. Humana/American Eldercare determined 9 hours per week of personal care services (PCS) and 36 hours per week of respite were medically necessary.

9. PCS and respite services are provided from 11: 00 a.m. to 8:00 p.m.; Monday through Friday.

10. Petitioner thereafter requested the following services:

- 31.5 hours of PCS
- 25 hours per week of additional respite services

- 2 hours per week of homemaker services
- 24.5 hours per week of companion services

11. Dr. Hernandez reviewed petitioner's request. The following Notices of Action were issued:

Service:	Notice Date:	Decision:	Rationale:
PCS	October 22, 2015	Denied	9 hours of PCS and 36 hours of respite meets petitioner's need. Not medically necessary.
Respite	October 30, 2015	Denied	36 hours of respite and 9 hours of PCS meets petitioner's need. Not medically necessary.
Homemaker	October 22, 2015	Denied	36 hours of respite and 9 hours of PCS meets petitioner's need. Not medically necessary.
Companion	October 22, 2015	Denied	36 hours of respite and 9 hours of PCS meets petitioner's need. Not medically necessary.

12. On November 6, 2015 petitioner's representative contacted the Office of Appeal Hearings and requested a fair hearing.

13. Petitioner's husband is 85 years of age. He was recently hospitalized for [redacted]. A family member provides some assistance on the weekends. He currently self-pays for an additional five hours per week of in-home assistance.

14. Petitioner's representative argues 24 hour care is necessary.

15. Respondent argues that 45 properly scheduled hours per week would meet the petitioner's need. This would include not using the hours in a consecutive block of hours. Rather, several shorter shifts throughout the day and evening should be implemented.

16. Respondent asserts placement in an assisted living or skilled nursing facility has been offered. Petitioner's representative declined this type of care.

CONCLUSIONS OF LAW

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

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

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

20. 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.

21. Humana/American Eldercare is the managed care entity providing petitioner's LTMC services.

22. Regarding the LTMC Program, Humana/American Eldercare and the respondent entered into a contractual relationship. The contract defines required services.

23. Florida Medicaid, which includes the LTMC Program, only covers those services determined to be medically necessary. See § 409.905 (4) (c), Fla. Stat.

24. The definition of medical necessity is found in Fla. Admin Code. R. 59G-1.010 and states:

> (166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:

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

25. Analysis is first directed to petitioner's request for additional respite and PCS. Respondent's contract with Humana/American Eldercare provides the following definitions:

> (21) Respite Care — 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.
>
> (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.

26. Petitioner is approved for 36 hours per week of respite and 9 hours per week of PCS. This equates to 45 services hours each week.

27. A respite provider assists an individual not able to care for themselves. As such, petitioner's personal care needs can be addressed by both respite and PCS providers.

28. Petitioner's need for both supervision and personal care is not disputed. The combined 45 hours for PCS and respite, however, are currently used in nine hour blocks; Monday through Friday. Compelling evidence was not presented that utilizing the 45 hours in multiple daily blocks during the course of seven days would jeopardize petitioner's health status.

29. Petitioner did not demonstrate that additional PCS and respite services are medically necessary.

30. Analysis is next directed to the new services categories requested by the petitioner. The contract provides the following definitions:

> (11) Homemaker Services — General household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control may be included in this service.
>
> (1) Adult Companion Care[1] – 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.

31. It is noted that the definition for PCS also identifies homemaker duties as a component of that service. A respite provider can also address meal preparation.

[1] Companion definition was found at: http://ahca.myflorida.com/medicaid/statewide_mc/plans.shtml

32. Evidence was not presented why those duties to be performed by a homemaker are not already being met by the respite and PCS providers.

33. Petitioner has not established that two hours a week of homemaker services are medically necessary.

34. Regarding companion services, petitioner's representative requested 24.5 hours each week. It is not clear when these hours would be utilized and for what purpose. Regardless, the current PCS and respite are able to address socialization needs. They are with the petitioner 45 hours per week. It was not demonstrated that personal interchanges could not take place during those timeframes.

35. Petitioner has not established that 24.5 hours per week of companion services is medically necessary.

36. Petitioner has not established that an increase in PCS and respite and adding homemaker and companion services have 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;
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider…

37. Petitioner has not demonstrated, by the greater weight of the evidence, that respondent's actions in this matter were improper.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 14 day of January, 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
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Judy Jacobs, Area 7, AHCA Field Office

FILED
Feb 09, 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-09326
APPEAL NO. 15F-09440

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 19 St. Lucie
UNIT: 88586

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on January 6, 2016 at 10:04 a.m. in [redacted] Florida and reconvened telephonically on January 27, 2016 at 10:31 a.m.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Ronda Lanum, supervisor

STATEMENT OF ISSUE

At issue is the amount of Food Assistance Program (FAP) benefits the petitioner was approved to receive at recertification. The petitioner carries the burden of proof by the preponderance of evidence in the FAP appeal.

The petitioner is also appealing the Medically Needy Program with an estimated share of cost (SOC). He is seeking a lower SOC. The petitioner caries the burden of proof by the preponderance of evidence in the Medicaid appeal.

PRELIMINARY STATEMENT

The Department presented one exhibit which was entered into evidence and marked as Respondent's Composite Exhibit 1. The petitioner presented two exhibits which were entered into evidence and marked as Petitioner's Composite Exhibits 1 and 2.

On January 27, 2016, the hearing reconvened. At that hearing, the Department presented one exhibit which was accepted into evidence and marked as Respondent's Composite Exhibit 2. No additional exhibits were presented by the petitioner.

[redacted] petitioner's brother, was present on January 6, 2016.

A continuance was granted to the petitioner for an in person hearing.

FINDINGS OF FACT

1. On October 21, 2015, the petitioner submitted a recertification application for FAP benefits and Medicaid benefits. He was the only person listed on his recertification application. He listed expenses for property taxes of $67.61, condominium maintenance of $6.25, homeowner's insurance of $163.25, electricity of $200, trash and telephone. He also listed medical expenses for prescription drugs of $8.38 and expenses for medical transportation of $31.25. He is 58 years old and receiving Social Security Disability income (SSDI) of $667. It is his only source of income. He is also receiving Medicare benefits. The state of Florida is paying his Medicare Part B premium. On his recertification application, he also listed total billed medical expenses

for [redacted] of $382.93, exit tax $29, dental lab/ dental cleaning of $30 and a dentist bill in Costa Rica of $1,212.

2. On October 27, 2015, the petitioner provided verification of his shelter expenses for property tax annually of $811.33, homeowners insurance of $1,524, flood of $430 and association fee of $75. He also provided proof of his medical expenses for co-payments for his prescriptions, transportation cost to his dentist in Costa Rica [redacted] dental invoice (bill) and lodging in Costa Rica. He provided his credit card statement which showed payments he made for dental expenses billed to him. His last payment was made on October 2, 2015. He also provided verification for seven different prescriptions every 90 days of $2.65 each.

3. On October 28, 2015, the petitioner contacted the Department regarding the verification.

4. On October 28, 2015, the Department pended the petitioner to provide monthly recurring medical bills.

5. On November 02, 2015, the Department contacted the petitioner to discuss his transportation expenses and informed him that transportation expenses can only be used to meet his SOC and not a medical expense in the FAP budget.

6. The petitioner's case record was updated with his medical costs of $6.18. He was determined eligible for $137 in FAP benefits for November 2015 ongoing.

7. The Department's calculation is as follows. To determine the FAP benefits for November 2015, December 2015, and January 2016 ongoing, the respondent counted the petitioner's gross monthly income of $667. It subtracted $155 resulting in a total adjusted income of $512. There were no excess medical expenses given as the

petitioner's total medical cost of $6.18 did not exceed the medical deduction of $35. The shelter cost of $236.15 was added to the Standard Utility Allowance of $345 to get the total shelter/utility cost of $581. Fifty percent of the adjusted net income ($256) is the standard shelter. This was subtracted from the total shelter/utility, resulting in $325.15. This was subtracted from the adjusted income ($512) resulting in $186 as the Food Assistance adjusted income. The maximum net income limit for a household size of one is $981. As the petitioner's net income was lower than the maximum net income limit, the respondent proceeded to calculate the benefit reduction. The Food Assistance adjusted income of $186 was multiplied by 30%, to get the benefit reduction of $57 (rounded up). This was subtracted from the maximum FAP amount of $194 resulting in $137. The Department used the same methodology for December 2015, ongoing.

7(a) November 2015, FAP Budget.

SSDI	$667
Total household income	667
Standard deduction for a household of 1	($155)
Excess medical expenses (6.18-35=0)	($0)
Adjusted income after deductions	**$512**
Shelter costs	$236.15
Standard utility Allowance	$345
Total shelter/utility cost	$581.15
Shelter standard (50% adjusted income)	($256)
Excess shelter deduction	$325.15
Adjusted income	$512
Excess Shelter Deduction	($325.15)
Adjusted income after shelter	**$186.85**

deduction

Thrifty Food Plan for HH1	$194
30% of $186.85	($57)
Monthly Allotment	$137

7(b). December 2015, FAP budget.

SSDI	$667
Total household income	667
Standard deduction for a household of 1	($155)
Excess medical expenses (7.07-35=0)	($0)
Adjusted income after deductions	**512.**
Shelter costs	$285.02
Standard utility Allowance	$345
Total shelter/utility cost	$630.02
Shelter standard (50% adjusted income)	($256)
Excess shelter deduction	$374.02
Adjusted income	$512
Excess Shelter Deduction	($374.02)
Adjusted income after shelter deduction	**$137.98**
Thrifty Food Plan for HH1	$194
30% of $137.98	($42)
Monthly Allotment	$152

7(c). January 2016, FAP budget.

SSDI	$667
Total household income	667
Standard deduction for a household of 1	($155)

Excess medical expenses (7.07-35=0)	($0)
Adjusted income after deductions	**$512**
Shelter costs	$216.27
Standard utility Allowance	$345
Total shelter/utility cost	$561.27
Shelter standard (50% adjusted income)	($256)
Excess shelter deduction	$305.27
Adjusted income	$512
Excess Shelter Deduction	($305.27)
Adjusted income after shelter deduction	**$206.73**
Thrifty Food Plan for HH1	$194
30% of $206.73	($63)
Monthly Allotment	$131

8. To determine the petitioner's SSI-Related Medicaid benefits, the respondent determined the petitioner's gross income of $667. The respondent determined the petitioner was not eligible for full Medicaid as he was receiving Medicare benefits. The respondent proceed to enroll him in the Medically Needy Program with a share of cost (SOC) based on his income.

9. The respondent performed the following budget calculations when it determined the petitioner's estimated SOC. It determined the petitioner's monthly gross income was $667. A $20 unearned income disregard was subtracted resulting to $647 as the petitioner's countable income. The Medically Needy Income Limit of $180 for household size of one was subtracted resulting to $467 as the petitioner's SOC.

10. On November 23, 2015, the respondent approved FAP benefits and sent the petitioner a Notice of Case Action informing him he was approved for $137 in FAP benefits. The same notice informed him that his Medically Needy has been reviewed and he was eligible for continued Medicaid coverage.

11. On November 6, 2015, the petitioner requested a hearing to have his FAP benefits reviewed and also to challenge his enrolment in the Medically Needy Program with an estimated SOC.

12. At the hearing, the petitioner argued that his out of pocket medical expenses for his dental implants, transportation and lodging in Costa Rica should be used as medical cost/deduction in both his FAP budget and SOC budget. He provided dental expenses billed on August 24, 2015 and August 25, 2015 for service in Costa Rica, [redacted] transportation of $382.93 ($765.86 for himself and his brother divided by two), travel insurance of $57.44. He provided an invoice with his brother's name from [redacted] lodge in Costa Rica for the period August 17, 2015, through August 27, 2015. He explained that he has to repay his brother for those expenses. The petitioner also provided a pharmacy printout from [redacted] showing he paid $2.65. There were seven recurring prescriptions every 90 days. He also provided proof of his doctor's visits and his patient responsibility for 14 doctors (average $43.19 monthly). The petitioner explained he also paid for homeowner's insurance, flood insurance, property taxes and homeowner's association. He provided three checks made payable to [redacted] Two of the checks were for his homeowners insurance, broken into two payments of $860 and $664. The other check was for his flood insurance of $430. He provided four checks made payable to [redacted] County Tax Collector for property tax

of $204.13, $210.44, $196.81, $199.95. He also provided a statement from [redacted] [redacted]Property Owners Association for $75 annually. The petitioner's verified monthly shelter cost is $236.25.

CONCLUSION 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.

The FAP benefits issue will be addressed first:

15. Federal regulation C.F.R. § 273.9 addresses income/allowable deductions budgeting in the FAP in part and states:

> (a) Income eligibility standards. Participation in the Program shall be limited to those households whose incomes are determined to be a substantial limiting factor in permitting them to obtain a more nutritious diet.
> (b) Definition of income…
> (2) Unearned income shall include, but not be limited to: …
> (ii) Annuities; pensions; retirement, veteran's, or disability benefits; worker's or unemployment compensation including any amounts deducted to repay claims for intentional program violations as provided in §272.12; old-age, survivors, or social security benefits…

16. Federal regulation 7 C.F.R. § 273.9(d) sets forth the specific deductions allowable in the calculation of the final Food Assistance Program benefit allotment. These **potential allowable deductions** are limited to include only: (1) standard deduction, (2) earned income deduction, (3) excess medical deduction, (4) dependent

care deduction, (5) child support deduction, (6) standard utility allowance, and shelter expenses.

17. The respondent must follow these federal budgeting guidelines when determining eligibility. It also directs the Department to consider Social Security Disability Income, as unearned income that must be included in the eligibility determination.

18. The federal regulation 7 C.F.R. § 273.10 (e) addresses "Calculating net income and benefit levels" as follows:

> (1) Net monthly income (i)…
> (A) Add the gross monthly income earned by all household members and the total monthly unearned income of all household members, minus income exclusions, to determine the household's total gross income…
> (C) Subtract the standard deduction.
> (D) If the household is entitled to an excess medical deduction as provided in §273.9(d)(3), determine if total medical expenses exceed $35. If so, subtract that portion which exceeds $35.
> (H) Total the allowable shelter expenses to determine shelter costs, unless a deduction has been subtracted in accordance with paragraph (e)(1)(i)(G) of this section. Subtract from total shelter costs 50 percent of the household's monthly income after all the above deductions have been subtracted. The remaining amount, if any, is the excess shelter cost, compute the shelter deduction according to paragraph (e)(1)(i)(I) of this section.
> (I) Subtract the excess shelter cost up to the maximum amount allowed for the area (unless the household is entitled to the full amount of its excess shelter expenses) from the household's monthly income after all other applicable deductions. Households not subject to a capped shelter expense shall have the full amount exceeding 50 percent of their net income subtracted. The household's net monthly income has been determined.
> (2) Eligibility and benefits…
> (ii)(A)…the household's monthly allotment shall be equal to the maximum food stamp allotment for the household's size reduced by 30% of the household's net monthly income…

19. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, at Appendix A-1, establishes the income and deductions standards as follows. Effective

October 2015, the 200% Federal Poverty level (FPL) for a household size of one is $1,962. A one-person assistance group's net income limit is $981, the standard deduction is $155 and the Standard Utility Allowance is $345. The same reference shows the maximum FAP benefits for one person as $194 effective October 2014.

20. The Policy Manual at section 2410.0355 addresses Allowable Medical Expenses (FS) and states:

> Allowable medical expenses are:
> **1. Medical and dental care,** including psychotherapy and rehabilitation services provided by a licensed practitioner authorized by state law, or by other qualified health professional**. (emphasis added)**
> 2. Hospitalization or outpatient treatment, nursing care, and nursing home care provided by a facility recognized by the state (an assistance group (AG) would continue to be eligible for an excess medical adjustment for the medical expenses of a former individual who is 60 or over or receives SSI or Social Security disability even after that individual becomes hospitalized, institutionalized or dies if the remaining AG individuals are legally responsible for payment of the expenses).
> 3. Prescription drugs when prescribed by a licensed practitioner authorized under state law, and other over-the-counter medication (including insulin), medical supplies, sickroom equipment (either rented or purchased), or other prescribed equipment when approved by a licensed practitioner or other qualified health professional.
> 4. Dentures, hearing aids, and prosthetics.
> 5. Eyeglasses or contact lenses prescribed by a physician skilled in eye disease or by the optometrist.
> 6. Health and hospitalization insurance policy premiums. If the insurance policy covers more than one AG individual, only that portion of the medical insurance premium assigned to the AG individual(s) eligible for the medical deduction may be allowed. In the absence of specific information on how much of the premium is for an AG individual eligible for a medical deduction, proration may be used to determine the amount to be allowed.
> 7. The cost of health and accident policies such as those payable in lump sum settlements for death or reimbursement, or income maintenance policies such as those that continue mortgage or loan payments while the beneficiary is disabled, are not deductible.
> 8. Medicare premiums related to coverage under Title XVIII of the Social Security Act, any cost sharing or spend down expenses incurred by Medicaid individuals.
> 9. Securing and maintaining a Seeing Eye or hearing dog, including the cost of dog food and veterinarian bills.

> **10. Reasonable cost of transportation and lodging to obtain medical treatment or services. Count the actual costs of transportation to get medical treatment or services, including costs of travel to buy medicine. If the actual cost of transportation is unknown, use the current mileage allowance in effect for state employees. (emphasis added)**
> 11. Maintaining an attendant, homemaker, home health aide, or child care or housekeeper services if necessary due to age, infirmity, or illness. In addition, an amount equal to one individual benefit shall be considered a medical expense if the AG furnishes the majority of the attendant's meals…

21. The above allows dental care as a deduction in the FAP program. It also allows for transportation costs and lodging as deductions for medical treatment. Therefore, based on the above policy, the petitioner is allowed deductions for dental expenses, transportation costs and lodging for only the days he had dental procedures performed.

22. The Policy Manual section 2410.0357 addresses Normally Recurring Medical Expenses (FS) and states:

> Normally recurring medical expenses shall be calculated based on medical expenses for which the assistance group (AG) expects to be billed or otherwise have due during the certification period less any expected reimbursements. Anticipation of medical expenses shall be based on the most current bill if it is the best indication of the anticipated expense. A history of past medical expenses can be used to anticipate continuing expenses. If past prescriptions and other medical expenses are obtainable, they may be used to average monthly costs if the expenses are expected to continue.
> The eligibility specialist can determine if they are anticipated by:
> 1. public or private medical insurance coverage,
> 2. discussion with the individual,
> 3. knowledge of the type of illness the individual has,
> 4. past history, including current verified medical expenses, and/or
> 5. contact with the doctor if necessary.
> If the AG is reasonably certain that a change will occur, the anticipated expense will be based on the best available information.
> AGs anticipating that they will incur a medical expense several months into the certification period and providing adequate verification at the time eligibility is determined can have the expense averaged over the entire certification period. One-time changes reported during a certification period will be allowed as a one-time expense in the amount billed or due

> or averaged over the remainder of the certification period at the AG's option.

23. The Policy Manual at section 2410.0358 Fluctuating Medical Expenses (FS) states:

> If normally recurring medical expenses fluctuate monthly but are anticipated for the certification period, average expenses over the certification period. If billed or due less often than monthly, average over the period between scheduled billings. When a normally recurring medical expense begins during the certification period, the expense, less reimbursements, is allowed beginning with the month the change would be effective.

24. The Policy Manual at section 2410.0360 addresses One-Time Medical Expense (FS) states:

> **For prospective budgeting and beginning months, one-time medical expenses might, in some instances, be anticipated. If anticipated and verified prior to certification, the assistance group (AG) is eligible for the medical disregard and has the option of deducting the full amount, less reimbursements, in the month billed or due, or averaging the amount due over the certification period.**

25. According to the above policy the petitioner can choose to average One-Time Medical Expenses (dental expenses) over his certification period. Since the petitioner incurred dental expenses in August 2015 this expenses can be averaged over his certification period.

26. The undersigned reviewed the Department's calculation of the petitioner's FAP budget for November 2015, ongoing and found the petitioner was credited with a standard deduction and an excess shelter deduction. There were no deductions for excess medical expenses. The Department only allowed a total medical cost of $6.18. According to the Department's Policy Manual, the petitioner's dental expenses (August 2015) is One-Time Medical Expense and can be averaged over his certification period.

The petitioner's transportation of $383.93 and his lodging (dental service dates) are allowable. The petitioner's Out of Pocket expenses to doctors are also allowed. On October 27, 2015, the petitioner provided proof of monthly shelter cost totaling $236.25 (home owners insurance, flood insurance, property tax and homeowners association). The Department approved FAP benefits on November 23, 2015 without consideration of his medical expenses or reported and verified shelter expenses in October 2015.

27. After considering the evidence, the testimony, and the appropriate authorities cited above, the hearing officer concludes the respondent erred in the calculation of the petitioner's FAP benefits. This appeal is remanded to the Department to allow the petitioner's medical expenses as stated above in his FAP budget and to also the update the shelter expense as verified by the petitioner on October 27, 2015 prior to the Department's disposition of the petitioner's application.

Medicaid benefits will now be addressed:

28. The Department determined the petitioner's Medicaid benefits under the SSI Related Program.

29. 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. 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.

31. The Policy Manual, at Appendix A-9, lists the MEDS-AD income limit as $864 for an individual effective July 2015.

32. The above controlling authorities explain the full Medicaid coverage group (MEDS-AD Demonstration Waiver) in the SSI-Related Program is for individuals whose income is below the federal poverty level and are not receiving Medicare. The MEDS-AD income limit for an individual is $864. The petitioner is receiving Medicare Part B paid by the state; therefore, he is 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:

33. 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.

34. 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.

35. The above authority explains the Medically Needy Program is a coverage group for aged, blind or disabled individuals who do not qualify for full Medicaid due to the level of income.

36. 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.

37. 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…"

38. Income budgeting is set forth in Fla. Admin. Code R. 65A-1.713. It states:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
> (h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses…
> (4) (c) Medically Needy. The amount by which the individual's countable income exceeds the Medically Needy income level, called the "share of cost", shall be considered available for payment of medical care and services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical costs. If countable income exceeds the Medically Needy income level the department shall deduct allowable medical expenses in chronological order, by day of service. Countable income is determined in accordance with subsection 65A-1.713(2), F.A.C. To be deducted the expenses must be unpaid, or if paid, must have been paid in the month for which eligibility is being determined or incurred and paid during the three previous calendar months to the month for which eligibility is being determined but no earlier than the three retroactive application months. The paid expense may not have been previously deducted from countable income during a period of eligibility. Medical expenses reimbursed by a state or local government not funded in full by federal funds, excluding Medicaid program payments, are allowable deductions. Any other expenses reimbursable by a third party are not allowable deductions. Examples of recognized medical expenses include:
> 1. Allowable health insurance costs such as medical premiums, other health insurance premiums, deductibles and co-insurance charges; and,
> 2. Allowable medical services such as the cost of public transportation to obtain allowable medical services; medical services provided or prescribed by a recognized member of the medical community; and personal care services in the home prescribed by a recognized member of the medical community.

39. Fla. Admin. Code R. 65A-1.716 (2), Income and Resource Criteria, sets forth the Medically Needy Income Level for one person at $180.

40. The above rule states the SOC is determined by subtracting the Medically Needy Income Level from the family's income. For the petitioner, the determination of the SOC is the monthly income of $667 less a $20 disregard, less the MNIL of $180, which resulted in a share of cost of $467 effective October 2015 and ongoing. Eligibility for a lower SOC is not found.

41. The Policy Manual at passage 2440.0102, Medically Needy Income Limits (MSSI) states:

> When the assistance group has met the technical eligibility criteria and the asset limits, it is enrolled. There is no income limit for enrollment. The assistance group is income eligible (entitled to Medicaid) once income is less than or equal to the Medically Needy Income Level (MNIL) or medical bills equal the amount by which his income exceeds the MNIL. Once medical bills are equal to this surplus income, referred to as share of cost, the assistance group is eligible.
> The eligibility specialist must determine eligibility for Medically Needy any time the assistance group's income exceeds the income limits for another full Medicaid Program.

42. A review of the rules did not find any exceptions to the income limits. The undersigned concludes the Department correctly followed its policy in determining the SOC. The undersigned concludes the respondent's actions to deny full-coverage Medicaid and enroll the petitioner in the Medically Needy Program with a monthly share of cost in the amount of $467 was a correct action. A lower share of cost was not found.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal for FAP benefit is granted and remanded to the Department to determine eligibility protecting the petitioner's application dated October 21, 2015 taking

into consideration the medical expenses and shelter expenses cited above. The Department is to issue any additional FAP benefits the petitioner may be eligible for, not duplicating benefits already received.

The appeal for full Medicaid benefits and/or a lower share of cost is denied. The respondent's action is upheld.

ANY FOOD STAMP BENEFITS DUE APPELLANT PURSUANT TO THIS ORDER MUST BE AVAILABLE WITHIN (10) TEN DAYS OF THIS DECISION OR WITHIN (60) SIXTY DAYS OF THE REQUEST FOR THE HEARING. ANY BENEFITS DUE WILL BE OFFSET BY PRIOR UNPAID OVERISSUANCES.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 09 day of February, 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] Petitioner
Office of Economic Self Sufficiency

FILED
Feb 17, 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-09374

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 December 28, 2015 at 11:53 a.m. and reconvened on January 13, 2016 at 8:32 a.m.

APPEARANCES

For Petitioner: [redacted] Daughter

For Respondent: Dianna Chirino, Senior Human Services Program Specialist, Agency for Health Care Administration

STATEMENT OF ISSUE

Whether it was appropriate for the Respondent to deny Petitioner's request for two additional hours of personal care services (PCS) five days per week. The Petitioner bears the burden of proof in this matter.

PRELIMINARY STATEMENT

Tracy Thomas, Appeals Coordinator II, and Dr. John Carter, Long-Term Care Medical Director, from Sunshine Health appeared as witnesses for the Respondent.

Appearing as Respondent's witnesses from Little Havana Activities and Nutrition Center were Gladys Johnson, Quality Assurance Director; Tatiana Sam, Case Manager Supervisor; Amparo Rodriguez, Case Manager; and Linda Albe, Director of Case Management.

The Respondent presented a composite document of 184 pages, which was entered into evidence and marked as Respondent Exhibit 1. The exhibit contained medical information, decision letters and documentation sent by the provider in support of the service request.

Petitioner has been receiving one hour of personal care services per day seven days a week as approved by the Sunshine Health LTC plan when she became a member of the plan effective December 1, 2013. Petitioner also received two hours of personal care services per day five days a week from AmeriHealth. From August 25, 2013 to February 13, 2015, Medicare covered skilled nursing as well as one hour of personal care services per day five days a week for the Petitioner. AmeriHealth provided the second hour of personal care services per day five days a week without reimbursement.

After AmeriHealth changed ownership, it terminated the two hours of personal care services per day five days per week effective November 2015. These services were being provided without reimbursement from February 2015 to November 2015. Because Medicaid did not authorize the additional two hours of personal care services

per day five days a week that the Petitioner received, Petitioner's request for the additional hours is a request for an increase in services approved by Sunshine Health.

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 68-year-old female who is a Medicaid and Medicare recipient. She is diagnosed with [redacted]

2. Petitioner attends adult day care five days a week from 9:00 a.m. to 4:00 p.m. She also receives three hours of homemaker services per week and seven hours of personal care services per week. She receives a total of 40 hours of services per week.

3. Petitioner lives with her daughter and son-in-law. The daughter is the primary caregiver and works full-time, arriving home between 7:30-8:00 p.m. Monday through Friday. The son-in-law works full-time including some weekends. He is unable to provide care to the Petitioner because he has a weak stomach for cleaning her drool, excrement and urine.

4. A request for an additional two hours of personal care services per day five days a week was received by Sunshine Health on August 25, 2015. On August 26, 2015, Sunshine Health sent the Petitioner a Notice of Action advising the requested additional personal care hours were denied because, "Based on Sunshine State Health ancillary tool, the member's current care plan meets the member's medical needs."

5. Petitioner filed a timely request for a fair hearing on November 9, 2015.

6. Petitioner needs assistance with her activities of daily living (ADLs), including keeping her clean due to her incontinence. Because Petitioner's son-in-law is unable to provide her care, the Petitioner's daughter is requesting two hours of personal care services Monday through Friday between 4:00 p.m. and 8:00 p.m. The daughter gets home by 8:00 p.m. and feeds Petitioner at that time. Petitioner cannot self feed and needs to be reminded to swallow.

7. Respondent asserted the forty hours of services provided to the Petitioner are sufficient to meet her medical needs. In addition, forty hours a year of respite care have been approved for the daughter. Respondent suggested the ten hours of personal care services and homemaker hours could be provided one hour in the morning and one hour in the afternoon Monday through Friday, and the respite hours could be used for weekends when needed.

8. Petitioner's daughter advised the home health aide takes longer than the approved one hour to care for her mother in the morning.

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

10. 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.

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

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

13. 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).

14. Fla. Stat. § 409.979 sets forth eligibility requirements for the Long-Term Care (LTC) Program:

> (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).

15. Covered services under the AHCA contract for LTC plans include Homemaker Services and Personal Care Services, among other services.

16. Personal Care services 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. Homemaker services are defined in the contract as follows:

> General household activities such as meal preparation and routine household care provided by a trained homemaker when the individual AHCA Contract No. [XXXXX], Attachment II, Exhibit 5, Page 17 of 128 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.

18. 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.
>
> Rule 59G-1.010 (166), Florida Administrative Code (F.A.C.) defines "medically necessary" or "medical necessity" as follows:
>
> "[T]he 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. Petitioner needs assistance with her activities of daily living and maintaining her continence. She receives three hours of homemaker services per week which Respondent says can be changed to personal care hours. This change would give Petitioner ten hours of personal care service hours that could be used one hour in the morning and one hour in the afternoon, when she returns from her adult day care.

20. Petitioner does not receive her evening meal until the daughter returns from work by 8:00 p.m. Petitioner's daughter provided no adequate explanation for needing two hours in the afternoon except Petitioner has always received two hours and that the home health aide takes more than an hour in the morning. Petitioner has failed to meet her burden of proof.

21. Respondent has provided sufficient evidence and testimony that the personal care and homemaker service hours, as well as the adult day care services, are sufficient to meet Petitioner's medical needs.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 17 day of February, 2016,

in Tallahassee, Florida.

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

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

FILED
Feb 01, 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-09393

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 December 11, 2015 at 1:30 p.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 action to partially deny Occupational Therapy (OT) service hours that were requested for the Petitioner for the certification period September 24, 2015 through February 23, 2016, was correct. Petitioner bears the burden of proof in this matter.

PRELIMINARY STATEMENT

The Petitioner did not submit any documents as evidence for the hearing.

Appearing as a witness for the Respondent was Darlene Calhoun, D.O.., Physician-Consultant with eQHealth Solutions, Inc. Respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Exhibits: Exhibit 1 – Statement of Matters; Exhibit 2 – Clinical History Notes; Exhibit 3 – Denial Notice; Exhibit 4 – Supporting Documentation (physician and parent letters, therapy reports).

FINDINGS OF FACT

1. The Petitioner's OT service provider [redacted] (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 eQHealth Solutions.

4. The medical information submitted by the provider contained, in part, the following information in regard to the Petitioner:

- 18 years old
- [redacted]

5. The Petitioner is also currently receiving speech therapy and physical therapy services through the Medicaid Program.

6. The Petitioner has been receiving occupational therapy services since at least 2012. He previously received three hours weekly of OT services, but this was reduced to one hour weekly approximately ten months ago.

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:

- Therapeutic activities
- Use of dynamic activities to improve functional performance
- Coordinating physical movements

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 modification request is not supported by the presented documentation of deficit/impairments and goals. The increase is not warranted at this time. Prior approved therapy services [one hour weekly] are sufficient." A notice of this determination was sent to all parties on September 29, 2015.

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 testified that the Petitioner is making steady but slow progress in his therapy, and his skills have regressed since the therapy was reduced from three hours to one hour weekly. She believes her son will have a good prognosis if he receives intensive therapy. She also stated her son still needs to learn how to cross the street and prepare meals.

12. The Respondent's witness, Dr. Calhoun, testified that the denial of the Petitioner's request for an increase in OT services was appropriate because he has met some of his therapy goals and is progressing in others.

13. OT service for children is a covered service under the Medicaid State Plan in Florida. These services are provided in accordance with the Respondent's Therapy Services Coverage and Limitations Handbook ("Therapy Handbook"), effective August, 2013.

CONCLUSIONS OF LAW

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 was assigned to the Petitioner since the Petitioner had been previously approved for one hour weekly of OT service and is seeking an increase in services. The standard of

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

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[1] must*

[1] "You" in this manual context refers to the state Medicaid agency.

> *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 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 has determined that one hour weekly is medically necessary rather than the three 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, Dr. Calhoun, stated that an increase in services was not warranted at this time since the Petitioner has met some of his therapy goals and is progressing in his other goals.

33. The Petitioner's mother believes her son's skills regressed after his OT services were previously reduced and he needs to have more intensive therapy.

34. After considering all the documentary evidence and witness testimony presented, the undersigned concludes that the Petitioner has not demonstrated that an increase in OT services is medically necessary at this time. The therapy report submitted establishes that the Petitioner has met two of five short-term goals and is progressing in his other three goals. The therapy report, dated August 14, 2015, also states he is

making fair progress in therapy and does not mention any areas of regression in skill level.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is DENIED.

NOTICE OF RIGHT TO APPEAL

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

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

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

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

FILED
Feb 01, 2016
Office of Appeal Hearings
Dept. of Children and Families

[redacted]

APPEAL NO. 15F-09398
16F-00149

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 10 Polk
UNIT: 88585

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on January 5, 2016 at 9:35 a.m.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Barbara Haley, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of November 6, 2015 terminating her Qualifying Individuals 1 (QI 1) Medicare Buy-In benefit. The respondent carries the burden of proof by the preponderance of evidence for the QI 1 benefit.

Petitioner is appealing the beginning date of Food Assistance benefits as the Department did not notify her of a policy change, which would have allowed her to

receive Food Assistance benefits sooner. The petitioner carries the burden of proof by the preponderance of evidence for the Food Assistance benefits.

PRELIMINARY STATEMENT

The Department submitted evidence on December 28, 2015, which was entered as Respondent Exhibit 1.

The record remained open through January 12, 2016 for the Department to submit additional evidence as related to the Food Assistance appeal requested during hearing on 1/5/2016. The Department submitted the information on January 11, 2016. The information was entered as Respondent Exhibit 2.

FINDINGS OF FACT

1. The Department issued a Notice of Case Action on September 3, 2013 to inform the petitioner her Food Assistance Program (FAP) benefit would end on September 30, 2013. The Notice provided the reason the benefits would end was “Your household’s income is too high to qualify for this program.

2. The Department explained in April 2, 2013 the policy changed for receipt of the minimum benefit of FAP. The policy outlined that one or two member assistance groups must be eligible for a benefit of $0 or more to receive the minimum monthly allotment of $16.

3. The Department believes the petitioner’s FAP benefit closed effective September 30, 2013 as the April 2, 2013 policy was applied to her case.

4. The Department explained on October 11, 2013 the Department rescinded the policy transmittal issued on April 2, 2013. The requirements for receipt of the minimum allotment for a one or two member household were included in a new

Transmittal C-13-10-0007. The Transmittal also provided instructions on how to handle reviews and applications for FAP benefits because of the policy change.

5. The Department believes notices were issued to those who would regain eligibility because of the October policy change, but could not recall during the hearing.

6. The petitioner submitted applications on December 2, 2013, November 26, 2014 and October 23, 2015 for SSI-Related Medicaid and Medicare Savings Plan benefits only. The petitioner did not select FAP on either application.

7. The petitioner submitted an application on November 9, 2015 for FAP only.

8. The Department issued a Notice of Case Action on November 13, 2015 approving the petitioner's November 9, 2015 application for FAP. The petitioner's November 2015 allotment was $11.00. The petitioner's FAP benefit beginning December 2015 is $16.

9. The petitioner reported she reapplied for FAP on November 9, 2015 after a conversation with a Department representative a few days prior to that date. The Department representative she spoke with advised she should have been eligible for FAP since the policy changed a month after her FAP closed.

10. The Department recorded in the "Running Record Comments" a petitioner inquiry on December 3, 2015 about the FAP benefits she should have received from October 2013 until her application on November 9, 2015.

11. The Department explained that because the petitioner did not mark her application for FAP each time she reapplied after September 2013, she did not have an application for benefits until November 2015.

12. The Department did not have an active assistance group to reinstate benefits when the policy changed and did not take action to reopen the FAP benefits.

13. The petitioner explained she did not believe she was eligible for FAP and did not mark her applications for benefits to which she did not believe herself to be entitled. She believes the Department should have notified her of the policy change in October 2013 so that she could have reapplied and not lost two years of FAP benefits.

14. The Department issued a Notice of Case Action on November 6, 2015 informing the petitioner that her Qualifying Individual 1 (QI 1) benefit was denied. The Notice indicates the reason for denial was "Your household's income is too high to qualify for this program" and "You are receiving the same type of assistance from another program."

15. The petitioner receives income in the amount of $1,077 from Social Security and $269.72 from [redacted] long-term disability. Her total income is $1,346.72 effective January 2015.

16. The Department cited the Income Limit effective July 2015 for the QI 1 program is $1,325.

17. The Department explained policy only allows a $20 disregard in the QI 1 eligibility determination.

18. The petitioner understands the rules as the Department explained them. However, being only $1.72 over the income limit for QI 1 puts her in a bad situation, as she will now have to pay her Medicare premium. She does not know how she will afford her expenses and the premium.

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

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

FOOD ASSISTANCE

21. Federal Food Assistance Regulations found in 7 C.F.R. § 273.10 "Determining household eligibility and benefits levels" states in relevant part:

> (e) Calculating net income and benefit levels…
> (2) Eligibility and benefits….
> (ii)(A) Except as provided in paragraphs (a)(1), (e)(2)(iii) and (e)(2)(vi) of this section, the household's monthly allotment shall be equal to the maximum food stamp allotment for the household's size reduced by 30 percent of the household's net monthly income as calculated in paragraph (e)(1) of this section.
> (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.

22. The Department's Policy Transmittal C-13-10-0007 dated October 11, 2013 "Food Assistance Minimum Benefit" states in relevant part:

This memorandum rescinds Transmittal C-13-04-0002 effective April 2, 2013, based on recent clarification from the Food and Nutrition Service, that all one and two member assistance groups (AGs) are eligible for the minimum monthly food assistance benefit allotment, which is 8% of the maximum allotment for a one person household.

Minimum Benefit Policy
The AG is eligible for the minimum monthly food assistance benefit allotment if the assistance group meets all regular eligibility requirements and:
• The AG has income less than or equal to the 200% gross income limit 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.

Providing the Food Assistance Minimum Allotment to Eligible AGs
Reviews:
When processing reviews for one or two member Temporary Cash Assistance or Medicaid AGs, staff must:
• Determine if the Department closed a food assistance minimum benefit AG in the case because the food assistance budget calculated a negative benefit for April 2013 or after
• Open the food assistance AG using the FIAT process explained in Attachment 1, if the case contains a closed negative food assistance minimum benefit AG and
Issue auxiliaries for past months' minimum food assistance benefits, to AGs closed or denied only because of the recent policy clarification. For months prior to November, the minimum benefit was $16 and for November 2013 and after, the minimum benefit will be $15. Do not issue an auxiliary for any month prior to April 2013 or when a valid application was on file, whichever is later
• For example, if a household applied in June 2013, failed and was denied due to the minimum allotment process, and is completing a review for another program now, open the food assistance case for October and ongoing, including the FIAT and complete an auxiliary for June, July, August, and September

23. The findings show the petitioner's benefits closed effective September 30, 2013 due to the policy change from April 2, 2013. The findings show the petitioner filed

an application to recertify her Medicaid benefits on December 2, 2013. The example in the above controlling authority explains a situation similar to this instant case. The undersigned concludes the Department failed to follow the instructions provided to reopen the food assistance case and issue the missing benefits due to the petitioner at that time.

24. 7 C.F.R. § 273.17 "Restoration of lost benefits" states:

> (a) Entitlement. (1) The State agency shall restore to households benefits which were lost whenever the loss was caused by an error by the State agency or by an administrative disqualification for intentional Program violation which was subsequently reversed as specified in paragraph (e) of this section, or if there is a statement elsewhere in the regulations specifically stating that the household is entitled to restoration of lost benefits. Furthermore, unless there is a statement elsewhere in the regulations that a household is entitled to lost benefits for a longer period, benefits shall be restored for not more than twelve months prior to whichever of the following occurred first:
>
> (i) The date the State agency receives a request for restoration from a household; or
>
> (ii) The date the State agency is notified or otherwise discovers that a loss to a household has occurred.
>
> (2) The State agency shall restore to households benefits which were found by any judicial action to have been wrongfully withheld. If the judicial action is the first action the recipient has taken to obtain restoration of lost benefits, then benefits shall be restored for a period of not more than twelve months from the date the court action was initiated. When the judicial action is a review of a State agency action, the benefits shall be restored for a period of not more than twelve months from the first of the following dates:
>
> (i) The date the State agency receives a request for restoration:
>
> (ii) If no request for restoration is received, the date the fair hearing action was initiated; but
>
> (iii) Never more than one year from when the State agency is notified of, or discovers, the loss.

25. The findings show the petitioner reapplied for Food Assistance on November 9, 2015 following a conversation with the Department. The findings also show the Department was aware of the petitioner's request to have her benefits restored on December 3, 2015. The policy transmittal issued by the Department did not require an application indicating Food Assistance to make the correction in 2013. The undersigned concludes Department failed to reopen the petitioner's FAP benefits upon her application in December 2013. In accordance with the above controlling authority, the undersigned concludes the petitioner is entitled to have her benefits restored for 12 months from the discovery date of the loss to the household. The undersigned further concludes the discovery date was November 2015 when the Department advised the petitioner to reapply for FAP.

QUALIFYING INDIVIDUALS 1

26. Fla. Admin. Code R 65A-1.702 "Special Provisions" states in part: "(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.)"

27. Fla. Admin. Code R. 65A-1.713 "SSI-Related Medicaid Income Eligibility Criteria" states in relevant part:

> (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.

28. 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.”

29. 20 C.F.R. § 416.1124 “Unearned Income we do not count” (c)(12) states, “(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.”

30. 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.

31. The findings show the petitioner’s income is from Social Security and long-term disability. The above controlling authorities identify both of these income types as unearned income. The findings show the petitioner’s total income is $1,346.72. The above controlling authority allows $20 of this income to be excluded. The undersigned concludes the petitioner’s countable income is $1,326.72 ($1,346.72 - $20 = $1,326.72). The undersigned further concludes the petitioner’s countable income of $1,326.72 does exceed the income limit to receive QI 1.

32. The undersigned reviewed all applicable rules and regulations and found no other allowable deduction allowed for QI 1 eligibility determination. Therefore, the undersigned concludes the Department’s action to terminate the petitioner’s QI 1 benefit

is correct as the QI 1 program has the highest limit of the three Medicare Savings Programs.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Food Assistance appeal (16F-00149) is granted. The Department is to restore the petitioner's minimum benefit amount beginning November 2014. The restoration is to include bringing the petitioner to the full minimum benefit for November 2015.

Based upon the foregoing Findings of Fact and Conclusions of Law, the Qualifying Individuals 1 appeal (15F-09398) is denied.

ANY FOOD STAMP BENEFITS DUE APPELLANT PURSUANT TO THIS ORDER MUST BE AVAILABLE WITHIN (10) TEN DAYS OF THIS DECISION OR WITHIN (60) SIXTY DAYS OF THE REQUEST FOR THE HEARING. ANY BENEFITS DUE WILL BE OFFSET BY PRIOR UNPAID OVERISSUANCES.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of 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 February, 2016,

in Tallahassee, Florida.

Melissa Roedel

Melissa Roedel
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

FILED
Jan 25, 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.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 17 Broward
UNIT: 88249

RESPONDENT.
_____/

APPEAL NO. 15F-09407

[redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on December 15, 2015 at 1:05 p.m.

APPEARANCES

For the Petitioner: [redacted] pro se

For the Respondent: Mary Triplett, ACCESS Supervisor

STATEMENT OF ISSUE

At issue is Respondent's action in denying Petitioner's application for SSI-Related Medicaid. Petitioner held the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The Florida Department of Children and Families ("Department" or "DCF") determines eligibility for SSI-Related Medicaid programs. In addition to other technical requirements, an individual must be disabled, blind, or aged (65 years or older) to be

eligible for SSI- Related Medicaid. The Department of Health's Division of Disability Determinations ("DDD") conducts disability reviews regarding medical eligibility for individuals applying for disability benefits under the federal Social Security and Supplemental Security Income programs and the state Medically Needy program. Once a disability review is completed, the claim is returned to DCF for a final determination of non-medical eligibility and effectuation of any benefits due.

Petitioner's sister, [redacted] was present as Petitioner's witness. Petitioner purposely disconnected from the call prior to the close of the hearing. The evidence was marked and entered without her presence. Respondent's exhibits 1 through 4 were marked and entered into evidence. Petitioner submitted no exhibits into evidence.

FINDINGS OF FACT

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

1. Petitioner submitted a paper application with Florida DCF on August 7, 2015 for SSI-Related Medicaid. The Department advised her to submit an application for disability to the Social Security Administration ("SSA") as part of her application for Florida SSI-Related Medicaid.

2. Petitioner submitted an application for disability with the SSA on August 19, 2015. SSA issued an unfavorable determination (N32) on November 2, 2015. Decision code N32 indicates Petitioner has the capacity for substantial gainful activity. The SSA determined that Petitioner's impairment was not sufficient to preclude her from engaging in all substantial gainful activity (SGA).

3. Petitioner did not yet appeal the SSA denial. Petitioner alleges no new condition/s not previously considered by SSA.

4. On November 3, 2015, DCF informed Petitioner of a denial of Medicaid eligibility for the months of August 2015 through December 2015. The reason for this decision is no household member met the disability requirement. The Division of Disability Determinations adopted the SSA's decision as Petitioner had a disability decision by the SSA within the past 12 months. There is no evidence that the Department conducted an independent disability determination.

5. Respondent contends that an adult without children may be eligible for Florida Medicaid coverage only if the adult is aged (over 65), disabled, or pregnant. Petitioner is not over 65 years old nor is she pregnant. Therefore, her eligibility is limited to the disabled category if she meets criteria for disability.

6. Respondent contends if SSA has denied disability within the past year and the decision is under appeal with SSA then the Department is bound by that federal decision, in accordance with Policy Manual sections 1440.1204 and 1440.1205 Technical Requirements (MSSI, SFP).

7. Petitioner moved to Florida due to hardship. She received Medicaid in Pennsylvania prior to her move. Since the move, her [redacted] has remained untreated because she doesn't have medical coverage in Florida. She believes without Medicaid coverage, she will remain untreated and will die. She contends it is unfair that simply moving states impacts her health care and she should be eligible in Florida as she was in Pennsylvania.

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

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

10. Fla. Admin. Code R. 65A-1.710 sets forth the rules of eligibility for SSI-Related Medicaid Coverage Groups. The MEDS-AD Demonstration Waiver is a coverage group for aged and disabled individuals (or couples), as provided in 42 U.S.C. § 1396a(m). For an individual less than 65 years of age to receive benefits, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. 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. 42 C.F.R. § 435.541 sets the standards for state disability determinations and 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...
>
> (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 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.

12. Petitioner was denied Social Security benefits as she was determined not to be disabled. Petitioner did not claim any new conditions not reviewed by the Social

Security Administration in making the determination of the denial. The Department adopted the unfavorable disability decision made by the Social Security Administration rather than making an independent disability determination. According to the above regulations, the Social Security Administration's denial of the petitioner's disability is binding and must be relied upon by the Department. Therefore, the Department correctly denied the petitioner's application for SSI-Related Medicaid benefits as she was determined not disabled.

13. After careful review of the evidence submitted and the relevant laws set forth above, the undersigned concludes the Department's action was proper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Petitioner's appeal is hereby 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 25 day of January, 2016, in Tallahassee, Florida.

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

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

FILED
Feb 08, 2016
Office of Appeal Hearings
Dept. of Children and Families

[redacted]

APPEAL NO. 15F-09410

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 09 Orange
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter January 5, 2016 at approximately 1:30 p.m.

APPEARANCES

For Petitioner: [redacted]

For Respondent: Lisa Sanchez
Senior Human Services Program Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is Respondent's denial of Petitioner's request for the extraction of four (4) wisdom teeth, as well as I.V. sedation. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

Petitioner's mother represented her at the hearing. Petitioner arrived after the hearing began and gave testimony.

The following individuals were present as witnesses for Respondent:

- Dr. Richard Goren, Chief Dental Officer, Liberty Dental
- Dr. Richard Hague, California Dental Director and Utilization Management Director, Liberty Dental
- Stephanie Shupe, Regulatory Research Coordinator, Staywell
- Jamira Dixon, Ancillary Coordinator, Staywell

Petitioner and her mother gave oral testimony, but did not move any exhibits into evidence. Respondent moved Exhibits 1 through 12 into evidence at the hearing. The record was held open for Respondent to submit additional evidence. Respondent submitted additional evidence, entered as Exhibit 13.

The undersigned took administrative notice of the following:

- The Florida Medicaid Provider General Handbook, July 2012
- The Florida Medicaid Dental Services Coverage and Limitations Handbook, November 2011

FINDINGS OF FACT

1. Petitioner is a 17-year-old female. At all times relevant to this proceeding, Petitioner was eligible to receive Medicaid services.

2. Petitioner is enrolled with Staywell as her Managed Medical Assistance (MMA) plan. Liberty Dental Plan ("Liberty") is Staywell's dental vendor.

3. On October 23, 2015, Petitioner's dentist submitted a prior authorization request for removal of all four (4) of her wisdom teeth and deep anesthesia.

4. On October 27, 2015, Staywell issued a Notice of Action denying the request. The reason given for the denial is that "Removal of asymptomatic (healthy) tooth/teeth is not a covered benefit," and [General anesthesia] is only a benefit when performed with covered Oral Surgery procedures." (Respondent's Exhibit 6).

5. Petitioner requested an internal appeal of the denial. A different dentist with Liberty who did not participate in the original decision reviewed the appeal. On December 8, 2015, Liberty issued an Appeal Recommendation upholding the denial.

6. The Appeal Recommendation stated “prophylactic extraction of asymptomatic impacted or erupted teeth is not a covered benefit.” (Respondent’s Exhibit 10). It also stated “Furthermore, the extraction of third molars based on general and inconclusive findings such as crowding, headaches, pressure, earaches or natural pains associated with eruption is not covered.”

7. Petitioner previously received braces. She first had them for two (2) years and had them removed. She subsequently needed them, and she had them for four (4) additional years. She currently uses a retainer. Petitioner’s mother said her daughter’s oral surgeon told her that if the wisdom teeth are not removed they will ruin some of the orthodontic work. Petitioner said she wasn’t sure of all of the details her dentist told her, only that the top two (2) wisdom teeth are impacted and the bottom (2) are not. She was told they are growing in sideways, which is putting pressure on her other teeth. Dr. Goren said the top two (2) teeth do not appear to be impacted, unless they are looking at the wrong records.

8. Petitioner testified she is in pain in all four (4) corners of her mouth, and the intensity is high enough where she cannot ignore it. Dr. Goren said pain from eruption of the teeth can last from one (1) to two (2) months on the low end and three (3) to four (4) months on the high end. Dr. Hague said the pain could last for six (6) months. Dr. Goren said the pain would vary over time, and that pain is per tooth.

9. Petitioner testified she first noticed the pain in August of 2015 and she went to see a dentist. Her mother said they did not do anything at the time because she expected the pain to go away. The pain level in October was worse than it was in August. Petitioner visited a different dentist, Dr. Scott Lawson with Greenberg Dental, who requested the removal of the wisdom teeth.

10. When asked during the hearing what pain level she was currently experiencing, on a scale of one (1) through ten (10), Petitioner said it was an eight (8). She said she takes aspirin or Advil in the morning and at night to help control the pain. She said she doesn't take anything during the middle of the day because of school rules on bringing medications.

11. Dr. Goren said they ask for a narrative from the dentist, but have not seen one. He said Liberty does not have any documentation of Petitioner's discomfort. He said he does not have any reason to dispute Petitioner's claim that she is in pain, but that some people tolerate pain more than others.

CONCLUSIONS OF LAW

12. 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.

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

14. This is a Final Order, pursuant to Sections 120.569 and 120.57, Fla. Stat.

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

16. 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.

17. The Florida Medicaid Dental Services Coverage and Limitations Handbook, November 2011 ("Dental Handbook"), is promulgated into law by Chapter 59G of the Florida Administrative Code.

18. Page 1-2 of the Dental Handbook provides:

> The adult Medicaid dental services program provides medically-necessary, emergency dental procedures **to alleviate pain** or infection to eligible Medicaid recipients age 21 and older. (emphasis added).
> ….
>
> The children's dental program provides full dental services for all Medicaid eligible children age 20 and below.

19. The Dental Handbook therefore provides for dental services for children under age 21 to alleviate pain.

20. Page 2-13 of the Dental Handbook lists covered oral surgery services. It states, in pertinent part:

> Surgery services for recipients under age 21 include extractions, surgical and adjunctive treatment of diseases, injuries, deformities, and defects of the oral and maxillofacial areas.

21. Pursuant to page 2-2 of the Dental Handbook, Medicaid will only reimburse for services that are 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 (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.

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. Goren and Dr. Hague agreed that, based upon the records they have, they do not see any evidence that the wisdom teeth need to be removed, and that doing so would be a prophylactic measure. However, Dr. Goren did not dispute Petitioner's claim that she is experiencing pain. He and Dr. Hague both stated pain associated with the eruption of wisdom teeth would vary over time and eventually end.

28. Petitioner has been experiencing pain since August of 2015. The pain worsened in October of 2015, which resulted in the request to have the teeth removed. At hearing in January of 2016, Petitioner gave credible testimony that her pain level had not improved since October. She said her pain level that day was an eight (8) on a scale of one (1) through ten (10). As Dr. Goren stated, pain is subjective and different people have different tolerances to pain.

29. It may very well be that what Petitioner experiences as an eight (8), someone else might experience as a much lower number. But she indicated that she takes medicine for the pain both in the morning and at night. The fact that she pointed out she is unable to take it during the day at school bolsters her claim that she is unable to ignore the pain because it implies she would take the medicine then if she could.

30. The undersigned has reviewed all pertinent rules and regulations, including EPSDT requirements. Petitioner has met her burden of proof to show, by the greater weight of the evidence, that the extraction of her wisdom teeth is medically necessary, because it would serve to ameliorate her ongoing pain.

DECISION

Based upon the foregoing, Petitioner's appeal is GRANTED. The Agency is directed to provide Petitioner with removal of all four (4) of her wisdom teeth, along with the deep sedation, 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 08 day of February, 2016, in Tallahassee, Florida.

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

FILED
Jan 25, 2016
Office of Appeal Hearings
Dept. of Children and Families

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

[redacted]

PETITIONER,

APPEAL NO. 15F-09421

Vs.

[redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 19 Indian River
UNIT: 88510

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on January 13, 2016 at 10:32 a.m.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Nikisha Williams, supervisor

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to enroll him in the Medically Needy Program. He is seeking full Medicaid. The petitioner carries the burden of proof by a preponderance of evidence.

PRELIMINARY STATEMENT

The respondent presented one exhibit, which was accepted and entered into evidence as Respondent's Composite Exhibit 1. The petitioner did not present any evidence. Also present for the petitioner was his mother [redacted]

FINDINGS OF FACT

1. On October 22, 2015, the petitioner submitted an application for Medicaid benefits. The petitioner's household consists of only himself (age 26). He was determined disabled by Social Security Administration (SSA). He was previously receiving Supplemental Security Insurance (SSI) but he is now receiving Social Security Disability Income (SSDI) of $896 monthly. The petitioner is not currently receiving Medicare benefits.

2. The respondent determined the petitioner's household income exceeded the income limit of $864 for full Medicaid benefits and enrolled him in the Medically Needy Program with a share of cost (SOC).

3. The respondent performed the following budget calculations when it determined the petitioner's estimated SOC. A $20 unearned income disregard was subtracted from the petitioner's SSDI of $896 and resulted in countable unearned income of $876. The Medically Needy Income Level for one person, $180 was subtracted resulting in the petitioner's final SOC of $696 in the SSI-Related Medically Needy Program.

4. By notice dated November 6, 2015, the respondent notified the petitioner he was eligible for Medically Needy Medicaid coverage.

5. On November 12, 2015, the petitioner requested an administrative hearing to challenge the decision.

6. The petitioner explained that if he is enrolled in the Medically Needy Program with an estimated SOC he will not be able to pay for medication.

CONCLUSIONS OF LAW

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

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

9. The petitioner has been determined disabled by Social Security. His Medicaid eligibility was determined under the SSI-Related Medicaid Program.

10. 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…"

11. Income budgeting for MEDS-AD is set forth in Fla. Admin. Code R. 65A-1.713. It states:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
> (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. (2) Included and Excluded Income. For all SSI-related coverage groups the department follows the SSI policy specified in 20 C.F.R. 416.1100, et seq…
> (4) Income Budgeting Methodologies. To determine eligibility SSI budgeting methodologies are applied except where expressly prohibited by 42 U.S.C. §1396, or another less restrictive option is elected by the state under 42 U.S.C. §1396(2000 Ed., Sup. IV)...

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. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, Appendix A-9, identifies 88 % of the federal poverty level for SSI-Related Medicaid under the MEDS-AD Program at $864 effective July 2015. The petitioner's total countable income of $876 (after $20 disregard) exceeds the income standard for full MEDS-AD as listed above. The respondent's action to deny full Medicaid Program benefits for the petitioner was within the rules and regulation of the Program. The petitioner is not eligible for full coverage Medicaid.

14. A review of the rules and regulations did not find any exception to meeting the income limits for the Program.

15. 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.

16. The above authority explains the Medically Needy Program is a coverage group for aged, blind or disabled individuals who do not qualify for full Medicaid due to their level of income.

17. 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.

18. 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.”

19. 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…

20. 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.”

21. The Policy Manual at passage 2440.0102, Medically Needy Income Limits (MSSI) states:

> When the assistance group has met the technical eligibility criteria and the asset limits, it is enrolled. There is no income limit for enrollment. The assistance group is income eligible (entitled to Medicaid) once income is less than or equal to the Medically Needy Income Level (MNIL) or medical bills equal the amount by which his income exceeds the MNIL. Once medical bills are equal to this surplus income, referred to as share of cost, the assistance group is eligible.
> The eligibility specialist must determine eligibility for Medically Needy any time the assistance group's income exceeds the income limits for another full Medicaid Program.

22. 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. Eligibility for full Medicaid is not found.

23. 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 $696 is within the rules of the Program.

DECISION

Based upon the 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 __25__ day of __January_____, 2016,

in Tallahassee, Florida.

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

FILED
Feb 01, 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-09433

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 December 17, 2015 at 10:00 a.m.

APPEARANCES

For the Petitioner: [redacted] Petitioner's mother

For the Respondent: Linda Latson, Registered Nurse Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the Respondent's denial of the Petitioner's 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 did not submit any documents as evidence for the hearing.

Appearing as witnesses for the Respondent were Dr. Daniel Dorrego, Dental Consultant, and Nicolas Calderon, Grievance and Appeals Supervisor, from DentaQuest, which is the Petitioner's dental services organization. Also present as a witness for the Respondent was Mindy Aikman, Grievance and Appeals Specialist from Humana, which is Petitioner's managed health care 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 and Chart Notes; Exhibit 3 – Notice of Action; and Exhibit 4 – Criteria/Review Forms.

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. She receives services under the plan from Humana, which utilizes DentaQuest for review and approval of dental services.

2. On or about November 4, 2015, the Petitioner's treating dentist or orthodontist (hereafter referred to as "the provider"), requested prior authorization from DentaQuest to install braces on her teeth. DentaQuest denied this request on November 5, 2015.

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:

> You need to get a score of 26 points on a test that gives points for crowded, missing and crooked teeth as well as spacing. Your test score was less than 26 so we cannot approve braces for you. We have told your dentist this also. Please talk to your dentist about your choices to treat your teeth.

4. Petitioner's mother testified her daughter needs the braces because she bites her lips and the braces will correct that problem. She also stated her daughter sometimes speaks with a lisp.

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 12. He also stated he reviewed the information sent in by the Petitioner's orthodontist and there was no mention of a lisp.

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

.

CONCLUSIONS OF LAW

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

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

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

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

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

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

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

13. 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. Petitioner's mother believes the braces should be approved for her daughter because she bites her lips and sometimes speaks with a lisp.

16. 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 12). He also stated there was no mention of a lisp in the records submitted for review.

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. 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 Petitioner's orthodontist requested the braces, this does not establish it is medically necessary. Respondent's witness testimony and the Handbook provisions addressing orthodontic treatment support the denial of the requested service.

DECISION

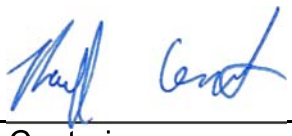
Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is DENIED.

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 __01__ day of __February____, 2016,

in Tallahassee, Florida.



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Copies Furnished To: [redacted] Petitioner
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FILED
Jan 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-09437

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 13 Hillsborough
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on December 30, 2015 at 1:00 p.m. in Tampa, Florida.

APPEARANCES

For the Petitioner: [redacted] pro se

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

STATEMENT OF ISSUE

At issue is whether the Agency properly denied Petitioner's requests for Depends underwear, Aveeno Skin Relief Moisturizer, Neutrogena Original Formula Soap, Bard Cunningham clamp, Dove bar soap, Ketoconazole cream and shampoo, and Desitin cream. Petitioner holds the burden of proof on these matters by the preponderance of evidence.

PRELIMINARY STATEMENT

The Agency for Healthcare Administration (AHCA or Agency) is responsible for administering Florida's Medicaid Program.

Petitioner testified and did not present any other witnesses. Serving as Respondent's witnesses were Carlene Brock (Quality Operations Nurse), Tracy Parks (Manager of Clinical Quality), Dr. Elizabeth Schnieder (Medical Director) and Lenora Fisher (Case Manager), all with Amerigroup.

The hearing officer took administrative notice of Sections 409.910, 409.962, 409.963, 409.964, 409.965, 409.973 Florida Statutes, Florida Administrative Code Rules 59G-1.001, 59G-1.010, 59G-4.070, the Florida Medicaid Durable Medical Equipment ("DME") and Medical Supply Services Provider Fee Schedule ("fee schedule"), and the DME and Medical Supply Services Coverage and Limitations Handbook.

Petitioner entered two exhibits into evidence, marked and entered as Petitioner's Exhibits 1 and 2, respectively. Respondent submitted eight exhibits during the hearing, marked and entered as Respondent's Exhibits 1 through 8, into evidence. The record closed on December 30, 2015.

Petitioner submitted an additional hearing request prior to hearing. In the interest of judicial economy, it was dismissed on the record at the hearing and will not be scheduled separately. Petitioner's new hearing request was for the hearing officer to lift [redacted] trespass warning, order a surgeon to perform bladder surgery, and reinstate him as a patient at the urology practice which discharged him for aggressive behaviors. The Office of Appeal Hearings has no jurisdiction over provider

actions, treatment choices, or patient discharges, in accordance with 42 C.F.R. §§ 431.220 and 431.201. There was no allegation in the new hearing request that the Respondent denied any properly made request for service, only disputes regarding actions his provider took. Therefore, all portions of the new hearing request were dismissed. Petitioner was given information to file complaints against the hospital and the provider through alternate channels, if he chooses to do so.

Petitioner requested a full copy of the DME Handbook, rules, and procedures. The Agency representative printed a copy of the DME Handbook and provided it to Petitioner after the hearing.

Amerigroup agreed to provide Petitioner with a list of alternative in-network providers for urology and incontinence supplies. This was for Petitioner's convenience and is unrelated to the decision on the issues on appeal.

FINDINGS OF FACT

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

1. Petitioner is an adult male over age 21 who is diagnosed with various [redacted]. He is considered disabled by the Social Security Administration. He is able to walk.

2. Petitioner's urologist provided a prescription for a [redacted] to assist with Petitioner's [redacted] The medical supply company submitted a request for T2029, which is a specialized medical item. [redacted] is the procedure code for the [redacted] Neither code is listed on the Medicaid DME Fee Schedule.

Amerigroup denied the clamp request as a non-covered benefit because the code does not appear on the fee schedule. Petitioner was notified of the denial by phone. Amerigroup did not issue a written denial notice because this occurred during a vendor transition period.

3. The medical supply company instead offered it to Petitioner at a cash price, rather than filing an insurance claim which would be denied. Amerigroup refused to pay cash to the supplier on Petitioner's behalf.

4. The [redacted] code does not appear on the Medicaid fee schedule. Therefore, Amerigroup will not cover it. Amerigroup stated there is no exception to request a non-covered item or unlisted procedure code for medical need for an adult over age 21.

5. Petitioner's plan has an over the counter benefit. As part of this benefit, certain common drugs and pharmacy items are covered by the plan, up to $25 per month in items.

6. Petitioner's request for Desitin cream was denied at the pharmacy. Desitin cream appears on Amerigroup's list of approved over the counter items. Amerigroup argues the denial was a pharmacy error, and the Desitin should be approved. Amerigroup attempted to process a claim for Desitin to ensure there wasn't a system error, and it was approved.

7. Petitioner alleges he was denied Ketoconazole cream and shampoo at the pharmacy. Amerigroup paid claims for these items on October 29, 2015. Therefore this request was not denied. Petitioner stated that some of the items he previously requested the hearing for were approved, but did not specify which ones.

8. Petitioner requested Depends diapers from the pharmacy. Petitioner's request for Depends was denied at the pharmacy because Medicaid does not cover incontinence diapers for people over the age of 21. Amerigroup did not issue a denial notice on this request.

9. Petitioner requested Neutrogena Original Formula Soap. The soap was denied at the pharmacy because there was no prior authorization request. The soap is not on a preferred drug list or over the counter approved list, so it requires prior authorization to determine if the request meets medical necessity. Amerigroup has not received a prior authorization request to determine medical necessity.

10. The pharmacy denied Petitioner's requests for Aveeno Skin Relief Moisturizer and Dove Bar soap. Both of these requests were denied because they are not pharmaceutical type items, but regular lotion and soap available in the store. They do not appear on Amerigroup's over the counter list. There are other Aveeno brand items on the list that are available through Amerigroup's over the counter plan, but the one Petitioner specifically requested was not on that list. There is no formula of Dove brand soap on the over the counter list.

11. Petitioner argues that medical necessity overcomes any limitation otherwise placed on Medicaid covered supplies. He has medical reasons for each request, and he believes any denial is a denial of needed medical care.

12. None of Petitioner's requests were reviewed for medical necessity, as defined by the Florida Administrative Code. His requests were all denied based on specific exclusions or limitations set by the Medicaid program. His medical conditions did not factor into the denial decisions at all.

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 120.80, Florida Statutes. The Office of Appeal Hearings provided the parties with adequate notice of the administrative hearing.

14. Florida Medicaid State Plan is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The program is administered by the Agency.

15. This hearing was held as a de novo proceeding pursuant to Florida Administrative Code Rule 65-2.056.

16. Section 409.912, Florida Statutes provides that AHCA shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care.

17. With regard to the need for Durable Medical Equipment and Supplies (“DME”), Section 409.906(10), Florida Statutes, states in relevant part, "[t]he agency may authorize and pay for certain durable medical equipment and supplies provided to a Medicaid recipient as medically necessary."

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

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

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

19. The DME and Medical Supply Services Coverage and Limitations Handbook ("DME Handbook") has been incorporated, by reference, into Florida Administrative Code Rule 59G-4.070(2). The DME Handbook defines DME services on page 1-2, as follows:

> Durable medical equipment (DME) is defined as medically-necessary equipment that can withstand repeated use, serves a medical purpose, and is appropriate for use in the recipient's home as determined by the Agency for Health Care Administration (AHCA)….
>
> Medical supplies are defined as medically-necessary medical or surgical items that are consumable, expendable, disposable, or non-durable and appropriate for use in the recipient's home….
>
> Orthotic devices are defined as medically-necessary devices or appliances that support or correct a weak or deformed body part, or restrict or eliminate motion in a diseased or injured body part.

20. Page 2-3 explains that each service request, if medically necessary, is further limited by the DME Handbook and the fee schedule:

> Many durable medical equipment (DME) items and services are limited to recipients under 21 years of age.

To determine whether a service is available to all recipients or limited to recipients under age 21 years of age, refer to the DME and Medical Supply Services Provider Fee Schedules and the service specific requirements described in this handbook.

Note: The DME and Medical Supply Services Provider Fee Schedules are available on the Medicaid fiscal agent's Web site at www.mymedicaidflorida.com. Select Public Information for Providers, then Provider Support, and then Fee Schedules. The fee schedules are incorporated by reference in 59G-4.071, Florida Administrative Code.

21. Page 2-97 sets forth the list of relevant non-covered DME items as follows:

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:…

- Diapers and incontinence briefs of any kind for recipients 21 years and older…
- Items or devices used or intended to be used for cosmetic purposes
- Non-sterile cotton tip applicators
- Personal comfort, convenience or general sanitation items…
- Routine and first aid items

22. Exceptions can be made to the non-covered item rule for recipients under 21 years of age, according to page 2-98 of the DME Handbook. Petitioner is over 21 so the exception would not apply to him.

[redacted]

23. Page 2-16 of the DME Handbook states in relevant part, as follows:

Durable medical equipment services or items that require prior authorization (PA) are indicated on the DME Fee and Medical Supply Services Provider Schedules with a "PA" designation. DME services or items that require PA include the following:…

DME items that do not have an assigned procedure code(s) listed on the fee schedules and are requested using the miscellaneous DME procedure code; and miscellaneous DME, which may include items such as external insulin pumps and custom cranial remolding devices…

24. Page 3-7 of the DME Handbook further explains non-classified or miscellaneous codes:

> The DME and Medical Supply Services Provider Fee Schedules have "nonclassified" procedure codes. Non-classified procedure codes allow the provider to request reimbursement from Medicaid when a reimbursable item does not have an established fee identified. Pricing non-classified procedure codes is established either by prior authorization or a By Report claim….
>
> Providers must use a non-classified procedure code when the item is reimbursable, but:
>
> The equipment requested needs to be customized to the physical condition of the recipient, and
>
> There is no less expensive treatment modality, equipment, or measures available to meet the recipient's medical needs….
>
> A provider may be reimbursed for a non-classified procedure code after the claim is approved and priced by AHCA.

25. The [redacted] was denied because the requested procedure code does not appear on the Medicaid Fee Schedule. However, based on the above authority, items without a code listed on the fee schedule can be requested using a miscellaneous DME code. A9900 is on the fee schedule and is titled "Miscellaneous DME Supply, Accessory, and/or Service Component of Another HCPCS Code." The fee schedule requires prior authorization for this code, which will be granted if the requested item meets medical necessity.

26. The Agency did not review whether Petitioner's request was medically necessary. It was denied simply because it wasn't on the list. It is not specifically excluded as a covered service based on the DME Handbook or any other authority.

27. The request as submitted and at issue during this appeal, which is a request using an unlisted HCPCS code, cannot be approved. Petitioner's provider may re-submit the request for the clamp, including all supporting documentation to show

medical need, using a miscellaneous code as set forth on the fee schedule. Upon receipt of the information and request for miscellaneous DME item, The Agency is required to determine medical necessity of the request.

Disposable Incontinence Supplies (Depends)

28. Disposable incontinence supplies are specifically excluded for recipients over 21 years of age on page 2-97 of the DME Handbook, excerpted above. The DME Handbook, on page 2-48, states the specific limitations on Disposable Incontinence Briefs, Diapers, Protective Underwear, Pull-Ons, Liners, Shields, Guards, Pads, Undergarments:

> **Medical Necessity**
> The disposable incontinence supplies as specified in the section are reimbursable only for use by individuals with chronic incontinence caused by a permanent physical or mental condition, including cerebral palsy and developmental delay.
>
> **Age Requirements**
> 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.

29. The limitation is reiterated on page 2-49 that disposable incontinence supplies are only for children "four through 20 years of age with a physical or mental condition that results in chronic incontinence." Petitioner is over 20 years of age. His physical condition is the reason for the incontinence. However, there is no exception in the rules for approval based on financial or other need for someone over 20 years old.

30. After careful review of the evidence submitted and the relevant laws set forth above, the undersigned finds the Agency's action in this matter was correct.

Over the Counter Items

31. Desitin cream is available at the pharmacy. The denial was a pharmacy processing error. Petitioner should return to the pharmacy for it. If Petitioner is unable to obtain it at the pharmacy, he or the pharmacy should contact Amerigroup. As this item is already approved, this request is dismissed as moot.

32. Amerigroup paid a claim for ketoconazole shampoo and cream on October 29, 2015. Therefore, this request was already provided to Petitioner and is dismissed as moot.

33. Neutrogena Original Formula Soap is not on the over the counter list or a preferred drug list. If it is not on an approved list, it requires prior authorization. Amerigroup has not received a request for prior authorization, so the request was denied at the pharmacy. Amerigroup has not yet made a determination as to whether this item is medically necessary. Therefore, this request is dismissed as not ripe for appeal because Amerigroup has not received the prior authorization request nor made a decision as to medical necessity on this item. Petitioner is encouraged to contact his provider to submit a prior authorization request showing medical reasons for this particular brand and formula soap.

34. Dove brand bar soap and Aveeno Skin Relief Moisturizer are personal sanitation items with no pharmaceutical or medical ingredients. These types of items are specifically excluded by the DME Handbook on page 2-98 as non-covered items (items or devices used or intended to be used for cosmetic purposes, personal comfort, convenience or general sanitation items, routine and first aid items). These items are not included on the expanded over the counter list of covered benefits under

Amerigroup's plan. Other Aveeno brand lotions with pharmaceutical components are on the list and may be obtained through the pharmacy if Petitioner did not meet the dollar limit that month. The Agency properly denied Petitioner's request for Dove bar soap and Aveeno Skin Relief Moisturizer.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 04 day of January, 2016,

in Tallahassee, Florida.

Danielle Murray
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished To: [redacted] Petitioner
Don Fuller, Area 6, AHCA Field Office Manager

FILED
Feb 01, 2016
Office of Appeal Hearings
Dept. of Children and Families

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

[redacted]

PETITIONER,

APPEAL NO. 15F-09438

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 December 14, 2015 at 11:35 a.m.

APPEARANCES

For the Petitioner: [redacted] husband

For the Respondent: Sheila Broderick, registered nurse specialist

STATEMENT OF ISSUE

Whether it is medically necessary for the petitioner to receive a Personal Emergency Response System (PERS) through Medicaid. The burden of proof was assigned to the petitioner.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (Agency or AHCA or respondent) administers the Florida Medicaid Program. Medicaid rules require that most recipients receive their Medicaid services through the Managed Care Plan. The Agency contracts with numerous health care organizations to provide medical services to its program participants. United Healthcare (United) is the contracted health care organization in the instant case.

By notice dated July 2, 2015, United informed the petitioner that her request for PERS through Medicaid was denied. The notice reads in pertinent part:

> You are not left alone for a long time. You have not had a bad fall. You can use a phone. A response system is in excess of your needs. Needs in Florida Medicaid are defined by law. For a service to be needed it must treat a problem. It must also be a common practice. It must also be just for you. … 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. … Services in excess of your needs are not medically necessary. The health plan will not cover an emergency response system for you.

The petitioner requested reconsideration. In August 2015, United informed the petitioner that the original denial decision was upheld.

On November 13, 2015, the petitioner timely requested a hearing to challenge the denial decision.

There were no additional witnesses for the petitioner. Petitioner's Composite Exhibit 1 was admitted into evidence.

Christian Laos, senior compliance officer with United, and Dr. Sloan Karver, medical director of United's Long Term Care Program (LTCP), were present as

witnesses for the respondent. Respondent's Composite Exhibit 1 was admitted 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. The petitioner (age 75) is a Florida Medicaid recipient. The petitioner is enrolled in United's LTCP. LTCP provides home health goods and services to individuals who would otherwise require nursing home placement.

2. The petitioner suffered a stroke which left her unable to walk or independently perform any of the activities of daily living. The petitioner is fed by G-tube. She has a catheter. The petitioner uses a wheelchair for mobilization.

3. The petitioner lives in the family home with her husband (age 77). He is the petitioner's primary caretaker; he has no disabling conditions and is not employed outside the home. The petitioner also receives 23 hours of home health care weekly through United LTCP.

4. The petitioner submitted a request for PERS to United on June 30, 2015.

5. PERS is an electronic device that connects to the phone line and includes a remote control which enables a patient to obtain emergency assistance.

6. All Medicaid goods and services must be medically necessary as determined through a prior service authorization process.

7. PERS is intended for bedbound patients who live alone or spend large periods of time alone. United determined that it was not medically necessary for the

petitioner to have PERS because she is never home alone. Her husband or a Medicaid funded home health aide is in the home with her at all times and can seek emergency medical services for her via traditional methods, such as calling 911.

8. PERS is to be utilized by the patient. United determined that the petitioner does not have the cognitive ability to use PERS. The petitioner's United case manager describes her condition in case notes dated June 29, 2015:

> C[ase] M[anager] visited member at her home…to complete plan of care. … Member's husband [redacted] was present. Member is alert, with minimal verbalization. Member can repeat small words with cues from husband. Member is oriented to person only. Member is not oriented to place and time. Member unable to answer CM questions…

9. United determined that PERS would be used by the petitioner's husband, who has no disability which prevents him from calling 911 to obtain emergency medical services.

10. Medicaid rule prohibits the provision of good or services for the convenience of the member or the member's caretakers.

11. The petitioner's husband argued that her medical condition is complex. It is necessary to obtain emergency medical services as quickly as possible. In the past, 911 operators have asked him too many questions in an attempt to assess the situation instead of relying on his judgement that emergency medical services are necessary. PERS bypasses the assessment process and immediately deploys emergency services.

12. The petitioner's husband acknowledged that he would be the primary operator of PERS, but believes his wife could be taught to use the remote control device because he taught her how to use the garage remote control in their home.

13. The petitioner's husband argued that PERS is inexpensive, $20 to $30 per month.

14. The petitioner's husband argued that Medicaid guidelines provide for PERS when an enrollee is at high risk for institutionalization.

CONCLUSIONS OF LAW

15. By agreement between AHCA and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to § 120.80, Fla. Stat.

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

17. At issue is denial of an emergency response system through Medicaid. 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, 7th Ed.).

19. The Florida Medicaid program is authorized by Fla. Stat. Chapter 409 and Fla. Admin. Code Chapter 59G. The Medicaid Program is administered by the

respondent. Section 409.905, Fla. Stat. addresses mandatory Medicaid services under the State Medicaid Plan:

> Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law…
>
> (4) HOME HEALTH CARE SERVICES.--The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home…
> (b) The agency shall implement a comprehensive utilization management program that requires prior authorization of all private duty nursing services, an individualized treatment plan that includes information about medication and treatment orders, treatment goals, methods of care to be used, and plans for care coordination by nurses and other health professionals. The utilization management program shall also include a process for periodically reviewing the ongoing use of private duty nursing services. The assessment of need shall be based on a child's condition, family support and care supplements, a family's ability to provide care, and a family's and child's schedule regarding work, school, sleep, and care for other family dependents; and a determination of the medical necessity for private duty nursing instead of other more cost-effective in-home services.
> (c) The agency may not pay for home health services unless the services are medically necessary …

20. All Medicaid goods and services must be medically necessary. The definition of medically necessary is found in the Fla. Admin Code. R. 59G-1.010 which states:

> (166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider…
> . . .
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

21. The respondent denied the petitioner's request for PERS. The respondent determined that the system was not medically necessary because the petitioner is never without a caretaker who can seek emergency medical services through traditional methods. In addition, the respondent determined that PERS was in excess of the petitioner's needs because the petitioner does not have the cognitive ability to use the system. The system would be used by the petitioner's husband; he has no disability which prevents him from utilizing traditional methods, like calling 911, to obtain emergency medical services.

22. The petitioner's husband argued that 911 operators ask too many questions, he would like medical services to come to the home without going through an assessment process; PERS is inexpensive; and petitioner could be taught how to operate PERS.

23. The controlling legal authorities state that Medicaid goods and services must be medically necessary and cannot be in excess of a recipient's needs. In addition, good and services cannot be provided for reasons of convenience. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that

the petitioner did not meet her burden in this matter. The petitioner did not prove that it is medically necessary for her to have an emergency response system. The petitioner is never home alone. Her husband or a Medicaid caregiver is always with her. She has 24/7 access to emergency medical services through traditional methods.

DECISION

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

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

Leslie Green

Leslie Green
Hearing Officer
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Tallahassee, FL 32399-0700
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Copies Furnished To [redacted] Petitioner
Debbie Stokes, Area 4, AHCA Field Office Manager

FILED
Feb 05, 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-09470
15F-09471

PETITIONER,

Vs.

CASE NO [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 17 Broward
UNIT: 88249

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on January 14, 2016 at 9:30 a.m., at [redacted].

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Emilienne Elien, supervisor.

STATEMENT OF ISSUE

At issue is whether the Department's actions to deny the petitioner's application for Food Assistance Program benefits and her enrollment in the Medically Needy Program are correct. The petitioner carries the burden of proof by the preponderance of evidence for both Programs.

PRELIMINARY STATEMENT

On May 12, 2015, the petitioner reported to the Sunrise Service Center to request a hearing challenging the denial of FAP benefits for her household and her enrollment in the Medically Needy (MN) Program. The hearing request was sent to the Office of Appeal hearings on November 12, 2015.

At the beginning of the proceeding, the undersigned addressed the timeliness of petitioner's appeal based on the Notice of Case Action at issue. The parties were advised that a ruling would be reserved to allow the hearing officer to review the case file and that a decision would be issued in the Final Order.

During the hearing, the petitioner submitted one (1) exhibit, which was accepted into evidence and marked as Petitioner's Exhibit 1. The Department presented 15 exhibits, which were marked as Respondent's Exhibits 1 through 15.

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 currently under appeal, the petitioner had been receiving FAP benefits for herself and one child. She last received $16 in April 2015.

2. On April 27, 2015, the petitioner submitted an online application requesting additional FAP and Medicaid benefits for herself, her 15 year-old daughter, her husband and their mutual child, [redacted] On that application, the petitioner reported that she was receiving Social Security benefits for herself and her children and that her husband was employed.

3. The petitioner and her children are United States citizens. She is disabled and has no work history. Her husband is a legal permanent resident with less than five years with that status, has less than ten years of work history, and therefore does not have 40 quarters. They have been married less than ten years. The husband is subject to a five-year ban for receipt of benefits.

4. The petitioner reported the following monthly expenses: $1,100 for rent, $150 for water/sewer, $20 for trash removal, $150 for telephone and $150 for electricity. This household is not considered a broad-based categorical eligible household and only needs to meet the net income limit to be eligible for FAP benefits. In addition, she is allowed excess medical expenses and is not subject to a shelter cap.

5. Petitioner's husband obtained Lawful Permanent Resident status on October 17, 2014, based on a System Alien Verification for Eligibility (SAVE) completed on him. The Department determined that the husband was not eligible for FAP benefits and only counted three members (petitioner and the two children) in the FAP assistance group (AG). The husband's ineligible is not being challenged.

6. The FAP budgeting process involves deducting some standard deductions as well as some of the recipients' actual expenses. Rent or mortgage is an allowable deduction as well as a standard deduction for utilities (SUA) and excess medical expenses.

7. Petitioner received $814 in monthly Social Security Disability (SSD) benefits and each of her two children receives $78, for a total of $971, *see* Petitioner's Exhibit 1. Petitioner's husband is employed and gets paid biweekly. He provided his paystubs dated March 26, 2015 ($1,494.31) and April 9, 2015 ($1,458.49) for verification, *see*

Respondent's Exhibit 8. The Department used a conversion factor of 2.15 to arrive at a total monthly gross earned income of $3,174.26. This amount was divided by four and the result multiplied by 3 to arrive $2,380.71 as countable prorated amount. This prorated amount was added to the $970 Social Security benefits to arrive at $3,350.71 total gross household income.

8. From the gross income of $3,350.71, a 20% ($476.14) earned income deduction; and a $155 standard deduction were subtracted to arrive at the $2,719.57 adjusted income, 50% of which becomes shelter standard ($1,359.78). With shelter/utility costs $1,497 ($1,160 shelter and $337 SUA), petitioner was allowed $137.22 excess shelter deduction, resulting in the Food stamp Adjusted income downward adjusted to $2,582.35.

9. This amount ($2,582.35) was compared to the maximum net monthly income of $1,650 (for a household with three eligible members) resulting in the petitioner failing the Food Assistance net income limit, *see* Respondent's Exhibit 6.

10. After a case review, petitioner was allowed $69.90 in excess medical expenses and $430.14 in child care deductions to arrive at the $2,199.47 adjusted income, 50% of which becomes shelter standard ($1,099.73). With shelter/utility costs $1,505 ($1,160 shelter and $345 SUA) petitioner was allowed $405 excess shelter deduction, resulting in the Food stamp Adjusted income downward adjusted to $1,794.20.

11. This amount ($1,794.20) was compared to the maximum net monthly income of $1,675 (for a household with three eligible members). The petitioner still failed the Food Assistance net income limit.

12. The Department determined the children's eligibility for full Medicaid benefits because the household income was below the income limit for children in their age group for a standard filing unit size of three. The petitioner was enrolled in the Medically Needy (MN) Program with an estimated SOC. Petitioner's husband is the only one employed, therefore she and the children are considered his tax dependents.

13. The petitioner was seeking full Medicaid for herself. . To begin the budgeting process for the petitioner for the Medically Needy Program, the Department added the husband two paychecks to arrive at $2,952.80 (1,494.31 + $1438.49). This amount was added to the $814 Social security benefits total, resulting in $3,766.80 as modified adjusted gross income (MAGI). To determine Medicaid eligibility for the petitioner, the household income of $3,766.80 was compared to the income limit for an adult with a household size of four, $364. As the income exceeded the maximum limit, she was found ineligible for full Medicaid benefits. As the petitioner was determined ineligible for full Medicaid, the respondent enrolled her in the Medically Needy (MN) Program.

14. To determine petitioner's estimated SOC the Medically Needy Income Level (MNIL) of $585 (for a standard filing unit size four) was subtracted from the $3,766.80 Gross monthly household income, resulting to the petitioner estimated SOC of $3,181. It was further reduced by $104.90 in medical insurance premium, resulting in the final estimated SOC to be $3,076 effective August 2015.

15. On April 29, 2015, the Department sent the petitioner a Notice of Case Action informing him that hers FAP application is denied because her income is too high to qualify for this program. Additionally, the notice explained that petitioner was enrolled in the Medically Needy Program with a $3,181 SOC, *see* Respondent's Exhibit 15. On

May 12, 2015, the petitioner reported to the Sunrise Service Center to request a hearing to challenge the Department's action, *see* Respondent's Exhibit 2, p 21. After a case review, the SOC was adjusted to $3,076, *see* Respondent's Exhibit 14.

16. The respondent explained that the petitioner is not eligible for full Medicaid because her household income exceeds the Family-Related Medicaid income limit for the household size and that her SOC was directly related to the household gross income. She explained that whenever incomes are received more often than monthly in the FAP, the Department is required to use the conversion factor of 2.15 (if received biweekly), 4.3 (if received weekly), or 2 (if received semimonthly). For Medicaid however, weekly incomes are multiplied by 4 and biweekly incomes are multiplied by 2. The respondent explained that the petitioner's husband is subject to a five-year ban before he can participate in any program as an eligible member. In addition, she explained that 75% of his gross income is used to determine eligibility for the three other household members. The respondent further explained that the petitioner is enrolled in the Medically Needy Program because she failed to meet the income guideline for Family-Related Medicaid.

17. The petitioner did not dispute the income amount used by the Department in the eligibility process. He asserted that his wife is in poor health and needs constant medical care. He acknowledged that he understands the benefits provided by the respondent are income-based, but believes that it is not fair for his wife to be denied FAP benefits and be enrolled in MN because of his income. The petitioner maintains his wife cannot meet her share of cost on a monthly basis. Petitioner believes his income should not count against his wife.

18. The Department's representative explained how the share of cost was determined and how it could be met. Petitioner was advised to submit all outstanding medical bills to the Department so that it can be determined when the share of cost is met and when Medicaid coverage could begin.

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

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

The undersigned first address the untimely appeal and jurisdiction issue.

21. On April 29, 2015, the Department sent the petitioner a Notice of Case Action informing her that her FAP application is denied because her income is too high to qualify for this program. In addition, the notice explained that she was enrolled in the Medically Needy (MN) Program with an estimated SOC. On May 12, 2015, the petitioner reported to the Sunrise Service Center to request a hearing challenging the Department's actions. The hearing request was sent to the Office of Appeal hearings on November 12, 2015. Therefore, the undersigned finds that petitioner's request is timely and retains jurisdiction. A decision will be made based on the merits of the case.

The Food Assistance issue will be addressed first.

22. Federal regulation C.F.R. § 273.9 addresses income/allowable deductions budgeting in the FAP in part and states as follows:

(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 eligiblity (sic) standards for the Food Stamp Program. Households which do not contain an elderly or disabled member shall meet both the net income eligibility standards and the gross income eligibility standards for the Food Stamp Program. Households which are categorically eligible as defined in §273.2(j)(2) or 273.2(j)(4) do not have to meet either the gross or net income eligibility standards. The net and gross income eligibility standards shall be based on the Federal income poverty levels established as provided in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)).
(b) Definition of income…
(1) Earned income shall include:
(i) All wages and salaries of an employee...
(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…
(d) *Income deductions.* Deductions shall be allowed only for the following household expenses:
(1) *Standard deduction*—
(2) Earned income 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. 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.…(emphasis added)
(4) Dependent care.
(5) Optional child support 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(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…

> (A) Continuing charges for the shelter occupied by the household, including rent,
> (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.

23. The respondent must follow these federal budgeting guidelines when determining eligibility. The regulation directs the Department to use gross income when determining eligibility. The FAP budgeting process involves deducting some standard deductions as well as some of the recipients' actual expenses. Rent or mortgage is an allowable deduction as well as a standard deduction for utilities and medical deductions. It also directs the Department to consider wages and Social Security benefits as incomes that must be included in the eligibility determination.

24. Federal regulations at 7 C.F.R. § 273.10, in relevant part states:

> (c) (2) Income only in month received. (i) Income anticipated during the certification period shall be counted as income only in the month it is expected to be received, unless the income is averaged. Whenever a full month's income is anticipated but is received on a weekly or biweekly basis, the State agency shall convert the income to a monthly amount by multiplying weekly amounts by 4.3 and biweekly amounts by 2.15, 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.

25. Petitioner and the children receive their Social Security benefits monthly and her husband receives his pays biweekly. The Department correctly converted the husband's biweekly income to monthly amounts using the 2.15 conversion standard before adding it to the SS benefits. The undersigned could not find a more favorable outcome than the income conversion done by the Department.

26. The federal regulation 7 C.F.R. § 273.10 (e) addresses "Calculating net income and benefit levels" as follows:

> (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 Sec. 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 Sec. 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.

27. The above-cited regulation describes the eligibility process and defines deductions and shows the steps in determining net income. The petitioner was credited with an earned income deduction, a standard deduction, an excess medical expense, and an excess shelter deduction from her gross income to equal her net income. There is no indication that petitioner was eligible for any other deductions.

28. The Department's Policy Manual, CFOP 165-22, (The Policy Manual) at passage 2610.0410 considers an ineligible noncitizen as technically ineligible to participate in the

FAP Program. Passage 2230.0400 addresses Technically Ineligible Individuals and states:

> **Technically Ineligible Individuals**
>
> Technically ineligible individuals fail a technical factor of eligibility. The technically ineligible individual may not be included in the household when food stamp benefits are determined. Treat the income, assets and expenses of technically ineligible individuals as follows:
>
> 1. Prorate the income of the ineligible individual and count all but the ineligible members share toward the eligibility of the remaining household members for individuals who fail to meet SSN requirements, are ineligible noncitizens, are serving child support sanctions, or have received all time limited months as an ABAWD. Exclude the income of the ineligible student;
> 2. Count the assets in their entirety for all technically ineligible individuals except the ineligible student. Exclude the assets of the ineligible student;
> 3. The 20% earned income deduction is allowed; and
> 4. Expenses billed to the technically ineligible member but paid entirely with the eligible member's income because the ineligible member has no income, count in full in the budget. If the expense is billed to the technically ineligible member, but paid for with the eligible member's income and the ineligible member's income, prorate the expense in the budget. If the expense is billed to and paid entirely by the technically ineligible member, prorate the expense in the budget; and
> 5. When the SFU contains a technically ineligible member, do not prorate the appropriate utility standard in the budget. Allow the full SUA, BUA, or Phone Standard if the dwelling is eligible for a standard.

29. In this instant case, the Department prorated the husband's income and included the appropriate portion in its calculation. He was allowed the 20% earned income deductions and the household expenses were fully counted in the budgets.

30. The Food Assistance standards for income and deductions appear in the Policy Manual at Appendix A-1. Effective October 1, 2014, a three-person assistance group net income limit was $1,650 at the time of action.

After subtracting all allowance deductions, the petitioner's final net income amount is $2,582.35. This amount exceeds the established net income limit for the petitioner's household.

31. After considering the evidence, testimony, and the appropriate authorities cited above, the hearing officer concludes that the respondent's action to deny the petitioner's FAP application is correct as the total household's gross income exceeds the applicable limit. The petitioner has failed to meet her burden that she is eligible for any Food Assistance. A more favorable outcome was not found.

The Medically Needy issue will now be addressed.

32. 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.

33. 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.

34. 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.

35. In accordance with the above controlling authorities, the Medicaid household group is the petitioner, his wife and their two children (four members). The findings show the Department determined the petitioner's eligibility with a household size of four. The undersigned concludes the Department correctly determined the petitioner's household size as four for Medicaid eligibility purposes.

36. 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.

37. 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).

38. The Policy Manual at Appendix A-7 indicates that for the Adult Income Limit of $364 and a Standard Disregard of $241 for Family-Related Medicaid Program with a family size of four. It also indicates the MNIL to be $585.

39. 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 $3,766.80. Step 2: There are no deductions provided as there was no tax return. Step 3: The total income of $3,766.80 less the standard disregard of $241 is $3,525.80. Step 4: The balance of $3,525.80 is greater than the income limit of $241 for the petitioner to receive full Medicaid. Step 5: With no MAGI disregard, the countable balance remains $3,525.80. This amount was greater than the income limit of $364. The undersigned concludes the petitioner is ineligible for Medicaid. The undersigned further concludes Medically Needy eligibility must be explored for the petitioner.

40. 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.

41. 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.

42. Effective January 2015, Appendix A-7 indicates that for a household of four, the MNIL is $585.

43. To determine the SOC the respondent determined the petitioner's household monthly to be $3,766.80. The Medically Needy Income Level of $585 for a standard filing unit size of four was subtracted resulting to the petitioner's estimated SOC of $3,181. It was further reduced by $104.90 in medical insurance premium, resulting in the final estimated SOC to be $3,076.

44. The hearing officer found that no exception to this calculation. It is concluded that a more favorable share of cost could not be determined. Eligibility for full Medicaid was not found.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are denied. The respondent's actions are upheld.

NOTICE OF RIGHT TO APPEAL

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeals are 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 05 day of February, 2016, in Tallahassee, Florida.

Roosevelt Reveil
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished [redacted], Petitioner
Office of Economic Self Sufficiency

FILED
Feb 17, 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-09485

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on January 26, 2016, at 9:10 a.m.

APPEARANCES

For the Petitioner: [redacted] pro se.

For the Respondent: Linda Latson, Registered Nurse Specialist, Agency for Health Care Administration (AHCA).

STATEMENT OF ISSUE

At issue is the Agency action through Better Health Care/DentaQuest to deny the petitioner's request for certain dental procedures. The petitioner carries the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

Present as witnesses for the respondent were Lourdes Gayo, Director of Member Services, Dr. Merlin Osorio, Medical Director, both from Better Health Care; Heidi

Penaranda, Complaint and Grievance Specialist, and Dr. Frank Manteiga, Dental Consultant, both from DentaQuest.

The record was left open for three days to obtain a statement from the petitioner and an additional four days to obtain a response from the respondent, for a total of seven days. Both parties provided statements and responses within the time frame allotted.

The respondent submitted into evidence Respondent Exhibit 1 through 3.

FINDINGS OF FACT

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

1. The petitioner lives in [redacted] and is a Medicaid recipient. He is enrolled in the Medicaid MMA (Managed Medical Assistance) Program with Better Health Care. Better Health Care is a Managed Care Organization that has been authorized by AHCA to make prior service authorization decisions for individuals enrolled in Medicaid MMA Programs. DentaQuest has been authorized by Better Health to make prior service authorization decisions requests for dental care.

2. On October 31, 2015, the petitioner's treating dentist submitted a prior authorization request to DentaQuest for dental procedures. He requested procedure [redacted] He also requested procedure code [redacted] which

[redacted]

3. DentaQuest sent an Authorization Determination Notice to the petitioner's treating dentist which states in regard to code [redacted] "Per dental director review the x-rays do not support the code requested. A less severe extraction code would be considered." [redacted] "Service is not covered." [redacted] "Per dental director review, partial is denied due to less than fifty percent bone support."

4. DentaQuest sent the petitioner a "Notice of Action" on November 3, 2015 regarding the above noted decision which states in part:

> After our review, this service has been: Denied…
>
> [redacted]
>
> Partial lower denture
>
> We made our decision 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 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. Requested service is not a covered benefit

5. The respondent's dental consultant witness indicated that most of the petitioner's teeth have a seventy percent bone loss, thus an easy extraction (of problem

teeth) would be more appropriate for the petitioner. He also indicated that procedure [redacted] would not have a positive long term prognosis for the petitioner. He explained that [redacted] is a [redacted], thus teeth without bone, such as with the petitioner's condition, will not hold up. He further explained that the cast metal partial will put a lot of pressure on the teeth that the partial is anchored to and thus the reason for this code will be considered a "poor prognosis". He further explained the [redacted] is an [redacted] and it is more forgiving, thus it would put less pressure on the anchor teeth.

6. He offered and indicated that [redacted] and [redacted] would be more appropriate dental procedures that could be approved for the petitioner if requested.

7. The DentaQuest complaint and grievance specialist witness indicated that the petitioner's dentist was advised of the alternative codes noted above, but that DentaQuest will contact the petitioner's dentist and advise him of the alternative codes. Additionally, the record was left open for the petitioner to himself contact his dentist and inform the dentist of the alternative codes.

8. The petitioner contacted this hearing official while the record was left open and verbally advised the undersigned hearing officer his dentist would not request any service for the petitioner using the alternative codes.

9. While the record was left open, DentaQuest provided a response:

> DentaQuest contacted [petitioner's] dental office and was told the dentist is willing to down code the extraction from D7210 to D7140. However, he cannot down code from D5214 to D5212 since [dentist] only makes metal framework with resin base partial denture.

10. The petitioner argued that he has pain in his teeth. He argued that he cannot chew his food and must eat only soup.

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

14. The Dental Services Coverage and Limitations Handbook (November 2011), which has been incorporated by reference into Chapter 59G-4 Fla. Admin. Code states on page 2-15:

> Extractions of all erupted teeth or exposed roots within a quadrant, same recipient and same date of service, are reimbursable with procedure code D7140, using D7140's reimbursement rate for each applicable extraction. This rule does not apply if an extraction within the quadrant is a surgical removal of an erupted tooth or the removal of an impacted tooth, which will be identified by the appropriate extraction procedure code.

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

(166) “Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

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

16. As shown in the Findings of Fact, the Agency through DentaQuest denied the request for dental procedures [redacted] tooth 23, 24, 25, 26 and 29,, [redacted], and [redacted].

17. For the case at hand, the respondent denied the requests for the above noted dental procedures based on not meeting medical necessity requirements. Especially, the provisions that indicate services must be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs. Other than [redacted], the respondent had offered alternative dental codes that could provide the petitioner with teeth extractions and partial dentures. The petitioner’s dentist agreed to the alternative

extraction [redacted], but not to the alternative partials [redacted]. Additionally, the respondent's dental witness made it clear that [redacted], a [redacted] will give a poor prognosis for the petitioner based on the petitioner's bone loss. [redacted]s not a covered benefit and was not discussed further by the petitioner's treating dentist. The bottom line for the petitioner as per his arguments is that he is in need of getting pain relief and being able to chew his food.

18. The hearing officer thus agrees that the Agency's determination to deny the dental code requests as noted above is correct.

19. After considering the evidence and all of the appropriate authorities set forth in the findings above, the hearing officer concludes that the petitioner has not met his burden of proof and the Agency's action denying the petitioner's request for the dental procedures is correct. The petitioner may want to explore acquiring another dental provider who is willing to request the alternative and more appropriate dental codes.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this __17__ day of __February_____, 2016,

in Tallahassee, Florida.

Robert Akel

Robert Akel
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

FILED
Feb 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-09493

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 December 18, 2015, at 11:30 a.m.

APPEARANCES

For the Petitioner: [redacted] Petitioner's daughter

For the Respondent: Marielisa Amador, Data Analyst, AHCA

STATEMENT OF ISSUE

At issue is the Agency action of October 27, 2015 partially denying the Petitioner's request for additional home health care service hours under the Long Term Care Program. The Petitioner bears the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

Appearing as witnesses for the Respondent were Dr. Sloan Karver, Medical Director for United Healthcare, and Christian Laos, Senior Compliance Manager for United Healthcare, which is Petitioner's managed care plan.

The Petitioner submitted medical records as evidence for the hearing, which were marked Petitioner Exhibit 1.

The Respondent submitted documents as evidence for the hearing consisting of the following which were marked as Respondent Exhibits: Exhibit 1 – Statement of Matters and Denial Notice; Exhibit 2 – Grievance System Screenshots; Exhibit 3 – Member Notes Reports; Exhibit 4 – Medical Assessment Form.

FINDINGS OF FACT

1. The Petitioner is seventy-five (75) years old and lives with her one of her daughters and two grandchildren (aged 3 and 8). The daughter is not currently working but is attempting to find employment. The Petitioner is non-ambulatory. She previously used a cane or walker to ambulate, but has fallen while doing so. She needs assistance with activities of daily living such as dressing and grooming. Her medical conditions include [redacted]

2. The Petitioner currently receives the following home health services – personal care 14 hours weekly, homemaker service 7 hours weekly, and companion

care 7 hours weekly – for a total of 28 hours weekly. She receives this assistance from 1:30 p.m. to 5:30 p.m. daily.

3. The Petitioner is a Medicaid recipient who was enrolled in the Statewide Medicaid Managed Care (SMMC) – Long Term Care (LTC) plan in July, 2014. She receives services under the plan from United Healthcare.

4. 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.

5. On or about October 19, 2015, Petitioner requested an additional 21 hours of companion care services weekly and an additional 7 hours of personal care services weekly, for a total of 28 additional hours weekly of home care services.

6. On October 27, 2015, United Healthcare sent a letter to Petitioner informing her that her request for additional services had been partially denied. A total of 31 hours weekly was approved. The letter stated the following as the reason for the denial:

> The health plan reviewed your needs for personal care. Personal care includes help for activities of daily living. This includes help for dressing and bathing. Based on our review you need personal care for 14 hours in a week.
> The health plan reviewed your needs for a homemaker. Homemaker care includes help for preparing meals and housekeeping. Only homemaker care that is for you, not the whole home, is covered. Based on our review you need homemaker care for 7 hours a week.
> The health plan reviewed your needs for companion care. Companion care is non-medical. Companion care is to help you perform activities. Companion care is also to help you socialize. Companion care is not

> covered only because you are alone. Based on our review you need companion care for 10 hours in a week.
> 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.

7. The Petitioner's daughter testified her mother needs additional assistance in the home because her condition has been deteriorating and she has lost a substantial amount of weight because she is constantly in the restroom. She also stated her mother has become severely depressed and cannot do anything on her own.

8. The Respondent's witness, Dr. Karver, testified that the partial denial of the requested services was appropriate because the hours (31 hours weekly) approved were sufficient to provide assistance to the Petitioner with home care. Dr. Karver also stated that the health plan may be able to offer nursing home placement if she requires more assistance than can be provided in the home. Another medical assessment can be performed by United Healthcare to determine the Petitioner's current health status.

CONCLUSIONS OF LAW

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

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

11. In accordance with Fla. Admin. Code § 65-2.060 (1), the burden of proof was assigned to the Petitioner since the issue involved a request for an increase in service hours.

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 effective July, 2014.

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

15. Covered services under the AHCA contract for LTC plans include Companion Care Services, Homemaker Services, and Personal Care Services, among other services.

16. Companion Care services 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.

17. Homemaker services 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.

18. Personal Care services 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.

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. 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 met the burden of proof in demonstrating that the services under the LTC Program should be increased by 28 hours weekly. The Petitioner undoubtedly has serious medical issues and needs assistance at home. The evidence presented establishes that the Petitioner's needs can be met with the 31 hours weekly of assistance which has been approved by United Healthcare, particularly since the Petitioner does not live alone. The Petitioner's family and caregivers are encouraged to request another medical assessment by United Healthcare if her condition has changed, and to explore other services available under the LTC Program which may more appropriately address her needs.

DECISION

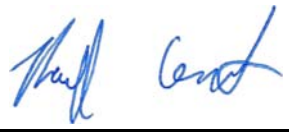
Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED.

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 February, 2016,

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
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Tallahassee, FL 32399-0700
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Copies Furnished To [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

FILED
Feb 11, 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-09525

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on January 19, 2016, at 12:40 p.m.

APPEARANCES

For the Petitioner: [redacted]
Petitioner's mother

For the Respondent: Stephanie Lang, R.N.
Registered Nurse Specialist/Fair Hearing Coordinator
Agency for Health Care Administration

STATEMENT OF ISSUE

Did the respondent prove by a preponderance of the evidence that it correctly terminated the petitioner's Prescribed Pediatric Extended Care ("PPEC") Services?

PRELIMINARY STATEMENT

[redacted] the petitioner's mother, appeared on behalf of the petitioner, Ethan Burgos-Bonilla ("petitioner"), who was not present. Ms. Bonilla may sometimes hereinafter be referred to as the petitioner's "representative".

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. Rakesh Mittal, M.D., Physician Reviewer with eQHealth Solutions, appeared as a witness on behalf of the Agency.

The respondent introduced Exhibits "1" through "6", inclusive, at the hearing, all of which were accepted into evidence and marked accordingly. The petitioner did not introduce any exhibits.

At the request of the respondent, the hearing officer took administrative notice of the following:

- Section 409.905, Florida Statutes.
- Florida Administrative Code Rules 59G-1.001, 59G-1.010, and 59G-4.260.
- The Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook, September 2013.

FINDINGS OF FACT

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 10-month old male with a history of [redacted]

2. Petitioner was eligible to receive Medicaid services at all times relevant to this proceeding.

3. The petitioner's medical history is remarkable for the following: [redacted] The petitioner also has a history of behavioral problems.

4. [redacted]

5. The petitioner has a ventriculoperitoneal shunt ("V-P shunt" or "ventricular shunt"). The shunt drains fluid from the ventricle to the general cavity of the abdomen.

6. The petitioner does not have any complications associated with his V-P shunt.

7. The petitioner is prescribed [redacted] and [redacted] but is not prescribed anti-seizure medication. Both the [redacted] and [redacted] are given orally. The petitioner receives his evening dose of [redacted] while at PPEC but takes no other medications there while attending.

8. Although the petitioner is diagnosed with [redacted], his PPEC records do not indicate any recent seizure activity.

9. The petitioner is ambulatory and on a regular diet. He can communicate verbally but has a limited vocabulary.

10. The petitioner has no recent emergency room visits or hospitalizations.

11. The petitioner has not had any recent changes in his medications. His medication regimen is not complex.

12. The petitioner was previously enrolled in a traditional daycare setting but was asked to leave due to his behavioral problems.

13. The child to teacher ratio in a traditional daycare can be as high as 25:1, whereas the child to center personnel ratio at a PPEC is generally 3:1.

14. The petitioner lives in the family home with his mother and one sibling. The petitioner's father was allegedly responsible for his injuries and is incarcerated in another state.

15. The petitioner's mother works in the retail industry. Her work hours and days vary.

16. The petitioner's mother has no physical limitations which limit her ability to provide care to the petitioner.

17. A PPEC is a non-residential center that serves three or more medically dependent or technologically dependent recipients under the age of 21 who require short, long-term, or intermittent medical care due to medically-complex conditions. A PPEC offers services that meet the recipients' physiological, developmental, nutritional, and social needs.

18. The petitioner was approved to receive PPEC Services Monday through Saturday for up to and including 12 hours per day in the prior certification period.

19. On November 2, 2015, the petitioner's PPEC provider submitted a prior authorization request to eQHealth Solutions for PPEC services to be provided for up to 12 hours per day, Monday through Saturday, for the certification period November 14, 2015 through May 11, 2016. PPEC services are normally certified for six-month periods.

20. eQHealth Solutions is the Quality Improvement Organization contracted by the Agency for Health Care Administration to review requests by Medicaid recipients in the State of Florida for PPEC Services.

21. eQHealth Solutions is delegated the responsibility of determining whether a requested service is medically necessary under the terms of the Florida Medicaid Program. eQHealth Solutions has the authority to present a case and act as a witness for the Agency for Health Care Administration.

22. A request for PPEC Services is submitted directly to eQHealth Solutions by a petitioner's PPEC provider. Once eQHealth Solutions receives the information, it completes a prior authorization review – it reviews the written request to determine if the services requested are medically necessary.

23. The petitioner's request was reviewed by an eQHealth Solutions Physician Reviewer on November 5, 2015. The Physician Reviewer determined on-going PPEC services were not medically necessary; however, the Physician Reviewer did approve 90-days of services to allow time to transition the petitioner out of PPEC.

24. The Physician Reviewer provided the following approval rationale for the decision:

> The patient is a 10 year old with a history of [redacted] appear to be well-controlled with no reported [redacted] The patient is ambulatory and verbal. The patient has behavioral issues. The clinical information provided does not support the medical necessity of the requested services; however, 3 months will be approved to allow time to transition the patient out of PPEC.

25. The Physician Reviewer also supplied the following clinical rationale for the decision:

> The clinical information provided does not support the medical necessity of the requested services. The patient does not appear to require skilled nursing. The remainder of the requested services are denied.

26. The evidence does not indicate the petitioner requested an internal review of the eQHealth Solutions decision. This case proceeded directly to the administrative hearing process.

27. The Agency for Health Care Administration administratively approved the continuation of petitioner's PPEC Services pending the resolution of this appeal.

28. The respondent's witness testified that Prescribed Pediatric Extended Care is designed for children that are medically complex and who require skilled nursing care. He testified PPEC services are generally for children who require ventilators for breathing assistance, apnea monitors, or gastrostomy tubes ("G-tubes"). He explained PPEC services may also be approved for children who have frequent seizures, such as five or six seizures per hour. The respondent's witness testified that the petitioner in the present case does not have a complex medication regimen and does not require skilled nursing services. Although the petitioner requires monitoring for behavioral problems, PPEC services may not be approved to monitor an individual for behavioral problems. He explained that, although the petitioner has a ventricular shunt, the shunt is operating properly and there are no complications associated with it. He further explained that any care provider may be trained to observe for symptoms associated with a malfunctioning shunt and call for emergency assistance if he or she observes such symptoms and that PPEC services may not be approved solely for the monitoring of a ventricular shunt.

CONCLUSIONS OF LAW

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

30. The Florida Medicaid Program is authorized by Chapter 409, Fla. Stat., and Chapter 59G, Florida Administrative Code. The Program is administered by AHCA.

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

32. The respondent in the present case is proposing to terminate previously approved services. Therefore, in accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof is assigned to the respondent.

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

34. 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…

35. 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.

36. 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.

37. The United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in *Moore v. Reese*, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the

following guiding principles in its opinion, which involved a dispute over private duty nursing:

> [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.
>
> (2) A state Medicaid plan must include "reasonable standards … for determining eligibility for and the extent of medical assistance" … and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.
>
> (3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."
>
> (4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."
>
> (5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. **The state is not required to provide medically unnecessary, albeit desirable, EPSDT services.** However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."
>
> (6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and my present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)) (emphasis added).

38. 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.

39. Section 409.913, Fla. Stat. governs the oversight of the integrity of the Florida Medicaid Program. Section (1)(d) sets forth the "medical necessity or medically necessary" standards, and states in pertinent part as follows

> "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice….
>
> Section (1)(d) goes on the further state:
>
> …For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

40. Section (1)(d) highlights that the Agency makes the final decision regarding whether or not a requested service is medically necessary; however, the hearing officer is the final decision making authority for the Agency. See § 120.80, Fla. Stat.

41. The Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook, September 2013 ("PPEC Handbook") is promulgated into law by Florida Administrative Code Rule 59G-4.260.

42. 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.

43. 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.

44. The testimony and documentary evidence in the instant matter fail to establish the medical necessity of PPEC services for the petitioner. The petitioner is not on a complex medication regimen, nor does he require the provision of skilled nursing services. The petitioner's level of illness does not reach the level of "medically complex" or "medically fragile," as defined in the Florida Administrative Code.

45. After carefully reviewing the EPSDT and medical necessity requirements set forth above, the hearing officer concludes the respondent has met its burden of proof, by the greater weight of the evidence, in terminating petitioner's PPEC services.

DECISION

Based upon the foregoing, the petitioner's appeal is DENIED and the decision of the Agency for Health Care Administration is AFFIRMED.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 11 day of February, 2016, in Tallahassee, Florida.

Peter J. Tsamis

Peter J. Tsamis
Hearing Officer
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1317 Winewood Boulevard
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Copies Furnished To: [redacted] Petitioner
Don Fuller, Area 6, AHCA Field Office Manager

FILED
Feb 11, 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-09549, 09550

PETITIONER,

Vs.

[redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 20 Collier
UNIT: 88521

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on January 29, 2016 at 9:05 a.m. CST.

APPEARANCES

For the Petitioner: [redacted] pro se
Alicia Fuller, friend and translator

For the Respondent: Ed Poutre, Economic Self-Sufficiency Specialist II,
Department of Children and Families

STATEMENT OF ISSUE

The Petitioner is appealing the Respondent's action to deny her application for Food Assistance (15F-09549). The Petitioner carries the burden of proof by a preponderance of the evidence.

There is a companion appeal, 15F-09550, for Medicaid. The Respondent stated that a Medicaid appeal was input in the FLORIDA System, possibly in error. The Petitioner states that she has made no appeal for Medicaid benefits. It was agreed by

all parties that Medicaid eligibility was not at issue. The Petitioner is currently receiving Medicaid benefits as she is also a recipient of Supplemental Security Income (SSI).

PRELIMINARY STATEMENT

Appearing as a witness and as translator/representative for the Petitioner is [redacted] who was sworn in as both a translator and witness. The Petitioner presented two individual packets which were admitted into evidence and marked as Petitioner's Exhibits 1 and 2. The Department presented two individual packets which were admitted in evidence and marked as Respondent's Exhibits 1 and 2.

FINDINGS OF FACT

1. There are multiple notices of case action (NOCA).

2. The Respondent states that the Petitioner was approved for Food Assistance in error and once discovered those benefits were discontinued (NOCA November 13, 2015). The reason given for this closure was "*Ningun miembro del grupo familiar cumple los requisitos de este programa."* (R65A-1.205) Google translate: "(not) any household member qualifies for this program."

3. The benefits were reinstated, again per Respondent in error (NOCA November 23, 2015). And denied for the final time on November 25, 2015 with the reason (paraphrased) opened in error and now closed, "*Ningun miembro del grupo familiar cumple los requisitos de este programa su caso se abrio por error y ahora ha sido cerrado* (R65A-1.205)." Google translate: "No household member meets the requirements of this program opened his case by mistake and has now been closed."

4. The Petitioner entered the United States on [redacted] on a visitor's visa as documented by a print out of her most recent I-94.

5. The Petitioner states that she did not enter the United States as a Parolee, Refugee or Asylum seeker. She provided documentation that she entered the US as a visitor.

6. The Petitioner states that she applied for the Adjustment of Status based on the Cuban Adjustment Act and was granted Permanent Residency but has no documentation stating that she was ever granted Cuban/Haitian Entrant Status prior to receiving Lawful Permanent Residency (LPR).

7. The Petitioner is a non-disabled SSI recipient, eligible because she is 80 years old.

8. When asked if she had ever been granted Cuban/Haitian Entrant Status during her process to become a Lawful Permanent Resident, she stated that she does not know, that she is not sure how she was labelled.

9. The Petitioner stated that other than a Cuban birth certificate, she has provided all the citizenship and immigration paperwork that she has.

10. The Category code on the Petitioner's Permanent Residence Card is CU6.

11. LPRs must be in the U.S. for five years as qualified non-citizens to be eligible for Food Assistance benefits.

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. Federal regulations at 7 C.F.R. § 273.4 states in relevant part:

> *(a) Household members meeting citizenship or alien status requirements*. No person is eligible to participate in the a Program unless that person is:
>
> (5) An individual who is both a qualified alien as defined in paragraph (a)(5)(i) of this section and an eligible alien as defined in paragraph (a)(5)(ii) of this section.
>
> (i) A qualified alien is:
>
> (A) An alien who is lawfully admitted for permanent residence under the INA;...
>
> (ii) A qualified alien, as defined in paragraph (a)(5)(i) of this section, must also be at least one of the following to be eligible to receive food stamps:
>
> (A) An alien lawfully admitted for permanent residence under the INA sho has 40 qualifying quarters as determined under title II of the Social Security Act, including qualifying quarters of work not covered by Title II of the Social Security Act, based on the sum of: quarters the alien worked; quarters credited from the work of a parent of the alien before the alien became 18 (including quarters worked before the alien was born or adopted); and quarters credited from the work of a spouse of the alien during their marriage if they are still married or the spouse is deceased.

15. The Department's Program Policy Manual CFOP 165-22 at section 1410.0106 states in part:

> A lawful permanent resident (LPR) is a noncitizen who lawfully immigrates to the U.S. and has permission to live and work in the U.S. LPRs may be eligible for food stamps based on citizenship if they entered the U.S.:
> 1. prior to 8/22/96 and have remained continuously present,
> 2. on or after 8/22/96 under a prior asylee, refugee, Amerasian, deportation withheld or Cuban/Haitian Entrant status, or
> 3. **on or after 8/22/96 and have lived in the U.S. as a qualified noncitizen for at least five years or if they can be credited with 40 quarters of work.** (Emphasis added)

16. In this case, the petitioner was admitted as a visitor and gained LPR status upon notice dated July 29, 2015. She has only been in the county since April 05, 2014, hence she cannot claim 40 quarters to forgo the 5-year ban.

17. Page 3-3 of the Refugee Program Eligibility Guide for Service Providers, 1/2015 states in part:

> Cuban Adjustment Act (CAA)
> Any Cuban who was admitted or paroled may, after one year of physical presence, apply for adjustment to legal permanent resident under the Cuban Adjustment Act of 1966. Persons previously eligible as Cuban/Haitian entrants who adjust status under the Cuban Adjustment Act maintain their eligibility for refugee services after adjustment. Some Cubans who adjust status under the Cuban Adjustment Act never held status as "Cuban/Haitian Entrants," however, and do not become eligible for refugee services upon adjustments.
>
> **The adjustment code CU6 on the Form I-551 (Permanent Resident Card) is insufficient evidence of eligibility for refugee programs** because it is also used for a person who never has status as a Cuban/Haitian entrant…(Emphasis added)
>
> The CU6 code may be used as evidence of Cuban nationality. While the date of residence on the Form I-551 may be the date an individual is paroled unto the United Stated, providers may not assume this is the date of entry for eligibility purposes as some individuals arrived in the United States with parole status or applied for parole later (see "Parole" section below). If applicants have surrendered their For I-94s to ISCIS on adjustment to permanent resident status, providers may be able to establish eligibility from documentation of earlier refugee program eligibility (such as an expired EAD or old passport), or by submission of Form G-639 (Freedom of Information/Privacy Act Request) to USCIS.

18. Petitioner claims no prior status that would exempt her from the 5-year ban, her CU6 code being insufficient evidence of eligibility for refugee programs. Although she is an SSI recipient, her eligibility is based on her age and not disability. Being aged is not a factor that would affect the Petitioner's LPR status.

19. After considering the evidence, testimony and the authorities cited above, the undersigned concludes that the Petitioner is a Lawful Permanent Resident subject to the 5-year ban and not currently eligible to receive Food Assistance benefits.

DECISION

Based on the foregoing Findings of Fact and the Conclusions of Law, the appeal is denied. The Respondent's action to discontinue receipt of Food Assistance benefits is affirmed. The companion Medicaid appeal 15F-09550 is withdrawn.

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 February, 2016,

in Tallahassee, Florida.

Gregory Watson

Gregory Watson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
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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

FILED
Feb 03, 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-09557

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on January 26, 2016, at 10:30 a.m.

APPEARANCES

For the Petitioner: [redacted] the petitioner's mother.

For the Respondent: Linda Latson, Registered Nurse Specialist, Agency for Health Care Administration (AHCA).

STATEMENT OF ISSUE

At issue is whether the Agency's denial of a dental procedure was correct. The petitioner carries the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

Present as witnesses for the respondent were Mindy Aikman, Grievance and Appeals Coordinator and Stacey Larson, Clinical Guidance Analyst, both with Humana;

Jacqueline Salcedo, Complaints and Grievances Representative with DentaQuest; and Dr. Susan Hudson, Dental Director with DentaQuest.

The respondent submitted into evidence Respondent Exhibit 1 and 2.

FINDINGS OF FACT

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

1. The petitioner is sixteen years of age and is a Medicaid recipient living in Broward County, Florida. She is enrolled in the Medicaid MMA (Managed Medical Assistance) Program with Humana. Humana is a Managed Care Organization that has been authorized by AHCA to make prior service authorization decisions for individuals enrolled in the Medicaid MMA Program. DentaQuest is contracted by Amerigroup to provide dental services and perform prior authorization reviews.

2. DentaQuest received a prior service authorization request from the petitioner's treating dental surgeon on October 26, 2015 for the removal of her four wisdom teeth, tooth numbers 1, 16, 17 and 32. DentaQuest reviewed this request and provided an Authorization Determination notice to the petitioner's dental provider on October 27, 2015. Tooth numbers 17 and 32 removal were approved (lower quadrant). Tooth numbers 1 and 16 were denied.

3. The above referenced notice indicated that the request for procedure code D7240 was denied for the two upper quadrant teeth. The determination reason provided indicated "there is no sign of infection or other medical reasons for tooth removal."

4. DentaQuest sent the petitioner a Notice of Action on October 27, 2015 regarding the above noted decision which states in part:

> We made this decision because:
>
> Must be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain
>
> Must be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs
>
> Must be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

5. The respondent's dental physician witness indicated DentaQuest had several dentist review the information presented by the petitioner's treating dental surgeon, that included the X rays, and found no evidence of infection, pathology or enough space between the teeth that would meet the criteria for the service request to be approved. She reiterated that the removal of the wisdom teeth (upper quadrant) does not meet the medical necessity criteria to be approved.

6. The petitioner's representative argued that the petitioner has complained to her of pain in her entire mouth and that she has a hard time eating. She also indicated that she gives the petitioner over the counter Tylenol for the pain. Despite the pain, the petitioner has not removed the wisdom teeth in the lower quadrant. She indicated that she was aware of the approval of the lower quadrant teeth being removed, but wanted to wait for an approval of all of the wisdom teeth removal so the removals could occur at one time.

7. The respondent witness, dental physician, indicated that the information provided shows the upper quadrant teeth have not broken through the skin and do not meet the criteria as noted above for removal.

CONCLUSIONS OF LAW

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

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

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

11. The Dental Services Coverage and Limitations Handbook, dated November 2011, has been incorporated by reference into Chapter 59G-4, Fla. Admin. Code and states on page 2-15:

> Extractions of all erupted teeth or exposed roots within a quadrant, same recipient and same date of service, are reimbursable with procedure code D7140, using D7140's reimbursement rate for each applicable extraction. This rule does not apply if an extraction within the quadrant is a surgical removal of an erupted tooth or the removal of an impacted tooth, which will be identified by the appropriate extraction procedure code.

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

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

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

13. Since the Petitioner is under twenty-one years of age, 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.

14. Under the above statute, the Agency offers dental services as an EPSDT service to Medicaid-eligible recipients less than twenty-one years of age.

15. The United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in *Moore v. Reese*, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, which involved a dispute over private duty nursing:

> (1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.
> (2) A state Medicaid plan must include "reasonable standards … for determining eligibility for and the extent of medical assistance" … and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.
> (3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."
> (4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."
> (5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to provide medically unnecessary, albeit desirable, EPSDT services. However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."
> (6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and my present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)).

16. 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.

17. As shown in the Findings of Fact, DentaQuest denied the petitioner's request for dental procedure code D7240, which is oral surgery to remove or extract two wisdom teeth, tooth numbers 1 and 16, upper quadrant.

18. For the case at hand, the respondent argued that after review of the information submitted for the request, including the X rays, DentaQuest found no evidence of infection, pathology or enough space between the teeth that would meet the criteria for the service request to be approved; therefore, the removal of the wisdom teeth (upper quadrant) does not meet the medical necessity criteria to be approved. The hearing officer agrees with the respondent's arguments.

19. After considering the evidence and all of the appropriate authorities set forth in the findings above, the hearing officer concludes that the petitioner has not met her burden of proof and the Agency's action denying the petitioner's request for the dental procedures is correct.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency

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

DONE and ORDERED this 03 day of February, 2016,

in Tallahassee, Florida.

Robert Akel

Robert Akel
Hearing Officer
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1317 Winewood Boulevard
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Copies Furnished To: [redacted], Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager
Ysabel Rodriguez

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

FILED
Feb 08, 2016
Office of Appeal Hearings
Dept. of Children and Families

[redacted]

APPEAL NO. 15F-09573

PETITIONER,

Vs.

[redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 07 Putnam
UNIT: 88371

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on December 29, 2015 at 11:35 a.m.

APPEARANCES

For the Petitioner: The petitioner was present and represented himself.

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

ISSUE

The petitioner is appealing the Department's action on November 18, 2015 to continue his enrollment in the Medically Needy (MN) program with an estimated monthly share of cost (SOC) of $1319.

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

PRELIMINARY STATEMENT

Appearing as a witness for the petitioner was his wife, [redacted]

Appearing as an observer was Pamela Vance, hearing officer for the Office of Appeal Hearings with DCF.

The record was held open until 5:00 p.m. on January 4, 2016 to allow the respondent to submit additional evidence. Evidence was received and entered as the Respondent Exhibit 3.

FINDINGS OF FACT

1. Prior to the issue under appeal, the petitioner was receiving Supplemental Security Income (SSI). The petitioner's wife began receiving Social Security income, which caused the petitioner to no longer be eligible for SSI effective March 31, 2015. The petitioner's full-coverage Medicaid was terminated effective April 30, 2015. The petitioner was enrolled in the MN program beginning May 2015.

2. On November 12, 2015, the petitioner's wife completed an application to recertify for Food Assistance Program (FAP) and Medicaid benefits for the petitioner, age 64, and herself, age 62.

3. The Department included in the MN budget, the petitioner's Social Security income in the amount of $597 and his wife's Social Security income in the amount of $983, for a total countable unearned income of $1580. The $1580 income exceeded the Medicaid for the Aged or Disabled (MEDS-AD) income limit of $1169 for two persons. The income was reduced by the $20 standard deduction to result in a countable income of $1560. The countable income of $1560 was reduced by the $241 Medically Needy Income Level (MNIL) for two persons for a remaining SOC in the

amount of $1319. Therefore, the Department continued his enrollment in the Medically Needy Program with an estimated SOC in the amount of $1319.

4. The petitioner does not dispute the amount of the monthly gross income for himself and his wife. The petitioner and the petitioner's wife confirm he was enrolled in the MN program since May 1, 2015 but he was not aware because he did not receive a notification. The petitioner's wife argues that when the petitioner was enrolled in the Prestige Plan and receiving full-coverage Medicaid, he could go to any pharmacy he wanted to get his prescriptions refilled.

5. The petitioner's wife contends that the petitioner received correspondence from his health plan provider, Prestige Plan, informing him that the open-enrollment period was ending and that if he did not want to make any changes, he did not have to take any action. He was instructed to make changes, if any, by the end of March 31, 2015. The petitioner and the petitioner's wife was under the impression that the petitioner was still covered under full-coverage Medicaid.

6. The petitioner's wife believes that the petitioner is entitled to receive full-coverage Medicaid because he has been determined disabled by the Social Security Administration (SSA). The petitioner's wife argues that the petitioner is undergoing a hardship when he has to get his prescriptions filled because the Department does not track his bills on time once he meets his SOC amount.

7. The petitioner argues that he has issues with going to the doctor now that he is on the MN program. The petitioner's wife contends that she was informed that there is no health plan or Medicaid identification card for the MN program. The petitioner's

husband receives a Notice of Case Action to inform him that he has met his monthly SOC for the previous month. The petitioner contends that once he meets the SOC, his doctor is required to get approval for his procedures and for his prescriptions; then it will take another five days to one week to get the prescription filled. The petitioner argues that he sometimes he goes through an entire month without getting his prescription filled if he does not get a procedure done early enough in the month in order to get his bill tracked for approval.

8. The petitioner's wife argues that sometimes the Department does not receive the faxed medical bills and she has to refax the bills. The petitioner's wife argues that on November 10, 2015, a medical bill was submitted to the Department. The petitioner's wife argues that the Medicaid for November 2015 was approved on November 17, 2015 and that the petitioner was able to get the prescription filled on November 18, 2015. The petitioner's wife argues there is a glitch in the system, which is detrimental to the petitioner's health. The petitioner's wife argues that the petitioner's health has declined, which is partly due to the inconsistency in taking his medication. The petitioner's wife believes the petitioner is following all the rules but keeps getting the runaround.

9. The Department explained that once the petitioner's SSI was terminated, he was no longer eligible for full-coverage Medicaid. The Medicaid program is income-based. The Department pointed out that the petitioner's SSI was terminated once his wife began receiving Social Security income. The Department explained that since the petitioner's SSI was terminated, he was no longer eligible for the full-coverage Medicaid

benefits that were attached to his receiving the SSI benefits. The evidence presented does not indicate that the petitioner receives Medicare.

10. The Department explained that when a medical bill is received for tracking, it attempts to respond within two days. The Department explained that it is allowed up to 10 days to track a medical bill. The Department's records show that on Friday, December 11, 2015, the petitioner submitted a medical bill with a service date of December 10, 2015. The Department tracked the petitioner's medical bill on December 14, 2015.

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. 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.

14. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, Appendix A-9, effective July 2015, sets forth the MEDS-AD income limit at $1169 for a

couple.

15. The above controlling authority explains that the full coverage Medicaid coverage group (MEDS-AD Demonstration Waiver) in the SSI-related Programs is for individuals who are not receiving Medicare and whose income is at, or below, 88 percent of the poverty level. The findings show that the petitioner does not receive Medicare; however, his household's income is above 88 percent of the poverty level for a couple. Therefore, the undersigned concludes that petitioner does not qualify for full coverage Medicaid as his and his wife's combined countable income is above 88 percent of the poverty level (currently $1169 for a couple).

16. 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.

17. 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.

18. 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…2 Level $241…

19. The Policy Manual, passage 2440.0322 Standard Disregard (MSSI) states in part,

> This policy applies to MEDS-AD, MN, QMB, SLMB, QI-1, Working Disabled, Protected Medicaid and EMA. A $20 per month standard disregard applies to any type (earned or unearned) of income other than income which is provided on the basis of need. The amount of the disregard is not increased for a couple, regardless of whether one or both individuals have income.

20. Fla. Admin. Code R. 65A-1.701, Definitions, states in part, "(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."

21. The Policy Manual, passage 2640.0500 SHARE OF COST (MSSI), explains the Medically Needy Program as:

> The eligibility specialist must determine eligibility for Medically Needy any time the assistance group's assets and/or income exceeds the appropriate categorical asset/income limits. The eligibility specialist determines whether the assistance group's assets are within the Medically Needy asset limits and whether the assistance group members meet the technical factors. If the Medically Needy asset limit is met and the

> assistance group meets all technical factors, the eligibility specialist determines the amount of countable income and computes a budget using the MNIL which is the same for both family and SSI-Related Medicaid coverage groups (refer to Appendix A-7).
>
> If income is equal to or less than the MNIL, there is no share of cost and the individual is eligible. Medicaid is authorized for individuals who are eligible without a share of cost.
>
> If income is greater than the MNIL, share of cost is determined for appropriate members. Appropriate members are enrolled but cannot be eligible until the share of cost is met.

22. The Respondent Exhibit 3 includes the Department's "ACCESS Case Maintenance Unit Guide" which explains the case management unit (CMU) procedures for bill tracking. The ACCESS CMU guide explains that the CMU processes the bill tracking for all medical bills it receives for those enrolled in the MN program. The guide states:

> a. Scanning Medical Bills: The Customer Service Centers will scan medical bills received at its site for enrolled Medically Needy cases to the CMU.
> b. Recurring Medical Bills: Regularly recurring medical bills received monthly by the CMU (i.e. pharmacy bills or recurring medical treatment such as dialysis or chemotherapy) should be processed as follows:
> - Track bills received by close of business the following day.
> - Track bills received on a Friday or Holiday by close of business the following business day.
> - Fax an AMIC to the provider, if requested by the customer or the provider.
>
> …
> d. One-time/infrequent Bills: Track one-time or infrequently recurring (less frequent than monthly) medical bills no later than 10 calendar days from date of receipt.

23. The petitioner and his wife argue that the Department's CMU does not track his bills in a timely manner in order to obtain medications necessary to treat his

worsening medical conditions. The petitioner's wife argues that the petitioner is inconsistent in taking his medications due to the Department's delay in processing his medical bills. The findings show that the petitioner regularly submits his medical bills on, or around, the 10th of each month. Based on the findings and the above authority, the undersigned concludes that the petitioner has recurring medical bills that are submitted on or around the 10th of each month. Therefore, the undersigned concludes that the Department was untimely in processing the medical bills for November 2015 and was timely in processing the medical bills submitted for the month of December 2015. The Department is to process the petitioner's submitted recurring medical bills as directed in its CMU bill tracking guide.

24. The income limit for a couple to be eligible for full Medicaid in the SSI-Related Programs is $1169. The petitioner's and the petitioner's combined countable income of $1580 exceeds the income limit for the petitioner to be eligible for full Medicaid Program coverage. The petitioner was enrolled in the Medically Needy Program with a share of cost. The petitioner's share of cost was calculated by including his and his wife's countable gross monthly income less the standard disregard and Medically Needy Income Level (MNIL) for a couple. The gross monthly household unearned income of $1580, less the $20 standard disregard and MNIL of $241, equals a share of cost of $1319. The hearing officer found no exception to this calculation. The undersigned concludes that the respondent's action to continue the petitioner's enrollment in the Medically Needy Program and to determine the amount of the monthly share of cost as $1319 was a correct action.

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 08 day of February, 2016, in Tallahassee, Florida.

Paula Ali

Paula Ali
Hearing Officer
Building 5, Room 255
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

FILED
Feb 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. 15F-09631

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 18 Brevard
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on January 14, 2016, at approximately 10:30 a.m.

APPEARANCES

For Petitioner: [redacted]
Petitioner's friend

For Respondent: Lisa Sanchez
Senior Human Services Program Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is whether or not Respondent's termination of Petitioner's adult diapers, chucks (underpads), and wipes was correct. The burden of proof is assigned to Respondent.

PRELIMINARY STATEMENT

Petitioner was present at the hearing but chose to be represented by Ms. Brennan ("Petitioner's representative"). Respondent presented the following witnesses:

- Carlene Brock, Quality Operations Nurse, Amerigroup
- Dr. Amy Zitiello, Lead Medical Director, Amerigroup

Petitioner moved Exhibit 1 into evidence. Respondent moved Exhibits 1 through 8 into evidence. The undersigned took administrative notice of the following:

- Florida Medicaid Provider General Handbook, July 2012.
- Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook, July 2010.

FINDINGS OF FACT

1. Petitioner is a 56-year-old female. At all times relevant to this proceeding, Petitioner was eligible to receive Medicaid services.

2. Petitioner is enrolled with [redacted] as her Managed Medical Assistance (MMA) plan.

3. Petitioner has [redacted], among other conditions. She has been urine incontinent for approximately 10 years. She uses 10-12 adult diapers per day.

4. Petitioner has to wear her diapers for longer than she should because she cannot afford to pay for more of them out-of-pocket. She has had urinary tract infections and rashes as a result of wearing the diapers for an extended period of time. Petitioner's representative testified that she receives $733 per month in SSI and does not have Medicare. She said approximately one-third (1/3) of Petitioner's income is expended on incontinence supplies.

5. On February 26, 2015, Petitioner's physician wrote a prescription for 60 or 90 chucks, 240 small or medium diaper pull-ups (8 per day), and 500 wipes, listing a diagnosis of incontinence.

6. [redacted]'s former vendor, [redacted] submitted a request for the diapers on March 9, 2015. The request did not list the chucks or the wipes.

7. On March 17, 2015, [redacted] issued a Notice of Proposed Action stating it was denying the request, for the certification period of March 9, 2015 through May 7, 2015. (Respondent's Composite Exhibit 4). The Notice states, in pertinent part:

> The outpatient service(s) is being denied because we cannot approve coverage for your adult pullups. Adult pullups are disposable and are not a covered benefit of your health plan. This decision is based on your health plan package and the Florida Medicaid Provider Handbook.

8. Despite the denial, Petitioner received diapers and underpads from [redacted] for March and April of 2015. Ms. Brock said they were never approved and Univita was never supposed to provide them.

9. Petitioner verbally requested two (2) appeals from [redacted], but both were dismissed due to lack of written follow up.

10. On June 10, 2015, [redacted] submitted a request for 90 underpads. On June 26, 2015, [redacted] issued a Notice of Action, denying the request. (Respondent's Composite Exhibit 6). The reason given for the denial was:

> The facts that we used to make our decision are: We cannot approve your adult diapers. We know you have trouble holding your urine. Your health plan only covers these for people less than 21 years old. You are 56 years old. This decision was based on the Florida Medicaid provider handbook on durable medical equipment and supply services….

11. Petitioner requested 200 units of pullups on June 23, 2015. On July 10, 2015, [redacted] issued a Notice of Action, again denying the pullups on the basis that they are not a covered benefit under her plan.

12. Petitioner filed a complaint regarding the denial, which [redacted] received on October 14, 2015. On November 4, 2015, [redacted] issued a letter again denying the pullups on the basis that they are not a covered benefit. The letter suggested that Petitioner reach out to [redacted]'s Case Management department for assistance.

13. Dr. Zitiello testified that the pullups, chucks, and wipes are not covered under [redacted]'s MMA plan, but that they are covered under [redacted]'s Long Term Care (LTC) plan. She suggested Petitioner look into getting enrolled in the LTC plan. Ms. Sanchez said an organization called Senior Resource Alliance can help Petitioner with starting the process.

14. Dr. Zitiello testified the requests for the supplies were not reviewed for medical necessity because they are not covered benefits, and that she is unable to determine their medical necessity based upon the information provided.

CONCLUSIONS OF LAW

15. 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.

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

17. This is a Final Order, pursuant to Sections 120.569 and 120.57, Fla. Stat.

18. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.). The burden of proof is assigned to Respondent in accordance with Fla. Admin. Code R.65-2.060(1) because Petitioner did in fact initially receive the supplies and then had them subsequently terminated, even if they were not supposed to be provided.

19. 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.

20. 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.

21. 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.

22. 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.

23. Dr. Zitiello testified she did not do a medical necessity analysis because the requested supplies are not covered. She said she could not conclude whether or not the supplies are medically necessary based upon the information provided.

24. Dr. Zitiello was correct. The requested supplies are non-covered items under [redacted]'s MMA plan, and Petitioner does not otherwise qualify for them under the DME Handbook, therefore no medical necessity analysis is required.

25. Respondent has met its burden of proof that it was proper to terminate providing Petitioner with incontinence supplies. The plain language of the DME Handbook states they are not covered.

26. Petitioner is encouraged to follow Dr. Zitiello's recommendation and contact AHCA and Senior Resource Alliance to try to enroll in a Long Term Care plan, where the incontinence supplies would be covered. Petitioner may also wish to inquire whether or not MMA plans offered by other Managed Care Organizations offer incontinence supplies as an expanded benefit.

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 15 day of Februarv, 2016,

in Tallahassee, Florida.

Rick Zimmer

Rick Zimmer
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished To: [redacted] Petitioner
Judy Jacobs, Area 7, AHCA Field Office

FILED
Jan 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. 15F-09653
APPEAL NO. 16F-00222

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 Palm Beach
UNIT: 88595

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on January 4, 2016, at 11:31 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Dotlin Williamson, supervisor.

STATEMENT OF ISSUE

At issue is the amount of Food Assistance Program benefits the petitioner was approved to receive at recertification. The petitioner carries the burden of proof in the FAP appeal by the preponderance of evidence.

The petitioner is also appealing the denial of full Medicaid and the enrollment in the Medically Needy Program with an estimated share of cost. She is seeking full Medicaid. The petitioner carries the burden of proof in the Medicaid appeal.

PRELIMINARY STATEMENT

The Department presented one exhibit at the hearing which was entered into evidence and marked as Respondent's Composite Exhibit 1. The petitioner did not present any exhibits at the hearing. The record was held open until January 8, 2016 for the respondent to provide the FAP and Medicaid budgets. The respondent submitted three additional exhibits which were accepted, entered into evidence and marked as Respondent's Composite Exhibits 2, 3 and Respondent's Exhibit 4. The petitioner provided one exhibit which was accepted, entered into evidence and marked as Petitioner's Exhibit 1. The record was closed on January 8, 2016.

FINDINGS OF FACT

1. On November 9, 2015, the petitioner submitted an application for recertification of Food Assistance Program (FAP) benefits through the Department's web site. The petitioner's household consists of herself (age 44) and her son (age 8). She was determined disabled and receives Social Security Disability Income (SSDI) of $870.90 monthly. She receives alimony of $900 monthly and child support of $27 monthly. These amounts were verified by a letter from the petitioner's attorney and Order of Final Dissolution of Marriage. She pays for Medicare part B $104.90 monthly. Her son was receives Social Security benefits (SS) of $204 based on her disability. She had expenses for rent of $1,200, electricity of $80 and telephone of $40. The petitioner listed monthly medical expenses of $60 for specialist co-pays. She listed no tax

deductions. The Department approved FAP benefits and Medicaid benefits without pending the petitioner to provide verification of her medical expenses for specialist co-pays. No deduction was given for her medical expenses for specialist co-pays.

2. On November 17, 2015, the respondent sent the petitioner a Notice of Case Action informing her that her Food Assistance Program benefits will stay the same. The same notice informed her she was eligible for continued Medicaid coverage.

3. The petitioner requested a hearing on November 20, 2015 to challenge the amount of FAP benefits she was approved to receive and also her enrolment in the Medically Needy program with an estimated SOC. The petitioner requested this hearing as her medical expenses had increased.

4. At the hearing, the Department offered to update the FAP budget and Medicaid budget with new medical expenses of recurring co-payments for specialist co-pays.

5. To determine the FAP benefits for October 2015 ongoing, the respondent added the petitioner's monthly gross alimony of $900, SSDI of $870, son's SS of $204 and child support of $27, resulting to the monthly unearned income of $2,001. A standard deduction of $155 was subtracted and an excess medical expense of $166.90 was subtracted resulting in total adjusted income of $1,679.10. The excess medical expenses were calculated by subtracting $35 from her total medical expenses of $201.90 ($104.90 Medicare Part B + $80 co-payments $12 prescriptions + $5 Humana). The shelter cost of $1,200 was added to the utility standard of $345 to get the total shelter/utility cost of $1,545. Fifty percent of the adjusted net income ($839.55) is the standard shelter. This was subtracted from the total shelter/utility, resulting in $705.45. This was subtracted from the adjusted income ($1,679) resulting in $973.65 as the Food

Assistance adjusted income. The maximum net income limit for a household of two is $1,328. As the petitioner's net income is lower than maximum net income limit, the respondent proceeded to calculate the benefit reduction. The Food Assistance adjusted income of $973.65 was multiplied by 30%, to get the benefit reduction of $293 (rounded up). This was subtracted from the maximum FAP amount of $357 resulting in $64. The $10 recoupment was subtracted resulting in $54 as the petitioner's monthly FAP.

SSDI	$870.00
Alimony	$900
SS(son)	$204
Child Support	$27
Total household income	$2,001
Standard deduction for a household of 2	($155)
Excess medical expenses ($201-$35.00)	($166.90)
Adjusted income after deductions	
Shelter costs	$1,200
Standard utility Allowance	$345
Total shelter/utility cost	$1,545
Shelter standard (50% adjusted income)	$839
Excess shelter deduction	$705
Adjusted income	$1,679.10
Excess Shelter Deduction	$705.45
Adjusted income after shelter deduction	$973.65
Thrifty Food Plan for HH 2	$357.00
30% of $973.65	($293)
Monthly Allotment	$64
Recoupment	$10
Recurring Monthly Allotment	**$54**

6. On January 14, 2016, the Department issued a new Notice of Case Action, advising the petitioner that she was eligible for $54 in FAP benefits. The same notice

informed that she will receive $144 more for October 1, 2015 through January 31, 2016. The Department supplemented the months October 2015 through January 2016.

7. 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).

8. The respondent performed the following budget calculations when it determined the petitioner's estimated SOC. Her alimony and SSDI were added to get her total monthly income of $1,770.90. The Medically Needy Income Limit of $387 for a household size of two was subtracted resulting to $1,383. Her insurance premium of $109.90 was subtracted resulting to the petitioner's SOC of $1,273.

9. By notice dated November 17, 2015, the respondent notified the petitioner her Medically Needy has been reviewed and the members listed below are eligible for continued Medicaid coverage. Her son's Medicaid benefit is not at issue.

10. The petitioner explained she is disabled and needs special food. She also asserts she stopped going to some of her doctors because she cannot afford to pay the co-payments.

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.

***The FAP benefits issue will be addressed first*.**

13. Federal regulation C.F.R. § 273.9 addresses income/allowable deductions budgeting in the FAP in part and states as follows:

> (a) Income eligibility standards. Participation in the Program shall be limited to those households whose incomes are determined to be a substantial limiting factor in permitting them to obtain a more nutritious diet.
> (b) Definition of income…
> (2) Unearned income shall include, but not be limited to: …
> (ii) Annuities; pensions; retirement, veteran's, or disability benefits; worker's or unemployment compensation including any amounts deducted to repay claims for intentional program violations as provided in §272.12; old-age, survivors, or social security benefits…
> (iii) Support or alimony payments made directly to the household from non household members.

14. Federal regulation 7 C.F.R. § 273.9(d) sets forth the specific deductions allowable in the calculation of the final Food Assistance Program benefit allotment. These potential allowable deductions are limited to include only: (1) standard deduction, (2) earned income deduction, (3) excess medical deduction, (4) dependent care deduction, (5) child support deduction, (6) standard utility allowance, and shelter expenses.

15. The respondent must follow these federal budgeting guidelines when determining eligibility. It also directs the Department to consider Social Security Disability Income, Social Security benefits, alimony and child support income as unearned incomes that must be included in the eligibility determination.

16. The federal regulation 7 C.F.R. § 273.10 (e) addresses "Calculating net income and benefit levels" as follows:

> (1) Net monthly income (i)…
> (A) Add the gross monthly income earned by all household members and the total monthly unearned income of all household members, minus income exclusions, to determine the household's total gross income…
> (C) Subtract the standard deduction.
> (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...
> (2) Eligibility and benefits…
> (ii)(A)…the household's monthly allotment shall be equal to the maximum food stamp allotment for the household's size reduced by 30% of the household's net monthly income…

17. The above-cited regulation describes the eligibility process and defines deductions. The petitioner was credited with a standard deduction, an excess shelter deduction and an excess medical deduction. There is no indication the petitioner was eligible for any other deductions.

18. The Food Assistance standards for income and deductions appear in the Department's Program Policy Manual CFOP 165-22 (Policy Manual), at Appendix A-1. Effective October 2015, the 200% Federal Poverty level (FPL) for a household size of two is $2,191. A two-person assistance group's net income limit is $1,328, the standard deduction is $155 and the standard utility allowance is $345. The same reference shows the maximum FAP benefits for two persons as $357 effective October 2015.

19. After considering the evidence, the testimony and the appropriate authorities cited above, the hearing officer concludes the respondent's action to approve $64 in

FAP benefits for October 2015 ongoing before $10 recoupment and $54 after recoupment for the petitioner is correct.

20. The hearing officer concludes the petitioner is not eligible for any additional FAP benefits based on the income and expenses presented and on the above-cited rules.

Medicaid Benefits will now be addressed

The petitioner has been determined disabled by Social Security. Her Medicaid eligibility was determined under the Family Related Medicaid as it was more advantageous for the petitioner.

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 passage 1830.0101 Income (MFAM) states:

…Taxable Unearned income is income for which there is no performance of work or services. Taxable unearned income may include:
1. Retirement, disability payments, unemployment/workers' compensation, etc.;
2. Annuities, pensions, and other regular payments;
3. Alimony and spousal support payments;
4. Dividends, interest, and royalties;
5. Prizes and awards;
6. Social Security and Social Security Disability Income.
Excluded income is income (earned or unearned) that is not counted when determining eligibility.

24. The Policy Manual at passage 1830.0700, addresses SUPPORT PAYMENTS (MFAM) and states:

Support payments are funds paid by a non-custodial parent or spouse intended for the support or maintenance of a member of the household. Support paid by a non-custodial parent is considered child support to the child for whom the payment is intended and is excluded.
All child support received or anticipated to be received for any member of the including delinquency or arrearages is excluded unearned income. Payments received for a child no longer in the home is considered a contribution and is also excluded.
Spousal support or alimony is an amount of money allocated from one spouse to another by the court as a result of a divorce or separation agreement. The amount of alimony received or anticipated to be received must be counted as unearned income minus any collection fees charged.

25. 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).

26. The Policy Manual at Appendix A-7 indicates the Family-Related Medicaid Income Limit for a parent in a household size of two as $241, the Standard Disregard of $146, the Medically Needy Income Limit (MNIL) of $387 and the MAGI Disregard of $66.

27. In accordance with the above controlling authorities, the undersigned calculated eligibility for Medicaid for the petitioner and did not find the petitioner eligible for full Medicaid as the petitioner's modified adjusted gross income is more than the income limit of $241 for a household of two. Step 1: The undersigned added the petitioner's SSDI of $870.90 to her alimony of $900 and child support resulting to the modified adjusted gross income of $1,770.90. Step 2: There are no deductions provided, as

there was no tax return. Step: 3: The total income of $1,770.90 less the standard disregard of $146 is $1,624.90. Step 4: The total countable net income of $1,624.90 was compared with the income standard for two of $241. Step 5: Since it was greater than the income standard, the MAGI disregards of $66 was subtracted, resulting to $1,558.90. This was compared to the income limit of $241 for full Medicaid. 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 eligibility must be explored for the petitioner.

The Medically Needy share of cost will now be addressed

28. 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".

29. 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…

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

31. The Department's Transmittal No. P-15-09-0009, dated September 18, 2015, addresses Medically Needy Budgeting for Family-Related Medicaid and states:

> **SFU/Counting Income for Medically Needy**
> Staff will continue to determine the Medicaid Standard Filing Unit (SFU) based on expected tax filing information as provided by the individual. If an assistance group (AG) is ineligible for full Medicaid coverage due to income, eligibility for Medically Needy coverage must be determined.
> A child with countable income must be excluded from the Family-Related Medically Needy AG if inclusion is not beneficial to the individual whose eligibility is being determined…
> If the AG's countable income is less than or equal to the Medically Needy Income Limit (MNIL) for the remaining household size, open the AG for Medically Needy with a $0 share of cost.
> If the AG's countable income is greater than the MNIL for the remaining household size, enroll the AG in Medically Needy with a share of cost as determined by the remaining countable income.
> **Note: Do not exclude a child(ren) with countable income from a full coverage Medicaid AG. This policy only applies to the Family-Related Medically Needy Program.**

32. The above transmittal explains that the petitioner's child's income is excluded in the petitioner's Medically Needy budget.

33. The undersigned carefully reviewed the Department's determination of the petitioner's share of cost budget and did not find any errors with the Department's calculation of the petitioner's SOC. Her SSDI of $870.90 was added to her alimony of $900 to get her modified adjusted gross income of $1,770.90. The MNIL of $387 was subtracted to get $1,383, less the medical insurance premiums of $109.90 resulting in the petitioner's share of cost of $1,273.

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

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law the petitioner's appeal for FAP benefit is denied.

As to the Medicaid appeal, the appeal is denied for full Medicaid and the respondent's action is upheld. As to the petitioner's SOC, 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 20 day of January, 2016, in Tallahassee, Florida.

Christiana Gopaul Narine

Christiana Gopaul-Narine
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
Jan 12, 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-09675

PETITIONER,

Vs.

[redacted]

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, a telephonic administrative hearing in the above matter was convened on January 8, 2016 at 1:36 p.m.

APPEARANCES

For the Petitioner: [redacted]
Petitioner's Mother

For the Respondent: Doretha Rouse
Registered Nurse Specialist

ISSUE

At issue is whether respondent's denial of petitioner's request for orthodontic services (braces) was correct. The burden of proof was assigned to the petitioner.

PRELIMINARY STATEMENT

Petitioner was not present for the proceeding. Petitioner's representative entered no exhibits into evidence.

Ms. Rouse appeared as both the representative and witness for the respondent. Present from DentaQuest were Dr. Susan Hudson, Dental Consultant and Jackelyn Salcedo, Compliance and Grievance Specialist. Present from Molina Healthcare (Molina) was Natalie Fernandez, Government Contract Specialist. Respondent's exhibit "1" and "2" were accepted into evidence.

Administrative notice was taken of the Florida Medicaid Provider General Handbook and the Dental Services Coverage and Limitations Handbook.

FINDINGS OF FACT

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

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

2. Petitioner's Medicaid services are provided through respondent's Statewide Medicaid Managed Care Program. Since August 1, 2014 her Medicaid services have been provided by Molina.

3. Orthodontic procedures, when medically necessary, are available to Florida Medicaid recipients under the age of 21.

4. On September 4, 2015 petitioner's orthodontist [redacted] submitted a prior authorization request for orthodontic treatment. The request was submitted to Molina's dental vendor, DentaQuest.

5. [redacted] submission included an Initial Assessment Form (IAF); dental photographs; and a narrative.

6. The IAF is used to determine the severity of dental conditions, including the malocclusion of teeth. Scoring is assigned by both diagnostic observation and dental measurement.

7. An IAF score of "26" or more may indicate 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 indention)
- Crossbite of individual anterior teeth. When destruction of soft tissue is present
- Severe traumatic deviations
- Overjet greater than 9mm with incompetent lips or reverse overjet greater than 3.5 mm with reported masticatory and speech difficulties

9. The above conditions can be considered as an "auto qualifier" for braces.

10. Dr. Cooper checked "Crossbite of individual anterior teeth. When destruction of soft tissue is present." As such, no further IAF scoring was required.

11. [redacted] noted the following:

- [redacted]

12. A DentaQuest dentist thereafter reviewed [redacted] submissions. All DentaQuest reviewers are licensed dentists and must pass quarterly reliability examinations.

13. Based on submitted information, the DentaQuest reviewer completed an IAF. The reviewer did not identify a crossbite of individual anterior teeth accompanied with

[1] An overjet is measured in millimeters. The measurement provided by [redacted] is not legible.

soft tissue destruction. As an "auto qualifier" for braces was not recorded, the reviewer proceeded to score the entire IAF.

14. The DentaQuest reviewer identified an anterior open bite and anterior crowding. The total IAF score was "13".

15. On September 8, 2015 DentaQuest notified petitioner that the request for orthodontic treatment was denied. 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 13 points.

16. The above denial stated petitioner could request an internal appeal.

17. Petitioner requested an internal appeal.

18. A second DentaQuest dentist thereafter reviewed all submitted information. On October 20, 2015 correspondence was issued upholding the original denial.

19. On November 19, 2015 the Office of Appeal Hearings timely received petitioner's request for a fair hearing.

20. Petitioner's representative confirmed the absence of the following:

- Cleft lip or palate
- Jaw problems
- Speech problems related to current dental conditions
- Facial injuries resulting in the current dental status

21. Petitioner has a dental spacer. The spacers inhibit dental hygiene.

22. Regarding a crossbite, Dr. Hudson agrees with the other DentaQuest reviewers. Additionally, tissue damage was not demonstrated by the submitted information.

CONCLUSIONS OF LAW

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

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

25. Fla. Admin. Code R. 59G-4.060 addresses dental services and states, in part:

> (2) All dental services providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Dental Services Coverage and Limitations Handbook, November 2011, … and the Florida Medicaid Provider Reimbursement Handbook, ADA Dental Claim Form, July 2008, which are incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which is incorporated by reference in Rule 59G-4.001, F.A.C.
>
> (3) The following forms that are included in the Florida Medicaid Dental Services Coverage and Limitations Handbook are incorporated by reference: Medicaid Orthodontic Initial Assessment Form (IAF), …

26. The Florida Medicaid Dental Services Coverage and Limitations Handbook (Dental Handbook) states, on page 2-2, "Medicaid reimburses for services that are determined medically necessary …"

27. In regard to medical necessity for Medicaid funded services, the definition is found in Fla. Admin Code. R. 59G-1.010 and states:

> (166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

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

28. 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 …

29. 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].

30. 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.

31. When considering whether the requested orthodontic service is medically necessary, analysis is further directed to the Dental Handbook. Page 2-15 states:

> Prior authorization is required for all orthodontic services. Orthodontic services are limited to those recipients with the most handicapping malocclusion. A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the patient by causing impaired mastication, dysfunction of the temporomandibular articulation, susceptibility to periodontal disease, susceptibility of dental caries, and impaired speech due to malposition of the teeth.

32. Pages 2-16 through 2-18 of continue by stating:

> Orthodontic procedures are limited to recipients under age 21 whose handicapping malocclusion creates a disability and impairment to their physical development.
>
> Criteria for approval is limited to one of the following conditions:
>
> - Correction of severe handicapping malocclusion as measured in the Medicaid Orthodontic Initial Assessment Form (IAF) …
> - Syndromes involving the head and maxillary or mandible jaws such as cleft lip of cleft palate
> - Cross-bite therapy, with the exception of one posterior tooth that is causing no occlusal interferences;
> - Head injury involving traumatic deviation; or
> - Orthognathic surgery, to include extractions, required or provided in conjunction with the application of braces.
>
> …
>
> The Medicaid Orthodontic Initial Assessment Form (IAF) is to be completed by the orthodontic provider at the initial evaluation of the recipient.

The IAF is:

- Designed for use as a guide by the provider in the office to determine whether a prior authorization (PA) request should be sent to the Medicaid orthodontic consultant; and
- A means by which the orthodontic provider may communicate to Medicaid's orthodontic consultant all the distinctive details pertaining to an individual case. …

…

A score of 26 or greater may indicate that treatment of the recipient's condition could qualify for Medicaid reimbursement, and the orthodontic provider should submit a prior authorization request to Medicaid for consideration of orthodontic services. A score of 26 or greater on the IAF is not a guarantee of approval. It is used by the provider to determine whether diagnostic records should or should not be sent to the orthodontic consultant.

…

A score of less than 26 indicates that treatment of the recipient's condition may not qualify for Medicaid reimbursement, and the request for prior authorization may be denied.

This does not say that such cases do not represent some degree of malocclusion, but simply that the severity of the malocclusion does not qualify for coverage under the Florida Medicaid Orthodontic Program.

33. A conflict exists between the IAF completed by petitioner's orthodontist and those completed by DentaQuest reviewers. The IAF completed by the referring orthodontist showed an "auto qualifier" for braces. This was refuted by two DentaQuest reviewers and Dr. Hudson.

34. Regarding a crossbite of interior teeth, page A-4 of the Dental Handbook requires "A minimum of 1.5 mm of tissue recession must be evident to qualify as soft tissue destruction in anterior crossbite cases."

35. The Findings of Fact do not establish whether petitioner's recession is at least 1.5 mm.

36. A hearing officer must consider all evidence; judge the credibility of witnesses; and draw permissible inferences from the evidence.

37. Compelling evidence was not presented to refute the IAF score of "13" as determined by DentaQuest reviewers.

38. It is not disputed the petitioner has a misalignment of teeth. The greater weight of evidence, however, does not establish petitioner's orthodontic status rises to the stringent requirement of a "most handicapping malocclusion" as defined by the Dental Handbook.

39. 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, …

40. 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.

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 12 day of January, 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
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Judy Jacobs, Area 7, AHCA Field Office

FILED
Feb 17, 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-09687

PETITIONER,

Vs.

[redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 Marion
UNIT: 09DDD

RESPONDENT.

_____/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 2:10 p.m. on December 22, 2015.

APPEARANCES

For the Petitioner: [redacted] petitioner's mother

For the Respondent: Sharon Ashley, ACCESS Supervisor

STATEMENT OF ISSUE

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

PRELIMINARY STATEMENT

By notice dated December 8, 2015, the respondent (or the Department) notified the petitioner she was denied Medicaid benefits. Petitioner timely requested a hearing to challenge the denial.

Petitioner was present and provided testimony. Petitioner submitted one exhibit, entered as Petitioner Exhibit "1". Respondent submitted five exhibits, entered as Respondent Exhibits "1" through "5". The record was held open until December 23, 2015, for the respondent to submit additional exhibits. The exhibits were not received. The record was closed on December 23, 2015. To date, the respondent's exhibits have not been received.

FINDINGS OF FACT

1. On November 6, 2015, petitioner (age 34) submitted a SSI-Related Medicaid application for herself. The application indicates petitioner is disabled.

2. Petitioner applied for disability through the Social Security Administration (SSA) on May 8, 2014. The SSA denied petitioner disability on August 21, 2014. Petitioner, through an attorney, appealed the SSA denial in October 28, 2014. The appeal is pending.

3. Respondent's representative alleges that on November 6, 2015, the Department called petitioner in an attempt to complete an interview. The record was held open for the respondent's representative to submit the Department's Running Record Comments (CLRC) to support her allegation. The CLRC was not received.

4. Respondent's representative alleges that on November 17, 2015, the Department mailed petitioner a Notice of Case Action (NOCA) requesting she contact the Department to complete a disability interview. The record was held open for the respondent's representative to submit said NOCA. The NOCA was not received.

5. Petitioner's mother claims that a NOCA for a disability interview from the Department was not received. Nor have they received a telephone call from the Department for a disability interview.

6. The respondent's representative alleges that the Department has not received the November 17, 2015, NOCA as return mail from the post office. The record was held open for the respondent's representative to submit the Department's Document Imaging printout that identifies correspondent from the Department to the petitioner and from the petitioner to the Department. The Department's Document Imaging printout was not received.

7. On December 8, 2015, the Department notified petitioner she was denied Medicaid benefits; "Reason: You failed to complete an interview necessary for us to determine your eligibility for this program."

8. Respondent's representative confirmed that the Department denied petitioner Medicaid solely on not completing a disability interview.

CONCLUSIONS OF LAW

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

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

11. Fla. Admin. Code R 65A-1.205 explains the eligibility determination process and states in part:

> (1) (a) The Department must determine an applicant's eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter**. It is the applicant's responsibility to keep appointments with the eligibility specialist** (emphasis added) and furnish information, documentation and verification needed to establish eligibility**. If the Department schedules a telephonic appointment, it is the Department's responsibility to be available to answer the applicant's phone call at the appointed time.** (emphasis added) If the information, documentation or verification is difficult for the applicant to obtain, the eligibility specialist must provide assistance in obtaining it when requested or when it appears necessary…

12. In accordance with the above authority, it is the applicant's responsibility to keep appointments, if the Department schedules a telephonic appointment.

13. Federal Regulation at 42 C.F.R. § 431.211 Advance notice, in part states:

> The State or local agency must send a notice at least 10 days before the date of action…

14. Federal Regulation at 42 C.F.R. § 438.404 Notice of action, in part sates:

> (a) Language and format requirements. The notice must be in writing and must meet the language and format requirements of §438.10(c) and (d) to ensure ease of understanding.
> (b) Content of notice. The notice must explain the following…
> (2) The reasons for the action…

15. The above authorities explain that the Department must send applicants a notice informing them of the action required. In this case, the respondent's representative argued that the Department mailed petitioner a NOCA on November 17, 2015, requesting petitioner call to complete a Medicaid disability interview. The Department did not submit said NOCA.

16. Petitioner argued that she did not receive the November 17, 2015, NOCA.

17. The evidence submitted does not establish that the Department mailed petitioner a NOCA stating that petitioner required a Medicaid disability interview. The evidence also

establishes that the Department denied petitioner Medicaid because she "failed to complete an interview necessary" to determine eligibility.

18. In careful review of the cited authorities and evidence, the undersigned concludes that the Department failed to notify the petitioner that an interview was required to determine Medicaid eligibility. Therefore, the case is remanded to the respondent for corrective action. IT IS HEREBY ORDERED that the respondent process petitioner's November 6, 2015, application and mail the petitioner a NOCA identifying requirements to determine Medicaid eligibility. This order does NOT guarantee that the petitioner will be eligible for Medicaid.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted and remanded to the respondent in accordance with the above 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 17 day of February, 2016,

in Tallahassee, Florida.

Priscilla Peterson

Priscilla Peterson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
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Copies Furnished To [redacted] Petitioner
Office of Economic Self Sufficiency

FILED
Feb 17, 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-09690

PETITIONER,

Vs.

CASE NO. [redacted]

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 December 23, 2015 at 1:43 p.m.

APPEARANCES

For Petitioner: [redacted] Mother

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 four hours of personal care services (PCS) six days per week for the certification period,

September 1, 2015 through February 29, 2016. Because this appeal involves an initial request for personal care services, the burden of proof was assigned to the Petitioner.

PRELIMINARY STATEMENT

Dr. Ellyn Theophilopoulos, physician reviewer with eQHealth Solutions, appeared as a witness for the Respondent. Carlos Rocha, Waiver Support Coordinator Supervisor, and Maria Figueredo, Waiver Support Coordinator, appeared as witnesses for the Petitioner.

The Respondent presented a composite document of 142 pages which was entered into evidence and marked as Respondent Exhibit 1. The exhibit contained medical information, decision letters, and documentation sent by the provider in support of the service request.

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 who is a Medicaid recipient. He is diagnosed with [redacted] Petitioner is ambulatory, continent, and independent with ADL care (bathing, toileting, grooming and dressing). He needs meal set up but can feed himself.

2. Petitioner attends two classes at Miami Dade Community College. He is enrolled in a special program for students with learning disabilities.

3. Petitioner lives with his mother and eight-year-old sister. The mother works from 9:00 a.m. to 12:00 p.m. Monday through Saturday. The mother has no medical limitations and can provide Petitioner assistance with his ADLs before and after work.

4. A request for service is submitted by a provider along with all information and documentation required for the Agency to make a determination of medical necessity for the level of service requested. A review is conducted for every new certification period but a request for modification may be submitted by a beneficiary at any time.

5. EQHealth Solutions has been contracted by the Agency to make Prior Authorization decisions for private duty nursing and personal care services for home health care. The Petitioner's request for four hours of personal care services was submitted on August 27, 2015 by the provider, Coordinating Solutions, Inc.

6. A "Notice of Outcome" was sent to the Petitioner on October 20, 2015 and provided the reason for denial as:

> …the services are not medically necessary as defined in 59G-1.010 (166), Florida Administrative Code (F.A.C.)…

7. A "Notice of Outcome" sent to the provider on October 20, 2015 gave the following clinical rationale for the decision:

> The patient is a 19 year old with [redacted] The patient is ambulatory, continent, and on a regular diet. The patient is independent with ADLs. The patient requires meal set up but can feed self. The patient lives with his mother who works 9 am to noon Monday through Saturday and has no medical limitations. The clinical information provided does not support the medical necessity of the requested services. The request appears to be for supervision which not a covered service. The PCS request is denied.

8. A reconsideration was requested on November 2, 2015 and a Notice of Reconsideration Determination was sent November 4, 2015. The reconsideration upheld the denial and provided the medical basis for the decision:

> The information submitted for reconsideration provided no evidence to support the reversal of the previous decision. The original decision is upheld.

9. The Petitioner filed a timely request for a fair hearing on November 20, 2015.

10. Petitioner needs assistance with meal preparation, organizing his room, completing homework, and returning to school to pick up his sister. He also likes to go to other places such as the library. The Petitioner's mother explained her son needs supervision because he acts without understanding the consequences. As an example, on one occasion he wrote checks for his sister for school forging the mother's signature. On another occasion, he walked into a lake and would have drowned if the mother had not been home at the time.

11. The Petitioner's Waiver Support Coordinator Supervisor stated the Petitioner needs the PCS services to be safe and that need meets Medicaid's medical necessity definition that the services are needed to protect life

12. The Respondent's witness from eQHealth noted that Petitioner was high functioning and had no need for personal care services. The mother is currently available to meet Petitioner's ADL needs. If her work schedule changes, the mother can re-request the services.

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. 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:

> Home health services are not considered emergency services.
>
> Medicaid reimburses services that are determined medically necessary and do not duplicate another provider's service.
>
> Rule 59G-1.010 (166), Florida Administrative Code (F.A.C.) defines "medically necessary" or "medical necessity" as follows:
>
> "[T]he 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. The Medicaid Handbook, page 1-2, also provides the following regarding personal care services, in relevant part…

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.

ADLs 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).

20. On page 1-3 of the Medicaid Handbook, the following definition of babysitting is provided:

> 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.

Babysitting services as defined in the Handbook are not medical services and are not covered by Medicaid.

21. 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.

22. Petitioner's primary need for personal care services is supervision to ensure his safety. As noted above, supervision is not a Medicaid covered service.

23. Respondent explained Petitioner is high functioning and does not have a need for personal care services beyond what the mother can provide before and after her work hours. Respondent's decision complies with the EPSDT standards for medical necessity. Petitioner has failed to meet his burden of proof.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 17 day of February, 2016,

in Tallahassee, Florida.

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

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

FILED
Jan 26, 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-09695
16F-00225

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 02 Gadsden
UNIT: 88630

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on December 18, 2015 at 2:03 p.m.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Theresa Nadeau, Economic Self-Sufficiency Specialist II

Sheila Rushing, Operations Management Consultant I

STATEMENT OF ISSUE

Petitioner is appealing the Department's denial of his application for Food Assistance on October 20, 2015 and for SSI-Related Medicaid on November 18, 2015. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The Department submitted evidence prior to the hearing, which was entered as Respondent Exhibit 1.

The record remained open for additional information on the Medicaid appeal through December 28, 2015. The Department issued the additional information to the petitioner regarding the SSI-Related Medicaid denial on December 18, 2015; it was sent to the undersigned on January 15, 2016. This information was entered as Respondent 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 submitted an application for Food Assistance and SSI-Related Medicaid on October 15, 2015.

2. The petitioner indicated on his application he has been convicted of a drug trafficking felony.

3. The Department reviewed the petitioner's application and confirmed through Florida Department of Corrections records the petitioner was convicted of on [redacted] of [redacted]

4. The Department issued a Notice of Case Action on October 20, 2015 to inform the customer his Food Assistance application was denied because he was convicted of a [redacted].

5. The petitioner completed his sentence for the [redacted]. He does not believe it should continue to affect his eligibility for Food Assistance.

6. The petitioner's conviction has not been expunged from his records by the courts.

7. The petitioner stated he did not understand the severity of the charges when he accepted the plea agreement in 2004. He stated he has been out of jail for seven years and had no problems. He was told while he was in prison he could apply for Food Assistance.

8. The Department issued a Notice of Case Action on October 20, 2015 requiring an interview to be completed with the petitioner regarding his SSI-Related Medicaid determination. The petitioner was to call for the interview on October 23, 2015 between 11:00 a.m. and 12:00 p.m.

9. The petitioner did not call the Department for the interview.

10. The Department attempted to call the petitioner on October 23, 2015 regarding for his disability interview. The petitioner did not answer the call. A voicemail was left for the petitioner to call back.

11. The petitioner did not complete the DDD interview within 30 days of his date of application for SSI-Related Medicaid.

12. The Department issued a Notice of Case Action on November 18, 2015 denying the petitioner's application for Medicaid as "You failed to complete an interview necessary for us to determine your eligibility for this program."

13. The petitioner did not inquire about his SSI-Related Medicaid denial until the scheduled hearing for his Food Assistance appeal.

14. The Department cannot establish eligibility for SSI-Related Medicaid without a disability decision made by either the Division of Disability Determinations

(DDD) or Social Security Administration. The Department cannot submit the disability request to DDD on the petitioner's behalf without first completing an interview to document disability-related information for DDD's consideration. The Department can waive the interview only if information from Social Security has been received documenting the medical information needed.

15. The Department will mail a new application, including all needed forms, to the petitioner.

16. The Department explained policy for reuse of an application during a 60-day period. However, it does not apply to this case. The policy allows for reuse of the application if the application was denied due to failure to return information. Therefore, the application cannot be reused in this situation. However, the Department advised the October 2015 application would protect the petitioner's dates of retroactive eligibility back to July 2015.

CONCLUSIONS OF LAW

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

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

FOOD ASSISTANCE

19. Federal Food Assistance Regulations at 7 C.F.R. § 273.11 "Action on households with special circumstances" states in relevant part:

> (m) *Individuals convicted of drug-related felonies.* An individual convicted (under Federal or State law) of any offense which is classified as a felony by the law of the jurisdiction involved and which has as an element the possession, use, or distribution of a controlled substance (as defined in section 102(6) of the Controlled Substance Act, 21 U.S.C. 802(6)) shall not be considered an eligible household member unless the State legislature of the State where the individual is domiciled has enacted legislation exempting individuals domiciled in the State from the above exclusion. If the State legislature has enacted legislation limiting the period of disqualification, the period of ineligibility shall be equal to the length of the period provided under such legislation. Ineligibility under this provision is only limited to convictions based on behavior which occurred after August 22, 1996. The income and resources of individuals subject to disqualification under this paragraph (m) shall be treated in accordance with the procedures at paragraph (c)(1) of this section.

20. The findings show the petitioner was convicted of a [redacted].

The undersigned acknowledges the petitioner's belief that he has served his sentence and the conviction should not be held against him in this program. In accordance with the Federal Food Assistance Regulation cited above, even a conviction of possession of a controlled substance classified as a felony would disqualify the petitioner from participation in the Food Assistance Program unless the exemption is met. The regulation sets forth that an individual convicted of distribution of a controlled substance classified as a felony shall not be considered an eligible household member unless the state legislature of the state where the individual resides enacts legislation exempting individuals from the exclusion in the federal regulation. The undersigned found no Florida Statute allowing the petitioner to be exempt from this regulation. The Department does have a written policy as shown in its policy manual citation below which only disqualifies those convicted of a felony for drug trafficking. This policy applies to all Florida residents applying for Food Assistance.

21. The Department's Policy Manual, CFOP 165-22, passage 1410.2200 "Individual Convicted of Felony Drug Trafficking (FS)" states:

> Food stamp benefits shall be denied to an individual who has been convicted of a felony for drug trafficking including agreeing, conspiring, combining, or confederating with another person to commit the act committed after 8/22/1996. This disqualification is a lifetime disqualification. Only the individual who was convicted will be penalized. If the illegal behavior that lead to the conviction occurred on or before 8/22/96, the disqualification does not apply regardless of the date of the conviction. If a court expunges the felony drug trafficking conviction, the individual is not subject to the disqualification. The individual must provide proof of the expungement.

22. The findings show the petitioner's felony drug trafficking conviction occurred after [redacted] The petitioner's conviction has not been overturned by the courts. The undersigned considered the petitioner's arguments; however, no exemption could be found to allow eligibility in this instant case. In accordance with the above controlling authorities, the undersigned concludes that unless the petitioner's conviction is expunged and he provides proof of such, the disqualification from participation in the Food Assistance program is correct.

SSI-RELATED MEDCIAID

23. Fla. Admin. Code R. 65A-1.205 "Eligibility Determination Process" states in relevant part:

> (1) …
> (a) The Department must determine an applicant's eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter. It is the applicant's responsibility to keep appointments with the eligibility specialist and furnish information, documentation and verification needed to establish eligibility. If the Department schedules a telephonic appointment, it is the Department's responsibility to be available to answer the applicant's phone call at the appointed time. If the information, documentation or verification is difficult for the applicant to obtain, the

> eligibility specialist must provide assistance in obtaining it when requested or when it appears necessary.
> …
> (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…, the eligibility specialist must give the applicant written notice to provide the requested information or to comply, allowing ten calendar days from request or the interview, whichever is later. For all programs, verifications are due ten calendar days from the date of written request or the interview, or 60 days from the date of application, whichever is later. In cases where the applicant must provide medical information, the return due date is 30 calendar days following the written request or the interview, or 60 days from the date of application, whichever is later. If the due date falls on a holiday or weekend, the deadline is the next working day. If the applicant does not provide required verifications or information by the deadline date the application will be denied, unless the applicant requests an extension or there are extenuating circumstances justifying an additional extension. The eligibility specialist makes the decision of whether to grant the request for extension. When the applicant provides all required information or verification, the eligibility specialist determines eligibility for the public assistance programs. If the eligibility criteria are met, benefits are authorized.
> …
> (3) The Department conducts phone or face-to-face interviews with applicants/recipients or their authorized/designated representatives when required for the application or complete eligibility review process…. The applicant/recipient or their authorized/designated representative must keep the interview appointment or reschedule the missed appointment….
> **(4) If an applicant or recipient does not keep an appointment without arranging another time with the eligibility specialist; or does not sign and date the applications described in subsection (1); or does not submit required documentation or verification the Department will deny benefits as it cannot establish eligibility.** (emphasis added)

24. The findings show the Department issued a Notice requiring an interview with the petitioner. The findings also show the petitioner received the notice and did not call for the interview, receive the call from the Department or make contact with the Department to reschedule the interview. In accordance with the above controlling authority, the undersigned concludes the applicant must keep an interview appointment

or reschedule the missed appointment. The undersigned further concludes, the petitioner did not keep an interview or reschedule an interview in this instant case.

25. The Policy Manual, passage 0640.0400 “Application Time Standards (MSSI, SFP) state in relevant part:

> The time standard begins upon receipt of a signed application. Process applications as soon as possible after the assistance group (AG) completes all eligibility requirements. If the household completes all requirements and provides all information, process the application by the 30th day after the application date. Process applications and determine eligibility or ineligibility within 90 calendar days after the date of the application for individuals who claim a disability.
> Disability/Blindness Decision:
> 1. **Conduct an interview and complete a disability/blindness packet within seven calendar days from the application date.**
> 2. Request a disability/blindness decision within two calendar days of receipt of appropriate information.
> 3. Submit the packet no more than nine calendar days following the date of application.

26. The Policy Manual, passage 0640.0401 “Requests for Additional Information/Time Standards (MSSI, SFP)” states in relevant part:

> If the Department needs additional information or verification from the applicant, provide:
> 1. a written list of items required in order to complete the application process,
> 2. the date the items are due in order to process the application timely, and
> 3. the consequences for not returning additional information by the due date.
> The verification/information due date is 10 calendar days after the date of the interview or if there is no interview requirement, 10 days after the date the pending notice is generated. In cases where medical information is required, the return due date is 30 calendar days from date of request. If the due date falls on a holiday or weekend, the deadline for the requested information is the next business day. At the individual’s request, extend the due date. Leave the case pending until the 30th day after the date of application to allow the household a chance to provide verifications. Assist applicants with getting missing verifications when needed.

27. In accordance with the above controlling authority, the undersigned concludes the Department correctly denied the petitioner's application for SSI-Related Medicaid when no contact was received by the 30th day following the date of application.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are denied and the Department's action is affirmed.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 26 day of January, 2016, in Tallahassee, Florida.

Melissa Roedel

Melissa Roedel
Hearing Officer
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Office of Economic Self Sufficiency

FILED
Feb 18, 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-09696

PETITIONER,

Vs.

[redacted]

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 January 28, 2016 at 10:37 am. All parties appeared telephonically from different locations.

APPEARANCES

For the petitioner: [redacted] pro se

For the respondent: Osvlado Cruz,
ACCESS Economic Self-Sufficiency Supervisor

STATEMENT OF ISSUE

At issue is whether the respondent's action to terminate petitioner's full Medicaid and instead enroll him in the Medically Needy Program with a $1454 Share of Cost (SOC) is proper. The burden of proof was originally assigned to the petitioner; however, after further review, the burden of proof is assigned to the respondent in accordance with Fla. Admin. Code R. 65-2.060 (1).

PRELIMINARY STATEMENT

By notice dated November 18, 2015, respondent notified petitioner that his full Medicaid would end November 31, 2015 and he was enrolled in the Medically Needy Program with a $1,454 SOC, effective December 1, 2015. Petitioner timely requested a hearing to challenge termination of full Medicaid and enrollment in the Medically Needy Program.

Petitioner did not submit any exhibits. Respondent submitted five exhibits, which were entered into evidence and marked as Respondent Exhibits "1" through "5". The record was held open until February 1, 2016 to submit additional evidence including application submitted by petitioner, income standards for Medicaid, and policy related to calculating income for Medicaid. The above mentioned information was provided on January 28, 2016, and the record was closed on February 1, 2016.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner received full Medicaid benefits.

2. On October 16, 2015, the petitioner submitted a web application for Medicaid benefits for himself and his wife. On that application, he reported 2 household members: himself and his wife. The petitioner asserts that he was only requesting Medicaid benefits for himself.

2. Petitioner is disabled and receives $855 in Social Security Disability Income (SSDI) per month. Petitioner is not currently receiving Medicare Part A and B. His wife is employed at [redacted] and is paid bi-weekly. There were no reported unpaid reoccurring medical expenses.

3. The respondent determined the household's income using paystubs provided by the petitioner. The income is as follows:

[redacted]	Date	Gross Amount
	10/02/20105	$892.89
	10/16/2016	$892.89
		$1,785.78

4. Petitioner does not have minor children, therefore, he is not eligible for Family Medicaid. To be eligible for Adult (SSI-Related) Medicaid, petitioner's income cannot exceed the $1,169 income limit. The next program available is the Medically Needy Program with a SOC.

5. Respondent determined petitioner's countable income as follows:

Unearned Income

$855.00	SSDI
- 20.00	unearned income disregard
$835.00	countable unearned income

Earned Income

$1,785.78	earned income
- 65.00	earned income disregard
- 860.39	½ remaining disregard
$860.39	countable earned income

6. Respondent determined petitioner's SOC as follow:

$860.00	earned countable income (rounded down)
+ 835.00	unearned countable income
- 241.00	Medically Needy Income Level (MNIL)
$1,454.00	SOC

7. On November 18, 2015, respondent mailed petitioner a Notice of Case Action notifying his Medicaid was terminated and he was enrolled in the Medically Needy Program with a $1,454 SOC.

8. Petitioner asserts he has too many expenses and should have full Medicaid because he is disabled and incurs too many household expenses.

CONCLUSIONS OF LAW

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

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

10. Fla. Admin. Code R. 65A-1.710, 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.

11. The Fla. Admin. Code R. 65A-1.713, SSI-Related Medicaid Income Eligibility Criteria states in part:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
> (a) For MEDS-AD Demonstration Waiver, income cannot exceed 88 percent of the federal poverty level…
> (h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses…
> (4)(c) Medically Needy. The amount by which the individual's countable income exceeds the Medically Needy income level, called the "share of cost", shall be considered available for payment of medical care and services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical costs. If countable income exceeds the

> Medically Needy income level the department shall deduct allowable medical expenses in chronological order, by day of service…To be deducted the expenses must be unpaid, or if paid, must have been paid in the month for which eligibility is being determined or incurred and paid during the three previous calendar months to the month for which eligibility is being determined but no earlier than the three retroactive application months…

12. The above authority explains to be eligible for full Medicaid; income cannot exceed 88 percent of the federal poverty level. Medically Needy provides coverage for individuals who do not qualify for full Medicaid due to income.

13. The Department's Program Policy Manual, CFOP 165-22 (The Policy Manual), at appendix A-9 (January 2016), identifies $1,169 as 88 percent of the federal poverty level for a household size of two.

14. The Policy Manual at section 2240.0604.03, Income of Spouse of Eligible Individual (MSSI, SFP) states:

> Each individual who is at least age 65, blind, or disabled, and whose countable income and assets do not exceed certain prescribed limits will be an eligible individual. If such an eligible individual is living in the same household with a spouse, who is neither aged, blind, nor disabled, the income and assets of the spouse (whether or not available to the individual) are considered in determining the eligible individual's income and assets, except in circumstances where this is deemed inequitable. An aged, blind, or disabled individual who has an eligible spouse may only qualify as an eligible individual if the combined countable income and assets of the couple do not exceed the income and asset limits specified for such couples.

15. Petitioner's wife's monthly earned income is calculated at $1,785.79. Petitioner's monthly unearned income is calculated at $855. Petitioner's countable monthly income $1,695 exceeds the $1,169 income limit to be eligible for full Medicaid. Therefore, petitioner is not eligible for full Medicaid.

16. Federal Regulations at 20 C.F.R. §416.1123 defines how unearned income is counted and states in relevant part:

> (b) Amount considered as income. We may include more or less of your unearned income than you actually receive.
> (1) We include more than you actually receive where another benefit payment (such as a social security insurance benefit) (see Sec. 416.1121) has been reduced to recover a previous overpayment. You are repaying a legal obligation through the withholding of portions of your benefit amount, and the amount of the debt reduction is also part of your unearned income. Exception: We do not include more than you actually receive if you received both SSI benefits and the other benefit at the time the overpayment of the other benefit occurred and the overpaid amount was included in figuring your SSI benefit at that time.

17. Federal Regulations 20 C.F.R. § 416.1124 explain unearned income not counted and states in part "(c) Other unearned income we do not count… (12) The first $20.00 of any unearned income in a month…"

18. Federal Regulations 20 C.F.R. §416.112(c) (5) explains a "$65 earned income in a month" disregard.

19. The Department's Program Policy Manual 2440.0321, Earned Income Disregard (MSSI, SFP) states "the earned income disregard is only applied to earned income. The amount of the disregard is $65 plus one half of the remaining earned income."

20. The Fla. Admin Code R. 65A-1.716 sets forth the MNIL at $241 for a household size of two.

21. In accordance with the authorities, respondent deducted $20 unearned income, $65 earned income disregard, ½ remaining disregard and $241 MNIL from $1,695, petitioner's countable earned income, to arrive at a SOC of $1,454.

22. The authority cited sets forth the income limits for full Medicaid as well as the rules for enrollment and budgeting methodologies for the Medically Needy Program. As the

petitioner's countable income of $1,454 exceeds the income limit for full Medicaid ($864), the respondent's action to terminate the petitioner's full Medicaid and enroll him in the MN program with a $1454 SOC was proper.

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 February, 2016, in Tallahassee, Florida.

Pamela B. Vance

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

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

FILED
Feb 08, 2016
Office of Appeal Hearings
Dept. of Children and Families

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 07 Putnam
UNIT: 88325

RESPONDENT.
_____/

APPEAL NO. 15F-09700

[redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on January 12, 2016 at 9:12 a.m.

APPEARANCES

For the Petitioner: The petitioner was present and represented herself.

For the Respondent: Diane Washington, Economic-Self-Sufficiency Specialist II for the Department of Children and Families.

ISSUE

The petitioner is appealing the Department's action on October 18, 2015 to enroll her in the Medically Needy (MN) program with an estimated monthly share of cost (SOC) of $788.

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

FINDINGS OF FACT

1. On October 8, 2015, the petitioner (age 67) completed an application for Food Assistance Program (FAP) and SSI-Related Medicaid benefits for herself only. The petitioner listed on her application gross monthly income of $988.

2. The Department determined the petitioner to be ineligible for full-coverage Medicaid due to her not meeting the Medicaid for the Aged or Disabled (MEDS-AD) income guideline for an individual. The Department enrolled the petitioner in the Medically Needy (MN) program.

3. The Department included in the MN budget, the petitioner's Social Security income in the amount of $988. The Social Security income in the amount of $988 was reduced by the $20 unearned standard deduction to result in total countable income of $968. The total countable income was reduced by the $180 Medically Needy Income Level (MNIL) for an individual for a remaining SOC in the amount of $788.

4. The petitioner does not dispute the amount of the monthly gross income for herself. The petitioner believes she is entitled to full-coverage Medicaid because she was eligible prior to moving to Florida from Virginia. The petitioner argues that she pays $555 for rent, automobile, and animal expenses; she does not have any money left to purchase her prescriptions. The petitioner is receiving Medicare; there was no evidence presented to show that the petitioner is receiving any Medicaid covered institutional care or waiver services.

5. The Department explained that the state of Florida runs its Medicaid program differently than the state of Virginia. The Department explained that its Medicaid

program is income-based. The Department explained that rent and her other expenses are not considered in its calculations for the Medicaid program.

CONCLUSIONS OF LAW

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

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

8. 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.

9. The above controlling authority explains that the full coverage Medicaid coverage group (MEDS-AD Demonstration Waiver) in the SSI-related Programs is for individuals who are not receiving Medicare and whose income is at, or below, 88 percent of the poverty level. If the individual is receiving Medicare, he or she is eligible for full-coverage Medicaid if eligible for Medicaid covered institutional care services, hospice, or other community based waiver services. The findings show that the petitioner receives Medicare but does not receive any of the community-based services

that would make her eligible for full-coverage Medicaid.

10. 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…

11. The Policy Manual, passage 2440.0322 Standard Disregard (MSSI) states in part,

> This policy applies to MEDS-AD, MN, QMB, SLMB, QI-1, Working Disabled, Protected Medicaid and EMA. A $20 per month standard disregard applies to any type (earned or unearned) of income other than income which is provided on the basis of need. The amount of the disregard is not increased for a couple, regardless of whether one or both individuals have income.

12. The petitioner was enrolled in the Medically Needy Program with a share of cost. The petitioner's share of cost was calculated by including her countable gross monthly income less the standard disregard and the Medically Needy Income Level (MNIL) for an individual. The gross monthly household unearned income of $988, less the $20 unearned income deduction and MNIL of $180, equals a share of cost of $788. The hearing officer found no exception to this calculation. The undersigned concludes that the respondent's action to enroll the petitioner in the Medically Needy Program and to determine the amount of the monthly share of cost as $788 was a correct action.

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 08 day of February, 2016, in Tallahassee, Florida.

Paula Ali

Paula Ali
Hearing Officer
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FILED
Jan 25, 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.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 13 Hillsborough
UNIT: AHCA

RESPONDENT.
_____/

APPEAL NO. 15F-09709

CASE NO.

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on January 6, 2016, at approximately 3:05 p.m.

APPEARANCES

For Petitioner: [redacted] Petitioner's mother

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

STATEMENT OF ISSUE

Whether the Agency was correct in denying Petitioner's requests for extractions of tooth numbers 1, 16, and 32. Petitioner's requests for extractions of teeth 1 and 32 were approved prior to hearing, so this order will only address the remaining denied extraction for tooth 16. The burden of proof on this issue was assigned to the Petitioner by a preponderance of the evidence.

PRELIMINARY STATEMENT

Petitioner's mother appeared and provided testimony. Appearing as witnesses for Respondent were Carlene Brock (Quality Operations Nurse with Amerigroup), Jacklyn Salcedo (Complaints and Grievance Specialist with DentaQuest) and Dr. Daniel Dorrego, D.D.S. (Dental Consultant Reviewer with DentaQuest).

Petitioner submitted no documentary exhibits. Respondent submitted nine exhibits into evidence, which were marked and entered as Respondent's Exhibits 1 through 9. The hearing officer took administrative notice of Florida Statues Sections 409.910, 409.962, 409.963, 409.964, 409.965, 409.973, Florida Administrative Code Rules 59G-1.001, 59G-1.010, and 59G-4.060, and the Florida Medicaid Dental Services Coverage and Limitations Handbook (November 2011).

FINDINGS OF FACT

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

1. Petitioner is a Medicaid recipient under 21 years of age. She had a lot of pressure and pain due to her wisdom teeth. Her dentist referred her to an orthodontist and oral surgeon for review and extraction. She bleeds often because she uses her back teeth and swollen gums to chew.

2. On or about November 27, 2015, Petitioner's dentist submitted a prior authorization request to Amerigroup for extraction of impacted teeth 1, 16, and 32. The remarks note that Petitioner is in pain, has [redacted] swollen gum tissue, moderate crowding, and wakes up at night due to teeth pressure. DentaQuest

handles the prior authorization reviews for Amerigroup members. Amerigroup requires prior authorization for some treatments for children under 21.

3. On December 1, 2015, Amerigroup denied Petitioner's request for the extractions because the documentation provided did not indicate medical necessity. Specifically, the December 1, 2015 denial stated:

> 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.

4. DentaQuest re-reviewed Petitioner's submission on December 16, 2015.

[redacted] DentaQuest could not prior authorize the request for tooth number 32 because it was already authorized and paid under another claim. However, DentaQuest did approve extraction of upper tooth number 1, based on the dentist's remarks in the original submission. The dental consultant reviewed the x-rays and determined tooth number 1 was impacting the root of tooth number 2 and needed to be extracted.

5. DentaQuest did not approve extraction of upper tooth number 16. The dental consultant reviewed the x-rays and determined tooth number 16 is not impacting the root of tooth number 15, and should erupt normally.

CONCLUSIONS OF LAW

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

7. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.

8. This hearing was held as a de novo proceeding pursuant to Florida Administrative Code Rule 65-2.056.

9. Section 409.912, Florida Statutes, notes that AHCA shall purchase goods and services for Medicaid recipients in the most cost-effective manner possible, consistent with the delivery of quality medical care. The statutes further provide that AHCA shall contract on a prepaid or fixed-sum basis with appropriately licensed prepaid dental health plans to provide dental services.

10. The Florida Medicaid Provider General Handbook (Provider Handbook) – July 2012 is incorporated by reference in Florida Administrative Code Rule 59G-4. In accordance with the Florida law, the Provider Handbook discusses managed care coverage, stating on page 1-27:

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee. Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

11. Page 1-30 of the Provider Handbook states: “An HMO’s services cannot be more restrictive than those provided under Medicaid fee-for-service.”

12. All Medicaid services must be medically necessary. Florida Administrative Code, 59G-1.010(166), defines medical necessity, as follows:

> “Medically necessary” or “medical necessity” means that the medical or allied

care, goods, or services furnished or ordered must:

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

…

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

13. The Medicaid Dental Services Coverage and Limitations Handbook (November 2011) (Dental Handbook) is promulgated into law by Rule 59G-4.060(2), Florida Administrative Code.

14. As the petitioner is under 21, a broader definition of medically necessary applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) requirements. Section 409.905, Fla. Stat., *Mandatory Medicaid services*, defines Medicaid services for children to include:

(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems…

15. The Dental Handbook states on page 1-2: "The children's dental program provides full dental services for all Medicaid eligible children age 20 and below."

16. The Dental Handbook states on page 2-2: "Medicaid reimburses for services that are determined medically necessary…"

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

> Covered Child Services (Ages under 21):
>
> The Medicaid children's dental services program may provide reimbursement for diagnostic services, preventive treatment, restorative, endodontic, periodontal, surgical procedures and extractions, orthodontic treatment, and full and partial dentures (fixed and removable) for recipients under age 21.
>
> Note: See the Florida Medicaid Provider Reimbursement Schedule for information on which dental procedure codes apply to recipients under age 21.

18. Extractions are covered under Medicaid for children under 21 if the extraction is medically necessary. In this case, the only testimony as to the medical need for the extraction of tooth number 16 is from DentaQuest's dental consultant.

19. In the absence of contrary testimony, Petitioner was unable to meet her burden of proof that tooth number 16 is a medically necessary extraction. Although her treating dentist initially recommended the extraction, that does not make it medically necessary under Medicaid's rules.

20. After careful review of the relevant authorities, the testimony and the evidence in this matter, the hearing officer concludes that the Agency properly denied Petitioner's request.

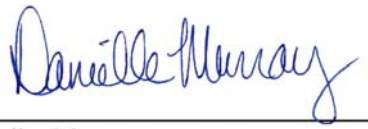
DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 25 day of January, 2016, in Tallahassee, Florida.



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

FILED
Feb 19, 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.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 66032

RESPONDENT.
_____/

APPEAL NO. 15F-09716

[redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on December 29, 2015 at 8:30 a.m.

APPEARANCES

For the petitioner: [redacted] pro se

For the respondent: Nydia Galarza, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the respondent's action to enroll him in the Medically Needy (MN) Program with a share of cost (SOC). Petitioner is seeking full Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

By notice dated November 13, 2015, the respondent notified the petitioner that his enrollment in the MN Program with a $543.00 SOC remained the same beginning November 2015.

Petitioner did not submit any exhibits. Respondent submitted one exhibit, entered as Respondent Exhibit "1". The record was held open until close of business on January 7, 2016 for additional evidence from the respondent. On December 29, 2015, additional evidence was received and entered as Respondent Exhibit "2". The record closed on January 7, 2016.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner (69) was receiving SSI-Related Medicaid MN benefits with a SOC of $543.00 for himself only. On November 6, 2015, petitioner submitted an interim contact letter to recertify his MN, Food Assistance Program (FAP), and Qualified Medicare Beneficiaries (QMB) benefits. FAP and QMB benefits are not the issue.

2. The petitioner receives $743.00 per month in Social Security Retirement (SSRE) benefits.

3. The respondent calculated the petitioner's total countable income as $723.00, after a $20.00 unearned income disregard was subtracted from his $743.00 SSRE benefits. The income limit for an aged/disabled individual to receive full Medicaid is $864.00. The petitioner's countable income is below this amount. However, petitioner is a Medicare recipient. Therefore, he remains only eligible for MN due to being a Medicare recipient.

4. The respondent determined the petitioner remained enrolled in the MN Program. To determine the SOC amount, the respondent determined the Medically Needy Income Level (MNIL) for a household size of one was $180.00, this amount was subtracted from $723.00. The respondent calculated the petitioner's SOC amount as follows:

5. Petitioner explained due to his age, he recently has experienced health issues and needs medical coverage to get the medical care he needs.

6. Medicare provides 80% coverage and QMB covers, in addition to the Medicare premiums; coinsurances and deductibles (20% balance remaining). Petitioner was encouraged to contact the Agency for Health Care Administration (AHCA) for coverage and payment under the QMB Program.

CONCLUSIONS OF LAW

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

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

9. Fla. Admin. Code R. 65A-1.710, SSI-Related Medicaid Coverage Groups, states in part:

> The Department covers all mandatory coverage groups and the following optional coverage groups:
> (1) MEDS-AD Demonstration Waiver. A coverage group for aged and disabled individuals (or couples), as provided in 42 U.S.C. § 1396a(m).
> …
> (5) Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. §§ 1396a and 1396d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance due to their level of income or resources. The program does not cover nursing facility care, intermediate care for the developmentally disabled services, or other long-term care services.

10. Fla. Admin. Code R. 65A-1.713 defines the income limits for SSI-Related Medicaid programs:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
> (a) For MEDS-AD Demonstration Waiver, income cannot exceed 88 percent of the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.
> …
> (h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses.

11. Fla. Admin. Code R. 65A-1.701(20) defines MEDS-AD Demonstration Waiver as:

> Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and **are not receiving Medicare** [emphasis added] or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services.

12. Florida Statutes § 409.904 sets forth the following regarding Medicaid:

> Optional payments for eligible persons.—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…
> (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** [emphasis added]…

13. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 2040.0813.03, Technical Requirements for MEDS-AD (MSSI) states:

> The individual must meet all of the following criteria:
> 1. Age or disability,
> 2. U.S. residency,
> 3. Citizenship,
> 4. Welfare enumeration,
> 5. Third party liability,
> 6. Application for other benefits they may be eligible to receive,
> 7. **Not be receiving Medicare** [emphasis added]…

14. According to the above regulations, an individual who receives Medicare is not eligible to receive full Medicaid. In this instance, the petitioner has Medicare benefits through Social Security Administration; therefore, he does not meet one of the technical requirements for full Medicaid.

15. The Policy Manual, passage 2640.0500, Share of Cost (MSSI) sets forth:

> The eligibility specialist must determine eligibility for Medically Needy any time the assistance group's assets and/or income exceeds the appropriate categorical asset/income limits. The eligibility specialist determines whether the assistance group's assets are within the Medically Needy asset limits and whether the assistance group members meet the technical factors. If the Medically Needy asset limit is met and the assistance group meets all technical factors, the eligibility specialist determines the amount of countable income and computes a budget using the MNIL which is the same for both family and SSI-Related Medicaid coverage groups (refer to Appendix A-7).
> If income is equal to or less than the MNIL, there is no share of cost and the individual is eligible. Medicaid is authorized for individuals who are eligible without a share of cost.

> If income is greater than the MNIL, share of cost is determined for appropriate members. Appropriate members are enrolled but cannot be eligible until the share of cost is met.

16. The Code of Federal Regulations 20 C.F.R. § 416.1124 defines unearned Income that is not counted in SSI – Related Medicaid programs:

> (C)(12) The first $20 of any unearned income in a month other than income in the form of in-kind support and maintenance received in the household of another (see §416.1131) and income based on need. Income based on need is a benefit that uses financial need as measured by your income as a factor to determine your eligibility.

17. Fla. Admin. Code R. 65A-1.716 (2), Income and Resource Criteria, sets forth the MNIL for one person at $180.00.

18. The SOC is determined by subtracting the MNIL from the individual's total countable income. For the petitioner, the determination of the SOC is his monthly SSRE (743.00) less a $20.00 unearned income disregard, less the MNIL of $180.00, which resulted in his SOC of $543.00 effective November 2015 and ongoing.

19. In careful review of the cited authorities and evidence, the undersigned concludes that the Department correctly enrolled the petitioner in the MN Program and calculated his SOC as $543.00 effective November 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 19 day of February, 2016,

in Tallahassee, Florida.

Cassandra Perez
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

FILED
Feb 23, 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.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 66292

RESPONDENT.
_____/

APPEAL NO. 15F-09761

[redacted]

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matted on December 28, 2015 at 1:00 p.m.

APPEARANCES

For the petitioner: [redacted] pro se

For the respondent: Jennifer Molnar, ACCESS Supervisor

STATEMENT OF ISSUE

At issue is the respondent's action to deny the Medicare Savings Plan (MSP), under Medicaid Qualifying Individual 1 (QI1) was proper. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

By notice dated September 15, 2015, the respondent notified the petitioner that her Medicaid QI1 application dated August 17, 2015 was denied due to income. Petitioner timely requested a hearing on October 7, 2015 to challenge the denial of

Medicaid QI1 benefits; however, the Department did not forward the petitioner's hearing request to the Office of Appeal Hearings until November 30, 2015.

The petitioner did not submit any exhibits. Respondent submitted three exhibits, entered as Respondent Exhibits "1" through "3". The record was held open until close of business on January 7, 2016 for submission of additional evidence from the respondent. On December 29, 2015, additional evidence was received and entered as Respondent Exhibit "4". The record closed on January 7, 2016.

FINDINGS OF FACT

1. Prior to the action under appeal, petitioner and her husband received Medicaid QI1 benefits from November 2014 through May 31, 2015. On August 17, 2015, petitioner submitted an application for MSP.

2. The respondent reviewed the application and verified the petitioner and her husband's Social Security Disability Income (SSDI) through the State of Florida on-line query.

3. The on-line query showed petitioner's SSDI amount was $976.81 and petitioner's husband's was $841.69. The total amount combined was $1,818.50. The respondent used $1,817.00 and calculated the QI1 budget as follows:

[redacted]

4. The respondent calculated the household countable income as $1,797.00, after a $20.00 unearned income disregard was subtracted from the household's income of $1,817.00. The income limit for a couple to qualify for QI1 benefits is $1,793.00. The respondent determined that the petitioner's household income ($1,797.00) exceeded the limit to qualify for Medicaid QI1.

5. Petitioner explained the correct SSDI she receives is $975.90 and her husband's is $840.90. Petitioner did not understand why she was no longer eligible for QI1 benefits. She explained her income has not changed.

6. The respondent recalculated the income and used $1,815.00 minus a $20.00 unearned income disregard, to determine the petitioner's household income as $1,795.00. The recalculated household income still exceeded the $1,793.00 QI1 income limit.

7. On January 2015, the income limit for QI1 was $1,802.00 for a couple. On April 2015, the income standard changed to $1,793.00 for a couple.

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. Section 409.904, Fla. Stat., Optional payments for eligible persons addresses who qualifies for this Program:

> 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.

11. 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 criteria, the next step is to determine income eligibility.

12. Fla. Admin. Code R. 65-1.702 Medicaid Special Provisions, in relevant 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…

13. 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.

14. 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.

15. The above authority explains 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. A couple must have income greater than 120% of the 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.

16. The above-cited regulations also explains that the QI1 Program can provide state Buy-in benefits for people with income at higher levels than the other programs.

17. On January 2015, the Department's Program Policy Manual (Policy Manual), Appendix A-9, set the Medicaid QI1 couple maximum income limit as $1,802.00.

Eligibility Standards for SSI-Related Programs – January 2015		
Coverage Group	**Income Limit**	**Asset Limit**
Supplemental Security Income (SSI) Individual* Supplemental Security Income (SSI) Couple*	$ 733 $ 1,100	$ 2,000 $ 3,000
ICP/HCBS/Hospice/HCDA Individual ICP/HCBS/Hospice/HCDA Couple	$ 2,199 $ 4,398	$ 2,000 $ 3,000
MEDS-AD/ICP-MEDS/Individual (88% FPL) MEDS-AD/ICP-MEDS/Couple	$ 871 $ 1,175	$ 5,000 $ 6,000
QMB Individual (100% FPL) QMB Couple	$ 990 $ 1,335	$ 7,160 $ 10,750
SLMB Individual (100-120% FPL) SLMB Couple	$ 1,187 $ 1,602	$ 7,160 $ 10,750
QI1 Individual (120-135% FPL) QI1 Couple	$ 1,335 $ 1,802	$ 7,160 $ 10,750

18. The Policy Manual, Appendix A-9, sets the current Medicaid QI1 couple maximum income limit as $1,793.00 as of April 2015. These standards change each year in accordance with federal law. Therefore, as of May 2015, the household income of $1,797.00 exceeded the income standard of $1,793.00.

19. 20 C.F.R. § 416.1124(c) (12) establishes a $20 disregard for "the first $20 of any unearned income in a month" and income can be reduced by that amount. Respondent deducted $20 from petitioner's $1,817.00 household income. Petitioner's countable income ($1,797.00) exceeded the $1,793.00 Medicaid QI1 income limit. During the hearing, petitioner did not agree with the household income calculated in the Medicaid

QI1 budget. The respondent recalculated the petitioner's household income based on her testimony at the hearing and deducted $20 from petitioner's $1,815.00 total household income. The petitioner's countable income ($1,795.00) continued to exceed the $1,793.00 Medicaid QI1 income limit.

20. After careful review of the cited authorities and evidence, the undersigned concludes there is no state rule or federal regulation that permits Medicaid QI1 eligibility when income exceeds the established income standards. The respondent followed rule in denying petitioner and her husband's August 17, 2015 application for Medicaid QI1 benefits due to the household's countable income exceeding the income limit for the program.

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 23 day of Februarv, 2016,

in Tallahassee, Florida.

Cassandra Perez
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

FILED
Jan 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. 15F-09767
15F-09768

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 Brevard
UNIT: 55207

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 1:00 p.m. on December 21, 2015.

APPEARANCES

For the Petitioner: [redacted] pro se

For the Respondent: Ivonne Morales-Serrano, ACCESS Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny the petitioner Medicaid Qualifying Individual 1 (QI1) is proper. Petitioner also has an issue with the respondent not approving Food Assistance (FA) benefits. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

By notice dated November 30, 2015, the respondent (or the Department) notified the petitioner his QI1 application was denied. Petitioner timely requested a hearing to challenge the denial of QI1 benefits. Petitioner is also challenging that the respondent did not approve FA benefits.

Pamela Vance, Hearing Officer, appeared as an observer. Petitioner did not submit exhibits. Respondent submitted six exhibits, entered as Respondent Exhibits "1" through "6". The record was closed on December 21, 2015.

FINDINGS OF FACT

1. On November 24, 2015, the petitioner submitted a Medicaid/Medicare Buy-In application. The application lists $836 income from Veterans Administration (VA) and $1,200 income from Social Security (SS).

2. Petitioner asserts that his November 24, 2015, specifically states he wants FA benefits.

3. Petitioner did not submit a FA application and the Medicaid/Medicare Buy-In application does not state that petitioner is also applying for FA benefits. The last time petitioner received FA was in 2014.

4. There are three types of Buy-In Programs; Qualified Medicare Beneficiary (QMB), Special Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual 1 (QI1). Buy-In Programs, if approved, pay for Medicare premium.

5. To be eligible for the Buy-In Programs, petitioner's income cannot exceed the following income standards:

$ 981	QMB
$1,177	SLMB
$1,325	QI1

6. The Department verified the petitioner receives $1,221 gross SS income and $836.13 gross VA income, which totals $2,057.13 monthly. The Department subtracted $20 unearned income disregard from $2,057.13, resulting in $2,037.13.

7. The highest Buy-In income standard is for QI1 ($1,325). Petitioner's $2,037.13 monthly income exceeds $1,325. Therefore, he is not eligible for QI1 benefits.

8. On November 30, 2015, the Department mailed petitioner a Notice of Case Action, notifying his QI1 application was denied.

9. Petitioner asserts that he is a World War II veteran and his VA money should not be counted as income; because he was informed by the IRS that VA income is not taxed.

10. Petitioner said he "is asking Governor Scott" to make an exception in his case.

11. The Hearing Officer explained that her decision is not reviewed by Governor Scott nor will her decision be sent to Governor Scott. And if petitioner wants Governor Scott informed he will need to notify the Governor himself.

CONCLUSIONS OF LAW

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

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

FOOD ASSISTANCE ISSUE

14. Federal regulations at 7 C.F.R. § 273.2 Office operations and application processing in part states:

> (2) Application processing. **The application process includes filing and completing an application form** (emphasis added) being interviewed, and having certain information verified…
> (b) **Food Stamp application form—**(emphasis added) (1) Content. Each application form shall contain:
> (i) In prominent and boldface lettering and understandable terms a statement that the information provided by the applicant in connection with the application for food stamp benefits will be subject to verification by Federal, State and local officials to determine if such information is factual; that if any information is incorrect, food stamps may be denied to the applicant; and that the applicant may be subject to criminal prosecution for knowingly providing incorrect information;
>
> (ii) In prominent and boldface lettering and understandable terms a description of the civil and criminal provisions and penalties for violations of the Food Stamp Act;

15. The above authority states, "The application process includes filing and completing an application form…" In this case, the petitioner did not submit an application for FA benefits. The application he submitted is titled "MEDICAID/MEDICARE BUY-IN APPLICATION" and nowhere on the application does it indicate that petitioner is also applying for FA. Therefore, the Department did not determine eligibility for FA benefits.

16. Fla. Admin. Code R. 65-2.042 Applicant/Recipient Fair Hearings address Fair Hearings and in part states

> The Department of Children and Family Services, hereinafter referred to as Department or Agency, is required to provide notice and an opportunity of a hearing to any applicant or recipient when the Department's action, intended action or failure to act would adversely affect the individual's or family's eligibility for an amount or type of Financial Assistance, Medical Assistance, Social Services, or Food Stamp Program Benefits, or where action on a claim for such assistance or services is unreasonably delayed…

17. Fla. Admin. Code R 65-2.056 Basis of Hearings, states:

> 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.

18. Fla. Admin. Code 65-2.046 Time Limits in Which to Request a Hearing states:

> (1) The appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs. 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.
> (3) This amendment is to be effective March 1, 1979.

19. The above authorities explain applicants may request a hearing within 90 calendars days from the date of the notice that is mailed notifying the applicant of the action taken by the Department. Or at any time within a FA certification period. In this case,

petitioner did not receive a notice regarding FA from the Department. And petitioner last received FA in 2014; therefore, he does not have a FA certification period.

MEDICAID ISSUE

20. 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.)…

21. Fla. Admin. Code R. 65A-1.713 SSI-Related Medicaid Income Eligibility Criteria in part states:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows…
> (b) For QMB, income must be less than or equal to the federal poverty level…
> (g) For SLMB, income must be greater than 100 percent of the federal poverty level but equal to or less than 120 percent of the federal poverty level…
> (j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. QI1 is eligible only for payment of the Part B Medicare premium through Medicaid…

22. The Department's Program Policy Manual, CFOP 165-22, Appendix A-9, sets forth the following the following income standards for an individual:

QMB	$ 981

SLMB	$1,177
QI1	$1,325

23. Petitioner argued that he is a World War II veteran and his VA money should not be counted as income; because he was informed by the IRS that VA income is not taxed.

24. Federal regulation at 20 C.F.R. § 416.1121 define different types of unearned income as follows:

> 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**… (emphasis added)

25. Additionally, the Department's Program Policy Manual, CFOP 165-22, (Policy Manual) passage 1840.0900 BENEFITS (MSSI, SFP) defines VA and SS as unearned income:

> Section 1840.0900 (inclusive) discusses types of benefits payable to individuals and their treatment as unearned income, including benefits such as:
> 1. Social Security payments;
> 2. private benefit income such as annuities, pensions, retirement, or disability (other than SSA);
> 3. **veterans payments**; (emphasis added)
> 4. Agent Orange benefits;
> 5. workers' compensation;
> 6. railroad retirement;
> 7. unemployment benefits;
> 8. striker support;
> 9. severance pay; or
> 10. death benefits.

26. In accordance with the above authority and policy manual, the Department included petitioner's $836.13 VA and $1,221 SS unearned income, totaling $2,057.13 as petitioner's household income.

27. Federal regulation at 20 C.F.R. § 416.1124(c) (12) establishes a $20 disregard for "the first $20 of any unearned income in a month". Respondent deducted $20 from petitioner's $2,057.13 income and arrived at $2,037.13 countable income.

HEARING OFFICER'S CONCLUSION

28. The evidence submitted establishes that the petitioner did not submit a FA application and is not currently receiving FA benefits. Additionally, petitioner's Medicaid/Medicare Buy-In application does not indicate that he was also applying for FA benefits.

29. In careful review of the cited authorities and evidence, the undersigned is dismissing petitioner's FA issue as non-jurisdictional.

30. The evidence also establishes that petitioner receives $836.13 VA income and $1,221 SS income.

31. Also in careful review of the evidence and cited authorities, the undersigned concludes the respondent was correct in denying petitioner Medicaid QI1 benefits due to exceeding the income limit.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the FA appeal is dismissed as non-jurisdictional and the Medicaid QI1 appeal is denied. The respondent's action on Medicaid QI1 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 January, 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
Feb 04, 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. 15F-09775: [redacted]
15F-09922:

CASE NO. [redacted]

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above matters on January 7, 2016 at 10:16 a.m.

APPEARANCES

For the Petitioners: [redacted]
Mother of each petitioner

For the Respondent: Lisa Sanchez
Senior Human Services Program Analyst

STATEMENT OF ISSUE

Whether respondent's denial of orthodontic treatment (braces) for each petitioner was proper. The burden of proof was assigned to each petitioner.

PRELIMINARY STATEMENT

Petitioners were not present. Their representative entered no exhibits into evidence.

Petitioner's representative did not receive respondent's proposed evidence. The representative selected to proceed with the hearing. The evidence was to be overnighted to the representative. The record was held open through January 14, 2016 for the representative to provide, if desired, a written response to respondent's documentary exhibits. A response was not received.

Ms. Sanchez appeared both as a witness and representative for the respondent. Present as witnesses for each petitioner from Molina Healthcare were: Natalie Fernandez, Government Contract Specialist; Carlos Galvez, Government Contract Specialist; Vanessa Martinez, Government Contract Specialist; and Alice Quiros, ABP of Government Contracts. Present from DentaQuest were Jacelyn Salcedo, Appeals and Grievance Specialist and Dr. Susan Hudson, Dental Consultant.

The following exhibits were accepted into evidence:

[redacted] Respondent's exhibits "1" – "2"
Respondent's exhibits "1" – "2"

Administrative notice was taken of the Florida Medicaid Provider General Handbook.

The record was held open through January 11, 2016 for respondent to provide a Medicaid Orthodontic Initial Assessment Form completed for Trinity Gonzales. Information was timely received and entered as respondent's exhibit "3".

SHARED 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 for both petitioners:

1. Petitioners are twins with a birth date of [redacted] At all times relevant to this proceeding each was Medicaid eligible.

2. Medicaid services for the petitioners are provided through respondent's Statewide Medicaid Managed Care Program. Since August 1, 2014 Medicaid services have been provided by Molina Healthcare.

3. DentaQuest is the dental vendor for Molina Healthcare. A DentaQuest dentist reviews information submitted for requested dental procedures and issues a determination.

4. All DentaQuest reviewers are licensed dentists and must pass quarterly reliability exams.

5. DentaQuest must be in compliance with relevant Florida Medicaid Coverage and Limitations Handbooks. This includes the Florida Medicaid Provider General Handbook and the Florida Medicaid Dental Services Coverage and Limitations Handbook.

6. Orthodontic treatment, when medically necessary, is available to Florida Medicaid recipients who are under the age of 21.

7. For each petitioner, the treating orthodontist submitted to DentaQuest an Initial Assessment Form (IAF).

8. The IAF is used to determine the severity of dental conditions, including the malocclusion of teeth. Scoring is assigned by both diagnostic observation and dental measurement.

9. An IAF score of "26" or more may indicate braces are medically necessary.

10. The treating orthodontist is not required to provide IAF scoring when one of the following conditions exist:

- Cleft palate deformities
- Deep impinging overbite. When lower incisors are destroying the soft tissue (more than an indention)
- Crossbite of individual anterior teeth. When destruction of soft tissue is present
- Severe traumatic deviations
- Overjet greater than 9mm with incompetent lips or reverse overjet greater than 3.5 mm with reported masticatory and speech difficulties

11. For each of the above, the IAF directs the treating dentist to "Indicate an 'X' if present and score no further". When present, these conditions can be considered as an "auto-qualifier" for braces.

[redacted]

12. On October 13, 2015 a request for braces and monthly orthodontic visits was received by DentaQuest. The submission included an IAF and facial photographs. A written justification did not accompany the submission.

13. Petitioner's treating orthodontist did not indicate an auto qualifier for braces. As such, the orthodontist proceeded with IAF scoring.

14. The orthodontist identified both an overjet and overbite.

15. An overjet is the extent of horizontal overlap between the upper and lower front teeth. The orthodontist's scoring for petitioner's overjet was "6".

16. An overbite is the extent of vertical overlap between the front upper and lower teeth. The orthodontist's scoring for petitioner's overbite was "6".

17. Regarding ectopic eruption and anterior crowding, the IAF directs: "If both anterior crowding and ectopic eruption are present in the anterior portion of the mouth, score only the most severe conditions. Do not score both conditions.

18. Petitioner's orthodontist scored ectopic eruption as "6" and anterior crowding as a "10".

19. The total IAF score submitted to DentaQuest was "28".

20. A DentaQuest dentist thereafter reviewed petitioner's x-rays.

21. Based on submitted information, the DentaQuest reviewer completed an IAF. The reviewer scored overjet as "2" and overbite as "4".

22. Because both ectopic eruption and anterior crowding were present in the anterior portion of the mouth, the DentaQuest reviewer only scored the most severe condition. A score of "10" was given for anterior crowding. No scoring was given for ectopic eruption.

23. The total score given by the DentaQuest reviewer was "16".

24. On October 15 2015 DentaQuest notified the petitioner that the request for orthodontic treatment was denied. 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 20 points[1].

25. Petitioner thereafter requested an internal appeal.

26. A second DentaQuest dentist then reviewed all submitted information. On November 11, 2015 correspondence was issued upholding the original denial.

27. On November 24, 2015 the Office of Appeal Hearings timely received petitioner's request for a fair hearing.

---

[1] The reference to an IAF score of 20 is incorrect. Petitioner's IAF score, as scored by DentaQuest reviewers, was 16.

28. Petitioner's representative argues her son's dental condition causes him to bite onto his jaw. He demonstrates language problems and receives speech therapy from the school system. His dental condition has had a negative impact on his self-esteem.

29. Respondent asserts the level of misalignment of petitioner's teeth is not severe enough to meet Medicaid criteria for braces. Such has been determined by two DentaQuest reviewers. Additionally, Dr. Hudson concurs with their determination.

30. On October 13, 2015 a request for braces and monthly orthodontic visits was received by DentaQuest. The submission included an IAF; x-rays; and facial photographs. No narrative was included with the submission.

31. The orthodontist checked: "Overjet greater than 9mm with incompetent lips or reverse overjet greater than 3.5 mm with reported masticatory and speech difficulties." Although this is considered an auto-qualifier for braces, the orthodontist continued to score the IAF. A "10" was given for both overjet and anterior crowding.

32. A DentaQuest dentist thereafter reviewed the submission.

33. Using submitted information, the DentaQuest reviewer completed an IAF. The reviewer identified no auto-qualifier for braces. A "5" was given for overjet "3" for overbite; and "2" for labio-lingual spread. The total IAF score was "10".

34. On October 15, 2015 Molina Healthcare issued a Notice of Action which denied the requested 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 10 points.

35. On November 24, 2015 the Office of Appeal Hearings timely received petitioner's request for a fair hearing.

36. Petitioner's representative asserts her daughter has a large overbite and can barely close her mouth. This has impacted her speech. She receives speech therapy through the school system.

37. Dr. Hudson argues the review completed by DentaQuest did not demonstrate a overjet greater than 9 mm with incompetent lips or reverse overjet greater than 3.5 mm accompanied with both chewing and speech difficulties. Although a misalignment of teeth exists, petitioner's dental status does not yet meet Medicaid criteria for braces.

CONCLUSIONS OF LAW

38. 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.

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

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

41. Fla. Admin. Code R. 59G-4.060 addresses dental services and states, in part:

> (2) All dental services providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Dental Services Coverage and Limitations Handbook, November 2011, … and the Florida Medicaid Provider Reimbursement Handbook, ADA Dental Claim Form, July 2008, which are incorporated by reference, and the Florida Medicaid Provider

> Reimbursement Handbook, CMS-1500, which is incorporated by reference in Rule 59G-4.001, F.A.C.
>
> (3) The following forms that are included in the Florida Medicaid Dental Services Coverage and Limitations Handbook are incorporated by reference: Medicaid Orthodontic Initial Assessment Form (IAF), …

42. The Florida Medicaid Dental Services Coverage and Limitations Handbook (Dental Handbook) states, on page 2-2, "Medicaid reimburses for services that are determined medically necessary …"

43. In regard to medical necessity for Medicaid funded services, the definition is found in Fla. Admin Code. R. 59G-1.010 and states:

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

44. As the petitioners are 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 …

45. 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].

46. 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 each petitioner is under the age of 21. The issues before the undersigned, therefore, focus upon whether the requested orthodontic services meet Florida's medical necessity criteria.

47. When considering whether the requested orthodontic services are medically necessary, analysis is further directed to the Dental Handbook. Page 2-15 states:

> Prior authorization is required for all orthodontic services. Orthodontic services are limited to those recipients with the most handicapping malocclusion. A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the patient by causing impaired mastication, dysfunction of the temporomandibular articulation, susceptibility to periodontal disease,

susceptibility of dental caries, and impaired speech due to malposition of the teeth.

48. Pages 2-16 through 2-18 of the Dental Handbook continue by stating:

Orthodontic procedures are limited to recipients under age 21 whose handicapping malocclusion creates a disability and impairment to their physical development.

Criteria for approval is limited to one of the following conditions:

- Correction of severe handicapping malocclusion as measured in the Medicaid Orthodontic Initial Assessment Form (IAF) …
- Syndromes involving the head and maxillary or mandible jaws such as cleft lip of cleft palate
- Cross-bite therapy, with the exception of one posterior tooth that is causing no occlusal interferences;
- Head injury involving traumatic deviation; or
- Orthognathic surgery, to include extractions, required or provided in conjunction with the application of braces.

…

The Medicaid Orthodontic Initial Assessment Form (IAF) is to be completed by the orthodontic provider at the initial evaluation of the recipient.

The IAF is:

- Designed for use as a guide by the provider in the office to determine whether a prior authorization (PA) request should be sent to the Medicaid orthodontic consultant; and
- A means by which the orthodontic provider may communicate to Medicaid's orthodontic consultant all the distinctive details pertaining to an individual case. …

…

A score of 26 or greater may indicate that treatment of the recipient's condition could qualify for Medicaid reimbursement, and the orthodontic provider should submit a prior authorization request to Medicaid for consideration of orthodontic services. A score of 26 or greater on the IAF is not a guarantee of approval. It is used by the provider to determine whether diagnostic records should or should not be sent to the orthodontic consultant.

…

> A score of less than 26 indicates that treatment of the recipient's condition may not qualify for Medicaid reimbursement, and the request for prior authorization may be denied.
>
> This does not say that such cases do not represent some degree of malocclusion, but simply that the severity of the malocclusion does not qualify for coverage under the Florida Medicaid Orthodontic Program.

[redacted]

49. A conflict exists between the IAF completed by petitioner's orthodontist and those completed by DentaQuest reviewers. Petitioner's orthodontist scored the IAF at 28. DentaQuest scored the IAF at 16.

50. Additional IAF information is found in respondent's Dental Handbook on page A-1. The IAF states: "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."

51. The Findings of Fact establish petitioner's orthodontist scored anterior crowding as 10 and ectopic eruption 6. The Dental Handbook directs that only the higher of the two should be scored.

52. When backing out the IAF score assigned for ectopic eruption, the IAF submitted by petitioner's orthodontist would be "22" as opposed to "28".

53. The DentaQuest reviewers agreed with the referring orthodontist when scoring anterior crowding as 10. Differences existed, however, when scoring overjet and overbite. Regardless, even when only evaluating the correctly scored IAF from the referring orthodontist, the score remains less than 26.

54. Page 2-18 of the Dental Handbook addressed borderline assessments. When an orthodontist believes a borderline assessment exists, the Dental Handbook requires

study models be presented for evaluation. No evidence was presented that study models were submitted by the treating orthodontist.

55. Evidence does not establish petitioner's speech issues are solely caused by his dental condition.

56. A hearing officer must consider all evidence; judge the credibility of witnesses; and draw permissible inferences from the evidence.

57. Compelling evidence was not presented to refute the IAF score of "16" as determined by DentaQuest reviewers.

58. Petitioner has not established, by the required evidentiary standard, that respondent's action in this matter was improper.

59. A conflict exists between the IAF completed by petitioner's orthodontist and that completed by a DentaQuest reviewer. The IAF completed by the referring orthodontist showed an "auto-qualifier" for braces. This was refuted by DentaQuest. The total IAF score computed by DentaQuest was "10".

60. Petitioner's orthodontist identified no other auto-qualifier for braces other than that related to overjet greater than 9mm.

61. It is noted that DentaQuest scored the overjet to be 5mm. Page A-3 of the Dental Handbook states "score the case exactly as measured, then subtract 2mm (considered the norm) and enter the difference as the score." As such, the petitioner's overjet is 7mm. This is still less than the 9mm required for the overjet to meet the criteria for an auto qualifier.

62. Petitioner's orthodontist provided no written justification for the IAF scoring.

63. Evidence does not establish petitioner's speech issues are solely caused by her dental condition.

64. Compelling evidence was not presented to refute the IAF findings of DentaQuest. As such, considerable weight is given to the testimony of Dr. Hudson.

65. Petitioner has not established, by the required evidentiary standard, that respondent's action in this matter was improper.

66. It is not disputed that both petitioners have a misalignment of teeth. The greater weight of evidence, however, does not establish their orthodontic status rises to the stringent requirement of a "most handicapping malocclusion" as defined by the Dental Handbook.

67. The request for braces by each petitioner have not satisfied the following condition of medical necessity:

> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program,

68. The undersigned has reviewed EPSDT and medical necessity requirements and applied such to the totality of the evidence. The petitioners have not established that respondent's denial of braces was incorrect.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal for [redacted] is denied. The appeal for [redacted] 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 Februarv, 2016,

in Tallahassee, Florida.

Frank Houston

Frank Houston
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
[redacted] Petitioner
Judy Jacobs, Area 7, AHCA Field Office

FILED
Jan 14, 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-09795
APPEAL NO. 15F-09796

PETITIONER,

Vs.

[redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 Palm Beach
UNIT: 88322

RESPONDENT.
_____/

ORDER OF DISMISSAL

A request for hearing in the above-styled matter is before the undersigned. On January 12, 2016, the petitioner's attorney, [redacted] provided a written statement indicating that the issue under appeal was resolved and she no longer needed the January 13, 2016, hearing. As there is no longer an issue before the hearing officer, appeals 15F-09795 and 15F-09796 are hereby dismissed.

DONE and ORDERED this 14 day of January, 2016,

in Tallahassee, Florida.

Christiana Gopaul Narine

Christiana Gopaul-Narine
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency
Marjorie Desporte, Esq
[redacted]

FILED
Feb 08, 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-09809
15F-09810
15F-09811

PETITIONER,

Vs.

[redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pinellas
UNIT: 88269

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on December 29, 2015 at 2:33 p.m. and on January 7, 2016 at 11:00 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the petitioner: [redacted] pro se

For the respondent: Ed Poutre, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action to deny her application for Food Assistance Program (FAP), Temporary Cash Assistance (TCA), and Medicaid benefits dated October 22, 2015.

Petitioner is also appealing the Department's subsequent action to approve her for $66 FAP benefits as she is seeking a higher amount. The petitioner carries the burden of proof by the preponderance of evidence for all issues.

PRELIMINARY STATEMENT

On November 30, 2015, the Department sent the petitioner a Notice of Case Action (NOCA) informing her that her application dated October 22, 2015 was denied because "we did not receive all the information requested to determine eligibility." The petitioner timely appealed this action on November 30, 2015.

During the hearing on January 7, 2016, the petitioner indicated that she was satisfied with the Department's action to correct her Medicaid benefits denial and withdrew her hearing request for this issue on the record.

The petitioner presented a total of 16 pages of evidence for the undersigned to consider, which were entered into the record as Petitioner's Composite Exhibit 1. The Department presented a total of 127 pages of evidence during the hearing for the undersigned to consider, which were entered into the record as Respondent's Exhibits 1 through 9. The record was held open until close of business January 7, 2016 for the Department to submit additional evidence. The Department submitted an additional 11 pages of evidence, which were entered into the record as Respondent's Exhibit 10. The record was closed on January 7, 2016.

FINDINGS OF FACT

1. On October 22, 2015, the petitioner submitted an application for FAP, TCA and Medicaid benefits for herself and her grandchild (age 5). She reported Veteran's Administration benefits of $1,447 per month. Child support income of $120 per month

was also reported. The petitioner reported rent of $1,368 and an electric expense with heating and cooling of $140 per month.

2. On October 27, 2015, the Department sent the petitioner a NOCA requesting the following:

We need to have a phone interview with you to determine your eligibility or to continue your benefits. Please call (239) 895 - 0223 on or before November 5, 2015 between the hours of 11:00 A.M and 4:00 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 Florida residency

You may also call 8667622237 to complete your interview between 8-5. I will be out of the office a few days. The application wasn't clear if you are applying to add [redacted], if so turn in their social security numbers, birth certificates and income they may receive. You will need to fax the closure of benefits letter from Georgia. Fax your veterans benefits & child support you receive. You entered you applied for unemployment compensation, fax verification if you have started receiving funds.

Requested items with an asterisk (*) must be provided if you are applying for food assistance.

3. An interview was completed with the petitioner by the Department on October 29, 2015. She reported the same information as listed on her application but clarified that the child support income that she receives is irregular. On October 29, 2015, the petitioner uploaded verification of her Veteran's Administration benefits to her MyACCESS account. The Department did not send the petitioner notification that it had received this information but it was still missing further verification to process her application.

4. On November 30, 2015, the Department sent the petitioner a NOCA informing her that her application dated October 22, 2015 was denied because "we did not receive all the information requested to determine eligibility."

5. On November 30, 2015, the petitioner submitted another application for benefits and requested a hearing on her prior denial. On December 7, 2015, the Department sent the petitioner a NOCA requesting the following information:

> We need the following information by December 17, 2015.
>
> *Proof of all gross income from the last 4 weeks using the "Verification Of Employment/Loss Of Income" form or you may send in your last 4 pay stubs
> Other - please see comments below
>
> We need proof of the last 4 weeks child support income as well as proof the assistance from another state ended and when please.
>
> Requested items with an asterisk (*) must be provided if you are applying for food assistance.
>
> Please return or fax the information to the return address or fax number listed above. If you need help getting this information, let us know right away.
> If you do not contact us or provide the requested information, we will be unable to determine your eligibility. We will deny your application or your benefits may end.

6. On December 8, 2015, the petitioner faxed verification of the child support income that she receives and a letter from the state of Georgia verifying her case had been closed on October 28, 2015. She has not received child support income since November 16, 2015. On December 18, 2015, the Department sent the petitioner a NOCA informing her that her benefits had been approved. She received TCA for a pro-rated amount of $84 for December 2015 and $180 for January 2016 and ongoing. She also received FAP benefits of $95 for December 2015 and $66 of January 2016 and ongoing.

7. During the hearing the petitioner explained that her Veteran's Administration benefits were awarded due to a disability. The Department agreed to lift the cap on her excess shelter deduction and recalculated her FAP benefits. The following methodology was used to calculate her FAP benefits:

$1,447.71 unearned income
+$ 180.00 Riverside/TCA benefit
$1,627.71 Total gross income

-$ 155.00 Standard deduction
$1,472.71 Adjusted income

$1,368.00 Shelter cost
+$ 345.00 Standard utility allowance
$1,713.00 Total shelter cost
-$ 736.00 Shelter standard (50% of the adjusted net income of $1,472.71)
$ 976.65 Excess shelter deduction

$1,472.71 Adjusted income
-$ 976.71 Excess shelter deduction
$ 496.06 Adjusted FAP income

$496.06 x 30% = $149 (benefit reduction)
$357 (Maximum FAP benefit amount for 2 persons) - $149 (benefit reduction) = $208

8. The Department issued auxiliaries of $113 for December 2015 and $142 for January 2016; therefore, the petitioner received $208 FAP benefits for December 2015 and $208 FAP benefits for January 2016. The respondent also explained that on January 4, 2016 an alert was received to impose a CSE sanction on the petitioner. This was in error and the Department corrected the issue before any loss in benefits occurred.

9. The petitioner was satisfied with the new calculation of FAP benefits and current level of TCA benefits. The only remaining issue for the undersigned to determine is if the Department was correct to deny her application for benefits dated October 22, 2015 for not returning the requested information. She was approved FAP benefits from December 1, 2015 and TCA from December 8, 2015. The petitioner believes that she is entitled to FAP and TCA benefits from her application dated October 22, 2015.

CONCLUSIONS OF LAW

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

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

IN REGARDS TO THE MEDICAID ISSUE:

12. The petitioner requested for her Medicaid appeal to be withdrawn as she was satisfied with the Department's action to correct this issue. Therefore, the undersigned dismisses the Medicaid appeal as withdrawn.

IN REGARDS TO THE FAP AND TCA ISSUES:

13. The Code of Federal Regulations appearing in 7 C.F.R. § 273.2, Office operations and application processing states in part:

> (h) *Delays in processing.* If the State agency does not determine a household's eligibility and provide an opportunity to participate within 30 days following the date the application was filed, the State agency shall take the following action:
> (1) *Determining cause.* The State agency shall first determine the cause of the delay using the following criteria:
> (i) A delay shall be considered the fault of the household if the household has failed to complete the application process even thought the State agency has taken all the action it is required to take to assist the household. **The State agency must have taken the following actions before a delay can be considered the fault of the household** [emphasis added]:
> …
> (C) **In cases where verification is incomplete, the State agency must have provided the household with a statement of required verification and offered to assist the household in obtaining required verification and allowed the household sufficient time to provide the**

> **missing verification. (emphasis added)** Sufficient time shall be at least 10 days from the date of the State agency's initial request for the particular verification that was missing.
> …
> (3) *Delays caused by the State agency.*
> (i) Whenever a delay in the initial 30-day period is the fault of the State agency, the State agency shall take immediate corrective action…The State agency shall also notify the household of any action it must take to complete the application process…
> (ii) **If the household is found to be eligible during the second 30-day period, the household shall be entitled to benefits retroactive to the month of application.** [emphasis added]

14. Fla. Admin. Code R. 65A-1.205 Eligibility Determination Process, states in part:

> (c) **If the eligibility specialist determines during the interview or at any time during the application process that the applicant must provide additional information or verification**, or that a member of the assistance group must comply with Child Support Enforcement or register for employment services, **the eligibility specialist must give the applicant written notice to provide the requested information or to comply**, allowing ten calendar days from request or the interview, whichever is later. **For all programs, verifications are due ten calendar days from the date of written request** or the interview, or 60 days from the date of application, whichever is later. In cases where the applicant must provide medical information, the return due date is 30 calendar days following the written request or the interview, or 60 days from the date of application, whichever is later. If the due date falls on a holiday or weekend, the deadline is the next working day. If the applicant does not provide required verifications or information by the deadline date the application will be denied, unless the applicant requests an extension or there are extenuating circumstances justifying an additional extension. The eligibility specialist makes the decision of whether to grant the request for extension. When the applicant provides all required information or verification, the eligibility specialist determines eligibility for the public assistance programs. If the eligibility criteria are met, benefits are authorized.

15. According to the above cited authorities, the Department was required to notify the petitioner when it received partial verification on October 29, 2015, that she was still missing information. It further needed to state what the missing verification was

and to contact the Department if she needed help in obtaining the missing verification. The Department did not notify the petitioner in writing that she was missing verification when she submitted her Veteran's Administration benefits verification on October 29, 2015. For thirty two days (from October 29, 2015 to November 30, 2015), there was no action taken by the respondent on the petitioner's case. The undersigned concludes the respondent erred in not notifying the petitioner of the missing information and allowing her time to submit the required verification.

16. Determining eligibility for temporary case assistance is set for in § 414.095 Fla. Stat. (2015). It states:

> (8) APPLICATIONS.—The date of application is the date the department or authorized entity receives a signed and dated request to participate in the temporary cash assistance program. The request shall be denied 30 days after the initial application if the applicant fails to respond to scheduled appointments, including appointments with the state agency responsible for administering the child support enforcement program, and does not contact the department or authorized entity regarding the application.
> (a) **The beginning date of eligibility for temporary cash assistance is the date on which the application is approved or 30 days after the date of application, whichever is earlier. (emphasis added)**
> (b) The add date for a newborn child is the date of the child's birth.
> (c) The add date for all other individuals is the date on which the client contacts the department to request that the individual be included in the grant for temporary cash assistance.
> (d) Medicaid coverage for a recipient of temporary cash assistance begins on the first day of the first month of eligibility for temporary cash assistance, and such coverage shall include any eligibility required by federal law which is prior to the month of application
> (10) DETERMINATION OF LEVEL OF TEMPORARY CASH ASSISTANCE.—Temporary cash assistance shall be based on a standard determined by the Legislature, subject to availability of funds. There shall be three assistance levels for a family that contains a specified number of eligible members, based on the following criteria:
> (a) A family that does not have a shelter obligation.
> (b) A family that has a shelter obligation greater than zero but less than or equal to $50.

(c) A family that has a shelter obligation greater than $50 or that is homeless.

THREE-TIER SHELTER PAYMENT STANDARD

Family Size	Greater than $50 Shelter Obligation
1	$180

17. The above cited authority directs the Department to authorize TCA benefits from the date on which the application is approved or 30 days after the date of application. The verification of child support income was sent to the Department by the petitioner on December 8, 2015. It showed that the petitioner received a total of $225 in child support income for the month of November 2015. This amount is over the maximum TCA allotment for the petitioner's grandchild of $180. Therefore, the petitioner is ineligible for the month of November 2015 due to being over income. However, 30 days after the date of application is November 21, 2015. The petitioner is ineligible for the month of November 2015, but eligible for the full TCA benefits for December 2015 as shown in the above regulation. As the petitioner already received $84 TCA benefits for December 2015, the undersigned concludes that she is eligible for an additional $96 TCA benefits for December 2015 ($180 - $84=$96).

18. The undersigned also concludes the petitioner is entitled to FAP benefits from her application date of October 22, 2015. Therefore, the undersigned hereby remands the matter back to the Department to complete the eligibility determination process for the petitioner's FAP benefits for October and November 2015. The Department is to preserve the petitioner's original application date of October 22, 2015 and determine her eligibility for FAP benefits from that date without duplicating benefits already issued. Once an eligibility determination is made, the respondent is to issue a new NOCA to the petitioner including her appeal rights.

19. After careful review of the evidence and controlling legal authorities, the undersigned concludes that the Department incorrectly denied the petitioner's October 22, 2015 application without giving her adequate written notification of the documentation missing to complete the process. Therefore, the Department is ordered to issue an additional $96 TCA benefits to the petitioner for December 2015. It is also ordered to determine the petitioner's FAP eligibility for October 2015 (from her October 22, 2015 application date) and for November 2015.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals concerning the Department's action to deny the petitioner's October 22, 2015 FAP and TCA application is GRANTED and remanded back to the Department to take corrective action as specified in the Conclusions of Law.

The appeal concerning the respondent's action to approve the petitioner for $66 FAP benefits effective December 2015 is dismissed as moot as the Department already took corrective action and increased the petitioner's FAP benefits to $208 and the petitioner was satisfied with this new amount

The appeal concerning the Medicaid benefits is dismissed as withdrawn.

ANY FOOD STAMP BENEFITS DUE APPELLANT PURSUANT TO THIS ORDER MUST BE AVAILABLE WITHIN (10) TEN DAYS OF THIS DECISION OR WITHIN (60) SIXTY DAYS OF THE REQUEST FOR THE HEARING. ANY BENEFITS DUE WILL BE OFFSET BY PRIOR UNPAID OVERISSUANCES.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 08 day of February, 2016,

in Tallahassee, Florida.

BrandyRicklefs

Brandy Ricklefs
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

FILED
Feb 17, 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-09813

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on December 30, 2015 at 8:34 a.m.

APPEARANCES

For Petitioner: [redacted] Mother

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 7.5 hours of Personal Care Services (PCS) seven days per week. Because this appeal involves an initial request for personal care services, the burden of proof was assigned

to the Petitioner.

PRELIMINARY STATEMENT

Appearing as Respondent's witnesses from South Florida Community Care Center (SFCCN) were Dr. Joselyn Mateo, Medical Director; Dr. Ruiz Venero, Chief Medical Officer; Catherine Ruiz, Grievance and Appeals Coordinator; Alex Fabano, Contract Manager; and Maria Jam-Crese, Director of Medical Management.

The Respondent presented a composite document of 52 pages, which was entered into evidence and marked as Respondent Exhibit 1. The exhibit contained medical information, decision letters and documentation sent by the provider in support of the service request.

Petitioner presented a composite document of 15 pages, which was entered into evidence and marked as Petitioner Exhibit 1. Petitioner presented a second document of 2 pages, which was entered into evidence and marked as Petitioner Exhibit 2.

FINDINGS OF FACT

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

1. Petitioner is a seven-year-old male Medicaid recipient. He is diagnosed with [redacted] which is a severe bleeding disorder which can result in [redacted] He requires immediate attention whenever he [redacted] Failure to adequately address this promptly and effectively can result in the need for emergency services.

2. Petitioner attends a small private school at which the staff have been provided training by the [redacted] on the Petitioner's condition and care needs. The school requires an aide to accompany the Petitioner during school hours and the parents have paid for an aide for the past two years. The aide has also been trained by the [redacted]

3. Petitioner is also diagnosed with [redacted]

4. Petitioner is requesting Personal Care Services (PCS) during his school hours and on days when school is out. Because the mother's work schedule varies, the request is for 7.5 hours a day seven days a week. The mother explained most weeks would only require 7.5 hours a day for five days to cover the school days.

5. A request for prior authorization for a Home Health Aide (HHA) was received by the South Florida Community Care Network (SFCCN) on November 17, 2015. On November 19, 2015, SFCCN sent the Petitioner a Notice of Action and provided the following facts as the basis for its denial:

> Medical necessity for personal care services could not be established.
> 1.) Personal care services are covered when there is a level of functional impairment. All functional impairments must be age-appropriate and consistent with the level of functional impairment.
> 2.) Medicaid will not cover:
> - Mental health and psychiatric services
> - Services which can be effectively and efficiently obtained outside the recipient's place of residence without any medical contraindications
> - Baby-sitting
> - Social services
> - Escort services
> - Day care or after school care
> - Assistance with homework
> - Companion sitting or leisure activities.

6. The Petitioner filed a timely request for a fair hearing on November 23, 2015.

7. In terms of the services requested, Petitioner's mother stated that what her son needs he cannot do for himself. The following is a list of many of the tasks the aide needs to perform (See page 3 of Petitioner Exhibit 1) while Petitioner is at school:

8. Respondent's doctor from South Florida Community Care Center (SFCCN) explained that many of the required tasks to be done necessitate clinical assessment skills which home health aides are not trained to provide. Additionally, much of the time requested involves supervision which is not a Medicaid covered service. The doctor acknowledged the Petitioner has medical needs that need to be addressed but the personal care services being requested were not appropriate.

9. Petitioner's mother noted the current aide is already trained in providing the services her son needs and should be covered by Medicaid. The mother has been paying for the aide for the last two years since the aide was required by the private

school as a condition of the Petitioner's attendance. The mother explained the private school was small and afforded more security and oversight for her son than could be expected in a large public school.

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:

> Home health services are not considered emergency services.
>
> Medicaid reimburses services that are determined medically necessary and do not duplicate another provider's service.

> Rule 59G-1.010 (166), Florida Administrative Code (F.A.C.) defines "medically necessary" or "medical necessity" as follows:
> "[T]he medical or allied care, goods, or services furnished or ordered must:
>
> (a) Meet the following conditions:
>
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
>
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
>
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
>
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

16. The Medicaid Handbook, page 1-2, provides the purpose and scope of home health services and states in relevant part:

> The purpose of home health services is to provide medically necessary care to an eligible Medicaid recipient whose medical condition, illness, or injury requires the care to be delivered in the **recipient's place of residence** [emphasis added].
>
> Home health services are medically necessary services, which can be effectively and efficiently provided in the **place of residence** of a recipient. Services include home health visits (nurse and home health aide), private duty nursing and personal care services for children, therapy services, medical supplies, and durable medical equipment [emphasis added].

17. The Medicaid Handbook, page 1-2, also provides the following regarding personal care services, in relevant part…

> 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.
>
> ADLs 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).

18. On page 1-3 of the Medicaid Handbook, the following definition of babysitting is provided:

> 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.

Babysitting services as defined in the Handbook are not medical services and are not covered by Medicaid.

19. 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.

20. Petitioner's primary need for personal care services is supervision at school to ensure his safety. As noted above, supervision is not a Medicaid covered service and home health aide services are provided in the recipient's home. Petitioner's secondary needs [redacted] These secondary needs are beyond the service tasks and training associated with a home health aide.

21. Respondent explained Petitioner has medical needs that need to be addressed but the home health aide services requested are not appropriate. Petitioner has failed to meet his burden of proof. Petitioner's mother is encouraged to work with the Petitioner's primary care provider and South Florida Community Care Center (SFCCN) to determine how the Petitioner's medical needs can be met. Respondent's decision is consistent with the EPSDT medical necessity requirements.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the Petitioner disagrees with this decision, the Petitioner may seek a judicial review. To begin the judicial review, the Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The Petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The Petitioner must either pay

the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 17 day of February, 2016,

in Tallahassee, Florida.

Warren Hunter
Hearing Officer
Building 5, Room 255
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Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

FILED
Feb 01, 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-09843

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 04 DUVAL
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above matter on January 14, 2016 at 11:06 a.m.

APPEARANCES

For the Petitioner: [redacted]
Appeals Coordinator
[redacted]

For the Respondent: Selwyn Gossett
Medical/Health Care Program Analyst

STATEMENT OF ISSUE

Whether respondent's denial of a wearable cardioverter defibrillator (LifeVest) was proper. The burden of proof was assigned to the petitioner.

PRELIMINARY STATEMENT

Petitioner was not present. A written authorization appointing [redacted] as petitioner's representative was provided. Petitioner's exhibit "1" was entered into evidence.

Mr. Gossett appeared both as a witness and representative for the respondent. Present from Sunshine Health were Tracy Thomas, Appeals Coordinator II and Dr. David Gilchrist, Medical Director. Respondent's exhibit "1" was entered into evidence.

The record was held open through January 21, 2016 for respondent to provide relevant InterQual Criteria and for the petitioner to provided relevant CMS National Coverage Policy.

Information was timely received from each party and entered as petitioner's exhibit "2" and 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. Petitioner's date of birth is [redacted] She is diagnosed with [redacted]

2. Petitioner was Medicaid eligible at all times relevant to this proceeding.

3. Petitioner's Medicaid services are provided through respondent's Statewide Medicaid Managed Care Program; specifically, the Managed Medical Assistance Program.

4. Sunshine Health is the managed care entity which provides petitioner's medical services.

5. A LifeVest is one of two types of cardioverter defibrillators. An implantable cardioverter defibrillator (ICD) is surgically inserted into the recipient's chest. A LifeVest is worn outside the body. Each type provides continuous monitoring of heart rhythms. When necessary, each provides an electrical shock directly to the heart.

6. A LifeVest is, in most instances, provided on a rental basis.

7. The medical coding for a Life Vest is K0606.

8. Due to abdominal pain, on July 18, 2015 petitioner was evaluated in the emergency room at Memorial Hospital of Jacksonville. On that day, petitioner was admitted into the hospital.

9. After admission, testing revealed a diseased gallbladder. On July 22, 2015 a [redacted] was performed.

10. Cardiac testing was also performed. Petitioner was diagnosed with [redacted] The test report stated, in part:

[redacted]

11. No comorbid conditions, such as [redacted]; [redacted]; or [redacted], were noted.

12. On July 25, 2015 petitioner was discharged from the hospital. At discharge she was provided with a LifeVest. Petitioner was to be re-evaluated in 90 days. If her EF remained low, and ICD would be implanted. In such an instance, the Life Vest would be returned.

13. Petitioner received, at an unspecified date, an ICD.

[1] Ejection Fraction. An EF is considered when evaluating the hearts blood pumping efficiency. An EF of less than 35% is considered to be abnormal.

14. On July 30, 2015 Sunshine Health received an authorization request for the Life Vest (K0606).

15. Using InterQual Criteria for a LifeVest, a Sunshine Health physician reviewed submitted information.

16. InterQual Criteria is a nationally recognized standard for medical treatment. The criteria is used by hospitals and insurance companies to determine the appropriate level of medical care.

17. On July 31, 2015 a Notice of Action was issued by Sunshine Health denying the request for a LifeVest. A LifeVest was not demonstrated to be medically necessary.

18. Petitioner's representative thereafter requested an internal appeal. [redacted] wrote, in part:

> According to CMS[2] National Coverage Policy, [redacted] meets criteria #3 for diagnosis [redacted] CMS a nationally recognized resource, does not allow for ICD placement within several months of the diagnosis because of the possibility that the patients LV function may improve enough that the ICD is no longer indicated. However, the patient remains at risk for sudden death during that time period. The Life Vest's role is to provide function as an external ICD during the waiting period. This is the standard of care for most insurance companies and physicians.

19. [redacted] who was not the initial physician reviewer, completed a second analysis of submitted information. [redacted] is board certified in both emergency and internal medicine.

20. On September 4, 2015 a Notice of Action was issued upholding the original denial. The notice stated, in part:

[2] Centers for Medicare & Medicaid Services.

> There is no history of cardiac arrest (sudden loss of heart function) without concomitant myocardial infarction (heart attack), ventricular arrhythmia (irregular heart beat), familial (family history) or congenital (from birth) conditions with high risk of life threatening ventricular tachycardia/arrhythmia, or prior implantable cardioverter defibrillator (automatic internal heart defibrillator) removal without immediate replacement. There is no contraindication (a reason that something should not be done) to the implantation of a cardioverter-defibrillator (automatic internal heart defibrillator), such as a heart attack less than 40 days ago or a coronary (heart) intervention such as a stent or bypass surgery within the past 12 weeks.

21. On November 25, 2015 the Office of Appeal Hearings timely received petitioner's request for a fair hearing.

22. [redacted] has 25 years of experience in the health care industry. A sizeable portion of her career has been in claims and benefits.

23. Post hearing, CMS material was presented. The Coverage Guidance for a wearable (K0606) states the DME is covered for Medicare beneficiaries if they meet one of the four criteria. Criterion # 3 is: "Either documented [redacted] or [redacted] and a [redacted]

24. Respondent asserts the prior authorization process was not followed. A Life Vest should have been requested prior to hospital discharge. Respondent asserts, based on InterQual Guidelines, the LifeVest would have been denied at that time. As opposed to a LifeVest, an ICD should have been implanted during the initial hospitalization period.

CONCLUSIONS OF LAW

25. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the

Office of Appeal Hearings to conduct this hearing pursuant to § 120.80, Fla. Stat.

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

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

28. 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 …

29. 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…"

30. The Findings of Fact establish a LifeVest is consider to be Durable Medical Equipment. As such, respondents Durable Medical Equipment/Medical Supply Services Coverage and Limitations Handbook (DME Handbook) is relevant to this proceeding. The DME Handbook has been promulgated into rule by Fla. Admin. Code R. 59G-4.070.

31. The DME Handbook requires medical supplies provided to a Medicaid recipient be medically necessary.

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

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

33. In this instant appeal, conflicting guidelines for the LifeVest exist.

34. It is noted the CMS Coverage Guidance for a LifeVest focuses on Medicare beneficiaries. It was not established this policy is mandatory for Florida Medicaid recipients. In particular, for those individuals over the age of 21.

35. Petitioner's ejection fraction is noted. Her cardiac status, however, did not warrant stents. Additionally, there is no evidence of a recent heart attack or irregular heartbeat.

36. Compelling evidence was not provided why an ICD should not have been initially implanted.

37. After weighing the testimony and documentary evidence of both parties, the undersigned assigns more weight to respondent's arguments.

38. Petitioner has not established, in a preponderant manner, that respondent's action in this matter was improper. The greater weight of evidence does not establish the following conditions of medical necessity have been satisfied:

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

DECISION

Based upon the foregoing Findings of Fact and Principles 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 01 day of February, 2016, in Tallahassee, Florida.

Frank Houston

Frank Houston
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard

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

FILED
Feb 17, 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-09869

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 January 8, 2016 at 10:00 a.m.

APPEARANCES

For the Petitioner: [redacted] Petitioner's father

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

STATEMENT OF ISSUE

At issue is whether the Respondent's action to partially deny Petitioner's request for Occupational Therapy (OT) service hours for the certification period October 23, 2015 through January 13, 2016, was correct. Respondent bears the burden of proving by a preponderance of the evidence that its decision was correct.

PRELIMINARY STATEMENT

Appearing as a witness for the Petitioner was [redacted], the Petitioner's occupational therapy provider. The Petitioner did not submit any documents as evidence for the hearing.

Appearing as a witness for the Respondent was Rakesh Mittal, M.D., physician-consultant with eQHealth Solutions, Inc. Respondent submitted the following documents as evidence for the hearing, which were marked Respondent Exhibits: Exhibit 1 – Statement of Matters and Clinical Information; Exhibit 2 – Denial Notices; and Exhibit 4 – Occupational Therapy reports.

FINDINGS OF FACT

1. The Petitioner's OT service provider, [redacted] (hereafter referred to as "the provider"), requested the following OT service hours for the certification period at issue: 12 units (3 hours) weekly. Each unit is the equivalent of fifteen (15) minutes.

2. eQHealth Solutions, Inc. is the Quality Improvement organization (QIO) contracted by the Respondent to perform prior authorization reviews for therapy services. The provider submitted the service request through an internet based system. The submission included, in part, information about the petitioner's medical conditions; his functional limitations; and other pertinent information related to the household.

3. eQHealth Solutions' personnel had no direct contact with the Petitioner, his family, or his physicians. All pertinent information was submitted by the provider directly to eQHealth Solutions.

4. The medical information submitted by the provider contained, in part, the following information in regard to the Petitioner:

- 20 years old
- [redacted]

5. The Petitioner also receives speech therapy and physical therapy through the Medicaid Program. He received 12 units (3 hours) weekly of occupational therapy in the prior certification period.

6. A Plan of Care was also submitted by the provider. The document was signed by a physician and outlined the type of assistance to be provided by the OT provider. The long-term goals include the following:

- Therapeutic exercises (ROM, strength, Endurance Stability)
- Therapeutic activity (Work Specific, ADL Specific, Computer skills, Work Readiness skills)
- Parent Education (Home Exercise Program, Home Safety)

7. A physician at eQHealth Solutions, who is board-certified in pediatrics, reviewed the submitted information and partially denied the requested OT services, approving only 4 units (1 hour) weekly rather than the requested 12 units (3 hours) weekly. The rationale for the decision was:

> The patient is a 20 year old with [redacted] who may benefit from continued OT addressing fine motor, visual motor, and ADL skills. The request is excessive based on the severity of the delay, goals submitted and the progress made over many years of therapy. A home exercise program should have been instituted by now. Four units one time per week is sufficient therapy at this developmental age.

A notice of this determination was sent to all parties on October 29, 2015.

8. The above notice stated that a reconsideration review of this determination by eQHealth could be requested, and additional information could be provided with the request for reconsideration. A reconsideration review was requested on November 10, 2015 by the Petitioner's provider.

9. A second physician at eQHealth Solutions reviewed the submitted information and upheld the initial decision to approve 1 hour weekly of OT services. A notice of this reconsideration decision was mailed to all parties on November 13, 2015.

10. The Petitioner thereafter requested a fair hearing and this proceeding followed.

11. The Respondent's witness, Dr. Mittal, testified that the reduction of the Petitioner's occupational therapy service to 1 hour weekly was appropriate because he has been receiving therapy for some time now and has made good progress. He also stated a home therapy program can supplement the therapy sessions with the provider.

12. The Petitioner's father testified that the parents do work with their son, but he needs to interact with different people as well.

13. The Petitioner's therapy provider testified that the Petitioner can perform physical tasks but his auditory processing skills still need work. She also stated he still needs help with social engagement skills, computer skills, and independently performing his ADLs (activities of daily living).

14. 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

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

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

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

18. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the Respondent since the Petitioner had been previously approved for 12 units weekly of speech therapy service and the Respondent is seeking to reduce this service to 4 units weekly. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

19. The Florida Medicaid Program is authorized by Chapter 409, Fla. Stat. and Chapter 59G, Fla. Admin. Code. The Medicaid Program is administered by the respondent.

20. The petitioner has requested 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.

21. The Centers for Medicare and Medicaid Services, State Medicaid Manual makes available to all State Medicaid agencies informational and procedural material needed by the States to administer the Medicaid program. It is the method by which the Health

Care Financing Administration (HCFA) issues mandatory, advisory, and optional Medicaid policies and procedures to the Medicaid State agencies.

22. The State Medicaid Manual in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services section states in part:

> 5010. Overview
> A. Early and Periodic Screening, Diagnostic and Treatment Benefit.-- Early and periodic screening, diagnostic and treatment services (EPSDT) is a required service under the Medicaid program for categorically needy individuals under age 21…
>
> 5110. Basic Requirements
>
> OBRA 89 amended §§1902(a)(43) and 1905(a)(4)(B) and created §1905(r) of the Social Security Act (the Act) which set forth the basic requirements for the program. Under the EPSDT benefit, you[1] must provide for screening, vision, hearing and dental services at intervals which meet reasonable standards of medical and dental practice established after consultation with recognized medical and dental organizations involved in child health care. You must also provide for medically necessary screening, vision, hearing and dental services regardless of whether such services coincide with your established periodicity schedules for these services. Additionally, the Act requires that any service which you are permitted to cover under Medicaid that is necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be provided to EPSDT participants regardless of whether the service or item is otherwise included in your Medicaid plan.

23. The service the petitioner has requested (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 …

[1] "You" in this manual context refers to the state Medicaid agency.

24. The issue to be decided is the medical necessity of the service or amount of service. The State Medicaid Manual provides for limitations on services as follows:

> 5110. Basic Requirements…
> …Services under EPSDT must be sufficient in amount, duration, or scope to reasonably achieve their purpose. The amount, duration, or scope of EPSDT services to recipients may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. Appropriate limits may be placed on EPSDT services based on medical necessity.
>
> 5122. EPSDT Service Requirements
> F. Limitation of Services.--The services available in subsection E are not limited to those included in your State plan.
> Under subsection E, the services must be "necessary . . . to correct or ameliorate defects and physical or mental illnesses or conditions . . ." and the defects, illnesses and conditions must have been discovered or shown to have increased in severity by the screening services. You make the determination as to whether the service is necessary. You are not required to provide any items or services which you determine are not safe and effective or which are considered experimental.
>
> 5124. Diagnosis and Treatment
> B. Treatment.--
> 1. General. - You must make available health care, treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services. Treatment services may be limited as described in §5122 F.

25. Once a service has been identified as requested under EPSDT, the Medicaid program determines the amount or necessity for that service based on the State of Florida's published definition of medical necessity. The Fla. Admin. Code R. 59G-1.010 defines medical necessity:

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

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

26. Based upon the information submitted by the Petitioner's provider, eQHealth Solutions completed a prior authorization review to determine medical necessity for the requested OT services.

27. In the Petitioner's case, the Respondent has determined that 4 units (1 hour) weekly of OT service is medically necessary, rather than the 12 units (3 hours) weekly requested by the Petitioner. The Petitioner was previously approved for 12 units of occupational therapy weekly.

28. Fla. Stat. § 409.913 governs the oversight of the integrity of the Florida Medicaid Program. Section (1)(d) sets forth the "medical necessity or medically necessary" standards, and states in pertinent part as follows:

> "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice….
>
> Section (1)(d) goes on to further state:

> …For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

29. Section (1)(d) highlights that the Agency makes the final decision regarding whether or not a requested service is medically necessary. As stated above, this proceeding is a de novo proceeding for the purpose of the Agency reaching its final decision. The final decision making authority for this proceeding has been delegated to the hearing officer in Fla. Admin. Code R. 65-2.066.

30. 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 .

31. 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.

32. 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.

33. The respondent's witness, Dr. Mittal, stated he believed Petitioner's therapy should be reduced since he has been making progress on his therapy goals and a home therapy program can be used to supplement the therapy sessions.

34. The Petitioner's occupational therapist stated the Petitioner still needs help in some areas although he can perform physical tasks.

35. After considering all the documentary evidence and witness testimony presented, the undersigned concludes the Respondent has not met its burden of proof in demonstrating it was correct in reducing the requested occupational therapy services for the certification period at issue. The Petitioner's therapist provided testimony that supports continuing the therapy at the prior level. Although the Petitioner has demonstrated good progress in his therapy and met many of his short-term goals, the therapy reports also indicate he still needs moderate assistance with ADL skills such as bathing and grooming. He also needs to improve his social interaction skills. The Plan of Care already includes parent education and home therapy, so the parents should continue supplementing the therapy sessions.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is GRANTED, and the Petitioner shall continue receiving 12 units of occupational therapy services weekly for the current certification period.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 17 day of February, 2016,

in Tallahassee, Florida.

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

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

FILED
Feb 10, 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-09886

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 20 Collier
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on January 8, 2016 at 11:30 a.m.

APPEARANCES

For the Petitioner: [redacted] Petitioner

For the Respondent: Susan Chillari, 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 a MRI scan was correct. The Petitioner bears the burden of proving his case by a preponderance of the evidence.

PRELIMINARY STATEMENT

Appearing as witnesses for the Respondent were Natalie Fernandez, Government Contracts Specialist, Alice Quiroz, A.V.P. of Government Contracts, Elvira Leyva, Health Care Services Manager, and Dr. Theresa Blanco, Medical Director, from Molina Healthcare, which is the Petitioner's managed health care plan.

The Petitioner submitted medical records as evidence for the hearing, which were marked as Petitioner Exhibit 1.

Respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Exhibits: Exhibit 1 – Authorization Request and Medical Records; Exhibit 2 – Denial Notice; and Exhibit 3 – Review Criteria.

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. He receives services under the plan from Molina Healthcare. He began his coverage with Molina on November 1, 2015.

2. On or about December 28, 2015, the Petitioner's treating physician (hereafter referred to as "the provider"), requested prior authorization from Molina to perform a MRI scan of the right knee. Molina denied this request on December 29, 2015 as not being medically necessary.

3. Molina sent Petitioner a Denial Notice dated January 4, 2016, which contained the following reason for the denial:

> The asked for MRI scan of your knee is not approved. Using standard and accepted rules a Molina Healthcare doctor has looked at this request and determined that, based on the medical records which were given to us, this test is not medically necessary. We see from the records your doctor sent us that you have knee pain. You have not had an injury to your knee. You do not have weakness or numbness anywhere on your body. You do not have signs of broken bones or infection in your knee. You have not completed 4 to 6 weeks of physical therapy and taking full-strength anti-inflammatory medicine which is needed before we can approve this MRI scan. Please talk to your doctor about your treatment options. If you still have the problem after you complete the treatment your doctor can send us a new request for the MRI scan.

4. The Petitioner suffers from pain in his knee due to a car accident he experienced in October, 2013. He had a prior hip replacement due to the car accident as well. He had an x-ray performed on his knee which did not reveal the cause of the pain.

5. The Petitioner also stated his prior health coverage was with a company called Integral Quality Care, which was acquired by Molina and he became covered by Molina on November 1, 2015. He believes that Integral had pre-authorized the MRI scan in October, 2015. However, neither party has any written copy of this pre-authorization determination.

6. The Respondent's expert witness, Dr. Blanco, testified that the denial of the Petitioner's request for the MRI scan was appropriate because medical necessity guidelines require a failure of attempted physical therapy treatments prior to approval of a MRI scan. Dr. Blanco also stated the information submitted by the Petitioner's provider did not document an attempt and failure of physical therapy. In addition, Dr. Blanco stated there was no record of any prior approval of the MRI by Integral Quality Care.

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, 7th Ed.).

12. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the Respondent. The Medicaid Handbook 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 Petitioner testified he is suffering from knee pain, he must also satisfy each of the remaining components of the rule's requirements concerning medical necessity. Respondent's medical expert testified that medical necessity guidelines require a failure of attempted physical therapy treatments prior to approval of a MRI scan and this was not established in the Petitioner's pre-authorization request. Although Petitioner's physician's reports indicate that out-patient physical therapy was prescribed, the outcome of that therapy has not yet been documented in the records.

16. Although the Petitioner's treating physician has requested the MRI scan, this does not in itself establish that this service is medically necessary according to the rule provisions outlined above.

17. Petitioner has not established by a preponderance of the evidence that his requested MRI scan is medically necessary as defined by Fla. Admin. Code R. 59G-1.010(166). After considering the evidence and relevant authorities set forth above, the undersigned concludes that the Petitioner has not met his 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 __10__ day of __February__, 2016,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
Dietra Cole, Area 8, AHCA Field Office Ma

FILED
Feb 18, 2016
Office of Appeal Hearings
Dept. of Children and Families

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

[redacted]

PETITIONER,

APPEAL NO. 15F-09958

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 04 Duval
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 5, 2016 at 3:07 p.m.

APPEARANCES

For the Petitioner: pro se

For the Respondent: Sheila Broderick, registered nurse specialist

STATEMENT OF ISSUE

Whether it is medically necessary for the petitioner to receive epidural steroid injections in her neck, upper-back and mid-back. The burden of proof was assigned to the petitioner.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (Agency or AHCA or respondent) administers the Florida Medicaid Program. Medicaid rules require that most recipients receive their Medicaid services through the Managed Care Plan. The Agency contracts with numerous health care organizations to provide medical services to its program participants. Molina Healthcare of Florida (Molina) is the contracted health care organization in the instant case.

By notice dated November 19, 2015, Molina informed the petitioner that her request for epidural steroid injections (ESI) in the neck, upper-back, and mid-back through Medicaid was denied. The notice reads in pertinent part:

> We have determined that your requested services are not medically necessary because the services…must meet accepted medical standards and not be experimental or investigational.
> …
> The asked for injections into your spine are not approved. Using standard and accepted rules a Molina Healthcare doctor has looked at this request and determined that, based on the medical records which were given to us, this procedure is not medically necessary. We see from the records your doctor sent us that you have neck and shoulder pain. Pain medicine is not helping. Your pain is in a portion of your spine for which this spine injection has not been proven to be effective. According to Molina policy, we do not cover procedures which have not been proven to be effective.

The petitioner timely requested a hearing to challenge the denial decision on December 1, 2015.

There were no additional witnesses for the petitioner. The petitioner did not submit exhibits.

The respondent presented several witnesses from Molina: Carlos Galvez, contract specialist; Rebecca Quintana, director of government contracts; Dr. Marc Bloom, chief medical officer; Elvis Leiva, manager of healthcare services; and Valeria Maguire, medical director. 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 Molina HMO.

2. The petitioner suffers from [redacted] which causes severe neck and back pain.

3. For several years, prior to enrollment with Molina, the petitioner received quarterly ESI and facet joint injections (numbing injections) in her neck and throughout her spine to manage the pain. The petitioner was enrolled with First Coast Advantage HMO during this period.

4. First Coast Advantage does not participate in Medicaid's new Managed Care Plan, implemented in late 2014. The petitioner was required to convert to a participating HMO. She was enrolled with Molina effective January 1, 2015.

5. All Medicaid goods and services must be medically necessary as determined through a prior service authorization process. HMOs may provide goods and services in excess of what is covered by Medicaid, but are not required to do so. During the

early 2015 HMO conversion period, Molina continued to approve the petitioner's ESI treatments without conducting a prior service authorization review, as part of its conversion agreement with AHCA.

6. Molina conducted its first ESI medical necessity review in May 2015. Molina concluded that there was insufficient evidence to prove that steroid injections in the neck/upper-back/mid-back regions were effective in treating chronic back pain. Medicaid precludes provision of services which are investigational or experimental in nature. Molina terminated the petitioner's ESI treatments in May 2015.

7. The petitioner continued to receive facet (numbing) injections throughout her spine after the ESI treatments were terminated.

8. On November 13, 2015, the petitioner's treating physician submitted a request to Molina to resume ESI treatments. The physician used procedure code 62310 – injections in the cervical (neck) and thoracic (upper and mid) regions of the spine.

9. Molina denied the request on November 19, 2015. Molina again concluded that the ESI treatments were not medically necessary because there was insufficient evidence to prove that steroid injections in the neck/upper-back/mid-back regions are effective in treating chronic back pain.

10. The petitioner argued that her treating physician used the wrong procedure code. She did not request steroid injections in the cervical (neck) region. She would like injections in the upper-back and mid-back only. The petitioner argued that the steroid injections she received in the past were more effective than any other treatment.

She argued without the steroid injections her back feels “like it is splitting into a thousand pieces” when she “stands at the sink for more than five minutes.”

11. Dr. Marc Bloom, Molina chief medical officer, testified that the combination of numbing injections and ESI treatments the petitioner received for several years make it clinically impossible to determine which treatment was effective. The doctor explained that ESI treatments are the industry standard of care for lower back pain only. There are no published reports or clinical trials which prove that ESI treatments are effective in any other region of the spine. Steroid injections in the neck/upper-back/mid-back are considered experimental. Medicaid does not reimburse for experimental services.

12. Dr. Bloom opined that other forms of pain management, such was oral medications and numbing injections, are the industry standard of care for pain management in the neck/upper-back/mid-back regions.

CONCLUSIONS OF LAW

13. By agreement between the AHCA and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to § 120.80, Fla. Stat.

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

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

16. In accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof was assigned to the petitioner.

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

18. The Florida Medicaid Program is authorized by Fla. Stat. Chapter 409 and Fla. Admin. Code Chapter 59G.

19. Fla. Admin. Code R. 59G-1.010(166) explains that medical or allied care, goods, or services furnished or ordered must meet the definition of medically necessary or medical necessity, and defines medical necessity as:

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

20. The cited authority explains that Medicaid goods and services must meet generally accepted professional medical standards and cannot be experimental or investigational in nature.

21. The respondent denied the petitioner's request for steroid injections to treat neck/upper-back/mid-back pain caused by [redacted] The respondent concluded that there was no evidence that ESI treatments are effective in the neck/upper-back/mid-back regions and therefore is considered experimental. Medicaid does not cover experimental procedures.

22. The petitioner argued that she should receive ESI because it is the pain management treatment that has provided her with the greatest relief. The petitioner's verbal testimony was the sole evidence offered regarding the effectiveness of ESI treatments.

23. Dr. Bloom, the only expert witness to testify during the hearing, opined that the requested ESI treatments are not medically necessary because there is no clinical evidence that steroid injections are effective in the neck and upper/mid back. Dr. Bloom opined that ESI treatments have proven to be effective only in the lower region of the spine.

24. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the petitioner did not meet her burden in this matter. The petitioner did not prove by a preponderance of the evidence that is medically necessary that she receive ESI treatments in the neck, upper-back, and mid-back regions.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the 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 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 February, 2016,

in Tallahassee, Florida.

Leslie Green

Leslie Green
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: [redacted], Petitioner
Debbie Stokes, Area 4, AHCA Field Office Manager

FILED
Jan 12, 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-10031
15F-10032

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 01 Walton
UNIT: 88630

RESPONDENT.
_____/

FINAL ORDER OF DISMISSAL

Pursuant to notice, a telephonic administrative hearing in the above referenced matter was convened on January 6, 2016 at 9:43 a.m.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Theresa Nadeau, Economic Self Sufficiency Specialist II

PRELIMINARY STATEMENT

A pre-hearing conference was held with the Department representative and the petitioner. Upon completion of the conference, the hearing convened.

Susan Dixon, hearing officer, observed the proceeding.

ISSUES

Whether the Respondent's denial of Petitioner's applications for Medicaid and Food Assistance was proper.

FINDINGS OF FACT

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

1. On January 29, 2015 a Notice of Case Action was mailed to Petitioner explaining that Medicaid coverage would end effective February 28, 2015 because Medicaid eligibility had been approved in error.
2. On April 24, 2015 a Notice of Case Action (NOCA) was mailed to Petitioner informing her that the Division of Disability Determination (DDD) did not find her to meet disability requirements; therefore, Medicaid eligibility was denied.
3. No subsequent Medicaid related NOCA's exist.
4. Medicaid was subsequently reapplied for on December 28, 2015 which is still in a pending status and for which there is no NOCA to date.
5. On June 15, 2015 a Notice of Expiration of Certification Period (NECP) was mailed to Petitioner. Petitioner was thereby notified that her eligibility to receive benefits from the Food Assistance Program (FAP) would end effective July 31, 2015.
6. July 2015 was the last month that the Petitioner was eligible for and received FAP benefits to date.

7. The Petitioner agrees that her hearing requests on both issues were made in December 2015.

8. The request date of record for these appeal hearings is December 2, 2015.

CONCLUSIONS OF LAW

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

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

11. Regarding hearing rights Fla. Admin. Code § 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:
> (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.

12. The Findings of Fact show petitioner failed to timely request a hearing in both the Food Assistance and Medicaid issues.

13. Petitioner has reapplied for assistance. Once the Department issues written notices, if petitioner is not satisfied with that action, she may request a hearing within 90 days from the date of the written notice.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, petitioner's appeal, due to the lack of jurisdiction, 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 12 day of January, 2016, in Tallahassee, Florida.

Gregory Watson

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
Feb 05, 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-10036

PETITIONER,

Vs.

CASE [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 Citrus
UNIT: 88005

RESPONDENT.

_____/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 1:05 p.m. on December 28, 2015.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Cindy Sarver, ACCESS Supervisor

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny the petitioner full Medicaid and instead enroll her in the Medically Needy (MN) Program with a Share of Cost (SOC) is proper. The respondent carries the burden of proof by the preponderance of evidence; not the petitioner as stated at the hearing.

PRELIMINARY STATEMENT

By notice dated December 9, 2015, the respondent (or the Department) notified the petitioner she was ineligible for full Medicaid and she was enrolled in MN with a

$501 SOC, effective December 2015. Petitioner timely requested a hearing to challenge enrollment in MN.

Petitioner did not submit exhibits. Respondent submitted four exhibits, entered as Respondent Exhibits "1" through "4". The record was closed on December 28, 2015.

FINDINGS OF FACT

1. Prior to the action under appeal, petitioner received Medicaid Extended Income (MEI). MEI is for applicants that were receiving full Medicaid and then due to receiving employment income they are no longer eligible for full Medicaid. MEI coverage is for 12 months maximum. Petitioner received MEI from December 2014 through November 2015.

2. On December 1, 2015, petitioner submitted an application to add Medicaid. Petitioner's household includes petitioner and four minor children. Medicaid for petitioner is the only issue.

3. Petitioner is employed at [redacted] (paid weekly) and the children receive child support income.

4. The Department determined petitioner's employment income using the following four paystubs provided by the petitioner.

PAY DATE	GROSS AMOUNT
11/13/15	$ 318.06
11/20/15	$ 369.59
11/27/15	$ 242.19
12/04/15	$ 255.96
	$1,185.80

5. For petitioner to be eligible for full Medicaid, her income cannot exceed $426; the Medicaid income limit for a household size of five. Petitioner's $1,185.80 exceeds $426. The next available program is MN with a SOC.

6. The Department calculated petitioner's SOC using only petitioner's income:

$1,185.80	petitioner's income
-$ 684.00	MN Income Level (MNIL) for a household size of five
$ 501.00	SOC (cents dropped)

7. On December 9, 2015, the Department mailed petitioner a Notice of Case Action, notifying her December 1, 2015 application was approved and she was enrolled in MN with a $501 SOC.

8. Petitioner stated that she cannot afford to be in MN with a $501 SOC and she needs full 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 Fla. Stat. § 409.285. This order is the final administrative decision of the Department of Children and Families under Fla. Stat. § 409.285.

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

11. Fla. Stat. § 445.029 Transitional medical benefits in part states:

> (1) A family that loses its temporary cash assistance due to earnings shall remain eligible for Medicaid without reapplication during the immediately succeeding 12-month period if private medical insurance is unavailable from the employer or is unaffordable…

12. Additionally, the Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 2030.0203, Transitional Coverage (MFAM), in part states:

> Transitional coverage provides extended coverage for up to 12 months, beginning with the month of ineligibility. Changes during this period, other than the child turning 18 or loss of state residence, do not affect the transitional Medicaid period. An ex parte determination must be completed prior to cancellation at the end of the transitional period.
> 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. The initial income budgeted for the assistance group must have been below the parent/other caretaker relative income limit (MA R- previously referred to as 1931 Medicaid). If more than one budget change is being acted on at the same time, a test budget(s) will be necessary to determine if the change in earned income is the sole cause of ineligibility.
> 2. At least one assistance group in the household was eligible for and received Medicaid with income below the parent/other caretaker relative income limit (MA R- previously referred to as 1931 Medicaid) in at least three of the preceding six months. The three months can include a month in which Medicaid was received in another state, or a retroactive month.
> All assistance groups (except individuals previously requesting not to receive Medicaid and children ages 18 to 21) in which the parent or other caretaker relative with new or increased earned income is a counted or eligible member are eligible for transitional coverage, provided all requirements are met.

13. In accordance with the above authority and Policy Manual, petitioner received 12 months MEI from December 2014 through November 2015. The next available program is the MN.

14. Federal Regulations at 42 C.F.R. § 435.603 "Application of modified adjusted gross income (MAGI)" states:

> (a) Basis, scope, and implementation. (1) This section implements section 1902(e)(14) of the Act.
> (2) Effective January 1, 2014, the agency must apply the financial methodologies set forth in this section in determining the financial eligibility of all individuals for Medicaid, except for individuals identified in paragraph (j) of this section and as provided in paragraph (a)(3) of this section.

> (b) Definitions. For purposes of this section—
> *Child* means a natural or biological, adopted or step child.
> *Code* means the Internal Revenue Code.
> *Family size* means the number of persons counted as members of an individual's household.…
> *Parent* means a natural or biological, adopted or step parent.
> *Sibling* means natural or biological, adopted, half, or step sibling.…
> (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…

15. In accordance with the above authority, the Department counted petitioner and her four minor children in petitioner's Medicaid eligibility.

16. 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… Total gross income includes earned and non-earned income from all sources…

17. In accordance with the above authorities, the Department included petitioner's $1,185 earned income in determining her Medicaid eligibility.

18. Fla. Admin. Code R. 65A-1.716 Income and Resource Criteria explains in part:

> (2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows:

Family Size	Income Level
5	$426

19. In accordance with the above authority, the petitioner is not eligible for full Medicaid due to her $1,185 income exceeding $426; the income limit for a household size of five.

20. Fla. Admin. Code R. 65A-1.707 Family-Related Medicaid 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…

21. The above authority explains the SOC is determined by subtracting the household income level (MNIL) from the gross income.

22. Policy Manual, Appendix A-7, sets forth the MNIL at $684 for a household size of five.

23. In accordance with the above authority (#20), the Department subtracted $684 (MNIL) from petitioner's $1,185 gross income, to arrive at $501 SOC.

24. In careful review of the cited authorities and evidence, the undersigned concludes that the respondent is correct in approving petitioner in the MN program with a $501 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 __05__ day of __February_____, 2016,

in Tallahassee, Florida.

Priscilla Peterson
_____

Priscilla Peterson
Hearing Officer
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Tallahassee, FL 32399-0700
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Office of Economic Self Sufficiency

FILED
Feb 04, 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. 15F-10056

CASE NO. [redacted]

FLORIDA DEPT OF
CHILDREN AND FAMILIES
CIRCUIT: 04 Duval
UNIT: 88264

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 19, 2015 at 2:50 p.m.

APPEARANCES

For the Petitioner: The petitioner was present and represented himself.

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

ISSUE

The petitioner is appealing the Department's action on September 16, 2015 to continue his enrollment in the Medically Needy (MN) program with an estimated monthly share of cost (SOC) of $1243.

The petitioner held the burden of proof in this case.

PRELIMINARY STATEMENT

Appearing as an observer was Pamela Vance, hearing officer for Office of Appeal Hearings.

The record was held open until 5:00 p.m. on December 1, 2015 to allow the respondent and the petitioner to submit additional evidence. Evidence was received and entered as the Respondent Exhibits 3-4 and the Petitioner Exhibits 2-3.

FINDINGS OF FACT

1. On August 26, 2015, the petitioner completed an application to recertify for Medicaid for himself. The petitioner receives $1180 in Social Security income and $373.27 in pension benefits. The petitioner pays alimony to a former spouse in the amount of $500 each month. On September 16, 2015, the Department notified the petitioner that he was enrolled in the MN program with an estimated monthly SOC in the amount of $1243.

2. The Department calculated the MN budget by including the petitioner's gross monthly Social Security income in the amount of $1180 and his pension income in the amount of $373.27, for a total gross income of $1553.27. The total gross income was subtracted by the unearned income disregard in the amount of $20 to result in $1533.27 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 $1353.27. The Department also subtracted the Medicare premium in the amount of $109.90 for a remaining SOC in the amount of $1243.

3. The petitioner does not dispute the income included in the Department's calculations. The petitioner argues that he pays $500 each month in alimony payments. The petitioner believes that since the alimony is included as income in calculating benefit levels, it should be included as a deduction to reduce his income so that he can be eligible for full-coverage Medicaid. The petitioner argues that he also pays $275 each month to an assistant who assists him with: "personal laundry, meal preparation, food shopping, cleaning, driving to doctors' appointments", as he is visually-impaired (Petitioner Exhibit 4).

4. The petitioner argues that he is unable to receive the "extra help" with his prescriptions, which he needs to be able to obtain the insulin necessary to treat his diabetes.

5. The Department explained that alimony payments are included as income but cannot be used as a deduction to reduce income according to its policy. The Department explained that the expense paid to provide personal care services cannot be allowed as a deduction for the MN program; only for its waiver programs. The Department explained that in order for the petitioner to be eligible for Medicaid, he would have to meet the income limit in the amount of $864 for an individual.

6. The petitioner does not receive any waiver services at this time. The petitioner was denied for the QI1 program due to exceeding the income limit; this denial is not under appeal.

CONCLUSIONS OF LAW

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

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

9. Federal Regulations at 20 C.F.R. § 416.1123, "How we count unearned income", states in part:

> (b) Amount considered as income. We may include more or less of your unearned income than you actually receive…(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 obligaton, [*sic*]…

10. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 1840.0705 Alimony (MSSI, SFP) states in part:

> Alimony is court ordered payment by a spouse or former spouse to an individual. An individual's countable income cannot be reduced because the court has ordered part of that income to be paid to a spouse. Court ordered support received by the spouse is unearned income. This applies even if the individual is institutionalized.

11. The above authorities instruct that even income which is withheld from unearned income to pay a legal obligation, including alimony payments, is counted as income. In petitioner's case, alimony payments are being deducted from his Social Security income. Therefore, the undersigned concludes that the Department was

correct to not reduce the petitioner's gross income due to alimony being deducted from his Social Security income.

12. The Policy Manual, passage 2440.0300 INCOME DISREGARDS (MSSI, SFP) introduces the types of income disregards as earned income disregard, standard disregard, student earned income, work expenses of the blind, ordinary and necessary expenses, optional deduction, and unearned income overpayment.

13. The Policy Manual, passage 2440.0322 Standard Disregard (MSSI) states in relevant part:

> This policy applies to MEDS-AD, MN, QMB, SLMB, QI-1, Working Disabled, Protected Medicaid and EMA. A $20 per month standard disregard applies to any type (earned or unearned) of income other than income which is provided on the basis of need.

14. The Policy Manual, passage 2440.0370 Ordinary and Necessary Expenses (MSSI, SFP) explains in part:

> Ordinary and necessary expenses which are deducted from the amount of unearned gross income are excluded. These are expenses incurred in obtaining income as the fees and costs necessary to establish entitlement or gain access to income. For example, attorney fees and medical examination fees connected with the filing of a lawsuit after an accident may be deducted from the settlement amount received.

15. The Policy Manual, passage 2440.0371 Optional Deductions (MSSI, SFP) states in relevant part:

> There are deductions, which are withheld at the source from an individual's income that must be included in the amount of unearned income counted. Examples of optional deductions include:
> 1. premium for Part B Medicare from a Social Security benefit…

16. The findings show that the petitioner pays a friend $275 each month to assist him with his cooking and cleaning. The above authorities allow as a deduction to income an earned income disregard, a $20 standard disregard, exclusion of student earned income, work expenses for the blind, ordinary and necessary expenses disregard, and overpayments. However, the authorities do not reference an expense related to assistance with daily living activities to be allowed as a deduction to income. Therefore, the undersigned concludes that the Department is correct to not include the expenses paid to assist the petitioner in cooking and cleaning services.

17. Fla. Admin. Code § 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.

18. The Policy Manual, Appendix A-9, effective July 2015, lists the MEDS-AD income limit as $864 for an individual.

19. The above controlling authorities 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 MEDS-AD income limit for an individual is $864. The findings show that the petitioner is receiving Medicare but is not receiving ICP, hospice, or community based services. Therefore,

the undersigned concludes that petitioner does not qualify for full coverage Medicaid.

20. The Fla. Admin. Code § 65A-1.716 sets forth the Medically Needy income levels and states :

> (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…

21. In this case, the petitioner's Social Security and pension incomes exceed the MEDS-AD income guidelines. As a result, the Department enrolled him in the MN program and assigned a SOC based on his gross income of $1553.27. After the deductions of the MNIL for one of $180, the $20 general exclusion, and the $109.90 Medicare premium, the remaining SOC was $1243.

22. A review of the rules did not find any exceptions to the income limits. The undersigned concludes the Department correctly followed its policy in counting the petitioner's gross income prior to any alimony payment deductions. The undersigned concludes that the respondent's action to enroll him in the Medically Needy Program with an estimated monthly share of cost in the amount of $1243, was a correct action.

23. The petitioner raised an issue during the hearing related to not being eligible for extra help, or Low Income Subsidy (LIS) program, to assist him in obtaining his prescriptions. The undersigned does not have jurisdiction over the LIS eligibility. However, Medicaid eligibility does affect eligibility for the LIS program.

24. The Department published Transmittal No. P-05-07-0019 on July 12, 2005 which explains the Medicare Part D Low Income Subsidy Program and states in part:

> The Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 created a prescription drug benefit called Part D that will be available starting January 1, 2006. Enrollment in Part D is voluntary and is available to all Medicare beneficiaries. The MMA also created a Low Income Subsidy (LIS) Program to help individuals with limited income and assets cover a portion of the costs associated with the new Medicare Part D benefit.
> The Social Security Administration (SSA) has primary responsibility for the LIS eligibility determination; however, states are required to assist applicants applying for the LIS Program both by accepting the LIS application and forwarding it to SSA for an eligibility determination, or when specifically requested, determining eligibility for the LIS Program. States are also responsible for screening LIS applicants for Medicare Savings Programs/buy-in (QMB, SLMB, QI1). Economic Self Sufficiency (ESS) staff must be prepared to handle both state and federal applications for the LIS using the guidelines provided in this memorandum…
> IMPACT ON OTHER BENEFITS
> The Medicare Part D benefit and LIS Program may affect other programs as listed below:
> • Food Stamps and Medically Needy: Portions of medical expenses covered by Medicare Part D or the LIS Program are not counted as expenses in a food stamp budget or when tracking bills for Medically Needy. Premiums, co-pays and deductibles paid by the client will be allowable medical expenses as allowed for in current policy.

25. The Department published Transmittal No. P-05-03-0006, March 22, 2005 which states in part:

> Medicare beneficiaries who qualify for full Medicaid or who are otherwise eligible for the buy-in programs (QMB, SLMB, and QI1) will be entitled to a Low Income Subsidy (LIS) to cover payment of the Part D premium and will only have to pay a small co-payment, similar to their current coverage under Medicaid. LIS benefits are also available to those with incomes up to 150% FPL and assets up to $10,000…Benefits available to this group through the LIS will vary depending on the individual's income an asset level.

26. Also addressing the LIS eligibility is a Departmental Question and Answer #199 which states, “Medicare recipients enrolled in the Medically Needy Program who meet their share of cost are Medicaid eligible and will automatically qualify for Extra Help With Medicare Prescription Drug Plan Costs (previously known as the Low Income Subsidy (LIS)).”

27. According to the above authorities, QI1 eligibility or other Medicaid eligibility would automatically give LIS eligibility. Medicare recipients enrolled in the MN program and who meet their share of cost are Medicaid eligible and will automatically be eligible for the LIS program. In the petitioner’s case, the findings show that he receives Medicare but is ineligible for the QI1 program; he is enrolled in the MN program. To assist the petitioner in his eligibility for the LIS program during the months he has met his monthly SOC, the Department may wish to furnish petitioner with a printout from the Medicaid file showing a history of his Medicaid eligibility dates as this affects his LIS eligibility.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is denied. The LIS issue is 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 04 day of February, 2016,

in Tallahassee, Florida.

Paula Ali

Paula Ali
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
Feb 17, 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-10387

PETITIONER,

VS.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 13 HILLSBOROUGH
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, a hearing in the above-styled matter convened on January 27, 2016 at 1:05 p.m. All parties appeared telephonically from separate locations.

APPEARANCES

For Petitioner: [redacted]

For Respondent: Stephanie Lang, RN Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

Whether Respondent properly denied Petitioner's request for a curved or swivel stair lift (single seat/railing). Petitioner held the burden of proof on this issue by a preponderance of the evidence.

PRELIMINARY STATEMENT

Petitioner represented himself and did not provide any documentary evidence or witnesses. Respondent's witness was Dr. Sloan Karver, Long Term Care Medical Director with United Health Care.

Respondent's Exhibits 1 through 10 were marked and entered into evidence. Petitioner did not submit any documentary evidence. The undersigned took administrative notice of 409.910, 409.962 through 409.965, 409.973, 409.98, 59G-1.001, 59G-1.010, 59G-4.070, and 42 C.F.R. 441.745(a)(ii)(A).

FINDINGS OF FACT

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

1. Petitioner is an elderly adult male with an unsteady gait and a history remarkable for [redacted] He does not use a walker, cane, or other adaptive device at this time. He receives services through United Health Care's Long Term Care plan.

2. In 2014, United Health Care agreed to pay for and install a stair lift in Petitioner's home to provide Petitioner access to the upstairs portion of his home. Petitioner's home has a stairway with a landing, which requires a change in direction. Petitioner has been unsatisfied with the two-part system that was installed. He believes this was done as a cost-saving measure. United's witness testified that she was not there for the installation and does not know why a two-part system was installed over other options.

3. The current stair lift is operated as follows: First, Petitioner sits and straps himself into a seat. Next, the stair lift raises him up the first four steps of the stair case. Then Petitioner must get out of the first seat and transfer into a second seat to go the rest of the way.

4. Petitioner complains that transferring into a second seat is very inconvenient and he often drops whatever he is carrying while trying to get into the seat. Petitioner testified that he frequently slips on the steps as he is trying to transfer, and he has fallen before but it hasn't required an emergency room visit.

5. Petitioner complained to United in the past that the stair lift shakes and he feels unsafe using it. United sent two providers to inspect the stair lift for safety and installation, and determined it was operating properly.

6. Petitioner requested a single railing stair lift on or about August 23, 2015. United denied the request by notice dated August 24, 2015. The stair lift was denied because "You have a stair lift. The lift has been inspected. The lift is working…. The request is for your convenience. Items for your convenience can not be approved."

7. Petitioner appealed the denial through the plan and it was upheld by notice dated October 12, 2015. The letter stated that the stair lift cannot be approved because a new one is "in excess of your needs and not medically necessary. You already have a stair lift. It is working correctly." Petitioner verbally requested a Medicaid Fair Hearing on December 18, 2015.

8. United requested records from Petitioner's physician to verify medical need. United's decision was based solely on the fact that Petitioner already has a stair lift and not on whether it was the appropriate stair lift for his needs.

9. Petitioner testified that because of the inconvenience and safety concerns, he sometimes uses the staircase rather than the stair lift. It is difficult for him to do so, and as he ages it becomes more difficult. The plan offered to place Petitioner and his wife into an assisted living facility if he is unable to navigate his home with the adaptive device provided. Petitioner has lived in his home for over twenty years and is on the long term care plan because he intends to stay in his home.

CONCLUSIONS OF LAW

10. 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.

11. 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.

12. The DME and Medical Supply Services Coverage and Limitations Handbook ("DME Handbook") has been incorporated, by reference, into Florida Administrative Code Rule 59G-4.070(2).

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, in accordance with Florida Administrative Code Rule 65-2.056.

15. 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).

16. Section 409.905 of the Florida Statutes addresses mandatory Medicaid services under the State Medicaid Plan:

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

17. Section 409.98, Florida Statutes (2015) lists the minimum required coverage that long term care plans must provide recipients. "Medical equipment and supplies" and "home accessibility adaptation" are on this list.

18. With regard to the need for DME, Section 409.906(10), Florida Statutes, states in relevant part, "[t]he agency may authorize and pay for certain durable medical equipment and supplies provided to a Medicaid recipient as medically necessary."

19. Similarly, the Handbook defines the guidelines for DME on page 1-2, as follows:

> Durable medical equipment (DME) is defined as medically-necessary equipment that can withstand repeated use, serves a medical purpose, and is appropriate for use in the recipient's home as determined by the Agency for Health Care Administration (AHCA).

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

> 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

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

21. In order for any service to be paid for by Medicaid, it must meet the above definition. Whether it meets the definition is determined by medical records and clinical documentation. Even if a doctor provided a prescription, that does not automatically make the item medically necessary or covered per the above rules.

22. Petitioner gave multiple reasons for wanting the new stair lift. First, he explained that he has difficulty carrying things. Although transferring to another chair while carrying items may be inconvenient, a new stair lift cannot be approved based solely on inconvenience based on the above rules. Petitioner's second reason was that he is worried about the safety of the lift, but the plan has inspected it and verified it is safe to use. The new stair lift cannot be approved based on unsupported concern.

23. Lastly, Petitioner testified that he often slips and has fallen on the landing when he gets out of one chair and transfers into another. This is the only reason which a new stair lift may be approved, but United did not review this complaint from Petitioner. The case manager noted during multiple visits that the Petitioner reported falls but no hospital visits. Petitioner's doctor's notes also support that he had at least one fall.

However, these records are hearsay without exception and cannot be relied upon to make a finding of fact in this hearing.

24. The plan clearly did not review all of the information when it reviewed Petitioner's request. The witness did not know why the prior lift was chosen over another, nor was she aware that the lift was inspected multiple times although it was in the provided case notes. The plan did not determine whether or not the current installation presents a safety concern due to Petitioner's unsteady gait and falls, or whether the type of stair lift requested is even an available option to Petitioner. The plan reviewed the request and denied simply because he has a device which accomplishes the same ends, without concern of whether that is the most appropriate for this recipient.

25. The plan also suggested that financial constraints may have played a role in the decision. The case manager's notes also detail that it would cost the plan just to have an estimate completed to determine whether Petitioner's request is possible due to construction reasons. It is clear that no estimate was done. Although medical necessity requires the approved service to be the least costly, equally effective alternative to meet the recipient's need, financial concern is not a proper reason to deny or choose an alternative that may not meet the recipient's needs. Cost may only be considered when choosing between available options that are all equally effective and safe for a recipient's needs.

26. After reviewing the totality of the evidence and legal authority, the undersigned finds that the Agency did not properly review Petitioner's request for medical necessity.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Petitioner's appeal is REMANDED to the Agency to review whether the current stair lift meets Petitioner's needs and the medical necessity rule. If the Agency finds that the current stair lift does not meet Petitioner's needs based on medical necessity, the Agency is instructed to determine whether another stair lift would meet medical necessity and is possible to install in his home. The Agency is instructed to issue a Notice of Case Action to Petitioner describing the decision and findings. If Petitioner's request is denied again after this Agency review, Petitioner will have the right to request another fair hearing.

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 February, 2016,

in Tallahassee, Florida.

Danielle Murray
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

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

State of Florida
Department of Children and Families

Rick Scott
Governor

Mike Carroll
Secretary

Date: 01/13/2016

To: Office of Economic Self Sufficiency

From: Nathan Koch, Chief
Office of Appeals Hearings

Subject: Final Order

RE: [redacted]
Appeal # 15F-08947
Circuit 09, Osceola - 49
Unit: [redacted] Service Site: [redacted]
Food Assistance Program
SSA# or Case #: 1441112821

The hearing request for the above individual has been completed and the final order is attached.

Please send correspondence to:
Office of Appeal Hearings
Building 5, Room 255
1317 Winewood Blvd.
Tallahassee, FL 32399-0700

The office telephone number is 850-488-1429, SC 278-1429.
The fax number is 850-487-0662, SC 277-0662.

State of Florida
Department of Children and Families

Rick Scott
Governor

Mike Carroll
Secretary

Date: 01/13/2016

To: Office of Economic Self Sufficiency

From: Nathan Koch, Chief
Office of Appeals Hearings

Subject: Final Order

RE: [redacted]
Appeal # 15F-10518
Circuit 09, Osceola - 49
Unit: [redacted] Service Site: [redacted]
Family Medicaid Program
SSA# or Case #: [redacted]

The hearing request for the above individual has been completed and the final order is attached.

Please send correspondence to:
Office of Appeal Hearings
Building 5, Room 255
1317 Winewood Blvd.
Tallahassee, FL 32399-0700

The office telephone number is 850-488-1429, SC 278-1429.
The fax number is 850-487-0662, SC 277-0662.

FILED
Jan 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. 15F-08947
15F-10518

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Osceola
UNIT: 66032

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing at the Department of Children and Families, Kissimmee, FL in the above-referenced matter at 12:30 p.m. on December 23, 2015.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Mercedes Diaz, ACCESS
Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's (or the Department) action to: 1) deny petitioner Food Assistance (FA) benefits and 2) deny petitioner and her daughter (TJ) Medicaid benefits is proper. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

By notice dated August 14, 2015, the Department notified the petitioner that: 1) FA for her household was denied, 2) Medicaid for petitioner's two sons were approved and 3) Medicaid for petitioner and [redacted] were denied. Petitioner timely requested a hearing to challenge the FA and Medicaid denials.

[redacted], petitioner's son, appeared as an observer. Petitioner did not submit exhibits. Respondent submitted four exhibits, entered as Respondent Exhibits "1" through "4". The record was held open until December 28, 2015 for the respondent to submit an additional exhibit. The exhibit was received timely and entered as Respondent Exhibit "5". The record was closed on December 28, 2015.

FINDINGS OF FACT

1. Prior to the action under appeal, petitioner received $2.00 monthly in FA for her household. Household includes petitioner, her two sons (ages 17 and 19) and her daughter, [redacted] (age 22). Also prior to the action under appeal, petitioner's 19 year old son was enrolled in the Medically Needy Program and her 17 year old son had full Medicaid. Petitioner and her daughter did not receive Medicaid. Petitioner said that she and her daughter were approved for "Obama Care".

2. On July 14, 2015, petitioner submitted a recertification application for her household. The benefits selected on the application that petitioner was applying for are FA and "MSP" (under SSI-Related Medicaid). Petitioner alleges she also applied for Medicaid benefits. The application indicates petitioner's daughter is employed at [redacted] And petitioner's two employments: 1) [redacted] ended on May 20, 2015

and 2) [redacted] ended on March 28, 2015. Medicaid for petitioner's sons are not an issue.

3. Petitioner did not require to be interviewed by the Department for the July 14, 2015 application.

4. On July 22, 2015, the Department mailed petitioner a Notice of Case Action (NOCA) that states in part:

> We need the following information by August 3, 2015.
> Proof of loss of income, last pay date and all income received in the month of 07/2015 using the "Verification Of Employment/Loss of Income" form or provide a letter for your job.
> Proof of all gross income from the last 4 weeks using the "Verification Of Employment/Loss of Income" form or you may send in your last 4 pay stubs.
> TANIA, PLEASE PROVIDE LOSS OF INCOME FROM [redacted] AND [redacted].
> [redacted] PLEASE PROVE LAST 4 WEEKS OF GROSS INCOME FROM [redacted].

5. Petitioner asserts that neither [redacted] nor [redacted] would give her written documents that she is no longer employed. Petitioner called the Department's Call Center (CC) to inform the Department she was unable to provide the loss of income verification.

6. The Department's Running Record Comments, dated July 31, 2015, confirm that petitioner called the CC and the CC advised petitioner to submit two collateral statements as loss of income verification.

7. Petitioner alleges that she asked her neighbor and people at her church to sign a collateral statement and no one would agree to sign it.

8. Petitioner said that she did not provide her daughter's paystubs because she did not have her loss of income verification to submit.

9. On August 14, 2015, the Department mailed petitioner a NOCA notifying her that: 1) FA for her household was denied, "Reason: We did not receive all the information requested to determine eligibility, 2) Medicaid for petitioner's two sons were approved and 3) Medicaid for petitioner and [redacted] were denied, "Reason: you or a member(s) of your household is not eligible due to failure to cooperate with child support enforcement, No household member are eligible for this program."

10. Respondent's representative stated that the petitioner is not Medicaid eligible because she has not cooperated with Child Support Enforcement (CSE). And [redacted] is not Medicaid eligible because she is over 19 years of age.

CONCLUSIONS OF LAW

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

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

FOOD ASSISTANCE ISSUE

13. Fla. Admin. Code R. 65A-1.602 Food Assistance Program Case Processing, in part states:

> (7) Child Support Enforcement (CSE) Cooperation. In accordance with Section 414.32, F.S. and 7 CFR 273.11(o)(1), Child Support Enforcement cooperation by a custodial parent or caretaker relative is required as a condition of eligibility for their food assistance when an absent parent exists, unless good cause for non-cooperation exists. For the purposes of this section, "absent parent" is defined as a putative or identified noncustodial parent of a child under 18 years of age…

> (c) Upon determination by the Department of Revenue, Child Support Enforcement that the custodial parent or caretaker relative's failure to cooperate was without good cause, a food assistance penalty will be imposed for the non-cooperative individual only and a notice of adverse action will be mailed to the individual pursuant to 7 C.F.R. 273.11(o)(3) and (4). The non-cooperative individual's income will be prorated in determining eligibility for the remaining AG members. The remaining AG members meeting eligibility requirements may be approved. The non-cooperative individual will be excluded until verification of CSE cooperation is received by the Department.

14. In accordance with the above authority, a parent with children under 18 years of age must cooperate with CSE to be eligible for FA benefits. And failure to cooperate results in a FA penalty. In this case, the Department of Revenue, CSE, notified the Department in 2014 to impose a non-cooperation penalty on the petitioner.

15. Federal Regulations at 7 C.F.R. § 273.2, explains verification requirements and in part states:

> (c)(5) Notice of Required Verification. The State agency shall provide each household at the time of application for certification and recertification with a notice that informs the household of the verification requirements the household must meet as part of the application process…
> (d) Household cooperation. (1) To determine eligibility, the application form must be completed and signed, the household or its authorized representative must be interviewed, and certain information on the application must be verified. If the household refuses to cooperate with the State agency in completing this process, the application shall be denied at the time of refusal. For a determination of refusal to be made, the household must be able to cooperate, but clearly demonstrate that it will not take actions that it can take and that are required to complete the application process…
> (f) Verification. Verification is the use of documentation or a contact with a third party to confirm the accuracy of statements or information…
> (1) Mandatory verification. State agencies shall verify the following information prior to certification for households initially applying:
> (i) Gross nonexempt income. Gross nonexempt income shall be verified for all households prior to certification…
> (h) Delays in processing. If the State agency does not determine a household's eligibility and provide an opportunity to participate within 30

> days following the date the application was filed, the State agency shall take the following action…
> **(5) Responsibility of obtaining verification. (i) The household has primary responsibility for providing documentary evidence to support statements on the application and to resolve any questionable information. The State agency must assist the household in obtaining this verification provided the household is cooperating with the State agency as specified under paragraph (d)(1) of this section.** (emphasis added)

16. Fla. Admin. Code R. 65A-1.205 Eligibility Determination Process, future explains verification and in part states:

> (1) (a) The Department must determine an applicant's eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter. It is the applicant's responsibility to keep appointments with the eligibility specialist and furnish information, documentation and verification needed to establish eligibility. If the Department schedules a telephonic appointment, it is the Department's responsibility to be available to answer the applicant's phone call at the appointed time. **If the information, documentation or verification is difficult for the applicant to obtain, the eligibility specialist must provide assistance in obtaining it when requested or when it appears necessary.**(emphasis added)

17. In accordance with the above authorities, the household has primary responsibility for providing verification and the Department must assist the household in obtaining the verification. In this case, the petitioner contacted the Department and reported she was unable to provide the loss of employment verification from her former employers.

18. There is no indication that the Department assisted the household in obtaining the loss of employment verification from the employers. Although, the Department informed the petitioner she could get two collateral contacts from two different individuals.

MEDICAID ISSUE

19. Fla. Stat. § 409.2572 Cooperation, in part states:

> (1) An applicant for, or recipient of, public assistance for a dependent child shall cooperate in good faith with the department or a program attorney in:

> (a) Identifying and helping to locate the alleged parent or obligor…
> (3) The Title IV-D staff of the department shall be responsible for determining and reporting to the staff of the Department of Children and Families acts of noncooperation by applicants or recipients of public assistance. Any person who applies for or is receiving public assistance for, or who has the care, custody, or control of, a dependent child and who without good cause fails or refuses to cooperate with the department, a program attorney, or a prosecuting attorney in the course of administering this chapter shall be sanctioned by the Department of Children and Families pursuant to chapter 414 and is ineligible to receive public assistance until such time as the department determines cooperation has been satisfactory.

20. In accordance with the above authority, petitioner is not eligible for Medicaid due to being sanctioned from CSE (Title IV-D staff) for noncooperation.

21. 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.
> (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…
> (3) Medicaid for children not yet age 19. To be eligible for this coverage group the child must meet the general requirements specified in Rule 65A-1.705, F.A.C

22. In accordance with the above authority, [redacted] is not eligible for Medicaid due to being age 22.

HEARING OFFICER CONCLUSON

23. In careful review of the cited authorities and evidence, the undersigned concludes the respondent erred by not assisting petitioner with the loss of income verification.

24. Therefore, the case is hereby remanded to the respondent for corrective action. The respondent shall assist the petitioner in verifying her loss of income and honor her July 14, 2015, date of application, for FA benefits. This Order does NOT guarantee that petitioner's household will be eligible for FA benefits.

25. Also in careful review of the cited authorities and evidence, the undersigned concludes the respondent was correct in denying petitioner and [redacted] Medicaid, due to ineligibility; petitioner for noncooperation with CSE and [redacted] for being age 22.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the FA appeal is granted and remanded to the respondent in accordance with the above Conclusions of Law. The Medicaid appeal is denied and the respondent's action is affirmed.

ANY FOOD STAMP BENEFITS DUE APPELLANT PURSUANT TO THIS ORDER MUST BE AVAILABLE WITHIN (10) TEN DAYS OF THIS DECISION OR WITHIN (60) DAYS OF THE REQUEST FOR THE HEARING. ANY BENEFITS DUE WILL BE OFFSET BY PRIOR UNPAID OVERISSUANCES.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 13 day of January, 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 [redacted], 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

[redacted]

PETITIONER,

Vs.

Administrator

[redacted]

RESPONDENT.
_____/

APPEAL NO. 15N-00094

CASE NO.

FINAL ORDER

Pursuant to notice, the undersigned convened two administrative hearings in the above-referenced matter on October 9, 2015 at 1:01 p.m.; and on January 12, 2016 at 10:07 a.m. at the [redacted]

APPEARANCES

For the Petitioner: [redacted] petitioner's wife

For the Respondent: [redacted] Executive Director
[redacted] Esq.

ISSUE

At issue is the facility's intent to discharge petitioner due to non-payment of a bill for services. A Nursing Home Transfer and Discharge Notice was issued on August 25, 2015. The facility has the burden of proof to establish by clear and convincing evidence that the discharge is appropriate under federal regulations found in 42 C.F.R. § 483.12.

PRELIMINARY STATEMENT

At both hearings, the petitioner was not present and was represented by [redacted] who testified. At the January 2016 hearing, the petitioner submitted one exhibit, which was accepted into evidence and entered as Petitioner's Exhibit "1". At the October 2014 hearing, the respondent was represented by [redacted] with [redacted] (hereafter "facility" or "Respondent"). At the October 2014 hearing, the respondent presented one witness who testified: [redacted] business office Manager with [redacted] At the January 2016 hearing, the respondent was represented by [redacted] Esq. At the January 2016 hearing, the respondent presented two witnesses who testified: [redacted] Executive Director and [redacted] Medicaid Billing Specialist both with [redacted] At the October 2014 hearing, the respondent submitted one exhibit, which was accepted into evidence and entered as Respondent's Exhibit "1". At the January 2016 hearing, the respondent submitted four exhibits, which were accepted into evidence and entered as Respondent's Exhibits "2" – "5".

The record was left opened until January 14, 2016 to allow the petitioner to submit additional evidence. On January 12, 2016, the petitioner submitted the additional evidence, which was entered into evidence as Petitioner's Exhibit 2. The record closed on January 14, 2016.

FINDINGS OF FACT

1. Petitioner entered the facility on July 11, 2014. Medicare paid for the petitioner's stay at the facility, in full, through August 25, 2014.

2. The facility discharged petitioner on August 25, 2014, and readmitted him on August 28, 2014. Petitioner has been a full time resident at the facility since August 28, 2014.

3. Applications for Institutional Care Program (ICP) Medicaid benefits were submitted to the Department of Children and Families on October 9, 2014; December 9, 2014; January 27, 2015; March 24, 2015; May 27, 2015; June 30, 2015; August 24, 2015; and November 30, 2015. All aforementioned ICP Medicaid applications were denied.

4. On June 23, 2015, the Department of Health Division of Disability Determination (hereafter "DDD") determined petitioner disabled effective February 1, 2015. The Medicaid date of application DDD utilized in their determination was May 27, 2015.

5. On August 25, 2015, the facility provided petitioner a Notice of Transfer and Discharge. The reason for discharge was "your bill for services at this facility has not been paid after reasonable and appropriate notice to pay".

6. On December 30, 2015, a Notice of Case Action from the Department of Children and Families was mailed to the facility informing them petitioner's December 1, 2015 Medicaid application was approved and petitioner's patient responsibility would be $0 per month from December 1, 2015 and ongoing.

7. Effective January 1, 2016, the facility billed petitioner for room and board for the following amounts for the following months:

$7,595 for October 1, 2014 through October 31, 2014
$7,350 for November 1, 2014 through November 30, 2014
$7,595 for December 1, 2014 through December 31, 2014
$7,595 for January 1, 2015 through January 31, 2015
$6,860 for February 1, 2015 through February 28, 2015

$7,595 for March 1, 2015 through March 31, 2015
$4,655 for April 1, 2015 through April 19, 2015
$2,829.75 for April 20, 2015 through April 30, 2015
$7,974.75 for May 1, 2015 through May 31, 2015
$7,717.50 for June 1, 2015 through June 30, 2015
$7,974.75 for July 1, 2015 through July 31, 2015
$7,974.75 for August 1, 2015 through August 31, 2015
$7,717.50 for September 1, 2015 through September 30, 2015
$7,974.75 for October 1, 2015 through October 31, 2015
$7,717.50 for November 1, 2015 through November 30, 2015

8. Effective January 1, 2016, the facility billed petitioner for other services, such as pharmacy drugs and therapy, for the following amounts for the following months:

$1,700.37 for October 2014
$206.94 for February 2015
$555.70 for March 2015
$66.49 for October 2015

9. Effective January 1, 2016, the petitioner paid the facility three payments toward his outstanding balance:

$1,250 on December 27, 2014
$1,510 on January 7, 2015
$3,000 on November 30, 2015

10. As of January 1, 2016, the petitioner's outstanding balance to the facility was $113,036.27.

11. The outstanding balance is for the months of October 2014 through November 2015. Petitioner was not billed for the month of September 2014 and Medicaid is paying petitioner's facility bill effective December 1, 2015 and ongoing. The months under issue are from October 2014 through November 2015.

12. Respondent argued the facility is moving forward with the discharge as petitioner owes an outstanding balance and has not made a payment arrangement with the facility to repay the outstanding balance.

13. Petitioner argued he wants to repay the outstanding balance to the facility and is making payments to the facility. He is also working with an attorney to have the Department of Children and Families approve his ICP Medicaid benefits effective October 2014 through November 2015.

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 § 400.0255(15), Fla. Stat. In accordance with that section, this Order is the final administrative decision of the Department of Children and Families.

15. The Code of Federal Regulations 42 C.F.R. § 483.12 limit the reasons for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the petitioner was sent notice indicating that he would be discharged from the facility as he had not paid his bill for services to the facility for the months of October 2014 through November 2015:

> (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…
> (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…

16. Petitioner made three payments to the facility during the period of December 2014 through November 2015. His three payments totaled $5,760. The facility billed petitioner his patient responsibility each month for the period of October 2014 through

November 2015. As of January 1, 2016, the petitioner's balance to the facility is $113,036.27.

17. Petitioner's ICP Medicaid benefits were approved effective December 2015 and ongoing and his attorney is working with the Department of Children and Families to approve his ICP Medicaid benefits effective October 2014. Petitioner has submitted eight applications to the Department of Children and Families for ICP Medicaid benefits since October 9, 2014. Furthermore, DDD determined petitioner disabled effective February 2015.

18. It is unknown when and if petitioner's ICP Medicaid benefits will be approved or the effective date of his ICP Medicaid benefits. As a result it is unknown if petitioner would still owe payments to the facility. Furthermore, petitioner has made three payments toward the outstanding balance and states he will continue to make payments until his attorney resolves all issues with his ICP Medicaid applications effective the month of October 2014.

19. The Department of Health and Human Services, Centers for Medicaid and Medicare Services, State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities states in part:

> A resident cannot be transferred for non-payment if he or she has submitted to a third party payor all the paperwork necessary for the bill to be paid. Non-payment would occur if a third party payor, including Medicare or Medicaid, denies the claim and the resident refused to pay for his or her stay.

20. Pursuant to the above authority, the aforementioned guidance to the Agency for Health Care Administration surveyors allows the reviewing of a discharge notice due to non-payment to be considered in this appeal. In this instance, petitioner has an

attorney working with the Department of Children and Families to resolve all issues with his ICP Medicaid benefits effective the month of October 2014. Furthermore, petitioner expressed a wish to continue to make payments towards his outstanding balance. Respondent must wait until the Department of Children and Families provides them a denial notice for petitioner's ICP Medicaid benefits for the months of October 2014 through November 2015 before proceeding with this discharge action.

DECISION

The appeal is GRANTED. The facility may not proceed with the discharge at this time. The facility must wait until the Department of Children and Families provides them a denial notice for petitioner's ICP Medicaid benefits for the months of October 2014 through November 2015 before proceeding with this discharge action and must give the petitioner adequate notice of any amounts due after any possible reductions as a result of payments from Medicaid.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 29 day of February, 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
[redacted]

Respondent
Ms. Patricia Reed Caufman
Agency for Health Care Administration
[redacted]

FILED
Jan 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. 15N-00101

PETITIONER,

Vs.

Administrator [redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned at 2:24 p.m. on December 9, 2015, at the [redacted] Florida.

APPEARANCES

For the Petitioner: The petitioner was present and represented himself.

For the Respondent: [redacted] facility administrator.

ISSUE

At issue is whether discharge intent was correct based on the safety of other individuals in the facility is endangered. The facility allows smoking in designated areas at the designated times. 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 October 21, 2015, the respondent informed the petitioner that it was seeking to discharge/transfer him from its facility because safety of other individuals in the facility is endangered. The petitioner timely requested a hearing on the matter and continues to reside at the facility pending the outcome of the hearing. The notice was signed by the attending physician.

Present as witnesses for the respondent were [redacted] unit manager, and [redacted] social services assistant.

A letter dated December 3, 2015 from the Agency for Health Care Administration (AHCA) indicated that AHCA did not find the facility in violation of any laws or rules. This was entered as Hearing Officer Exhibit 1.

FINDINGS OF FACT

1. The petitioner has resided at the facility since May 2013. The petitioner was given a copy of the "Resident Smoking Policy" which states: "It is against Daytona Beach and Health and Rehabilitation Center's policy to have cigarettes or smoking materials in resident's room or on resident's person." There is a designated smoking area at the facility.

2. The "Resident Smoking Policy" instructed of the designated smoking area and the allowable smoking times. The policy also stated that cigarettes and smoking materials are to be given to the nurse for safe-keeping. The smoking policy was signed by the petitioner on April 16, 2015. The Facility Smoking Policy (Effective October 1,

2010) states under the heading "Process", subtitle 1, Resident Smoking, paragraph two: "Any resident that fails to comply will be addressed with the Administrator and Social Services Director and documented in your medical record. Repeat incidences will result in a 30 day notice of discharge for non-compliance. There will be one warning given and 30 day notice of discharge will be issued after second incident of non-compliance."

3. The facility's records indicate periods when the petitioner was observed smoking at non-designated times. The Departmental Notes dated April 20, 2015 state: "This writer went to the smoking area to do supervise smoking with the resident's and this resident was already out smoking at a non-smoking time…" The Notes dated June 23, 2015 state: "This writer went to see this resident who was outside smoking at a non-smoking time, this resident was reeducated on the smoking policy…"

4. The Departmental Notes dated October 21, 2015 reports:

> Unit Manager came to this writer and reported that resident was smoking in his room. Upon entering his room, resident had oxygen on via nasal canula and the smell of smoke was prevalent. Resident denied smoking, upon observation a Altoids tin was noted in resident lap, when I touched it with my hand it was very hot to touch. Upon opening, 2 ½ cigarettes with 1 lighter was noted and ½ time size of marijuana. Resident had just put cigarette out in the tin…Complete room check done, findings: 2 knifes, scissors, 2 packs of cigarettes, additional lighter, clorax spray, pliers and aerosol air freshner…Will offer nicotine patch for resident use…

5. The Departmental Notes continued on October 21, 2015 states: "This writer offered resident nicotine patch. Resident stated he does not want a nicotine patch. MD notified of incident. New order given to d/c resident to son."

6. On October 21, 2015, the facility issued a Nursing Home Transfer and Discharge Notice advising petitioner that the effective date of the transfer was

November 20, 2015. The reason cited was, "The safety of other individuals in this facility is endangered." The facility included on the notice the explanation that the petitioner was "witnessed smoking in his room with his oxygen on nasal canula" and that this act endangered the safety of other individuals in the facility.

7. The Notice was signed by the Administrator on October 21, 2015. The petitioner also signed the Notice on October 21, 2015. The Nursing Home Transfer and Discharge Notice was signed by the petitioner's physician, [redacted] Respondent Exhibit 2 includes Physicians Orders List signed by the petitioner's physician, [redacted] on October 21, 2015 which states: "Resident to be discharged to [redacted] (son)…"

8. The petitioner acknowledges that he was aware that he cannot have smoking materials in his room; he admits to having smoking materials in his possession in his room. The petitioner denies smoking in his room or smoking outside of the designated hours.

9. The respondent contends that its records indicate that the petitioner continued to have in his possession materials, such as bleach, knives, and illegal drugs (Respondent Exhibit 2). The respondent also contends that the petitioner endangered his safety and the safety of other individuals in the facility by having unauthorized smoking materials in his room and by smoking around an oxygen tank.

10. Due to disputed, relevant findings of whether petitioner smoked in his room, the undersigned must make the finding. Petitioner admitted to having smoking materials in his room and petitioner was aware this was against the facility's policy. The

facility offered its documented notes and testimony of petitioner having smoking materials in his room and the reasons supporting the belief that petitioner smoked in his room while wearing oxygen. The undersigned finds it persuasive that petitioner did in fact, smoke in his room.

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 § 400.0255(15), Fla. Stat. In accordance with said authority, this order is the final administrative decision of the Department of Children and Families.

12. Federal Regulations appearing 42 C.F.R. § 483.12, sets forth the reasons a facility may involuntary discharge a resident as follows: Admission, transfer and discharge rights.

> (a)(2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--
> (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
> (ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
> (iii) The safety of individuals in the facility is endangered;
> (iv) The health of individuals in the facility would otherwise be endangered;
> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
> (vi) The facility ceases to operate.

13. Florida Statute 400.0255, Resident transfer or discharge; requirement and procedures; hearing.--, informs at (15) (b) that the burden of proof must be clear and convincing evidence.

14. 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 and requirements of the controlling authorities have been met.

15. Federal regulations limit the reason for which a Medicaid or Medicare certified nursing facility may discharge a patient. In the instant case, the respondent proposes to discharge the petitioner due to the safety of other individuals in the facility is endangered as he is not complying with the smoking policy.

16. Federal regulations at 42 C.F.R. § 483.12 states in part:

> (a) Transfer and discharge—
> (1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.
> (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--
> (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
> (ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(iii) The safety of individuals in the facility is endangered;
(iv) The health of individuals in the facility would otherwise be endangered;
(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(vi) The facility ceases to operate.
(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by--
(i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and
(ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.
(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must--
(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.
(ii) Record the reasons in the resident's clinical record; and
(iii) Include in the notice the items described in paragraph (a)(6) of this section.
(5) Timing of the notice. (i) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice may be made as soon as practicable before transfer or discharge when--
(A) the safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (a)(2)(iv) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(ii) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(i) of this section; or
(E) A resident has not resided in the facility for 30 days.
(6) Contents of the notice. The written notice specified in

> paragraph (a)(4) of this section must include the following:
> (i) The reason for transfer or discharge;
> (ii) The effective date of transfer or discharge;
> (iii) The location to which the resident is transferred or discharged;
> (iv) A statement that the resident has the right to appeal the action to the State;
> (v) The name, address and telephone number of the State long term care ombudsman;
> (vi) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and
> (vii) For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.
> (7) Orientation for transfer or discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. (emphasis added)

17. The above cited authorities set forth the conditions which must exist for a nursing home to involuntarily discharge a resident.

18. Florida Statutes 400.0255, Resident transfer or discharge; requirements and procedures; hearings, states in relevant part:

> (3) Any notice indicating a medical reason for transfer or discharge must either be signed by the resident's attending physician or the medical director of the facility, or include an attached written order for the discharge or transfer. The notice or the order must be signed by the resident's physician, medical director, treating physician, nurse practitioner, or physician assistant…
> (7) At least 30 days prior to any proposed transfer or discharge, a facility must provide advance notice of the proposed transfer or discharge to the resident and, if known, to a family member or the resident's legal guardian or representative, except, in the following circumstance, the facility shall give notice as soon as practicable before the transfer or discharge:

> (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; or
> (b) The resident's health or safety or other residents or facility employees would be endangered, and the circumstances are documented in the resident's medical records by the resident's physician or the medical director if the resident's physician is not available.

19. The respondent's reason for discharge is "The safety of other individuals in this facility is endangered." This is one of the reasons given in the above federal law to permit discharge from a facility. According to the above controlling statute, this discharge reason would require documentation from the resident's physician. The petitioner's attending physician signed the discharge notice and provided a statement on his recommendation.

20. The petitioner was aware of the smoking policy. He admits having smoking materials in his room. The findings also show petitioner smoked in his room. This certainly could have lead to very serious safety consequences for everyone in the building. After review of the entire record as well as the controlling authorities, the undersigned concludes that the nursing facility has established that the safety of other individuals in the facility was endangered. The physician agreed and signed the applicable discharge document. The undersigned concludes the respondent has properly issued the 30 day advance discharge notice.

21. 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 forgoing Findings of Fact and Conclusions, the appeal is denied and the facility may proceed with its proposed discharge in accordance with the Agency for Health Care Administration's rules and regulations.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 13 day of January, 2016, in Tallahassee, Florida.

Paula Ali

Paula Ali
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
[redacted] Respondent
Mr. Robert Dickson, AHCA

FILED
Jan 14, 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. 15N-00102

PETITIONER,

Vs.

Administrator
[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, a hearing in the above-referenced matter convened on December 3, 2015 at 2:16 p.m. at the [redacted] Center, located in Green Cove Springs, Florida.

APPEARANCES

For the Petitioner: The petitioner was present and represented herself.

For the Respondent: [redacted] executive director.

ISSUE

At issue is the facility's intent to discharge petitioner due to non-payment of a bill for services; a Nursing Home Transfer and Discharge Notice was issued on October 22, 2015 with an effective date of November 21, 2015.

The facility has the burden of proof to establish by clear and convincing evidence that the discharges are appropriate under federal regulations found in 42 C.F.R. §483.12.

PRELIMINARY STATEMENT

Appearing as witnesses for the respondent were [redacted] business office manager, [redacted] director of clinical services, and [redacted] social services director.

FINDINGS OF FACT

1. The petitioner, 68, has been a resident of the respondent's facility since March 23, 2015. In June 2015, the petitioner was approved for ICP Medicaid with a patient responsibility in the amount of $1429.

2. The facility has been issuing monthly statements on the 15th or 20th of each month since the petitioner's admission to inform of balances owed. The respondent explained that its system did not allow the printing of the monthly statements issued to the petitioner. The respondent's evidence includes the "Activity Report" where the business office documents any type of communication which took place between the petitioner and the facility from May 19, 2015 through November 17, 2015.

3. On June 9, 2015, the "Activity Report" notates that the "Resident is refusing to pay." On August 26, 2015, the report indicates a phone call was made to the son regarding the petitioner's balance owed to the facility; a voicemail was left according to the notes. On August 26, 2015, the notes indicate that the petitioner's son returned the phone call and that the son stated the petitioner is aware of the balance and that he is

not responsible for payment. The respondent contends that the petitioner's son informed the facility that the petitioner is paying for an apartment within the community.

4. The "Activity Report" shows that on October 2, 2015, a phone call was made to the petitioner regarding the balance owed to the facility but she refused to pay. The notes dated October 22, 2015 states that a phone call was made to the petitioner and that she refuses to pay.

5. The respondent contends that nothing has been paid on the petitioner's account since her admission and that the current balance owed is $7604.34.

6. The petitioner does not dispute that she owes money to the facility. The petitioner acknowledges that she has been receiving the monthly statements. The petitioner argues that she informed an employee with the facility that she can make monthly payments but her message was not relayed to the administrator. The petitioner contends that she would like to move back to the home where she used to live but is unsure of its suitability.

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 s. 400.0255(15), Fla. Stat. In accordance with that section this order is the final administrative decision of the Department of Children and Families. In this case, the discharge notice indicates the petitioner is to be discharged from the respondent/facility based on non-payment.

8. Federal Regulations at 42 C.F.R. § 483.12(a) states in relevant part:

> (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…(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; …

9. According to the above federal authority, the facility may not discharge except for certain reasons, of which one is when the resident has failed, after reasonable and appropriate notice to pay for the stay at the facility.

10. The petitioner has an outstanding balance owed to the facility for the cost of her care. The facility has notified the petitioner's power of attorney of the balance due for the cost of the petitioner's care on a monthly basis.

12. The petitioner acknowledges receipt of the monthly billing statements; she met with the staff to discuss a monthly payment plan. Therefore, the undersigned concludes the facility has followed the above controlling authority to issue reasonable and appropriate notice prior to issuing the discharge notice.

13. Based on the findings and the federal and state controlling authorities, the undersigned concludes the facility's discharge is proper.

14. 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.

15. 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

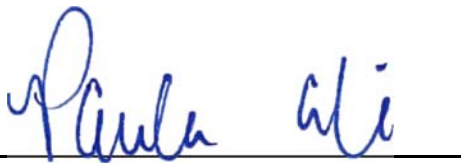
Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied. The facility may proceed with the discharge action in accordance with the Agency for Health Care Administration's rules and guidelines.

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 __14__ day of __January_____, 2016,

in Tallahassee, Florida.



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Copies Furnished To: [redacted] Petitioner
[redacted] Respondent
Mr. Robert Dickson, AHCA

FILED
Feb 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. 15N-00103

PETITIONER,

Vs.

ADMINISTRATOR
[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on December 17, 2015 at 10:10 a.m. in Pensacola, Florida

APPEARANCES

For the Petitioner: [redacted] Ombudsman

For the Respondent: [redacted] Facility Administrator

STATEMENT OF ISSUE

At issue is whether the facility's intent to discharge the petitioner due to inability to meet his needs in the facility based on Federal Regulations found at 42 C.F.R. § 483.12 is correct. A Nursing Home Transfer and Discharge Notice was issued on October 20, 2015. The facility has the burden of proof to establish by clear and convincing evidence that the discharge is appropriate.

PRELIMINARY STATEMENT

The petitioner's children, [redacted] son, [redacted] daughter, and [redacted] daughter, appeared as witnesses for the petitioner. [redacted] Risk Manager, and [redacted], Director of Nursing appeared as witnesses for the facility.

[redacted] state ombudsman, and Greg Watson, hearing officer, appeared as observers with no objection from either party.

Agency for HealthCare Administration (AHCA) submitted a letter on November 30, 2015 informing the undersigned an unannounced visit was made to the facility by AHCA staff on November 12, 2015. AHCA staff did not note any violation of laws or rules found during the visit to the facility.

The ombudsman requested the undersigned take judicial notice of a decision made by the administrative law judge (ALJ) in Docket No. 1293 A-211, Washington State Office of Administrative Hearings for the Department of Social and Health Services. In this case, the ALJ ruled that the facility was able to meet the petitioner's needs and did not allow the discharge action sought by the facility. The ombudsman also requested the undersigned to take judicial notice of Final Orders 11N-00024 and 15N-00088 issued by the Office of Appeal Hearings for the Department of Children and Families, in which the hearing officers concluded that the facility did not provide clear and convincing evidence that it could not meet the petitioner's needs. The undersigned concludes that the petitioner's situation in this case is similar to the residents' situations in the cases provided by the ombudsman. For this reason, Judicial Notice has been taken by the undersigned.

As the facility's attorney was not able to be present at the hearing, the undersigned allowed the record to remain open through January 11, 2016 for submission of Proposed Final Orders from both parties. The hearing recording was distributed to both the ombudsman and the facility's attorney on December 28, 2015.

FINDINGS OF FACT

1. The petitioner was admitted to this facility in May 8, 2015. Upon admission to the facility, the respondent acknowledged the petitioner has cognitive deficits and a diagnosis of [redacted] The petitioner has difficulty walking and has abnormalities in his gait and mobility. The petitioner's family is unable to care for him at home.

2. The respondent contends that its facility is unable to meet the petitioner's needs due to his risk of falls unless he is receiving one-on-one care. The respondent explained one-on-one care is not a service routinely provided by the facility.

~~3.~~ The respondent issued a Nursing Home Transfer and Discharge Notice to the petitioner on October 20, 2015 citing "Your needs cannot be met in this facility" as the reason for discharge. The notice also indicated, "Requiring one-on-one care due to physical risks."

4. The respondent documented the petitioner's care plan on May 11, 2015 the petitioner is at risk for further falls due to problems with gait and balance. The note also shows the petitioner has a history of falls prior to admission to this facility. (Respondent Exhibit 1, page 2)

5. In August 2015, the petitioner's falls became more frequent with six per month documented for August, September and October 2015. (Respondent Exhibit 2)

One of the falls resulted in a trip to the emergency room for hip pain evaluation. Two of the falls resulted in skin tears.

6. The petitioner's son described the petitioner as enjoying walking as an activity throughout his lifetime. However, due to the petitioner's declining physical abilities, he now requires assistance when walking. The son explained that due to his [redacted] and [redacted] the petitioner does not understand that he cannot just get up and walk when he wants. The son does not believe his father understands he has a risk for falling now when he walks and he needs to wait for assistance.

7. The respondent has attempted multiple interventions to attempt to prevent the petitioner from falling. The interventions included non-skid footwear; replacing the Velcro belt with a clip belt; alternate bed placement; fall mat usage; 30-minute checks, door alarm to bathroom, environmental changes, wheelchair alarm, placed by nurses station for monitoring, high back reclining wheelchair with anti-roll backs to wheelchair and one-on-one care. These are documented in the petitioner's care plan.

8. The respondent explained the intervention of 30-minute checks on the petitioner was successful, but falls occurred when the 30-minute check order expired.

9. The respondent began using one-on-one care only with the petitioner on October 18, 2015. The respondent did not document any falls occurring after the one-on-one care began.

10. Although the petitioner's physician signed the Transfer and Discharge Notice, no supporting documentation from the petitioner's medical record or testimony of the physician was offered to explain why the physician believed the petitioner's needs could not be met in the facility.

11. The respondent confirmed that at the time of the AHCA inspection, the petitioner was on one-on-one care, he did not have any falls, and all of his needs were being met.

12. The respondent explained they meet the staffing needs in accordance with standards set by the state.

13. The respondent explained one-on-one care is not a service the facility provides long term as it takes staff away from caring for other residents.

14. The respondent has other one-on-one care residents in the facility. The respondent explained these residents have the one-on-one care provided privately, as they or their family pays for the companion or caregiver. If the petitioner's family chose to provide a companion or one-on-one caregiver, the respondent would allow the petitioner to remain in the facility.

15. The petitioner's family expressed satisfaction in the care the petitioner receives in the facility. They further expressed concern for his welfare should he be discharged as they all work and are not home full time to care for their father.

16. The respondent was unable to answer the question of how the petitioner's discharge to a family member's home would meet his needs.

CONCLUSIONS OF LAW

17. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to § 400.0255(15), Fla. Stat. In accordance with said authority, this order is the final administrative decision of the Department of Children and Families.

18. Federal Regulations appearing 42 C.F.R. § 483.12, sets forth the reasons a facility may involuntary discharge a resident as follows: Admission, transfer and discharge rights.

> (a)(2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--
> (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
> (ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
> (iii) The safety of individuals in the facility is endangered;
> (iv) The health of individuals in the facility would otherwise be endangered;
> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
> (vi) The facility ceases to operate.

19. Florida Statutes § 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;”

20. The facility issued a discharge notice based on its belief that the petitioner’s needs could not be met in the facility. 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.

21. 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.

22. 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.

23. The respondent bears the burden of proof, by clear and convincing evidence, to show that the facility is unable to meet the petitioner's needs. The undersigned concludes that the respondent's position that the petitioner's need for one-on-one care that cannot be met at its facility does not, in and of itself appear to meet the intent of the allowable discharge reasons in the Federal Regulations, specifically that a discharge is necessary due to the facility's inability to meet his needs. The federal regulation is clear the intent of a discharge under this stated reason is when the transfer or discharge is necessary for the resident's welfare **and** the resident's needs cannot be met in the facility.

24. Federal Regulations 42 C.F.R. § 483.25 "Quality of Care" states in relevant part:

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.
> …
> (h) Accidents. The facility must ensure that—
> (1) The resident environment remains as free of accident hazards as is possible; and
> (2) Each resident receives **adequate supervision** and assistance devices to prevent accidents. (emphasis added)

25. The respondent demonstrated the ability to meet the petitioner's needs in the facility by providing one-on-one care. The respondent also demonstrated the ability to meet the petitioner's needs while the petitioner was on a "30-minute check order", but falls happened before the order was given and once the order expired. The above controlling authority requires the respondent to provide the necessary care and services for the residents they serve. Although the respondent reported one-on-one care is not a service the facility provides, this does not exempt the respondent from the federal requirement to provide the care or service when it is necessary so that adequate supervision is provided to prevent accidents.

26. Although the physician signed the Nursing Home Transfer and Discharge Notice, the respondent did not provide any evidence to show that the discharge was necessary for his welfare. This is both a federal and state requirement.

27. Based upon the evidence presented, the undersigned concludes the nursing facility has failed to establish by clear and convincing evidence that the petitioner's needs cannot be met **and** the discharge is necessary for the petitioner's welfare. The undersigned concludes that the respondent's intent to discharge the petitioner from its facility is not consistent with the above controlling authorities.

DECISION

Based on the above Findings of Fact and Conclusions of Law, the appeal is granted. The facility has not established that this discharge is permissible under federal or state regulations.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 15 day of February, 2016, in Tallahassee, Florida.

Melissa Roedel

Melissa Roedel
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
[redacted] Respondent
Ms. Donna Heiberg
Agency for Health Care Administration
[redacted]

FILED
Feb 01, 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.

Administrator

[redacted]

RESPONDENT.
_____/

APPEAL NO. 15N-00107

CASE NO.

FINAL ORDER

Pursuant to notice, the undersigned convened a nursing home discharge hearing in the above-referenced matter on December 10, 2015 at 1:15 p.m., at [redacted] [redacted] Florida.

APPEARANCES

For the petitioner: [redacted] petitioner's wife

For the respondent: [redacted] Nursing Home 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. A Nursing Home Transfer and Discharge Notice was issued on November 2, 2015. The facility has the burden of proof to establish by clear and convincing evidence that the discharge is appropriate.

PRELIMINARY STATEMENT

The petitioner was not present; however, petitioner's wife represented the petitioner. All parties appeared in person.

Witnesses for the respondent were nursing home (NH) clinical social worker, [redacted] NH business manager, [redacted] and NH social services director, [redacted]

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.

By Discharge Notice dated November 2, 2015, the respondent notified the petitioner that he was to be discharged from the nursing facility effective December 2, 2015, due to non-payment of bill for services.

The petitioner did not present any exhibits. The respondent presented one exhibit, which was accepted into evidence and marked as Respondent Exhibit "1". The record closed on December 10, 2015.

FINDINGS OF FACT

1. The petitioner (72) entered the facility on June 18, 2015. On July 31, 2015, the respondent discussed with the petitioner the option of long term care. Medicare part A paid for services rendered until August 31, 2015.

2. Once petitioner's Medicare part A ended, he became a private pay individual who is responsible for the total amount of the facility's bill for services rendered.

3. On August 20, 2015, petitioner applied for Institutional Care Program (ICP) Medicaid benefits with the Department of Children and Families (DCF). Petitioner was pended for assets verification.

4. On September 22, 2015, DCF denied petitioner's application due to not submitting the necessary information to determine eligibility.

5. On November 2, 2015, the respondent issued the petitioner a Nursing Home Transfer and Discharge Notice that indicated petitioner would be discharged from the facility effective December 2, 2015 due to non-payment of bill for services. The discharge location listed was the petitioner's home address: [redacted] in [redacted]

6. The petitioner's past due balance was $33,145.08 for the months of September 2015 through December 1, 2015.

7. Mrs. [redacted] did not dispute the amount owed to the facility and she acknowledged being aware of the financial obligation to the facility. She explained that she was seeking sponsors (Mrs. [redacted] was not specific who she sought sponsorships from) and reapplied for ICP Medicaid benefits on October 3, 2015 by certified mail to DCF, Post Office Box 1770 Ocala, Florida, 34478 and included all necessary documents for the petitioner's ICP Medicaid eligibility to be determined. As of the hearing date, petitioner had not yet received a notification from DCF informing him of the status of his ICP Medicaid application. Furthermore, Mrs. [redacted] explained she has made payments towards the patient responsibility. Petitioner was given by the facility a patient responsibility of $1,510 per month pending the outcome of the Medicaid application on August 20, 2015. Mrs. Setzer paid $549.91 to the facility on October 30, 2015. To date, the petitioner owes the facility $33,145.08.

8. The respondent explained the facility has access to DCF's on-line query when a patient submits an application. The respondent explained the last application submitted

to DCF was on August 20, 2015; it could not verify another application had been submitted to DCF on October 3, 2015 as indicated by Mrs. [redacted] Furthermore, the respondent explained that due to not seeing any other application submitted to DCF, the respondent requested documentation from Mrs. [redacted] that she had applied again. The respondent attempted to communicate with Mrs. [redacted] on the status of the application and to obtain copies to further assist her with the application process, but Mrs. [redacted] refused to provide any information. As of the date of the hearing, Mrs. [redacted] has not provided any documentation regarding the new application she alleges to have submitted to DCF and has not provided a copy of said application to the respondent.

9. Mrs. [redacted] explained family members and her attorney are assisting her with the application process and she did not feel comfortable providing a copy of the application or her household's financial information to the respondent.

10. No documentation was provided at the hearing to show an ICP Medicaid benefits application was pending with DCF for the petitioner.

CONCLUSIONS OF LAW

11. The jurisdiction to conduct this hearing is conveyed to the Department of Children and Families by Federal Regulations appearing at 42 C.F.R. § 431.200. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to s. 400.0255(15), Fla. Stat. In accordance with that section, this order is the final administrative decision of the Department of Children and Families.

12. Federal Regulations appearing at 42 C.F.R. § 483.12, Admission, transfer and discharge rights, sets forth the limited reasons a Medicaid or Medicare certified nursing facility may involuntary discharge a resident and states in part:

> (a)(2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--
> (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
> (ii) The transfer or discharge is appropriate because the president's health has improved sufficiently so the resident no longer needs the services provided by the facility;
> …
> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid…

13. The Department of Health and Human Services, Centers for Medicaid and Medicare Services, State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities states in part:

> A resident cannot be transferred for non-payment if he or she has submitted to a third party payor all the paperwork necessary for the bill to be paid. Non-payment would occur if a third party payor, including Medicare or Medicaid, denies the claim and the resident refused to pay for his or her stay.

14. 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.

15. 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. As of the date of the hearing, the petitioner's balance owed to the facility was $33,145.08. This fact is not disputed.

16. Petitioner's wife alleged that she had submitted a certified ICP Medicaid application to DCF on October 3, 2015 and that she was seeking benefits to pay for the facility's unpaid charges for the petitioner; however; this is unknown. No evidence was proffered to indicate an application was submitted on October 3, 2015 or that said application is pending.

17. The hearing officer concludes that the facility has given the petitioner reasonable and appropriate notice to pay for the petitioner's stay at the facility. Based on the evidence presented, the nursing facility has established that the petitioner has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. 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.

18. 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 01 day of February, 2016,

in Tallahassee, Florida.

Cassandra Perez
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
[redacted]
Respondent
Ms. Theresa DeCanio
Agency for Health Care Administration
[redacted]

FILED
Feb 26, 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. 15N-00125

PETITIONER,

Vs.

ADMINISTRATOR
[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on February 4, 2016, at 2:28 p.m., at the [redacted] located in Jacksonville, Florida.

APPEARANCES

For the Petitioner: The petitioner was present and represented herself.

For the Respondent: [redacted] Chief Executive Officer of the facility.

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 December 11, 2015, the respondent informed the petitioner that the facility was seeking to discharge/transfer her due to nonpayment. On December 17, 2015, the petitioner timely requested a hearing to challenge the discharge/transfer.

Appearing as witnesses for the petitioner was [redacted] son to the petitioner.

Appearing as witnesses for the respondent were [redacted] Director of Social Services, [redacted] Chief Financial Officer, and [redacted] Chief Officer.

Appearing as an observer was [redacted] board member and facility's attorney.

A letter dated January 19, 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.

FINDINGS OF FACT

1. The petitioner, age 84, has been a resident in the facility, between discharges to hospitals and home, since 2005. The petitioner was a self-paying resident until her ICP Medicaid was approved in December 2015 or January 2016. Her patient responsibility is $3384.89 according to the Notice of Case action dated January 19, 2016.

2. The respondent contends that it issues a monthly billing statement directly to the petitioner and by mail to the petitioner's son. Respondent Exhibit 2 includes billing statements mailed to the petitioner's son for the months of March 2015 through December 2015.

3. The petitioner's son acknowledges receiving the billing statements. The petitioner's son argues that his mother did not understand that she owed the facility anything because she paid a total of $346,138.08 to the facility with the sale of another piece of property *(Petitioner Exhibit 1, page 1)*. The petitioner believes she paid the facility with the sale of her home in New York. The petitioner's son does not understand why the facility waited until the balance reached $97958.46 to inform him of the balances owed. The petitioner's son contends that the petitioner should be transferred to another facility and not discharged to home, as stated on the Nursing Home Transfer and Discharge Notice.

4. The facility contends that the petitioner's son should have been aware of the increasing balance because he was receiving the monthly billing statements. The facility explained that it believed the petitioner's attorney was assisting in the completion of the petitioner's application for ICP Medicaid and that the attorney was assisting the

petitioner's family in utilizing her assets to pay for her care at the facility. The facility acknowledges receiving payment from the sale of one of the petitioner's two homes; the payment received was applied to her account. The facility contends that it initiated the discharge process when it was discovered in December 2015 that the petitioner's assets were unavailable to pay for her care. The facility explained that it does not intend to discharge the petitioner to an unsafe environment.

5. The petitioner's son wishes for the petitioner to remain in the facility as it is a Jewish facility and will allow his mother to adhere to her kosher diet. The petitioner's son believes discharging his mother from the facility will be detrimental to her well-being. The petitioner's son contends that he has made efforts to work with the facility in an attempt to resolve the issue and that he has offered to work for the facility to repay the balance owed. The petitioner offered to work for the facility in an effort to pay unpaid balance and remain as a resident.

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 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.

7. Federal Regulations appearing 42 C.F.R. § 483.12, sets forth the reasons a facility may involuntary discharge a resident as follows: Admission, transfer and discharge rights.

> (a)(2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--
> (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
> (ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
> (iii) The safety of individuals in the facility is endangered;
> (iv) The health of individuals in the facility would otherwise be endangered;
> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
> (vi) The facility ceases to operate.

8. Based on the evidence presented, the nursing facility has established that the petitioner has failed to pay for her stay at the facility after receiving 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.

9. The petitioner's acknowledges receipt of the monthly billing statements; he offered to work for the facility in an attempt to repay the balance owed. Therefore, the undersigned concludes the facility has followed the above controlling authority to issue reasonable and appropriate notice prior to issuing the discharge notice.

10. Based on the findings and the federal and state controlling authorities, the undersigned concludes the facility's discharge is proper.

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. 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

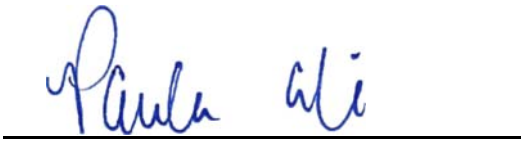
Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied. The facility may proceed with the discharge action in accordance with the Agency for Health Care Administration's rules and guidelines.

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 __26__ day of __February_____, 2016,

in Tallahassee, Florida.



Paula Ali
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Copies Furnished To: [redacted] Petitioner
[redacted]
Respondent
Mr. Robert Dickson,
Agency for Health Care Administration
[redacted]

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

[redacted]

APPEAL NO. 16F-00009
16F-00010

PETITIONER,

Vs.

[redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 20 Collier
UNIT: 88287

RESPONDENT.
_____/

ORDER OF DISMISSAL DUE TO WITHDRAWAL

Pursuant to notice, an administrative hearing convened telephonically at 11:08 a.m. CST on February 10, 2016. Petitioner represented herself. Ed Poutre, Economic Self-Sufficiency Specialist II, represented the Department.

Once on record, Petitioner verbally withdrew the hearing requests indicating the issues have been resolved. Therefore, the appeals are dismissed as withdrawn.

DONE and ORDERED this 12 day of February, 2016,

in Tallahassee, Florida.

Gregory Watson
_____

Gregory Watson
Hearing Officer
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FILED
Feb 12, 2016
Office of Appeal Hearings
Dept. of Children and Families

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

FILED
Feb 23, 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-00017
APPEAL NO. 16F-01120

PETITIONER,

Vs.

CASE NO. [redacted]

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: [redacted]

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 (ages1 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 per 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.

Christiana Gopaul Narine

Christiana Gopaul-Narine
Hearing Officer
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Office of Economic Self Sufficiency

FILED
Feb 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. 15F-10325
15F-10326
16F-00066

PETITIONER,

Vs.

[redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 Marion
UNIT: 02555

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 10:50 a.m. on January 13, 2016. The hearing was reconvened at 8:20 a.m. on January 25, 2016.

APPEARANCES

For the Petitioner: [redacted] pro se

For the Respondent: Tia Island-Hooker, ACCESS Supervisor

STATEMENT OF ISSUE

At issue is whether petitioner's Food Assistance (FA) and Temporary Cash Assistance (TCA) benefit amounts approved by the respondent are correct. And whether the respondent's denial of petitioner's Medicaid is proper. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

By notice dated October 1, 2015, the respondent (or the Department) notified the petitioner her August 31, 2015, application was denied, due to not receiving the requested information to determine eligibility. Petitioner timely requested a hearing to challenge the denial.

Maria Reinante, ACCESS Economic Self-Sufficiency Specialist II, appeared as an interpreter for the petitioner. Petitioner did not submit exhibits. Respondent submitted 14 exhibits, entered as Respondent Exhibits "1" through "14". The record was held open until February 4, 2016, for the petitioner to submit exhibits. Petitioner's exhibits were not received. The record was closed on February 4, 2016.

FINDINGS OF FACT

1. Petitioner submitted: (1) a FA, TCA and Medicaid application on August 31, 2015, (2) a change report on September 30, 2015, (3) a FA, TCA and Medicaid application on October 28, 2015, (4) a change report on December 7, 2015 and (5) a FA, TCA and Medicaid application on December 17, 2015. Petitioner's issues are for FA and TCA for her household and Medicaid for herself; for all applications and change reports.

2. Petitioner's August 31, 2015 application for FA, TCA and Medicaid lists household members as petitioner and her minor child ([redacted] age 10 months). The application does not list income or expenses.

3. On September 2, 2015, the Department mailed petitioner a Notice of Case Action (NOCA), requesting petitioner call for an interview on or before September 11, 2015. The NOCA also requested petitioner provide Social Security Card (SSC) for her, birth certificate, SSC and current immunization (shot) records for her child.

4. On September 8, 2015, the Department interviewed the petitioner for the August 31, 2015 application. Petitioner reported herself and [redacted] in the household, living with a friend. Petitioner also reported she last worked in 2013.

5. On September 9, 2015, the Department mailed petitioner a NOCA, requesting petitioner provide verification that her case in Puerto Rico (PR) was closed, by September 21, 2015.

6. On September 15, 2015, the Department approved petitioner expedited FA; $11 for August 2015 (prorated using .032 proration rate to the August 31, 2015 application) and $357 for September 2015 (maximum amount for a household size of two).

7. And on September 16, 2015, the Department mailed petitioner two NOCA's:

> NOCA one, approved expedited FA for $11 in August 2015, $357 in September 2015 and $357 October 2015 through January 2016 for petitioner and TRC. The NOCA also informed petitioner that she must provide verification that case in PR was closed by September 30, 2015. NOCA two, requested petitioner provide current shot records for her minor child, closure letter from PR and for petitioner to work register.

8. Petitioner submitted a change report to add her other two children ([redacted] age five and [redacted] age three) on September 30, 2015.

9. Also on September 30, 2015, the Department denied petitioner her August 31, 2015 application; due to not receiving the requested information, they also closed her case.

10. The Department's Document Imaging System (DIS) is a system that tracks documents sent by the Department to the petitioner and from the petitioner to the Department. The DIS shows that petitioner did not return verification that her case in PR was closed or work registered by September 30, 2015.

11. The Department's Running Records Comments (CLRC), dated September 30, 2015, states the petitioner provided SSC, birth certificate, identification and shot record (without an expiration date). The CLRC does not indicate that petitioner work registered.

12. And on October 1, 2015, the Department mailed petitioner a NOCA, notifying her August 31, 2015, application was denied, due to not receiving the requested information to determine eligibility.

13. On October 5, 2015, the Department mailed petitioner a NOCA, requesting petitioner provide verification that her case in PR was closed by October 15, 2015.

14. Respondent's representative stated that petitioner's September 30, 2015, change report was not processed because petitioner's case was already closed. And the October 5, 2015, NOCA was sent in error.

15. Petitioner applied for FA, Cash and Medicaid for her household on October 28, 2015. Household members listed include the petitioner, her boyfriend [redacted], their mutual child ([redacted] and petitioner's two other children [redacted]). The application indicates that petitioner is employed at [redacted].

16. On October 30, 2015, the Department mailed petitioner two NOCA's:

> NOCA one, requested petitioner call for an interview by November 9, 2015, provide income verification and verification that her case in PR is closed.
> NOCA two, approved Medicaid for CR and notified petitioner she is ineligible for Medicaid.

17. On November 4, 2015, the Department interviewed the petitioner for the October 28, 2015 application. Petitioner reported five members in her household; petitioner, her

boyfriend ([redacted], their mutual child [redacted] and petitioner's two other children [redacted]. Petitioner reported working at [redacted]

18. On November 6, 2015, the Department mailed petitioner a NOCA, requesting verification that her case in PR was closed and income verification for the last four weeks.

19. On November 16, 2015, the Department received a fax from PR showing petitioner's case was closed on September 15, 2015. The document states that petitioner did not received benefits in October 2015.

20. Petitioner submitted a change report on December 7, 2015; to report her employment at [redacted] ended on November 28, 2015 and that she received the last pay on December 4, 2015. The change report also states her employment started on October 1, 2015 and she received $1,315.80 weekly income.

21. The Department incorrectly used $1,315.80 as household monthly income for the October 2015, November 2015, December 2015 and January 2016 FA budgets; to arrive at $72 in FA for October 2015 (prorated to October 28, 2015 application) and $725 in FA for November 2015, December 2015 and January 2016 for her household of five.

22. And on November 10, 2015, the Department mailed petitioner a NOCA notifying the October 28, 2015 application was approved for FA; $72 for October 2015 and $725 for November 2015 through March 2016. The NOCA also informed petitioner that the October 28, 2015 application was denied for TCA, due to household hold income.

23. On December 15, 2015, the Department mailed petitioner two NOCA's:

NOCA one, requested petitioner provide verification that she is a Florida resident by December 28, 2015.
NOCA two, requested petitioner provide loss of income verification from [redacted] by December 28, 2015.

24. Petitioner asserts that she submitted loss of employment verification on December 16, 2015. The record was held open until February 4, 2016, for the petitioner to provide said verification. Petitioner did not submit the December 16, 2015, loss of employment verification.

25. The Department's DIS does not indicate that a loss of employment was received from the petitioner. Although, it does indicate that the petitioner submitted a Verification of Employment from [redacted] on November 6, 2015. The employment verification shows petitioner made $1,224 in the month of October 2015.

26. Petitioner submitted another FA, TCA and Medicaid application for her household on December 17, 2015. Household includes the petitioner, her boyfriend [redacted] their mutual child [redacted] and petitioner's two other children [redacted]. The application indicates petitioner last worked at [redacted] which ended on November 28, 2015 and last pay received was on December 4, 2015. Expenses listed include $150 rent, $50 telephone and $75 electricity; and under the "Expense Summary" section of the application it states "Yes" under "Heating and Cooling Costs".

27. On December 18, 2015, the Department called petitioner's employer to verify that petitioner was no longer employed. The employer informed the Department that CR had been employed and he received his last pay from [redacted] on November 27, 2015; the employer also informed the Department that petitioner was terminated on November 28, 2015.

28. On December 21, 2015, the Department mailed petitioner a NOCA, requesting she call for an interview by December 28, 2015.

29. On December 22, 2015, the Department interviewed the petitioner for the December 17, 2015 application. Petitioner reported her household includes herself, her boyfriend [redacted], their mutual child [redacted] and petitioner's two other children [redacted] and no household income.

30. On December 23, 2015, the Department mailed petitioner a NOCA, requesting immunization records for children under five years old and to work register by January 4, 2016.

31. On December 28, 2015, the Department mailed petitioner three NOCA's:

> NOCA one, approved (1) $771 FA for her household effective February 2016 through March 2016 and (2) Medicaid for petitioner effective January 2016.
> NOCA two, approved $771 FA for her household for January 2016.
> NOCA three, requested current immunization records for the children and petitioner and CR to work register.

32. The maximum FA benefit for a household size of five is $771. Although, the Department had previously approved petitioner $725 in FA benefits (#22) for January 2016, the above NOCA approved petitioner's household $771 FA for January 2016.

33. The Department's CLRC, dated January 4, 2016, states the petitioner and [redacted] work registered on December 31, 2015. And the Department verified that the children's immunization records were current.

34. The Department approved petitioner TCA benefits on January 4, 2016. They prorated the January 2016 TCA benefits to January 4, 2016 (date immunization records

were verified) using a .90 proration factor to arrive at $383 ($426 maximum TCA for a household size of five multiplied by .90); and $426 TCA for February 2016 and ongoing.

35. The Department recalculated petitioner's February FA budget to include the TCA benefits as follows:

$426.00	TCA
-$197.00	standard deduction
$229.00	adjusted income
$150.00	shelter
+$ 37.00	phone standard
$187.00	shelter/utility cost
-$114.50	50% adjusted income ($229/2)
$ 72.50	excess shelter/deduction
$229.00	adjusted income
-$ 72.50	excess shelter/deduction
$156.50	adjusted income after deductions

30% of $156.50= $47 (round up) benefit reduction

36. The Department subtracted $47 from $771 (maximum FA benefits for a household size of five) to arrive at $724 in FA benefits.

37. On January 5, 2016, the Department mailed petitioner a NOCA; (1) approving TCA, $383 for January 2016 and $426 for February 2016 and ongoing, (2) decreasing FA from $771 to $724 effective February 2016 through March 2016 and (3) approving Medicaid for the household.

38. The Department's representative agreed to recalculate petitioner's household FA benefits for October 2015 (starting with the October 28, 2015 application), November 2015 and December 2015; due to the Department using an incorrect income amount. The representative also agreed to mail petitioner a new NOCA (with appealable rights) identifying the correct FA amounts.

39. The Department's representative stated that petitioner was enrolled in the Medically Needy (MN) Program with a Share of Cost (SOC), prior to authorization of full Medicaid. However, the representative did not indicate which months the petitioner had MN or the SOC amounts. Evidence was not submitted as to how the SOC amounts were determined.

40. The Department's representative agreed to reevaluate petitioner's Medicaid eligibility back to the August 31, 2015 application and mail petitioner a new NOCA (with appealable rights) identifying petitioner's Medicaid eligibility.

41. Petitioner asserts that in accordance with the Department's policy (0610. 0600), she is not required to provide verification that her case in PR is closed.

CONCLUSIONS OF LAW

42. 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.

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

FOOD ASSISTANCE ISSUE

44. The Department's Program Policy Manual (Policy Manual), CFOP, Appendix A-1, sets forth $357 maximum FA for a household size of two.

45. Federal Regulations at 7 C.F.R. § 273.10, explains FA date of eligibility and in part states:

> (a) (ii) A household's benefit level for the initial months of certification shall be based on the day of the month it applies for benefits and **the household shall receive benefits from the date of application** (emphasis added)…

46. In accordance with the above authority, the Department prorated petitioner's August 2015 FA benefits for her and her child to the August 31, 2015 date of application; using .032 proration rate to arrive at $11 ($367 X .032 = $11, round up) in FA benefits.

47. The Department also approved petitioner $357 FA (maximum FA amount for a household size of two) for September 2015. The Department closed petitioner's FA on September 30, 2015, for not providing verification that her case in PR was closed.

48. Petitioner argued that in accordance with the Department's policy (0610.0600), she is not required to provide verification that her case in PR is closed.

49. Policy Manual, CFOP, section 0610.0600 NON-DUPLICATION OF ASSISTANCE (FS) states:

> Recipients may not receive benefits from more than one state or be included in more than one AG in any month.
> Nutritional Assistance Program (NAP) benefits from Puerto Rico are the same as food stamp benefits in the United States. However, if the customer moves to the United States, the NAP benefits do not count as income to the household and the household is not receiving duplicate benefits. **It is not necessary to attempt to contact Puerto Rico to confirm the closure of the NAP case prior to approval of food stamp benefits**… (emphasis added)

50. The above Department policy clearly states that "It is not necessary to attempt to contact Puerto Rico to confirm the closure of the NAP case prior to approval of food stamps benefits."

51. The Department incorrectly closed petitioner's FA case for not submitting verification that her case in PR was closed. As a result, the Department erred by not processing petitioner's September 30, 2015, change report to add her two additional children.

52. The Department calculated petitioner's October 2015 through December 2015 FA benefits for application dated October 28, 2015, using an incorrect monthly income amount of $1,315.80. The $1,315.80 is a weekly income amount that petitioner reported on a change report dated December 7, 2015; when she reported she had lost her employment.

53. The Department's representative agreed to recalculate petitioner's FA amounts from the October 28, 2015 application date, for October 2015 through December 2015, using verified income amounts.

54. Federal Regulation at 7 C.F.R § 273.9, defines income and allowable deductions. It states in part:

> (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:
> (i) Assistance payments from Federal or federally aided public assistance programs, such as supplemental security income (SSI) or Temporary Assistance for Needy Families (TANF)…
>
> (d) Income deductions. Deductions shall be allowed only for the following household expenses:
> (1) Standard deduction…
> (6) Shelter costs…
> (ii) Excess shelter deduction. Monthly shelter expenses in excess of 50 percent of the household's income after all other deductions…
> (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); and, a limited utility allowance (LUA) that includes electricity and fuel for purposes other than heating or cooling, water, sewerage, well and septic tank installation and maintenance, telephone…

55. Policy Manual, CFOP, Appendix A-1, sets forth for a household size of five the following:

$771	maximum FA allotment
$197	standard deduction
$ 37	telephone standard
$345	standard utility allowance (SUA)

56. Federal Regulations at 7 C.F.R. § 273.10, explains income and deduction calculations. It states in 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…
> (i) To determine a household's net monthly income, the State agency shall…
> (A) Add the gross monthly income earned by all household members and the total monthly unearned income of all household members…
> (C) Subtract the standard deduction…
> (H) Total the allowable shelter costs…Subtract from total shelter costs 50 percent of the household's monthly income after all the above deductions have been subtracted. The remaining amount, if any, is the excess shelter cost…
> (I) Subtract the excess shelter cost...
> (2) Eligibility and benefits…
> (ii)(A)… the household's monthly allotment shall be equal to the maximum food stamp allotment for the household's size reduced by 30 percent of the household's net monthly income …

57. The cited authorities set forth income and allowable deductions in the FA benefit determination. The Department included petitioners $426 TCA and allowable deductions (standard deduction, shelter and telephone standard) in the FA calculation to arrive at $724 FA starting February 2016.

58. Petitioner's December 17, 2015 application indicates petitioner pays $75 electricity for heating and cooling. The Department erred by giving petitioner a $37 telephone standard instead of the $345 SUA.

TEMPORARY CASH ASSISTANCE ISSUE

59. Policy Manual, CFOP, section 1420.0509.01 Immunization (TCA) in part states:

> Applicants and recipients for Temporary Cash Assistance (TCA) who have a preschool child under age five must complete appropriate childhood immunizations for the child as a condition of eligibility. If the immunization requirement is not met, the child is sanctioned. The child's income and assets must be counted. If the only child in the assistance group does not meet the requirement, TCA is denied/terminated.

60. Fla. Admin. Code R. 65A-4.216 Immunization Program in part states:

> (2) Any written statement containing information that the immunizations are current, the date the next immunization is due and the dated signature of a health care professional licensed under Chapter 458, 459 or 460, F.S., or authorized designee is acceptable as verification for immunization requirements. DH Form 680, 11/96, Florida Certification of Immunization, incorporated by reference, is an example of acceptable verification. Oral verification through direct contact between departmental staff and the health care professional or their authorized designee is allowed when the participant is unable to obtain written verification. DH Form 680 when signed by a healthcare professional licensed under Chapter 458 or 459, F.S., also will be used as verification of good cause for failure to immunize a child due to a permanent medical condition. DH Form 681, 5/99, Religious Exemption from Immunization, incorporated by reference, signed by the county public health director or administrator is acceptable verification of good cause for failure to immunize a child because of religious beliefs.

61. The above policy manual and authority explain current immunization records are required for children under age five to receive TCA. The petitioner submitted incomplete immunization records on September 30, 2015. The Department verified that the petitioner's two minor children had current immunization on January 4, 2016.

62. Fla. Admin. Code R. 65A-4.209 Income in part states:

> (2) To be financially eligible for TCA, the total average gross monthly income less any applicable disregards of the standard filing unit cannot exceed the applicable payment standard for the assistance group. These standards and disregards are found in Sections 414.095(10) and (11), F.S…

63. Fla. Stat. § 414.095 (10) DETERMINATION OF LEVEL OF TEMPORARY CASH ASSISTANCE in part states:

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

Family Size	Zero Shelter	Less than $50	Greater than $50
2	$158	$205	$241
5	$289	$362	$426

64. In accordance with the above authority, a household size of five with a shelter obligation greater than $50 and $426 monthly income is not eligible for TCA benefits.

65. Petitioner received $1,224 employment income in the month of October 2015; which is more than the $426 income standard to be eligible for TCA.

66. Fla. Stat. § 414.095 - explains eligibility for temporary cash assistance, in part states:

> (1) ELIGIBILITY.—An applicant must meet eligibility requirements of this section before receiving services or temporary cash assistance under this chapter, except that an applicant shall be required to register for work and engage in work activities in accordance with s. 445.024, as designated by the regional workforce board…

67. Fla. Stat. § 445.024, Work requirements, in part states:

> (2) WORK ACTIVITY REQUIREMENTS.--Each individual who is not otherwise exempt from work activity requirements must participate in a work activity for the maximum number of hours allowable under federal law…

68. In accordance with the above authorities, to be eligible for TCA benefits, TCA applicants must work register and participate in a work activity, unless an exemption is met. Petitioner and [redacted] do not meet an exemption; therefore, they are required to work register.

69. Petitioner and [redacted] work registered on December 31, 2015.

70. Fla. Stat. § 414.095 - Determining eligibility for temporary cash assistance, in part states:

> (8) (a) APPLICATIONS.—The date of application is the date the department or authorized entity receives a signed and dated request to participate in the temporary cash assistance program. The request shall be denied 30 days after the initial application if the applicant fails to respond…

71. In accordance with the above authority, the Department denied petitioner's August 31, 2015 TCA application on September 30, 2015; 30 days from the August 31, 2015 application date; due to petitioner not completing work registration and not providing current immunization records for TRC.

72. In accordance with the above authorities (#62 and #63), petitioner was not eligible for TCA for the October 28, 2015 application due to income. Petitioner received $1,224 employment income in October 2015.

73. The Department approved petitioner TCA benefits on January 4, 2016; when they verified that the immunization records for the children were current. The Department prorated petitioner's January 2016 TCA ($383) benefits to January 4, 2016. The

Department also approved the full TCA benefit amount of $426 for a household size of five starting February 2016.

MEDICAID ISSUE

74. The Department approved petitioner full Medicaid effective in January 2016. The respondent's representative argued that the petitioner was enrolled in the MN Program prior to receiving full Medicaid. Although, the Department did not submit evidence to explain how they determined petitioner SOC.

75. Respondent's representative agreed to reevaluate petitioner's Medicaid eligibility back to the August 31, 2015, date of application, and mail petitioner a NOCA (with appealable rights) identifying her Medicaid eligibility.

HEARING OFFICER'S CONCLUSION - FA ISSUE

76. The evidence submitted establishes that the petitioner and her child ([redacted] received the proper amount of FA benefits for August 2015 and September 2015.

77. In careful review of the cited authorities, policy manual and evidence, the undersigned concludes that the Department incorrectly closed petitioner's FA case on September 30, 2015.

78. The Department erred by not processing petitioner's September 30, 2015, change report to add her two other children to her case; due to not receiving verification from PR that her case was closed. The Department's own policy (#49) clearly states that "It is not necessary to attempt to contact PR to confirm the closure of the NAP case prior to approval of food stamps benefits."

79. The Department also erred by including a $37 telephone standard instead of a $345 standard utility allowance in petitioner's February 2016 FA budget calculation.

80. The undersigned hereby REMANDS the case to the Department for corrective action. The Department is to process petitioner's September 30, 2015, change report to add her two children to the FA budget.

81. Respondent's representative agreed to recalculate petitioner's FA benefits effective with petitioner's October 28, 2015 application for October 2015 through December 2015. The Department is to recalculate petitioner's FA budgets from September 30, 2015 through December 2015. The Department is also to recalculate petitioner's February 2016 and ongoing FA budget to include the SUA. The Department is to mail petitioner new NOCA's (with appealable rights) identifying the FA amounts effective from September 30, 2015 through December 2015 and February 2016 and ongoing.

HEARING OFFICER'S CONCLUSION -TCA ISSUE

82. In careful review of the cited authorities and evidence, the undersigned concludes that the Department was correct in denying petitioner TCA benefits for the August 31, 2015 and October 28, 2015 applications.

83. The Hearing Officer also concludes, the Department is correct in approving petitioner's TCA benefits effective January 4, 2016; $383 for January 2016 (prorated to January 4, 2016) and $426 for February 2016 and ongoing.

HEARING OFFICER'S CONCLUSION -MEDICAID ISSUE

84. In careful review of the cited authorities and evidence, the undersigned agrees that petitioner's Medicaid needs to be reevaluated back to August 31, 2015. The Department is to mail petitioner a new NOCA (with appealable rights) with status of her Medicaid eligibility.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are both granted and denied. The FA appeal is REMANDED to the Department for corrective action as identified in the Conclusion of Law. The TCA appeal is denied and the Department's action is affirmed. And the Medicaid issue is dismissed as moot, since the Department has agreed to recalculated petitioner's Medicaid eligibility back to August 31, 2015.

ANY FOOD STAMP BENEFITS DUE APPELLANT PURSUANT TO THIS ORDER MUST BE AVAILABLE WITHIN (10) TEN DAYS OF THIS DECISION OR WITHIN (60) DAYS OF THE REQUEST FOR THE HEARING. ANY BENEFITS DUE WILL BE OFFSET BY PRIOR UNPAID OVERISSUANCES.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 15 day of February, 2016,

in Tallahassee, Florida.

Priscilla Peterson

Priscilla Peterson
Hearing Officer
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Office of Economic Self Sufficiency

FILED
Feb 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-00490 and 16F-00491

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 13 Hillsborough
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 17, 2016 at 3:09 p.m.

APPEARANCES

For the Petitioner: [redacted] Quality Specialty Pharmacy

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

STATEMENT OF ISSUE

At issue is whether the Agency properly denied Petitioner's request for prescription medication [redacted] Petitioner held the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The Agency for Healthcare Administration (AHCA or Agency) is responsible for administering Florida's Medicaid Program. AHCA contracts with managed care plans to

provide services, including pharmacy services, to Medicaid recipients in Florida. The managed care plans provide prior authorization reviews for requested services.

Petitioner was not present and did not provide testimony. She was represented by a representative from her pharmacy. [redacted] was present as Petitioner's representative and witness. [redacted] Pharmacist, Quality Specialty Pharmacy, provided testimony for Petitioner. Respondent's witnesses were Susan Frischman (Senior Compliance Analyst), Debra Smith (Director of Pharmacy), and Dr. Marc Kaprow (Executive Director of the Long Term Care Program) with United Healthcare.

Respondent submitted fourteen exhibits, marked and entered as Respondent's Exhibits 1 through 14, into evidence. The hearing officer took administrative notice of Sections 409.910, 409.912, 409.962 through 409.965, 409.973, and 409.91195 of the Florida Statutes (2015), Florida Administrative Code Rules 59G-1.001, 1.010, 4.255, 4.250, and the Medicaid Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook (July 2014).

FINDINGS OF FACT

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

1. Petitioner is an adult female diagnosed with chronic [redacted] Type 1a. She is treatment naïve (has not been treated before) and has a [redacted] Scores can range from [redacted] with [redacted] being no [redacted] She has a high viral load. She is seeing a specialist physician for her treatment. She is a member of United Healthcare's Medicaid managed care plan.

2. Petitioner's treating specialist submitted a preauthorization request to the Agency for [redacted] on or about September 14, 2015. The request was denied by notice dated September 15, 2015. The notice indicated that it was denied because there was no indication Petitioner was being treated for [redacted]

3. Petitioner's specialist requested an expedited reconsideration of the denial, on or about October 12, 2015. He acknowledged in his letter and supporting documentation that Petitioner does not have [redacted], but requested reconsideration due to the drug therapy's effectiveness. In support of this request, he provided a letter of medical necessity citing to guidelines, medical journals, and studies. He also provided Petitioner's clinical notes and lab results to support the request for [redacted]

4. The plan reviewed the submitted documentation and upheld the denial. The denial notice dated October 15, 2015, stated in relevant part:

> …This decision was made per the UnitedHealthcare Florida Community & State Guideline Viekira. You have asked for [redacted] is given when you have [redacted] The notes we received from your doctor do not show you have [redacted] Please speak with your doctor about this.

5. The plan denied the preauthorization request for [redacted] because Petitioner's condition must meet certain criteria to be approved for these particular drugs. Based on the plan's review of Petitioner's medical records, Petitioner's condition does not meet the specific criteria for [redacted]

6. Petitioner requested a fair hearing to dispute the denial. She contends that she should be granted the [redacted] because she has a risk of developing

[redacted]f left untreated. She has had high iron levels in the past, which may be explained by concurrent gallstones at the time. She has a family history of cancer, which can lead to a greater risk of cancer in general for this Petitioner. She argues that professional medical societies have created guidelines for the drugs' use which indicates use at earlier [redacted] is beneficial, and those guidelines should be adopted here.

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 120.80, Florida Statutes.

8. The Florida Medicaid program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The program is administered by the Agency.

9. This hearing was held as a de novo proceeding pursuant to Florida Administrative Code Rule 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. Section 409.912, Florida Statutes (2015) provides that AHCA shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To this end, the Agency has contracted with managed care organizations to provide medical coverage to enrolled recipients.

12. The Florida Medicaid Provider General Handbook (Provider Handbook) – July 2012 is incorporated by reference in Florida Administrative Code Rule 59G-5.020. In accordance with the Florida law, the Provider Handbook discusses managed care coverage, stating on page 1-27:

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.
>
> Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

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

14. All Medicaid covered services must be "medically necessary" as defined by law. Florida Administrative Code, 59G-1.010(166), defines medical necessity, as follows:

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

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

15. In order to determine "medical necessity," the Agency has created guidelines. The guidelines are "consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational." For prescription drugs, the managed care plan has adopted the Agency's guidelines.

16. For prescription drugs, Sections 409.912(8)(a)(14) through 409.912(16), Florida Statutes (2015), are instructive. Pursuant to Section 409.912(8)(a)(14), "the agency may require prior authorization for Medicaid-covered prescribed drugs." Section 409.91195 describes how the Agency creates and maintains such a process and creates the guidelines through a committee.

17. The Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook (July 2014) ("The Handbook") is promulgated into law by Florida Administrative Code Rule 59G-4.250. The Handbook echoes the information from the Florida Statutes.

18. The Agency has the authority to manage its prior authorization process, including establishing criteria for approval. It established specific criteria for Viekira Pak and Ribavirin. The Medicaid drug criteria for [redacted] require at least Stage [redacted] for approval. Petitioner's scores show her [redacted] is not that advanced, so she does not meet the established criteria for [redacted] and [redacted] The guidelines account for co-morbid diseases and other issues which would create a medical need for the drugs. There are no exceptions to the guidelines for

special cases not included in the criteria. Petitioner is entitled to all the benefits, support, and care the State of Florida may furnish to a person in her circumstances, except when eligibility is limited by law, such as here.

19. Petitioner argues that the medication should be approved because it has been shown to be useful in people with less extreme [redacted] Additionally, some professional medical organizations use guidelines which support the drugs' use in [redacted] cases. However, the fair hearing process is not the forum to challenge existing rules. The fair hearing process is to review the Agency's action based on the existing rules and regulations. The hearing officer must determine whether the "decision on eligibility or procedural compliance was correct at the time the decision was made." Fla. Admin. Code R 65-2.056(3). Based on the rules and regulations in effect at the time the decision was made, the Agency properly denied Petitioner's request. There is no rule or exception permitting the Agency to authorize the [redacted] for a recipient who does not meet the established guidelines. There is no rule or exception permitting the hearing officer to create or change Agency rules or policy to make such exceptions.

20. Petitioner did not meet her burden of proof to show that she meets the criteria to receive this medication. She is encouraged to work with her physician and the Agency to find a medication that will meet her needs and can be approved.

21. After careful review of the evidence submitted and the relevant laws set forth above, the undersigned finds the Agency's action in this matter was correct.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 22 day of February, 2016,

in Tallahassee, Florida.

Danielle Murray
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Don Fuller, Area 6, AHCA Field Office Manager

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

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

[redacted]

PETITIONER,

Vs.

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

RESPONDENT.
_____/

APPEAL NO. 15F-10578
16F-00739

CASE NO. [redacted]

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

Cassandra Perez
Hearing Officer
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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

[redacted]

PETITIONER,

Vs.

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

RESPONDENT.
_____/

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

CASE NO.

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 [redacted] 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

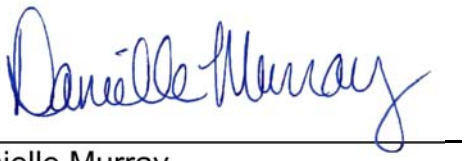
Petitioner's requests for hearing based on alleged plan delay in providing a referral are dismissed. The hearing officer finds no apparent delay in an Agency or plan decision on a claim for service which would provide hearing rights, and even if there were a delay, there would be no available or practical 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 February, 2016,

in Tallahassee, Florida.



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

FILED
Feb 09, 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-10321
16F-00808

PETITIONER,

Vs.

[redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 17 Broward
UNIT: 88249

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on February 2, 2016, at 1:00 p.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Eric Eckhardt, economic self-sufficiency supervisor.

STATEMENT OF ISSUE

At issue is whether the Department issued the correct amount of Food Assistance Program benefits (FAP) to the petitioner. Additionally, whether the Department's is correct enrolling petitioner's 3-year old child in the Medically Needy Program. The petitioner carries the burden of proof by the preponderance of evidence for both Programs.

PRELIMINARY STATEMENT

Pamela Vance, Hearing Officer with the Office of Appeal Hearings, appeared as an observer.

The petitioner did not provide any evidence for the undersigned to consider. The respondent submitted eight (8) exhibits, which were marked as Respondent's Exhibits 1 through 8.

The record was left open for one additional day through February 3, 2016 for the respondent to provide additional information to the undersigned for review. The evidence was timely received, entered into evidence, and marked as Respondent's Exhibits 9 through 12. The record then closed on February 3, 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, the petitioner had been receiving FAP and Medicaid Program benefits for his child only. The household consisted of three members: the petitioner, his wife and their 3 year-old daughter. His shelter obligation was $1,620.

2. On November 13, 2015, the petitioner submitted a web application requesting additional Medicaid benefits. The petitioner's household now consists of himself, his wife and their two mutual children, ages 3 & 0 [redacted] There are no disabled members in the household. The petitioner is subject to both the gross and the net income tests and is subject to a shelter cap, and is not allowed excess medical expenses.

3. Petitioner and his wife are here on work visas (E-1 visas). The E-1 visa is a nonimmigrant visa which allows foreign nationals to get employment in the United States. The petitioner and his wife are not refugees or asylees and are not eligible for any assistance. Their mutual children are United States citizens and are the only ones receiving benefits. Petitioner's household has medical insurance coverage through his employment. The petitioner did not report any household expenses on his application.

4. The FAP budgeting process involves deducting some standard deductions as well as some of the recipients' actual expenses. Rent or mortgage is an allowable deduction as well as a standard deduction for utilities (SUA) and excess medical expenses. Effective December 2015, the petitioner's rental obligation is $1,260. The deductions originally used to determine the eligibility effective January 2016 included the monthly rent of $630 and the standard utility allowance (SUA) of $345.

5. Petitioner received earned income of $1,846.15 biweekly and provided the Department with verification. The Department used a conversion factor of 2.15 to arrive at a total monthly gross earned income of $3,969.22. This amount was divided by four and the result multiplied by 2 to arrive $1,984.62 as countable prorated amount.

6. From the gross countable income of $1,984.62, a 20% ($396.92) earned income deduction; and a $155 standard deduction were subtracted to arrive at the $1,432.70 adjusted income, 50% of which becomes shelter standard ($716.35). With shelter/utility costs $975 ($1,260 shelter/2 and $345 SUA), petitioner was allowed $258.65 excess shelter deduction, resulting in the Food stamp Adjusted income downward adjusted to $1,174.05.

7. This amount ($1,174.05) was compared to the maximum net monthly income of $1,328 (for a household with two eligible members). A 30% benefit reduction occurred in the amount of $353, resulting in the petitioner's household being approved for $16 n Food Assistance. The Department used the same methodology and gross countable income of $1,620 to approve $129 in FAP benefits for December 2015, *see* Respondent's Exhibits 1 through 8.

8. The petitioner was seeking full Medicaid for his children. Petitioner is the only one employed, therefore his wife and their children are considered his tax dependents for Medicaid purposes. To begin the budgeting process, the Department added the petitioner's two paychecks to arrive at $3,692.30. This amount is considered as modified adjusted gross income (MAGI) for the household. To determine Medicaid eligibility for the children, the household MAGI of $3,692.30 was compared to the income limit for each child based on their individual age group in a household size of four.

9. The Department determined the newborn's eligibility for full Medicaid benefits because the household income was below the income limit ($4,042) for children under one year in a standard filing unit size of four. As the income exceeded the maximum limit ($2,688) for children ages 1 through 5, the 3-year old child was found ineligible. As the 3-year-old child was determined ineligible for full Medicaid, the respondent enrolled the child in the Medically Needy (MN) Program.

10. To determine petitioner's estimated SOC the Medically Needy Income Level (MNIL) of $585 (for a standard filing unit size four) was subtracted from $3,692.30, the

gross monthly household income, resulting to the child estimated SOC of $3,107, *see* Respondent's Exhibits 9 through 12.

11. On December 2, 2015, the Department sent the petitioner a Notice of Case Action informing him of its actions. On December 17, 2015, the petitioner timely requested an appeal to challenge the FAP benefits level. The Medicaid appeal was requested during the February 2, 2016 hearing.

12. The respondent explained that the FAP benefit level is based on petitioner's wages and the expenses at the time of action. The respondent explained that the 3-year old child is not eligible for full Medicaid because the household income exceeds the Family-Related Medicaid income limit for the household size and that her SOC was directly related to the household gross income. He explained that whenever incomes are received more often than monthly in the FAP, the Department is required to use the conversion factor of 2.15 (if received biweekly), 4.3 (if received weekly), or 2 (if received semimonthly). For Medicaid however, weekly incomes are multiplied by 4 and biweekly incomes are multiplied by 2. The respondent explained that December 2015 budget was incorrect because only $1,620 was counted as opposed to $1,984.62 in January 2016, resulting in more FAP benefits for that month. The respondent further explained that the petitioner's 3-year old is enrolled in the Medically Needy Program because she failed to meet the income guideline for Family-Related Medicaid.

13. The petitioner did not dispute the income amount used by the Department in the eligibility process. He acknowledged that he understands the benefits provided by the respondent are income-based, but believes that it is not fair for him and his wife not to be included. Petitioner's contends that by having E-1 visas, they should have more

privileges than a regular nonimmigrants and be included in the benefits. During the hearing, petitioner reported $160 for car insurance and $210 for car notes and requested that his prior eligibility period be reviewed by the undersigned.

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.

The Food Assistance issue will be addressed first.

16. Federal regulation C.F.R. § 273.9 addresses income/allowable deductions budgeting in the FAP in part and states as follows:

> (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 eligiblity (sic) standards for the Food Stamp Program. Households which do not contain an elderly or disabled member shall meet both the net income eligibility standards and the gross income eligibility standards for the Food Stamp Program. Households which are categorically eligible as defined in §273.2(j)(2) or 273.2(j)(4) do not have to meet either the gross or net income eligibility standards. The net and gross income eligibility standards shall be based on the Federal income poverty levels established as provided in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)).
> (b) Definition of income…
> (1) Earned income shall include:
> (i) All wages and salaries of an employee...
> (d) *Income deductions.* Deductions shall be allowed only for the following household expenses:
> (1) *Standard deduction*—

> (2) Earned income 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. 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.…(emphasis added)
> (4) Dependent care.
> (5) Optional child support 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(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…
> (A) Continuing charges for the shelter occupied by the household, including rent,
> (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.

17. The respondent must follow these federal budgeting guidelines when determining eligibility. The regulation directs the Department to use gross income when determining eligibility.

18. Federal regulations at 7 C.F.R. § 273.10, in relevant part states:

> (c) (2) Income only in month received. (i) Income anticipated during the certification period shall be counted as income only in the month it is expected to be received, unless the income is averaged. Whenever a full month's income is anticipated but is received on a weekly or biweekly basis, the State agency shall convert the income to a monthly amount by multiplying weekly amounts by 4.3 and biweekly amounts by 2.15, 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.

19. Petitioner is employed and gets paid biweekly. The Department correctly converted his biweekly income to monthly amounts using the 2.15 conversion standard. The undersigned could not find a more favorable outcome than the income conversion done by the Department.

20. The federal regulation 7 C.F.R. § 273.10 (e) addresses "Calculating net income and benefit levels" as follows:

> (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 Sec. 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 Sec. 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.

21. The above-cited regulation describes the eligibility process and defines deductions and shows the steps in determining net income. The petitioner was credited with an earned income deduction, a standard deduction, and an excess shelter deduction from his gross income to equal his net income. No excess medical expenses were allowed. There is no indication that petitioner was eligible for any other deductions.

22. The Department's Policy Manual, CFOP 165-22, (The Policy Manual) at passage 2610.0410 considers an ineligible noncitizen as technically ineligible to participate in the FAP Program. Passage 2230.0400 addresses Technically Ineligible Individuals and states:

> **Technically Ineligible Individuals**
>
> Technically ineligible individuals fail a technical factor of eligibility. The technically ineligible individual may not be included in the household when food stamp benefits are determined. Treat the income, assets and expenses of technically ineligible individuals as follows:
>
> 1. Prorate the income of the ineligible individual and count all but the ineligible members share toward the eligibility of the remaining household members for individuals who fail to meet SSN requirements, are ineligible noncitizens, are serving child support sanctions, or have received all time limited months as an ABAWD. Exclude the income of the ineligible student;
> 2. Count the assets in their entirety for all technically ineligible individuals except the ineligible student. Exclude the assets of the ineligible student;
> 3. The 20% earned income deduction is allowed; and
> 4. Expenses billed to the technically ineligible member but paid entirely with the eligible member's income because the ineligible member has no income, count in full in the budget. If the expense is billed to the technically ineligible member, but paid for with the eligible member's income and the ineligible member's income, prorate the expense in the budget. If the expense is billed to and paid entirely by the technically ineligible member, prorate the expense in the budget; and

> 5. When the SFU contains a technically ineligible member, do not prorate the appropriate utility standard in the budget. Allow the full SUA, BUA, or Phone Standard if the dwelling is eligible for a standard.

23. In this instant case, the Department prorated the husband's income and included the appropriate portion in its calculation. He was allowed the 20% earned income deductions, and only half the rental expense. He received the full standard utility allowance.

24. The Food Assistance standards for income and deductions appear in the Policy Manual at Appendix A-1. Effective October 1, 2014, the maximum FAP benefit for a household size of two is $357 and the Standard Utility Allowance is $337. Effective October 1, 2015, a two-person assistance group net income limit was $1,650 at the time of action, and the standard utility allowance is $345. The maximum FAP benefits remains $357 and the minimum benefits $16.

25. The undersigned review the prior eligibility period and found no mathematical errors. Additional FAP benefits was not found.

26 After considering the evidence, testimony, and the appropriate authorities cited above, the hearing officer concludes that the respondent's action to approve $16 in Food Assistance benefits for the petitioner effective January 2016 is correct. The petitioner received $129 in December 2015, the undersigned reviewed the budget and could not conclude that the petitioner was eligible for any additional benefits based on the income and expenses presented and the above-cited rules. The petitioner has failed to meet his burden that he is eligible for any Food Assistance.

The Medically Needy issue will now be addressed.

27. 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.

28. 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.

29. 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.

30. In accordance with the above controlling authorities, the Medicaid household group is the petitioner, his wife and their two children (four members). The findings show the Department determined the petitioner's eligibility with a household size of four to determine Medicaid eligibility for the 3-year old child. The undersigned concludes the Department correctly determined the petitioner's household size as four for Medicaid eligibility purposes.

31. 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.

32. 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).

33. The Policy Manual at Appendix A-7 indicates that for the Family Medicaid Income Limit as $2,688 and a Standard Disregard of $141 for Family-Related Medicaid Program with a family size of four. It also indicates the MNIL to be $585.

34. 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 $3,692.30. Step 2: There are no deductions provided as there was no tax return. Step 3: The total income of $3,692.30 less the standard disregard of $141 is $3,551.30. Step 4: The balance of $3,551.30 is greater than the income limit of $2,688 for the 3-year old to receive full Medicaid. Step 5: With $101 MAGI disregard applied, the countable balance remains $3,450.30. This amount was greater than the income limit of $2,688. The undersigned concludes that the petitioner's 3-year old child is ineligible for Medicaid. The undersigned further concludes Medically Needy eligibility must be explored for the child.

35. 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.

36. 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.

37. Effective January 2015, Appendix A-7 indicates that for a household of four, the MNIL is $585.

38. To determine the child's SOC the respondent determined the petitioner's household monthly to be $3,692.30. The Medically Needy Income Level of $585 for a standard filing unit size of four was subtracted resulting to the petitioner's daughter estimated SOC of $3,107.

39. The hearing officer found that no exception to this calculation. It is concluded that a more favorable share of cost could not be determined. Eligibility for full Medicaid was not found.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are 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 09 day of Februarv, 2016,

in Tallahassee, Florida.

Roosevelt Reveil

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

FILED
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-04016

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 Brevard
UNIT: 55118

RESPONDENT.
_____/

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: [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 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], [redacted] 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.

Priscilla Peterson

_____

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

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

FILED
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]

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 [redacted]

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 involuntary discharge a resident as follows: Admission, transfer and discharge rights.

> (a)(2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--
> (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
> (ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
> (iii) The safety of individuals in the facility is endangered;
> (iv) The health of individuals in the facility would otherwise be endangered;
> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
> (vi) The facility ceases to operate.

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.

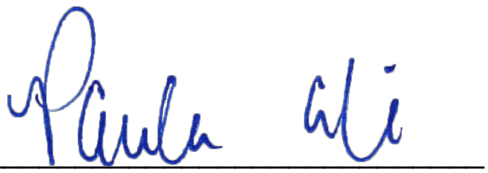
NOTICE OF RIGHT TO APPEAL

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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