Mar 24, 2016
Office of Appeal Hearings
STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

Vs.
AGENCY FOR HEALTH
CARE ADMINISTRATION (AHCA)
CIRCUIT: 01 Okaloosa
UNIT: AHCA
RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on March 22, 2016 at 11:29 a.m.

APPEARANCES
For the Petitioner:

For the Respondent: Cindy Henline, medical healthcare analyst with AHCA

## STATEMENT OF ISSUE

Petitioner is appealing the following issues: 1) Medicaid HMO's denial of an ambulance provider's reimbursement request for services provided to the petitioner; 2) Medicaid HMO's failure to provide petitioner with a local primary care physician and endocrinologist; 3) Medicaid HMO's failure to repair a malfunctioning piece of medical equipment; 4) Medicaid HMO's failure to find a participating dentist who specializes in

FINAL ORDER (Cont.)
critical care patients; and 5) a Medicaid provider's failure to deliver companion care services.

## PRELIMINARY STATEMENT

The Agency for Health Care Administration (Agency or AHCA or respondent) administers the Florida Medicaid Program.

The proceeding was initially scheduled to convene on January 15, 2016 and then on February 24, 2016. Continuances were granted due to conflicts in the petitioner's scheduled.

Present as witnesses for the petitioner:

The petitioner submitted documentary evidence which was admitted into the record as Petitioner's Composite Exhibit 1.

There were no additional witnesses for the respondent. The respondent did not submit documentary 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 68) is a Florida Medicaid recipient. The petitioner, due to her age and impairments, is dually enrolled in Medicaid's Managed Care Plan (MCP) and Medicaid's Long Term Care Plan (LTCP). MCP provides standard medical services such as doctor's visits and hospital inpatient services. Humana Health Insurance (Humana) is the petitioner's MCP HMO. LTCP provides in home support services to

FINAL ORDER (Cont.)
15F-09147
PAGE-3
individuals who would otherwise require nursing home placement. United Healthcare (United) is the petitioner's LTCP HMO. The petitioner is also enrolled with Medicare. Medicare is the petitioner's primary health insurance. Medicaid is the payer of last resort.
2. The petitioner's medical diagnoses includes The petitioner is verbal and ambulatory. She independently performs the activities of daily living. The petitioner lives alone. She receives four hours of housekeeping services weekly through LTCP.
3. The petitioner has numerous medical appointments each month and interacts with over 100 different medical vendors. For approximately two years, she has been experiencing difficulties locating medical providers (she needs a local primary care physician, an endocrinologist, and a dentist that specializes in treating critical care patients) and coordinating caregiver services (her home healthcare agency cannot locate a companion caregiver willing to visit the petitioner's rural home). The petitioner has registered numerous complaints with Humana and United, her HMOs, but the issues have not been resolved.
4. The petitioner has a home medical alert system with a remote activation device through the LTCP. The system allows her to access emergency medical services. The remote activation device malfunctioned a month ago. The petitioner has called United numerous times, but the HMO has not sent a vendor out to the petitioner's home to repair or replace the device.

FINAL ORDER (Cont.)
15F-09147
PAGE-4
5. Humana, the petitioner's MCP HMO, refuses to reimburse an ambulance vendor for transportation services provided to the petitioner in August 2015.
6. The petitioner argued that she is often exhausted because of her complex medical issues and cannot manage her health care services alone. She would like AHCA and the HMOs to work together to resolve the issues detailed above and help coordinate her health care services.
7. The respondent argued that the Office of Appeal Hearings does not have jurisdiction over the petitioner's issues because the issues do not involve an adverse agency action effecting the petitioner's participation in the Medicaid Program. The petitioner has provider relations and provider reimbursement issues which should be addressed via AHCA's consumer complaint system.

## CONCLUSIONS OF LAW

8. Federal Medicaid Regulations at 42 C.F.R. § 431.220 states in relevant part, "(a) The State agency must grant an opportunity for a hearing to the following: (1) Any applicant who requests it because his claim for services is denied or is not acted upon with reasonable promptness (2) Any recipient who requests it because he or she believes the agency has taken an action erroneously..."
9. The Centers for Medicare \& Medicaid Services' State Medicaid Manual, publication \#45, states in part:

2900 FAIR HEARINGS AND APPEALS
Section 1902(a)(3) of the Social Security Act requires that States 'provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness.' Regulations
implementing this section of law are found at 42 CFR 431 Subpart E. In addition, certain court decisions further amplify and modify the law and regulations governing the provision of notices and hearings to Medicaid applicants and recipients. Where appropriate, those decisions are cited. 2900.1 Basic Responsibility (42 CFR 431.200 and 431.205).--Establish policies and procedures for assuring a system of fair hearings that meet all the requirements of the regulations and instructions.

Notify and make available to the applicant or recipient the hearing procedures required by regulations and these instructions, if any of the following events occur:
o denial of eligibility,
o the claim is not acted upon with reasonable promptness,
o termination of eligibility or covered services,
o suspension of eligibility or covered services, or
o reduction of eligibility or covered service
10. The above federal authority explains that an opportunity for a hearing must be granted when a Medicaid claim for service has been denied or when a recipient believes the agency has taken an action erroneously. The State Medicaid Manual further explains the recipient's right to a hearing when either Medicaid eligibility or a claim for a service under Medicaid is denied, terminated, reduced or delayed.
11. The Office of Appeal Hearings does not have jurisdiction over Medicaid provider reimbursement or provider relations issues. The petitioner's issues should be directed to AHCA's Consumer Complaint Office at 1-888-419-3456.

## DECISION

The appeal is dismissed as non-jurisdictional.

## NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL

FINAL ORDER (Cont.)
15F-09147
PAGE-6

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 $\qquad$ 24 day of March , 2016,
in Tallahassee, Florida.


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

Copies Furnished To: Petitioner<br>Marshall Wallace, Area 1, AHCA Field Office Manager

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

APPEAL NO. 16F-00198
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 February 19, 2016 at 8:30 a.m.

## APPEARANCES

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

## STATEMENT OF ISSUE

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

## PRELIMINARY STATEMENT

The Petitioner was present for the hearing and was represented by her case manager at The Petitioner did not submit any documents as evidence for the hearing.

The Respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Exhibits: Exhibit 1 - Statement of Matters and Authorization Request (with attached medical records); Exhibit 2 - Denial Notice; and Exhibit 3 - Additional Medical Records.

Appearing as witnesses for the Respondent were Dr. Jeannette Rios, Medical Director, and Diana Anda, Grievance/Appeals Manager, from Simply Healthcare, which is the Petitioner's managed health care plan.

## FINDINGS OF FACT

1. The Petitioner is an adult Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) - Managed Medical Assistance (MMA) plan. She receives services under the plan from Simply Healthcare.
2. On or about December 16, 2015, the Petitioner's treating physician (hereafter referred to as "the provider") requested prior authorization from Simply Healthcare to perform bariatric surgery on the Petitioner. Simply Healthcare denied this request on December 21, 2015 based on medical necessity criteria. The denial notice stated the following:

FINAL ORDER (Cont.)
16F-00198
PAGE-3
Your request for bariatric surgery is denied because according to the information received you have not made a diligent effort to achieve healthy body weight. There is no documentation that you have been following a consistent medically supervised weight loss diet plan prior to the decision to operate.
3. The Petitioner has been diagnosed with obesity, high blood pressure, scoliosis, and depression. She is seeking the bariatric surgery as a means of achieving weight loss.
4. The Respondent's witness, Dr. Rios, testified that the applicable medical necessity criteria for this type of surgery require there be documentation that the patient has tried and failed a medically supervised weight loss program for at least six months prior to approval of the surgery. Dr. Rios also stated the medical records submitted by the Petitioner's treating physician refer to a 1,400 calorie diet, but there is no specific information about what was tried and why the diet failed. In addition, the medical records indicate the patient gained weight, and there was no indication why the patient could not use appetite suppressants.
5. The Petitioner's representative believes her request for the bariatric surgery should be approved because she has tried to follow a 1,400 calorie diet for about 6 months, but she cannot afford to utilize diet programs such as Weight Watchers or Jenny Craig. She also stated the Petitioner cannot take certain medications because it will increase her blood pressure.
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.

FINAL ORDER (Cont.)
16F-00198
PAGE - 4

## 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 $\S 120.57$.
9. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
10. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the Petitioner. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at $1201,7^{\text {th }}$ Ed.).
11. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the Respondent. The Medicaid Handbook referred to above is incorporated by reference in Fla. Admin. Code R. 59G-4.001.
12. The Medicaid Handbook and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:
"Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
(a) Meet the following conditions:
13. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
14. 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;
15. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

FINAL ORDER (Cont.)
16F-00198
PAGE - 5
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.
13. Although the Petitioner's representative testified she has been following a 1,400 calorie diet, she must also satisfy each of the remaining components of the rule's requirements concerning medical necessity. Respondent's medical expert testified that medical necessity guidelines require a documented trial and failure of a medically supervised weight loss program and this was not established in the Petitioner's preauthorization request. Although the Petitioner's treating physician has requested the bariatric surgery, this does not in itself establish that this service is medically necessary according to the rule provisions outlined above.
14. Petitioner has not established by a preponderance of the evidence that her requested gastric bypass procedure is medically necessary as defined by Fla. Admin. Code R. 59G-1.010(166). The submitted medical records do not contain sufficient documentation of a supervised weight loss program. Although the records generally refer to a 1,400 calorie diet, there is no additional documentation such as diet logs to show what foods were being consumed and why the diet failed to produce weight loss. After considering the evidence and relevant authorities set forth above, the undersigned concludes that the Petitioner has not met her burden of proof in establishing that the Respondent's action was incorrect.

FINAL ORDER (Cont.)
16F-00198
PAGE -6

## DECISION

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

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 16 day of March_, 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:
PETITIONER
RHEA GRAY, AREA 11, AHCA FIELD OFFICE MANAGER

# STATE OF FLORIDA <br> DEPARTMENT OF CHILDREN AND FAMILIES OFFICE OF APPEAL HEARINGS 

APPEAL NO. 16F-00436
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 February 26, 2016, at 11:30 a.m.

## APPEARANCES

For the Petitioner: tioner's daughter

For the Respondent: Monica Otalora, Senior Program Specialist

## STATEMENT OF ISSUE

At issue is the Agency action denying the Petitioner's request for additional home health services (homemaker services, companion services, and personal care services) under the Long Term Care (LTC) Program. Petitioner bears the burden of proof in this matter by a preponderance of the evidence.

## PRELIMINARY STATEMENT

The Petitioner submitted various sets of medical records as evidence for the hearing, which were marked Petitioner Exhibits 1 through 4.

Appearing as witnesses for the Respondent were Dr. Sloan Karver, Medical Director, and Christian Laos, Senior Compliance Analyst, from United Healthcare, which is Petitioner's managed health care plan.

The Respondent submitted documents as evidence for the hearing consisting of the following which were marked as Respondent Exhibits: Exhibit 1 - Statement of Matters; Exhibit 2 - Grievance System Screenshots; Exhibit 3 - Denial Notice; Exhibit 4 - Grievance and Appeal Documents; Exhibit 5 - Medical Assessment; Exhibit 6 Member Notes Report.

## FINDINGS OF FACT

1. The Petitioner is eighty-three (83) years of age and lives with her daughter, her daughter's husband, and four minor grandchildren. She suffers from She is non-ambulatory, incontinent, and wheelchair bound. She is fed through a feeding tube because her stomach was removed due to $\square$ She is also on continuous oxygen.
2. The Petitioner is a Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) - Long Term Care (LTC) Plan. She receives services under the plan from United Healthcare.

FINAL ORDER (Cont.)
16F-00436
PAGE -3
3. The Agency For Health Care Administration (AHCA) is responsible for management of the managed long-term care plan contracts; statewide policy decisions and interpretation of all federal and state laws; and rules and regulations governing the contract. Managed Care Organizations such as United Healthcare provide services to Medicaid recipients pursuant to a contract with AHCA.
4. The Petitioner currently receives a total of thirty-five (35) hours weekly of home health services through United Healthcare, which is allocated as follows: fourteen (14) hours weekly of personal care assistance, fourteen (14) hours weekly of homemaker services, and seven (7) hours weekly of companion services weekly. The Petitioner utilizes these services for five hours daily, from 7:30 a.m. to 12:30 p.m. every day of the week.
5. The Petitioner made a request to United for additional home care services consisting of a total of forty-four (44) hours weekly of home health care services. On November 4, 2015, United sent a letter to Petitioner denying her request for the additional home health care services. The letter stated the requested services were denied because the hours requested were in excess of her needs and therefore not medically necessary. The letter contains an apparent error or discrepancy because it stated that the Petitioner was currently approved for 40 hours of assistance weekly. It was explained at the hearing that the Petitioner was actually approved for only 28 hours weekly at that time, and this was subsequently increased by United to the current total of 35 hours weekly.

FINAL ORDER (Cont.)
16F-00436
PAGE -4
6. Petitioner's daughter stated her mother should be approved for the additional hours because she needs total assistance throughout the day and cannot be left alone. She stated it takes more than one person to transfer her mother to the shower and she must be turned in her bed every 15 minutes to avoid bed sores. She also stated her mother consumes 5 cans of formula daily and this makes her go to the bathroom often. The daughter also stated she has her own health problems such as a hernia and she has 4 minor children to take care of, aged 12 years old (twins), 10 years old, and 13 years old. She is seeking the additional service hours so she can pick up her children from school in the afternoon. She also stated she wanted to obtain employment, but could not do so because she must take care of her mother.
7. The Respondent's witness, Dr. Karver, stated that United Healthcare determined that thirty (30) hours weekly was the amount of medically necessary assistance required to meet the Petitioner's needs. She stated that the LTC program is not designed to provide total care at home. She also stated respite care could possibly be approved to provide a break to the caregiver.

## CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat. § 409.285. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.
9. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 652.056.
10. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the Petitioner since the issue involved a request for an increase in services. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at $1201,7^{\text {th }}$ Ed.).
11. Fla. Stat. $\S 409.979$ sets forth eligibility requirements for the Long-Term Care Program and states:
(1) Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:
(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.
(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).
12. As stated in the Findings of Fact, the Petitioner was determined to be eligible and enrolled in the Long Term Care Program.
13. The Petitioner requested a fair hearing because she believes her services under the Program should be increased.
14. Fla. Stat. § 409.98 lists the services which must be covered by Long-Term Care plans. Respite care, companion care, personal care assistance, and homemaker services are among the services available from Long-Term Care plans and are addressed in the AHCA contract.

FINAL ORDER (Cont.)
16F-00436
PAGE -6
15. The Petitioner currently receives Homemaker services, which are defined in the contract as:

General Household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control are included in this service.
16. The Petitioner also currently receives Personal Care services, which are
defined in the contract as follows:
A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.
17. The Petitioner also currently receives Companion Care services, which are defined in the contract as follows:

Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discreet services. The provision of companion services does not entail hands-on nursing care. This service includes light housekeeping tasks incidental to the care and supervision of the enrollee.
18. The AHCA contract also provides that a Plan "may place appropriate limits on a service on the basis of such criteria as medical necessity, as defined by the Agency, or for utilization control, consistent with the terms of this Contract, provided the services furnished can be reasonably expected to achieve their purpose."
19. Fla. Stat. § 409.912 requires that Respondent "purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care."
20. The Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012, and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:
"Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.
6. After considering the evidence and testimony presented, the hearing officer concludes that the Petitioner has not demonstrated that her services under the LTC Program should be increased to 44 hours weekly of the combined home health care services. The Petitioner clearly needs assistance with all her activities of daily living (ADLs). The evidence presented, however, establishes that the Petitioner's needs can

FINAL ORDER (Cont.)
16F-00436
PAGE -8
be met with the 35 hours weekly of in-home assistance which has already been approved by United. The Petitioner and her daughter may also be better served if the home health services are divided between the morning and afternoon hours rather than as a continuous 5 hours of service daily. Respite care services may also be available to provide additional relief to the caregiver.

## DECISION

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

## NOTICE OF RIGHT TO APPEAL

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

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


[^0]FINAL ORDER (Cont.)
16F-00436
PAGE -9

Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Apr 20, 2016
STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES OFFICE OF APPEAL HEARINGS

Office of Appeal Hearings Dept. of Children and Families

APPEAL NO. 16F-00486
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 February 29, 2016 at 8:30 a.m.

## APPEARANCES

For the Petitioner:
For the Respondent:


Monica Otalora, Senior Program Specialist Agency for Health Care Administration (AHCA)

## STATEMENT OF ISSUE

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

## PRELIMINARY STATEMENT

The Petitioner did not submit any documents as evidence for the hearing.
The Respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Exhibit 1: authorization request, denial notice, and supporting medical records.

Appearing as witnesses for the Respondent were Dr. Jorge Cabrera, Chief Medical Officer, and Summer Brooks, Contract Manager, from Coventry Healthcare, which is the Petitioner's managed health care plan.

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

## FINDINGS OF FACT

1. The Petitioner is a forty-four (44) 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 Coventry Healthcare.
2. On or about December 28, 2015, the Petitioner's treating physician (hereafter referred to as "the provider"), requested prior authorization from Coventry Healthcare to perform bariatric surgery on the Petitioner. Coventry Healthcare denied this request on December 31, 2015 based on medical necessity criteria. The denial notice stated the following:

According to the information sent by your doctor there is no written proof that you took part in a doctor supervised weight loss program for 6 months and it happened within the 12 months before asking for surgery.

FINAL ORDER (Cont.)
16F-00486
PAGE - 3
3. The Petitioner has been diagnosed with

She is seeking the bariatric surgery as a means of achieving weight loss.
4. The Respondent's witness, Dr. Cabrera, testified that the applicable medical necessity criteria for this type of surgery require there be documentation that the patient has tried and failed a medically supervised weight loss program for at least six months prior to approval of the surgery.
5. The Petitioner stated she believes her request for the bariatric surgery should be approved because of her medical conditions. She also stated she suffers from shortness of breath and cannot climb stairs. She stated she has tried many diets but can only stay on the diet for about a week at a time and then gets tired of it.
6. Services under the Medicaid State Plan in Florida are provided in accordance with the Respondent's Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July, 2012.

## CONCLUSIONS OF LAW

7. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Fla. Stat. § 120.80.
8. This is a final order pursuant to Fla. Stat. § 120.569 and $\S 120.57$.
9. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

FINAL ORDER (Cont.)
16F-00486
PAGE - 4
10. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the Petitioner. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, $7^{\text {th }}$ Ed.).
11. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the Respondent. The Medicaid Handbook referred to above is incorporated by reference in Fla. Admin. Code R. 59G-4.001.
12. The Medicaid Handbook and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:
"Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
(a) Meet the following conditions:

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

FINAL ORDER (Cont.)
16F-00486
PAGE - 5
concerning medical necessity. Respondent's medical expert testified that medical necessity guidelines require a documented trial and failure of a medically supervised weight loss program and this was not established in the Petitioner's pre-authorization request. Although the Petitioner's treating physician has requested the bariatric surgery, this does not in itself establish that this service is medically necessary according to the rule provisions outlined above.
14. Petitioner has not established by a preponderance of the evidence that her requested bariatric surgery is medically necessary as defined by Fla. Admin. Code R. 59G-1.010(166). The submitted medical records do not contain sufficient documentation of a supervised weight loss program. The Petitioner also admitted she has not been able to follow any diet plan for more than a one week period. After considering the evidence and relevant authorities set forth above, the undersigned concludes that the Petitioner has not met her burden of proof in establishing that the Respondent's action was incorrect.

## DECISION

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

## NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the Petitioner disagrees with this decision, the Petitioner may seek a judicial review. To begin the judicial review, the Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The Petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days

FINAL ORDER (Cont.)
16F-00486
PAGE -6
of the date stamped on the first page of the 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 $\qquad$ 20 day of April , 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@myffamilies.com

Copies Furnished To: PETITIONER
RHEA GRAY, AREA 11, AHCA FIELD OFFICE MANAGER

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

Apr 05, 2016

PETITIONER,
Vs.
AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 04 Nassau
UNIT: AHCA
RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on March 28, 2016 at 10:26 a.m.

## APPEARANCES

For the Petitioner:


For the Respondent: Sheila Broderick, registered nurse specialist with AHCA

## STATEMENT OF ISSUE

Whether the respondent was correct to deny the petitioner's request for dental services through Medicaid. The petitioner bears the burden of proof by a preponderance of the evidence.

## PRELIMINARY STATEMENT

The Agency for Health Care Administration (Agency or AHCA or respondent) administers the Florida Medicaid Program. Medicaid rules require that most recipients

FINAL ORDER (Cont.)
16F-00662
PAGE - 2
receive their Medicaid services through the Managed Care Plan. The Agency contracts with numerous health care organizations to provide medical services to its program participants. Staywell WellCare Company (Staywell) is the contracted health care organization in the instant case.

By notice dated October 16, 2015, Staywell informed the petitioner that her request for a porcelain crown for tooth \#30 was denied. The notice reads in pertinent part: "[t]his procedure is not listed as covered by the plan."

The petitioner requested reconsideration.
By notice dated January 5, 2016, Staywell informed the petitioner that the original denial decision was upheld.

The petitioner timely requested a hearing on January 14, 2016.
There were no additional witnesses for petitioner. The petitioner did not submit documentary evidence.

The respondent presented three witnesses from Staywell: Stephanie Shupe, regulatory research coordinator; Kelly Carr, vendor account manager; and Dr. Richard Hague, dental director. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

The record was held open until close of business on the day of the hearing for the submission of additional evidence. Evidence was received from the respondent and admitted as Respondent's Composite Exhibit 2. The petitioner did not submit 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 62) is a Florida Medicaid recipient. The petitioner is enrolled with Staywell HMO.
2. All Medicaid goods and services must be medically necessary. Specified goods and services require prior authorization that is performed by the respondent, a contracted HMO or other designee.
3. The petitioner's treating dentist filed a prior service authorization request with Staywell for a porcelain crown for tooth \#30 (procedure code D2751) on October 13, 2015. The tooth is fractured, a part of the tooth has "broken off."
4. Staywell determined that requested dental service was not a covered benefit and denied the request on October 16, 2015.
5. Dr. Hague, Staywell dental director, explained that Medicaid only covers emergency dental care (i.e., drainage of abscesses) and dentures for enrollees age 21 and over.
6. The petitioner argued that it is discriminatory to base benefit coverage on the age of the Medicaid enrollee. She has worked hard to save all of her teeth, to avoid dentures. Maintaining her teeth are important to her. The crown costs $\$ 900$. Her monthly income is $\$ 728$. She cannot afford to pay out of pocket for the crown. She already pays out of pocket for oral exams and dental cleaning. Medicaid should cover the cost of the crown.

## CONCLUSIONS OF LAW

7. By agreement between the AHCA and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Section 120.80, Florida Statutes.
8. This is a final order pursuant to Sections 120.569 and 120.57, Florida

Statutes.
9. This hearing was held as a de novo proceeding pursuant to 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.
11. The standard of proof in an administrative hearing is by a preponderance of the evidence (See Fla. Admin. Code R. 65-2.060(1)). The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, $7^{\text {th }}$ Ed.).
12. The Florida Medicaid Program is authorized by Chapter 409 Florida Statutes and Fla. Admin. Code Chapter 59G.
13. Fla. Admin. Code R. 59G-1.010(166) explains that medical or allied care, goods, or services furnished or ordered must meet the definition of medically necessary or medical necessity, and defines medical necessity as:
"Medical necessary" or "medical necessity" means that medical or allied care, goods, or services furnished or ordered must:
(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational;
4. Be reflective of the level of service that can safely be furnished, for which no equally effective and more conservative or less costly treatment is available statewide; and,
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. . .
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods or services medically necessary, or a medical necessity, or a covered service.
6. Fla. Admin. Code R. 59G-4.060 addresses Medicaid 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. ...
7. The Florida Medicaid Dental Services and Limitations Handbook (Dental

Handbook), November 2011, addresses adult (enrollees ages 21 and over) services on page 1-2:

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. Emergency dental care for recipients 21 years of age or older is limited to a problem focused oral evaluation, necessary radiographs in order to make a diagnosis, extractions, and incision and drainage of an abscess. Full and removable

FINAL ORDER (Cont.)
16F-00662
PAGE - 6
partial dentures and denture-related services are also covered services of the adult dental program.
16. The cited authorities explain that Medicaid will only reimburse for dental services that are medically necessary and covered by the program. Covered dental services for adults age 21 and older are limited to emergency care and denture/denture preparation services. Dental crowns are not covered for adults age 21 and older.
17. The respondent denied the petitioner's request for a porcelain crown for tooth \#30. The petitioner is 62 years old. The undersigned could find no exception in law which would allow for the crown to be covered by Medicaid. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the respondent's decision in this matter was correct.

## DECISION

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

FINAL ORDER (Cont.)
16F-00662
PAGE - 7

$$
\text { DONE and ORDERED this } 05 \text { day of __ April_, 2016, }
$$ in Tallahassee, Florida.



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

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

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

PETITIONER,
vs.
FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 Marion
UNIT: 88256
RESPONDENT.

## FINAL ORDER OF DISMISSAL

THIS CAUSE is before the undersigned hearing officer following multiple continuances, and Petitioner's failure to appear for telephonic status conference.

1. Via Prehearing Order issued January 4, 2016, Petitioner was advised that because he had been granted numerous continuances since August of 2015, his hearing would be scheduled just one more time, during February of 2016. He was further notified that the undersigned is unable to mail out responses to his letters, but would assist in answering any questions posed during telephonic conferences.
2. Also in the Prehearing Order, the undersigned explained that Petitioner does not have the right to have counsel appointed for an administrative hearing, but provided the contact number for the Florida Bar in the event Petitioner wished to hire counsel at his own expense. The undersigned further informed Petitioner that if he was unable to

FINAL ORDER OF DISMISSAL (Cont.)
15F-05583 \& 15F-06013
Page 2 of 4
obtain counsel, he would need to decide whether to represent himself or withdraw his request for hearing.
3. On January 25, 2016, the undersigned contacted Petitioner, via Language Line (a telephone translation service), to notify him that his appeals would be set for telephonic status conference to discuss his cases and prepare to accommodate him for an in-person hearing date. Petitioner stated that he did not have time to talk, and would need a notification sent in writing. The undersigned confirmed that a Notice would be issued, and Petitioner disconnected the call.
4. Via Notice issued January 27, 2016, the parties were notified that the abovestyled matters would convene for telephonic status conference on February 2, 2016 at 3:00 p.m. The Notice specified that this conference was to set a face-to-face/in-person hearing ("Conferencia telefónica para programar audiencia en persona").
5. On January 27, 2016, the undersigned again contacted Petitioner, and left him a voicemail, via Language Line, indicating the date and time for status conference and noting that he would receive written Notice confirming same.
6. On February 1, 2016, Petitioner contacted the Office of Appeal Hearings to request his hearing be continued and scheduled to convene face-to-face. Petitioner was reminded that this was not his final hearing, but a telephonic status conference to set a date and time for hearing, in-person. The undersigned personally spoke to Petitioner, stating that he must call in for the conference to make appropriate hearing arrangements; however, Petitioner indicated he would not participate until the hearing officer sent written responses to every one of his letters, and would not pick a date and time for hearing until he was ready to proceed.

FINAL ORDER OF DISMISSAL (Cont.)
15F-05583 \& 15F-06013
Page 3 of 4
7. Prior to disconnecting the call on February 1, 2016, the hearing officer advised Petitioner that due to several months of continuances and delays, if Petitioner did not call in for the status conference, his appeals would be dismissed.
8. On February 2, 2016, Respondent, the Department of Children and Families (DCF), confirmed via e-mail that it had contacted Petitioner for a supervisory review of his case, and had received indication that he would not participate in the status conference. The undersigned responded, asking DCF to call in, as scheduled, in the event Petitioner appeared to discuss his appeals.
9. On February 2, 2016, the undersigned hearing officer and Respondent's representative were on the conference line and ready to proceed with the status conference at 3:00 p.m. After waiting 15 minutes for Petitioner to appear, the undersigned went on the record to confirm that the Department was present and Petitioner had failed to dial into the conference line.

WHEREFORE, in accordance with all previously issued Notices, Orders, and correspondence to Petitioner, the above-captioned appeals are hereby 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.

FINAL ORDER OF DISMISSAL (Cont.)
15F-05583 \& 15F-06013
Page 4 of 4
DONE and ORDERED this 07 day of March 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:
Petitioner
Uttice ot Economic Self Sufficiency

Mar 22, 2016
STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES



PETITIONER,

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

## RESPONDENT.



## FINAL ORDER

Pursuant to notice, this matter convened for hearing before Hearing Officer Patricia C. Antonucci on October 21, 2015 at approximately 10:00 a.m. and reconvened on December 10, 2015 at approximately 1:00 p.m. All parties and witnesses appeared via teleconference.

## APPEARANCES

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

## STATEMENT OF THE ISSUE

At issue is Petitioner's April 10, 2015 request for 49 hours per week of Home Health Services (including personal care, homemaker, and companion), as provided by her daughter through the Long-Term Care (LTC) Participant Directed Care (PDO)

Program. Originally, Respondent, the Agency for Health Care Administration (AHCA),

FINAL ORDER (Cont.)
15F-06219
Page 2 of 21
through its contracted health plan, United Healthcare (United), approved 36 of these 49 hours. Following testimony at hearing, United noted that its decision regarding the hours was based on a misunderstanding that Petitioner was living with her daughter/provider and receiving home delivered meals. As such, Respondent amended its approval to include additional time for meal preparation and chores, resulting in total Home Health Services (HHS) of 42.5 hours per week.

Petitioner contests the denial of the remaining 6.5 hours per week, which she contends are needed solely for preparing meals. Petitioner bears the burden of proving, by a preponderance of the evidence, that Respondent's decision is incorrect. Petitioner also contests Respondent's refusal to authorize the amended recommendation of 42.5 hours, retroactive to the date of her April 10, 2015 request.

## PRELIMINARY STATEMENT

Petitioner was not present at hearing, but was represented by her daughter/PDO services provider. The Respondent was represented by AHCA Medical/Health Care Program Analyst, Selwyn Gossett. Respondent presented one additional witnesses: Marc Kaprow, D.O., Executive Director of Long Term Care with United Healthcare Community Plan Florida (Petitioner's managed care plan). Also present on the conference line was Christian Laos, Senior Compliance Analyst with United Healthcare (United).

Respondent's Exhibits 1 through 11, inclusive, and Petitioner's Exhibits 1 through 9, inclusive, were accepted into evidence. Administrative Notice was taken of Fla.

Admin. Code R. 59G-1.010 (166), and Fla. Stat. § 409.98. Following testimony, the

FINAL ORDER (Cont.)
15F-06219
Page 3 of 21
record was held open so that Respondent could supplement the record with information referenced during the hearing that was neither filed with the Office of Appeal Hearings nor provided to Petitioner. Additional time was allotted for Petitioner to file a response upon receipt of this supplemental documentation.

Respondent failed to timely file documentation; however, when Petitioner contacted the Office of Appeal Hearings, she was instructed to contact Respondent, directly, to arrange for receipt of the additional evidence. Respondent supplemented the record with pertinent portions of its contract with United (entitled "Attachment II, Exhibit II-B - Effective Date: November 1, 2015 LONG-TERM CARE (LTC) MANAGED CARE PROGRAM"), as well as a hyperlink to the contract ("LTC Contract"), in its entirety. ${ }^{1}$ The LTC Contract is hereby entered as Respondent's Exhibit 12.

The parties proceeded to engage in e-mail correspondence, copying same to the hearing officer. As the e-mail exchanges indicated some confusion regarding the status of the case, the parties were notified that the matter would reconvene for hearing on December 10, 2015.

At the reconvened hearing, the undersigned's role in the hearing process was again explained to the parties. Petitioner stated her intent to file a complaint regarding United's handling of her case. Petitioner was provided with the contact number for AHCA's complaint line. Respondent also e-mailed Petitioner instructions for filing a complaint online, and again provided the hyperlink to the LTC Contract (along with all

[^1]FINAL ORDER (Cont.)
15F-06219
Page 4 of 21
other AHCA contracts, which have not been considered, herein). Additional testimony regarding United's decision was secured, and United again amended its recommendation for total HHS service hours per week. Upon United's refusal to authorize these services retroactively, Respondent was asked to provide documentation to support United's proffered policy of prohibiting retroactive authorization. No such documentation was received, and the record of this matter closed. This Order follows.

## 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 100-year old female, born in 1916. She resides in her own home, with occasional stays at her daughter's house when she is ill, has multiple doctor's appointments to attend, or (as in the past) when her own home is undergoing repairs. At all times relevant to these proceedings, the Petitioner has been eligible to receive Medicaid services.
2. The Petitioner has multiple diagnoses, including

suffers from back pain.
3. Petitioner's physician noted a decline in her overall health beginning in 2014, at which time Petitioner began to require maximum assistance with her daily needs. While the Petitioner is unable to care for herself, she does not wish to move in with her daughter, preferring to remain living in her own home.

FINAL ORDER (Cont.)
15F-06219
Page 5 of 21
4. Petitioner initially received care under the LTC Program through agency-based providers; however, when Petitioner's daughter noted that the Petitioner had a line of dirt beneath her chest from improper bathing, and that the meals being prepared for Petitioner were not $\square$ she and Petitioner decided to enroll in the PDO option. Petitioner now utilizes family members as her paid supports/providers. She also receives medical supplies, and a personal emergency response system (PERS) for monitoring while she is home, alone.
5. Petitioner's daughter lives approximately 20 minutes from Petitioner, by car, but travels to Petitioner's house each day to provide her personal care, companion, and homemaker services.
6. Prior to the action at issue, Petitioner was receiving 15 hours of HHS per week. After Petitioner's daughter tracked the amount of time she spends caring for Petitioner each day, Petitioner requested that HHS increase to 49 hours per week. Petitioner submitted this request to United on or about April 10, 2015.
7. Via letter/Notice of Case Action (Notice) dated April 17, 2015, Petitioner was notified, in pertinent part:

UnitedHealthcare has reviewed your request for 49 total hours of weekly companion, personal care and homemaker services, which we received on 0410/2015, the total number of hours approved is 36 hours a week. After our review, this service has been:

DENIED: 13 hrs On 4/16/15.
We made our decision because:
... The time approved is based on the amount of time a trained caregiver can perform the service.... You do not live alone. The amount of time approved is

FINAL ORDER (Cont.)
15F-06219
Page 6 of 21
only for the portion of an activity spent on your behalf.... You get meals delivered to your home. For cooking 280 minutes a week were approved.

The Notice further informed Petitioner that the 36 hours authorized included 20 hours/week in personal care, 9 hours/week in homemaking, and 7 hours/week of companion care.
8. Petitioner timely appealed this decision through United. United initially rejected her appeal as filed by an unauthorized party, and initially rejected Petitioner's subsequent submission for billing of 36 HHS hours (stating that while her appeal was pending, Petitioner was only authorized to receive her original 14 hours); however, Petitioner noted at hearing that United corrected these actions and began paying for 36 hours per week of service, starting July of 2015. United also corrected the authorization to 36 hours per week, retroactive to April, 2015.
9. At hearing on October 21, 2015, United's Long Term Care Director, Dr. Kaprow, testified regarding United's calculation of the service hours Petitioner requires. Per Dr. Kaprow, Petitioner was assigned a caseworker, who conducted an evaluation of Petitioner's needs, and submitted the resultant Clinical Assessment (conducted October 23, 2014), and Functional Assessment (January 7, 2015) to United.
10. Dr. Kaprow testified that while the case manager can approve some service hours for a member, if the requested hours are above a certain frequency, the request is reviewed by a physician. Dr. Kaprow, himself, reviewed Petitioner's request, and determined that 36 hours of HHS per week were sufficient to meet her needs. It was his opinion that Petitioner's daughter was requesting additional hours to seek financial gain.

FINAL ORDER (Cont.)
15F-06219
Page 7 of 21
11. Although United completed the Clinical and Functional Assessments, and entered same into evidence, it was Dr. Kaprow's position that United does not utilize the case managers' recommendations within the assessments when determining the appropriate service allocations. Essentially, United reviews portions of the assessments, but ignores the rest.
12. Notably, Petitioner's Functional Assessment reflects, in part, that Petitioner requires total assistance with meal preparation, and shows her case manager's recommendation of 60 minutes per day (i.e., 420 minutes/week, as opposed to the approved 280 minutes/week) for this, distinct, task.
13. At hearing, Petitioner's daughter testified that she has cared for her mother for some time, and believes United is concerned about money, whereas she is concerned with Petitioner's actual needs, and providing her the best service possible through the PDO program. She further clarified that the Petitioner does not reside with her. Petitioner did stay with the daughter in April of 2015, while her own home was being treated for black mold. Petitioner's daughter could not recall, offhand, when she returned to her own residence. Review of United's case notes reflects that Petitioner was back in her own home no later than May 20, 2015.
14. Although Petitioner's residence is clearly documented in United's case notes, Dr. Kaprow was unaware that Petitioner lived alone. In consideration of the extra time needed for Petitioner's daughter to complete care in a separate household, Dr. Kaprow adjusted his recommendation to include additional time for cleaning, shopping, and meal preparation, resulting in an overall increase of 4 hours towards homemaker

FINAL ORDER (Cont.)
15F-06219
Page 8 of 21
services. Dr. Kaprow noted that this increase (to a total of 40 HHS hours/week) was not for the purposes of settlement negotiation, and would thus be effective, immediately.
15. Petitioner indicated that she still wished to challenge the denial of the remaining 9 hours requested per week. Petitioner's daughter noted that while she agrees with the remainder of United's calculations, she believes that the extra 9 hours per week are required solely for meal preparation, as she cooks three meals per day for the Petitioner and allots one hour to cook each meal. Petitioner also expressed concern as to United's practice of ignoring the assessment-based recommendations of its case managers, who actually meet with the members face-to-face, to evaluate their needs.
16. When hearing reconvened on December 10, 2015, United again noted that it does not utilize case manager recommendations, but instead, relies upon the clinical experience of its physician reviewers, coupled with an estimate as to how much time it would take a trained provider to complete the required tasks. In the instant case, Dr. Kaprow noted that United considered Petitioner's regular diet and receipt of home delivered meals, and determined that the time requested for meal preparation was excessive.
17. Petitioner testified that Petitioner has not received home delivered meals since April of 2015. Indeed, review of United's case notes reflects that home delivered meals were terminated on April 22, 2015. Again, although United had this information at the time of the initial request to increase HHS, it does not appear that said information was reviewed.
18. In consideration of the lack of home delivered meals, Dr. Kaprow agreed to increase the total time allotted for meal preparation to one hour per day, for a total

FINAL ORDER (Cont.)
15F-06219
Page 9 of 21
increase of 2.5 hours per week in homemaker services. This brought United's final recommendation to 42.5 weekly hours: 20 hours of personal care (no change), 15.5 hours of homemaker services (+ 2.5 hours), and 7 hours of companion care (no change), per week. Again, this recommendation was not for the purposes of settlement, and was implemented as of the date of hearing. However, Dr. Kaprow noted that the requested hours per week for meal preparation remained excessive, stating that the time considered is "man hours" spent preparing food, not the time it takes for the food to cook in the oven or on the stove. He also noted that each, individual provider under the PDO program can only bill for 40 hours per week. As such, the additional 2.5 hours (in excess of 40) must be provided by a family member other than Petitioner's daughter. 19. Petitioner requested that the undersigned consider whether the remaining 6.5 hours of her requested 49 per week should be approved for meal preparation tasks, and asked that Dr. Kaprow's amended recommendations be authorized, not only as of the respective dates of hearing, but retroactive to the date of her initial, April request.
20. Dr. Kaprow testified that United does not apply prior authorizations retroactively, noting that Petitioner's daughter should not have logged hours she was not authorized to receive, and that it would be improper for her to state that she provides as much care as needed, but bills only for what is authorized. He further stated that Petitioner, herself, must be the one to verify the number of hours worked, and that it would be difficult for her to recreate a timeline for dates in the past.
21. Petitioner testified that she provides all the care her mother needs, regardless of reimbursement, and that this amounts to 49 hours per week. She also requested that

FINAL ORDER (Cont.)
15F-06219
Page 10 of 21
AHCA investigate United's decision to ignore portions of its assessment tool. Petitioner was provided with the AHCA complaint line to address this concern.

## CONCLUSIONS OF LAW

22. 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.
23. 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.
24. This is a Final Order, pursuant to § 120.569 and $\S 120.57$, Fla. Stat.
25. This hearing was held as a de novo proceeding, in accordance with Fla. Admin.

Code R. 65-2.056.
26. The burden of proof in the instant case lies with Petitioner, who has requested an overall increase to her authorized services. The standard of proof in an administrative hearing is preponderance of the evidence. (See Fla. Admin. Code R. 65-2.060(1).)
27. Florida Statutes $\S 409.905$ 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....
(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; a family's and child's schedule regarding work, school, sleep, and care for other family dependents; and a determination of the medical necessity for private duty nursing instead of other more cost-effective in-home services....
(c) The agency may not pay for home health services unless the services are medically necessary....
28. With regard to managed care, per Fla. Stat. § 409.965

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

History.-s. 6, ch. 2011-134; s. 4, ch. 2014-57.
29. Fla. Stat. § 409.972 adds to the list of those exempt; however, no evidence was presented to demonstrate that Petitioner may opt-out of managed care for her LongTerm Care needs.
30. Section 409.978, Florida Statutes, provides that the "Agency shall administer the long-term care managed care program," through the Department of Elder Affairs and through a managed care model. Fla. Stat. § 409.981(1), authorizes AHCA to bid for

FINAL ORDER (Cont.)
15F-06219
Page 12 of 21
and utilize provider service networks to achieve this goal. In the instant case, the provider network/HMO is United Healthcare.
31. Respondent contends that its contract with United governs the provision of Long Term Care for its enrollees and its determination as to the medical necessity of services for same. The undersigned does not have jurisdiction to rule upon a contractual agreement as the sole legal authority over a Medicaid Fair Hearing. However, Fla. Admin. Code R. 59G-13.030, which previously promulgated theThe Medicaid Aged and Disabled Adult Waiver Services Coverage and Limitations Handbook, was repealed on August 28, 2014. As such, the undersigned can only review United's determinations in conjunction with its contract-based guidelines, governing legal authority, and general provisions of prior authorization and medical necessity.
32. The July 2012 Florida Medicaid provider General Handbook ("the Handbook"), promulgated into rule by Fla. Admin. Code R. 59G-5.020, sets forth requirements for services provided under managed care or health maintenance organization (HMO) plans, such as United. Page 1-27 of the Handbook specifies:

If a recipient is an HMO member, the provider must seek authorization from the HMO in which the recipient is currently enrolled prior to providing services covered by the HMO, unless it is an emergency. (emphasis added)
33. Pages 1-28 through 1-30 of the Handbook include HHS as services covered by HMOs, for which the plans can require prior authorization, and page B-15 defines "prior authorization" as "[a] request submitted to the fiscal agent, Medicaid, or a peer review organization for permission to perform one or more specific procedures." As part of its

FINAL ORDER (Cont.)
15F-06219
Page 13 of 21
prior authorization review, United conducts a review as to the medical necessity of any requested service.
34. 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.
6. Respondent does not deny that HHS services are necessary to prevent significant disability, or that they are non-experimental. As such, Fla. Admin. Code R. 59G-1.010(166) subsections (a)(1) and (a)(3) are not in dispute. To determine whether these services are individualized/not excessive, reflective of the level of service needed,

FINAL ORDER (Cont.)
15F-06219
Page 14 of 21
and/or furnished in a manner that is not primarily for convenience (subsections (a)(2)(4)
and (5)), one must look to the parameters of the services, themselves.
36. The service defintions contained within United's policy guidelines and the LTC

Contract (Section V) include:
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.

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.

Adult Companion Care - Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discreet services. The provision of companion services does not entail hands-on nursing care. This service includes light housekeeping tasks incidental to the care and supervision of the enrollee. (emphasis added)
37. As noted, each of these services include aspects of meal preparation. A separate portion of the LTC Contract authorizes members to participate in the PDO program, and to utilize family members as service providers. Although Dr. Kaprow opined that Petitioner's daughter is seeking additional hours in pursuit of financial gain, because the PDO program specifically permits payment to family members for the provision of HHS services, this claim is largely without merit.
38. Petitioner does not contest United's calculation of any service hours, except for those related to meal preparation. Although United did not review the case manager's

FINAL ORDER (Cont.)
15F-06219
Page 15 of 21
recommendation within the Functional Assessment, the undersigned has reviewed same, noting that Petitioner's case manager recommended 60 minutes per day for preparing meals. The undersigned notes that United's initial review of Petitioner's needs, living situation, and the services she receives appeared haphazard and lacking in thoroughness, and concludes that the initial recommendation of 36 hours per week of HHS was incorrect. However, following clarification from Petitioner, United amended its authorization, and has now allotted 60 minutes per day for meal preparation, as well as increased time to faciliate other tasks.
39. Based upon the totality of the evidence, the undersigned concludes that 60 minutes per day for meal preparation is reasonably calculated to meet Petitioner's needs. While it is understood that Petitioner's daughter may spend more time making Petitioner's meals, as Dr. Kaprow noted, only "man hours" spent in preparation can be considered, and only those hours which would be required by a trained care provider may be authorized. The undersigned agrees that an additional 6.5 hours, in addition to what United has approved, per week for meal preparation is excessive, and is thus out of compliance with Fla. Admin. Code R. 59G-1.010(166)(a)(2). As such, these hours cannot be considered medically necessary.
40. Petitioner's daughter is obviously dedicated to her mother, and her determination to see that she receives the best care possible is commendable. However, there is little evidence to suggest that Respondent's recommendation for 42.5 hours of HHS per week is insufficient to meet Petitioner's current needs. As such, Petitioner has not met her burden of proof to show that denial of the remaining 6.5 weekly service hours is improper.

FINAL ORDER (Cont.)
15F-06219
Page 16 of 21

## Retroactive Authorization/Reimbursement

41. With regard to Petitioner's request for retroactive authorization of the 42.5 total hours per week, and in light of United's failure to provide supportive documentation regarding its position on prohibiting same, the undersigned has conducted substantial research regarding a hearing officer's authority to order "corrective payments."
42. Pursuant to 42 U.S.C. § 1396(a)(3) and its implementing authority within the Code of Federal Regulations, Petitioner reserves the right to fair hearing when a request for services is denied, ignored, or when the Agency undertakes erroneous action. Per 42 C.F.R. § 431.220:
(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. (emphasis added)
43. In terms of retroactive payment for services, the scope of review is tied to "incorrect action," and is thus more limited. Indeed, 42 C.F.R. § 431.246 allows for corrective payments, only as follows:

The agency must promptly make corrective payments, retroactive to the date an incorrect action was taken, and, if appropriate, provide for admission or readmission of an individual to a facility if-
(a) The hearing decision is favorable to the applicant or beneficiary; or
(b) The agency decides in the applicant's or beneficiary's favor before the hearing.
(emphasis added)
44. Similarly, per F. Admin. Code R. 65-2.066 (Final Orders):

Page 17 of 21
(1) Orders issued by the hearings officers of the Office of Appeal Hearings of the Department of Children and Family Services are final orders and shall be implemented immediately.
(6) In the Final Order the hearings officer shall authorize corrective action retroactively to the date the incorrect action was taken.
(7) The Final Order shall include notice of opportunity for judicial review.
45. Whereas 42 C.F.R. $\S 431.220$ differentiates between a service that is denied and an erroneous action, but establishes the right to hearing for either occurrence, 42 C.F.R. § 431.26 and Fla. Admin. Code R. 65-2.066 provide remedy only with regard to incorrect action. "Action" is not defined within the specified portion of the Florida Administrative Code, but it is defined in 42 C.F.R.
431.201, which states:

Action means a termination, suspension, or reduction of Medicaid eligibility or covered services. It also means determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act.
(emphasis added)
46. In the instant case, Petitioner is contesting partial denial of a request to increase her HHS. As such, there is no "termination, suspension, or reduction" of Medicaid services, and thus, no "action" (erroneous or otherwise) for which the undersigned can provide financial relief.
47. The concept of a hearing officer's authority to order retroactive payment/corrective action for services only if the action at issue is a termination,

FINAL ORDER (Cont.)
15F-06219
Page 18 of 21
suspension, or reduction finds support in the fact that Medicaid fair hearings are largely characterized as "recipient service-based," in terms of what is provided to the Medicaid recipient, as opposed to "payment-based," i.e., whether or not the provider receives reimbursement for services rendered. Once a service is prior authorized at a certain level and frequency, the recipient has a vested interest and reasonable expectation that said service and coverage of same will continue, absent a change in circumstances. As such, any timely request to challenge a proposed termination, suspension, or reduction of a previously authorized service generates an additional right to continuation of said service, pending the outcome of fair hearing (See, e.g., 42 C.F.R. § 438.420(b)).
48. A distinction arises when the request is for an increase to the frequency of a service, such as Petitioner's request to increase her initial allocation of 15 weekly HHS hours to a total of 49 HHS hours per week. In this case, if a provider (and through the PDO program, Petitioner's daughter is her provider) opts to furnish the service at the increased level before receiving authorization to do so, she assumes the risk of not being reimbursed when and if said increase is ultimately approved. In reviewing a similar case, involving a hospital (provider)'s provision of psychiatric services to a Medicaid recipient, the Florida's First District Court of Appeals found:
... once [Petitioner] received the continued psychiatric treatment he'd asked for, he no longer needed agency review of [the HMO]'s decision not to authorize the treatment. Rather, the issue at that point became whether ... [the] Hospital could be paid by Medicaid for the services it had rendered without prior authorization. And that is not, under 42 U.S.C. section 1396a(a)(3) [or the CFR], an issue that a Medicaid beneficiary has the right to seek a fair hearing on.
(J.W. c/o Dawn v. Agency for Health Care Administration, 178 So.3d 542 (1st DCA 2015), emphasis original.)

FINAL ORDER (Cont.)
15F-06219
Page 19 of 21
49. Again, though in the instant Petitioner's case, it is proper to review the service authorization, itself, so as to determine how many HHS hours are needed to meet Petitioner's needs, ordering payment for service hours rendered before authorization occurred would constitute a payment-based review, inconsistent with governing authority.
50. Although there is a somewhat older body of case law that suggests corrective action may be appropriate in certain circumstances, such as when a service is discontinued after being authorized via Final Order (See French v. Dep't of Children and Families, 920 So.2d 671. (Fla. App. 5th Dist. 2006)) or when Medicaid eligibility (and/or resulting coverage) is wrongfully denied (See, e.g., Randall v. Lukhard, 709 F.2d 257 (4th Cir.1983)), given the wording of the legal authority discussed above, and the ruling in the J.W. case, the undersigned concludes that such conditions do not exist in the instant case.
51. Absent direction from a District Court of Appeals to the contrary, the undersigned hearing officer is not able to order retroactive payment paid to Petitioner's daughter/provider. However, per 42 U.S.C. § 1396u-2(b)(4):

Each 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)
52. It appears to the undersigned that, had United more thoroughly reviewed

Petitioner's living situation and then-current array of services at the time her request to increase HHS was first submitted, the plan may have arrived at its decision to authorize

FINAL ORDER (Cont.)
15F-06219
Page 20 of 21
42.5 HHS hours per week well in advance of hearing. Indeed, United seemed more focused on preventing Petitioner's daughter from obtaining (what it perceived to be) financial gain than on determining Petitioner's actual level of need. It is regrettable that United did not avail itself of the opportunity to resolve this matter without resorting to formal proceedings, and did not provide better customer service to Petitioner, consistent with her medical needs. In consideration thereof, United is encouraged to work with Petitioner's daughter, should she choose to file a grievance pursuant to 42 U.S.C. § 1396u-2(b)(4). Additionally, because the request for reimbursement was presented to both the hearing officer and to United within the one-year time limit for filing grievance (Fla. Stat. § 641.511), should Petitioner chose to bring the issue of retroactive payment before United, United is encouraged to consider the grievance as timely filed, and respond, accordingly.

## DECISION

Petitioner's appeal is DENIED, insofar as the hearing officer finds that 42.5 hours of HHS per week is sufficient to meet her needs. Petitioner's request for retroactive authorization and/or reimbursement for 42.5 service hours is also DENIED, based upon the specifics of her appeal; however, Petitioner retains the right to bring the latter issue before a more appropriate forum, as noted, above.

## NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with

FINAL ORDER (Cont.)
15F-06219
Page 21 of 21
the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees 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 $\quad 22$ day of $\qquad$ , 2016,
in Tallahassee, Florida.


Patricia C. Antonucci<br>Hearing Officer<br>Building 5, Room 255<br>1317 Winewood Boulevard<br>Tallahassee, FL 32399-0700<br>Office: 850-488-1429<br>Fax: 850-487-0662<br>Email: appeal.hearings@myflfamilies.com<br>Petitioner<br>Debbie Stokes, Area 4, AHCA Field Office Manager

Copies Furnished To:

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

APPEAL NO. 15F-06560
PETITIONER,
VS.
FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 DADE
UNIT: 66709
RESPONDENT.

## STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny her application for disability-related Medicaid benefits. The petitioner carries the burden of proving her position in this appeal 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 Medicaid 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.

Appearing for the petitioner on both hearing dates was

The petitioner was also present at both hearings.
Appearing as a witness for the respondent at both hearings were Sylvia Stokes, Operations Management Consultant for DCF, and Lauren Coe, Program Operations Administrator with the Division of Disability Determinations (DDD).

FINAL ORDER (Cont.)

Serving as a medical translator for a portion of the December $16^{\text {th }}$ hearing wa


Serving as a medical translator for the remainder of the hearing was
At the January
$27^{\text {th }}, 2016$ hearing, the petitioner (through counsel) waived all translation services.

The hearing was originally scheduled to be held on September $21^{\text {st }}, 2015$. The hearing was rescheduled for October $28^{\text {th }}, 2015$ and December $16^{\text {th }}, 2015$, both times at the petitioner's request.

Petitioner's exhibits 1-6 were admitted into evidence. Respondent's objection to exhibit 6 was noted. Exhibit 1 is comprised of two exhibits originally presented as Petitioner's A and K. Pages 49 through 134 of the petitioner's exhibits were, upon agreement of all parties, removed, as they were duplicative of documents included in Petitioner's Exhibit 1. Pages 136 through 146 were also removed as these were duplicative of the respondent's evidence.

The respondent submitted a total of 508 pages into evidence. These were marked as Respondent's Composite Exhibits 1. Page 335 of the exhibits was removed upon agreement from all parties, as this page was not relevant to the petitioner's case and should not have been included.

The record was held open until February $19^{\text {th }}, 2016$ to allow both parties to submit Proposed Final Orders. The respondent requested an extension until February $22^{\text {nd }}, 2016$, which was granted. Both orders were received and the record was closed.

On February $12^{\text {th }}, 2016$, the counsel for the petitioner filed a Post-Hearing Motion to Overrule DCF Objection, which seeks to overrule the respondent's objection to the admission of Petitioner's Exhibits as described above. As all objections raised by the respondent were already ruled upon during the hearing, the petitioner's motion is hereby denied.

No Notice of Case Action informing the petitioner of the respondent's action was submitted into evidence. On July $23^{\text {rd }}, 2015$, the petitioner filed an appeal to challenge the respondent's action. Absent evidence to the contrary, the appeal is considered to have been filed timely.

## FINDINGS OF FACT

1. The petitioner, 30 years of age, applied for Medicaid on April $6^{\text {th }}, 2016$. A copy of the application was not in evidence; however, this fact is not disputed.
2. As the petitioner is under the age of 65 and has no minor children in her custody, she must meet the criteria of disabled or blind in order to be eligible for Medicaid.
3. The petitioner, born and raised in Cuba, attended a special school for children with learning disabilities. The petitioner left school at the age of 15 years, contending that she had not learned anything.
4. The petitioner has had since the age of 4. Although it was established during the hearing that the petitioner had not had an

FINAL ORDER (Cont.)
15F-6560
PAGE 5
in over a year, the petitioner cannot (and does not) live alone for fear of a recurrence.


#### Abstract

5. The petitioner suffers from depression and anxiety. Additionally, the petitioner is and has borderline intellectual functioning. The petitioner also alleges $\quad$ The petitioner struggles in social interactions, and is given to panic attacks and hallucinations. The petitioner furthermore suffers from memory loss and due to such, is unable to carry out long-term instructions


6. The petitioner can only eat blended foods as her jaw is given to dislocating, and she has trouble swallowing due to
7. Approximately one year ago, the petitioner lost consciousness, fell, and suffered a dislocation on her back.
8. Physical exam from
dated January 26, 2015, shows chief complaint low back pain from motorcycle accident one year ago while riding with husband. Motor strength was $5 / 5$, no pathological reflexes noted, deep tendon reflexes equal bilaterally, and normal range of motion in all extremities. Assessment indicates chronic low back pain mostly axial. Treatment plan shows schedule joint injection, start gabapentin 300 mg , add Tylenol $500-1000 \mathrm{mg}$, start flexeril 5 mg , continue to alternate between naproxen and ibuprofen, and continue home exercises for core strengthening,

FINAL ORDER (Cont.)
15F-6560
PAGE 6
remain physically active, avoid sedentary lifestyle and follow up within four months.
9. Physical exam, dated May 7, 2015, shows no motor deficits were present, coordination was grossly normal, and gait was normal. Assessment indicates $\quad$ well controlled.
10. Physical exam, dated October 14, 2015, shows normal motor strength and gait. Mental status is listed as awake, alert, oriented to person, place, and time.
11. DDD's Case Analysis Report dated May $20^{\text {th }}, 2015$ (page 325 of the respondent's exhibits, states, in pertinent relative part, as follows:

..

12. On May $20^{\text {th }}$, 2015, an examiner for DDD completed a Physical Residual Functional Capacity Assessment (page 327 of the respondent's exhibits). In the Exertional Limitations section of the assessment, it was determined that the petitioner can occasionally lift and/or carry 20 pounds, and can frequently lift and/or carry 10 pounds. It was determined that the petitioner can stand and/or walk about 6 hours in an 8-hour workday, and that the petitioner can sit with normal breaks about 6 hours in an 8 -hour workday. It was determined that the petitioner can push and/or pull (including operation of hand and/or foot controls) unlimited, other than as shown for lift and/or carry.
13. In the Postural Limitations section, the assessment indicates that the petitioner has occasional difficulty climbing a ramp, stairs, ladder, rope, or scaffold.
14. The assessment indicates no manipulative, visual, or communicative limitations.
15. In the Environmental Limitations section, the assessment indicates that the petitioner has no such limitations, with the exception of hazards such as machinery and heights where she would need to avoid even moderate exposure.

## FINAL ORDER (Cont.)

15F-6560
PAGE 8
16. , interview dates February

11, 2014 and February 16, 2014, shows petitioner's diagnoses as

17. Psychiatric and Psychosocial Evaluation form completed by $\square$ [| dated June 23, 2014, shows petitioner was treated by $\quad$ on two occasions, February 11, 2014 and June 23, 2014.
 the petitioner has moderate restrictions with activities of daily living such as grooming, personal hygiene, maintenance, shopping, and cooking as well as other marked restrictions.
18. On May $19^{\text {th }}, 2015$, a medical consultant for DDD completed a
 The conclusions of this
assessment indicate that the petitioner's ability to remember locations and worklike procedures and her ability to understand and remember very short and simple instructions are not significantly limited; however, her ability to understand and remember detailed instructions is moderately limited. No marked limitations were noted.
19. For understanding and memory issues, the MRFC indicates that the petitioner's abilities in the following areas were not significantly limited: to

FINAL ORDER (Cont.)
15F-6560
PAGE 9
remember locations and work-like procedures; and to understand and remember very short and simple instructions. The petitioner's ability to understand and remember detailed instructions was determined to be moderately limited.
20. For sustained concentration and persistence issues, the MRFC indicates that the petitioner's abilities in the following areas were not significantly limited: to carry out very short and simple instructions; to maintain attention and concentration for extended periods; to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances; to sustain an ordinary routine without special supervision; to make simple workrelated decisions; to complete a normal workday and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods. However, the MRFC indicates that the petitioner's abilities in the following areas were moderately limited: to carry out detailed instructions, and to work in coordination with or proximity to others without being distracted by them.
21. For social interaction issues, the MRFC indicates that the petitioner's abilities in the following areas were not significantly limited: to interact appropriately with the general public; the ability to ask simple questions or request assistance; the ability to accept instructions and respond appropriately to criticism from supervisors, and the ability to maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness. The

FINAL ORDER (Cont.)
15F-6560
PAGE 10
petitioner's ability to get along with coworkers or peers without distracting them or exhibiting behavioral extremes was determined to be moderately limited.
22. For adaptation issues, the MRFC indicates that the petitioner's abilities in the following areas were not significantly limited: to respond appropriately to changes in the work setting; to be aware of normal hazards and take appropriate precautions, and to set realistic goals or make plans independently of others. The petitioner's ability to travel in unfamiliar places or use public transportation was determined to be moderately limited.
23. On May $19^{\text {th }}, 2015$, a medical consultant for DDD completed a Psychiatric Review Technique (PRT) (page 340 of the respondent's exhibits). For
present", but "does not precisely satisfy the diagnostic criteria above." For (affective disorders), a medically determinable impairment is present, but does not does not precisely satisfy the diagnostic criteria above." For , a medically determinable impairment (anxiety) is present, but does not does not precisely satisfy the diagnostic criteria above." The petitioner's functional limitations were rated in each of these three listings.
24. The degree of limitation for restriction of ADL's and difficulties in maintaining concentration, persistence or pace were rated "mild", and difficulties in maintaining social functioning was rated "moderate." No marked limitations were noted. For listings

determinable impairment was found.
25. DDD completed its five-step sequential evaluation process on the petitioner and based on the above, determined that the petitioner has the residual functional capacity to do "light" work, and a mental residual functioning capacity indicating that she can understand, retain, and carry out simple instructions. Based on this evaluation, DDD determined that the petitioner is capable of performing jobs such as a silver wrapper, cleaner and polisher, and plate stacker.

## CONCLUSIONS OF LAW

26. 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.
27. This hearing was held as a de novo proceeding pursuant to Fla.

Admin. Code R. 65-2.056.
28. Fla. Admin. Code R. 65A-1.710 sets forth the rules of eligibility for SSIRelated 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

FINAL ORDER (Cont.)
15F-6560
PAGE 12
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.
29. 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.
30. Federal Regulation 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

FINAL ORDER (Cont.)
15F-6560
PAGE 13
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 $\S 416.909$, 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).)
31. In evaluating the first step, it was determined that the petitioner is not engaging in SGA. The first step is met.

FINAL ORDER (Cont.)
15F-6560
PAGE 14
32. In evaluating the second step, the petitioner's physical impairments are considered severe and meet requisite durational requirements. The second step is met.
33. The third step requires determining whether the petitioner's
impairments meet or equal the "Listing of Impairments" indicated in Appendix 1 to subpart P of section 404 of the Social Security Act. In the instant case, the petitioner was evaluated under the following listing:
1.04 Disorders of the spine (for example, herniated nucleus, pulposus, spinal arachnoiditis, spinal stenosis, osteoarthritis, degenerative disc disease, facet arthritis, and vertebral fracture), resulting in compromise of a nerve foot (including the cauda equina) or the spinal cord. With:
A. Evidence of nerve root compression characterized by neuroanatomic 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 sever 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 severe chronic nonradicular pain and weakness, and resulting in inability to ambulate effectively, as defined in 1.00B2b.

The petitioner does not meet the listing above based on the medical records presented. Although petitioner suffers from chronic low back pain, the objective medical records show she maintains full motor strength and range of motion, and

FINAL ORDER (Cont.)
15F-6560
PAGE 15
a normal gait. The petitioner ambulates without the need for any assistive devices.
34. The petitioner was also evaluated under the following listing:


The petitioner does not meet the listing above based on medical records presented, as the petitioner has not manifested any symptoms of epilepsy in over a year.
35. The petitioner was evaluated under the following listing:


The petitioner does not meet the listing above based on medical records
presented, as the petitioner has not manifested any symptoms of epilepsy in over a year.
36. The petitioner was evaluated under the following listing:


The petitioner does not meet the listing above based on medical records provided. No objective medical evidence was presented to support diagnoses of cerebral trauma and/or central nervous vascular accident sufficient to meet the severity of the above listings.
37. The petitioner was evaluated under the following listing:

A. Demonstration of a loss of specific cognitive abilities or affective changes and the medically documented persistence of at least one of the following:

1. Disorientation to time and place; or
2. Memory impairment, either short-term (inability to learn new information), intermediate, or long-term (inability to remember information that was known sometime in the past); or

FINAL ORDER (Cont.)
15F-6560
PAGE 17
3. Perceptual or thinking disturbances (e.g., hallucinations, delusions); or
4. Repeated episodes of decompensation, each of extended duration;

OR
C. Medically documented history of a chronic organic mental 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.

Medical records provided indicate that while a medically determinable impairment may be present under this listing, the petitioner's short- and long-term memory, as well as her cognitive abilities, was determined to be intact. No evidence was presented through physical examination or laboratory tests to demonstrate the presence of a specific organic factor judged to be etiologically related to an abnormal mental state and loss of previously acquired functional abilities. Therefore, the petitioner does not meet the criteria requirement of this listing.
38. The petitioner was evaluated under the following listing:

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
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:
4. Marked restriction of activities of daily living; or
5. Marked difficulties in maintaining social functioning; or
6. Marked difficulties in maintaining concentration, persistence, or pace; or
7. 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:
8. Repeated episodes of decompensation, each of extended duration; or
9. 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
10. 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.

Medical records presented indicate that the petitioner does not meet the criteria required for this listing. Although the petitioner's medical records indicate a diagnosis of depression, the objective medical evidence failed to showed any marked restriction of daily activities, marked difficulties in maintaining social functioning, marked difficulties in maintaining concentration, persistence, or pace, or repeated episodes of decompensation each of an extended duration to meet the severity required in the AB or C criteria. Furthermore, there is no medical evidence of any chronic disorder of duration of at least two years.
39. The petitioner was evaluated under the following listing:
12.06 Anxiety-related disorders: In these disorders anxiety is either the predominant disturbance or it is experienced if the individual attempts to master symptoms; for example, confronting the dreaded object or situation in a phobic disorder or resisting the obsessions or compulsions in obsessive compulsive disorders. 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 both A and C are satisfied.
A. Medically documented findings of at least one of the following:

1. Generalized persistent anxiety accompanied by three out of four of the following signs or symptoms:
a. Motor tension; or
b. Autonomic hyperactivity; or
c. Apprehensive expectation; or
d. Vigilance and scanning; or
2. A persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation; or
3. Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week; or
4. Recurrent obsessions or compulsions which are a source of marked distress; or
5. Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress;
AND
B. Resulting in at least two of the following:
6. Marked restriction of activities of daily living; or
7. Marked difficulties in maintaining social functioning; or
8. Marked difficulties in maintaining concentration, persistence, or pace; or
9. Repeated episodes of decompensation, each of extended duration.
OR
C. Resulting in complete inability to function independently outside the area of one's home.

Medical records indicate that although the petitioner has anxiety, she does not precisely satisfy the diagnostic criteria in this listing. The objective medical evidence failed to showed any marked restriction of daily activities, marked difficulties in maintaining social functioning, marked difficulties in maintaining concentration, persistence, or pace, or repeated episodes of decompensation each of an extended duration to meet the severity required in the $A B$ or $A C$ criteria. There was also no indication that the petitioner's condition(s) result(s) in complete inability to function independently outside the area of her home.
40. The fourth of the five-step determination process is to determine whether the petitioner's impairments prevent her from

FINAL ORDER (Cont.)
15F-6560
PAGE 21
performing past relevant work. As the petitioner has no work history, it is appropriate to continue to step five.
41. The fifth step requires considering the petitioner's residual functional capacity, and whether the petitioner can perform other work in the national economy. The objective medical evidence shows that the petitioner can perform other work in the national economy, performing jobs that require light activity and simple instructions, in accordance with medical-vocational guideline 202.17. See 20 C.F.R. § 416.969. Such jobs include silver wrapper, cleaner and polisher, or plate stacker.
42. The cumulative evidence shows while the petitioner may have some medically determinable impairments, these impairments do not rise to the level of severity required in the criteria listed above, and should not preclude her from engaging in work in the national economy. Therefore, the hearing officer concludes that the petitioner is found at step five not to be disabled, in accordance with medical-vocational guideline 202.17 and the objective medical evidence.

## 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

FINAL ORDER (Cont.)
15F-6560
PAGE 22
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 $\qquad$ 24 day of $\qquad$ March 2016, in Tallahassee, Florida.


Justin Enfinger
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.hearings@myFLfamilies.com
Copies Furnished To
Office of Economic Self Sufficiency
Leslie Hinds, Esq.
Kelly Shami
Javier Ley-Soto, Esq.
Luiz Miranda

Mar 25, 2016

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

Office of Appeal Hearings
Dept. of Children and Families

APPEAL NO. 15F-08668
PETITIONER,
Vs.
FLORIDA DEPARTMENT
CASE NO. OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pasco
UNIT: 883CF
RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on February 9, 2016, at 10:40
a.m.

APPEARANCES
For Petitioner:


For Respondent: Alicia Gonzalez, Esq. Assistant Regional Counsel Suncoast Region
Florida Department of Children and Families

## STATEMENT OF ISSUE

Did the Department of Children and Families ("DCF" or "Department") prove by a preponderance of the evidence that it correctly terminated the petitioner's Institutional Care Program ("ICP") Medicaid coverage? paralegal with the Hook Law Group, appeared as a witness for the petitioner.

Alicia Gonzalez, Assistant Regional Counsel for the Suncoast Region of the Department of Children and Families, appeared on behalf of the Department of Children and Families. The following individuals from the Department of Children and Families appeared as witnesses on behalf of the Department: Signe Jacobson, Economic Self Sufficiency Specialist II; and Kathy Kowalik, Senior Human Services Program Specialist.

The petitioner introduced Exhibit "1", inclusive, at the hearing, which was accepted into evidence and marked accordingly. The respondent introduced Exhibits " 1 " through " 12 ", inclusive, at the hearing, which were also accepted into evidence and marked accordingly. The hearing officer took the petitioner's tax return into evidence and marked it as petitioner's Exhibit "2". At the respondent's request, the hearing officer took administrative notice of Florida Administrative Code Rule 65A-1.303.

## 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 single individual who was admitted to a skilled nursing facility on June 1, 2009.
2. The petitioner was previously approved to receive ICP Medicaid from April 1, 2014 through October 31, 2015.

FINAL ORDER (Cont.)
15F-08668
PAGE - 3
3. The petitioner submitted an application for redetermination on August 31, 2015.
4. A data exchange is an electronic exchange of information which occurs between the Department of Children and Families and various financial institutions.
5.
 s a provider of banking and other financial services.
6. After the petitioner submitted her application for redetermination on August 31, 2015, the respondent received an alert through the data exchange process indicating a high balance in the petitioner's bank account with account number ending

7. In response to the alert, the respondent mailed two Notices of Case Action on September 10, 2015. One Notice of Case Action was sent to the petitioner while the other was sent to her representative.
8. The purpose of the Notices of Case Action mailed on September 10, 2015 was to request additional information needed to determine the petitioner's eligibility for ICP Medicaid.
9. The September 10, 2015 Notice of Case Action mailed to the petitioner states the following:

It is time to review your monthly medical expenses: Provide verification that these 3 expenses have been paid for the last 6 months: 4/2015 to $9 / 2015$. 2. Provide proof of your monthly income and all related expenses for your property in Washington. 3. Each individual can set aside $\$ 2500$ or less for burial. See DCF Form 2302. You must provide this form that any income you declare has been set aside for burial. 4. Provide bank statements, all pages for the for $6 / 1 / 2015$ to $8 / 31 / 2015$. 5. You may be enrolled in medically needy until all verifications have been received.

FINAL ORDER (Cont.)
15F-08668
PAGE-4
10. In response to the Department's request for additional information, the petitioner provided the three bank statements requested for the Wells Fargo account with The statements provided reflect the following information:

| Statement Period | Ending Balance |
| :---: | :---: |
| May 29, 2015 - June 25, 2015 | $\$ 4,526.88$ |
| June 26, 2015 - July 27, 2015 | $\$ 3,524.64$ |
| July 28, 2015 - August 27, 2015 | $\$ 4,209.12$ |

11. Pursuant to the information it received during the redetermination process, the respondent determined that the petitioner was over the allowable asset limit and her request for continuing Medicaid was denied.
12. The Department mailed a Notice of Case Action dated September 30, 2015 to the petitioner informing the petitioner of its intent to terminate her ICP Medicaid effective October 31, 2015. The Notice of Case Action explains the reason for the termination is because "The value of your assets is too high for this program" and cites Florida Administrative Code Rule 65A-1.712.
13. In addition to the the petitioner has other assets which include the following: checking account; savings account; stock and bond account; and burial account.
14. In addition to the intangible assets listed in the previous paragraph, the petitioner owns real property in both Florida and Washington State.

FINAL ORDER (Cont.)
15F-08668
PAGE - 5
15. The petitioner's real property in Florida was excluded as an asset in the determination process because it is considered to be her homestead. The petitioner's real property in Washington State was excluded as an asset because it is considered to be income-producing property.
16. On her August 31, 2015 application for assistance, the petitioner listed the market value of the real property she owns in Washington State and the improvements thereon as $\$ 500,000$.
17. On her 2014 federal income tax return, the petitioner lists the annual rental income received from her real property in Washington State as $\$ 11,700$. This is equal to $\$ 975$ per month.
18. The petitioner's $\square$ is titled solely in the petitioner's name. The account lists the petitioner's attorney-in-fact as the beneficiary of the account and the words "Rental Operating Account" appear in the account title.
19. It is the value of the petitioner's Wells Fargo account with account number ending in 8826 that is placing her over the asset limit for ICP Medicaid.
20. It is the position of the petitioner's representative that the money in the petitioner's $\longrightarrow$ is used to pay expenses associated with the petitioner's income producing property in Washington State and, therefore, should not be counted as an asset and used to disqualify the petitioner from receiving ICP Medicaid.
21. There is no evidence indicating the petitioner's $\square$ is an escrow account.
22. There is no evidence indicating the petitioner's has any legal restrictions.
23. The petitioner has unrestricted access to the funds in her
24. There are legitimate operating expenses associated with the operation of the petitioner's income producing property in Washington State.
25. The Department has a written policy in place through which to arrive at a net income figure from income producing property after expenses are deducted from the gross rents received.
26. The net income received from income producing property is a part of the equation used to determine a patient's responsibility for ICP services.
27. The petitioner has owned and disclosed both her income producing property in Washington State and the Wells Fargo account ending in account number 8826 during previous certification periods.
28. The Department did not address in detail the computation of the allowable expenses associated with the petitioner's income producing property in Washington State. A chart was not provided showing the applicable expenses associated with the property and the impact of the amortization of those expenses on the petitioner's Wells Fargo account ending in 8826.

## CONCLUSIONS OF LAW

29. 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.

FINAL ORDER (Cont.)
15F-08668
PAGE - 7
Stat § 409.285. This Order is the final administrative decision of the Department of
Children and Families under § 409.285, Fla. Stat.
30. This proceeding is a de novo proceeding, pursuant to Fla. Admin. Code R. 65-2.056.
31. The respondent is purporting to terminate the petitioner's ICP Medicaid.

Therefore, in accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof is hereby assigned to the respondent.
32. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, $7^{\text {th }}$ Ed.).
33. Fla. Admin. Code R. 65A-1.712 sets forth SSI-Related Medicaid Resource

Eligibility Criteria, which includes the ICP Program, and states in part:
(1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C.,
(f) Property that is essential to the individual's self-support shall be excluded from resources if it is producing income available to the individual which is consistent with its fair market value. This includes real and personal property used in a trade or business; non-business income-producing property; and property used to produce goods or services essential to an individual's daily activities [emphasis added].
Liquid resources other than those used as part of a trade or business are not property essential to self-support [emphasis added]. For the purpose of this section, mortgages are considered non-liquid resources, if they were entered into on or before September 30, 2004.

FINAL ORDER (Cont.)
15F-08668
PAGE-8
34. Federal Regulation 20 C.F.R. § 416.1220 sets standards for property
essential to self-support and states in part:
Property essential to self-support can include real and personal property (for example, land, buildings, equipment and supplies, motor vehicles, and tools, etc.) used in a trade or business (as defined in $\S 404.1066$ of part 404), nonbusiness income-producing property (houses or apartments for rent, land other than home property, etc.) and property used to produce goods or services essential to an individual's daily activities [emphasis added]. Liquid resources other than those used as part of a trade or business are not property essential to self-support [emphasis added]. If the individual's principal place of residence qualifies under the home exclusion, it is not considered in evaluating property essential to self-support.
35. Fla. Admin. Code R. 65A-1.716 sets forth the Income and Resource Criteria.
(5) SSI-Related Program Standards.
(a) SSI (42 U.S.C. §§ 1382 - 1383c) Resource Limits:

1. $\$ 2000$ per individual.
2. Fla. Admin. Code R. 65A-1.205 sets forth the Eligibility Determination Process.
(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.
3. Fla. Admin. Code R. 65A-1.303 discusses Assets. It states the following:
(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.
4. The ACCESS Program Policy Manual at 1840.0504 discusses the

Computation of Rental Income (MSSI, SFP) and states the following:
Net rental income is gross rent minus ordinary and necessary expenses paid or anticipated to be paid in the same taxable year. Ordinary and necessary expenses are those necessary for the production or collection of rental income. Expenses recognized by the IRS and paid during the same taxable year can be deducted from unearned rental income.
Allowable expenses include:

1. real estate taxes,
2. interest on debts,
3. utilities,
4. maintenance,
5. repairs (i.e., minor correction to existing structure),
6. the cost of advertising for renters,
7. lawn service,
8. interest and escrow, and
9. homeowner's insurance.

Expenses of managing a rental property are allowable if the expenses are reasonable and necessary. To be considered reasonable, the charge for managing the individual's rental property is limited to $10 \%$ or less of the gross rental income, which should be the community standard charged by local real estate managers. Higher managing expenses may be allowed if the individual can present evidence (e.g., two statements from a knowledgeable source) that such charges are the standard in the particular geographic area of the property.
39. The ACCESS Program Policy Manual at 1640.0544 addresses Income

Producing Property (MSSI, SFP) and explains the following:
An individual can exclude the fair market value of any income producing property he owns that is essential to self-support.
40. The ACCESS Program Policy Manual at 1640.0548 talks about Income Producing Property (MSSI, SFP) and states the following:

Any income producing property (including equipment) may be excluded from assets if it annually produces income consistent with its fair market value. The individual's statement that the property produces a reasonable return may be accepted. If the rate of return is questionable, the eligibility specialist must require verification from a knowledgeable source. The following types of income producing property may be excluded:

1. Property that annually produces income consistent with its fair market value, even if used only on a seasonal basis. Such property shall include rental and vacation homes.
2. The ACCESS Program Policy Manual at 1640.0549 discusses Rate of

Return Less Than Reasonable (MSSI, SFP) and states the following:
Income producing property that does not generate income consistent with its fair market value is counted as an asset in full. However, consideration must be given as to why certain properties generate less income than others in the same geographic area (e.g., run-down properties). The income received may be the fair market value for that particular property. In addition, a less than reasonable rate of return is considered acceptable when the following conditions are met:

1. The property is used in a business or non-business income producing operation; and
2. Unusual or untoward circumstances (e.g., a fire, street repairing in front of a store) cause a temporary reduction in the net return; and
3. The usual net rate of return is reasonable; and
4. The individual expects the property to again produce a reasonable return within 18 months of the end of the taxable year in which the unusual incident that caused the reduction in rate of return occurred.

Obtain the individual's explanation for the decline in earnings and documentation of prior earnings (e.g., tax returns). If a convincing explanation is furnished and there is a reasonable expectation that the property will again produce a reasonable rate of return, notify the individual that he has 18 months from the end of the taxable year in which the unusual incident that caused the reduction in net return occurred to again have a reasonable net rate of return.

FINAL ORDER (Cont.)
15F-08668
PAGE-11
If, at the end of the prescribed time period, the property is not producing a reasonable net return, the value of the property is considered an includable asset. If property does not generate income consistent with its fair market value, the property will count in full as an asset.
42. As shown in the Findings of Fact, the Department did not approve the petitioner's request for ICP Medicaid benefits based due to the petitioner being over the asset limit as a result of the money available to her in the

The petitioner's representative argued that the money in the petitioner's Wells Fargo account is used to pay expenses associated with the petitioner's income producing property in Washington State and should, therefore, not disqualify her from receiving ICP Medicaid. As shown above, property that is essential to the individual's self-support shall be excluded from resources if it is producing income available to the individual which is consistent with its fair market value. However, liquid resources other than those used as part of a trade or business are not property essential to self-support. The petitioner's Wells Fargo account does not qualify as property that is essential to self-support. The nonbusiness income-producing rental property does not rise to the level of a business or trade. There is also nothing in the petitioner's tax return evidencing an intent to operate a business.
43. The petitioner is confusing assets and income. The Department has a written policy in place which allows for the deduction of reasonable operating expenses from gross rents to arrive at net rental income. This policy is not applicable to assets. The petitioner was not disqualified due to being over income; she was disqualified due to being over assets. The Wells Fargo account is an asset whose value was determined as the lump sum available to the petitioner.

FINAL ORDER (Cont.)
15F-08668
PAGE-12
44. The rules for asset or resource limits for the ICP Program are clear. The petitioner's assets are over the prescribed limit of $\$ 2,000$. Therefore, the Department correctly denied the petitioner's application for ICP Medicaid.
45. Pursuant to the above, the petitioner has not met her burden of proof that the respondent incorrectly denied her request for ICP Medicaid.

## 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.

Eligibility Criteria, which includes the ICP Program, and states in part:
(1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C.,
(f) Property that is essential to the individual's self-support shall be excluded from resources if it is producing income available to the individual which is consistent with its fair market value. This includes real and personal property used in a trade or business; non-business income-producing property; and property used to produce goods or services essential to an individual's daily activities [emphasis added]. Liquid resources other than those used as part of a trade or business are not property essential to self-support [emphasis added]. For the purpose of this section, mortgages are considered non-liquid resources, if they were entered into on or before September 30, 2004.
34. Federal Regulation 20 C.F.R. § 416.1220 sets standards for property essential to self-support and states in part:

Property essential to self-support can include real and personal property (for example, land, buildings, equipment and supplies, motor vehicles, and tools, etc.) used in a trade or business (as defined in $\S 404.1066$ of part 404), nonbusiness income-producing property (houses or apartments for rent, land other than home property, etc.) and property used to produce goods or services essential to an individual's daily activities [emphasis added]. Liquid resources other than those used as part of a trade or business are not property essential to self-support [emphasis added]. If the individual's principal place of residence qualifies under the home exclusion, it is not considered in evaluating property essential to self-support.

FINAL ORDER (Cont.)
15F-08668
PAGE - 14
DONE and ORDERED this 25 day of March , 2016,
in Tallahassee, Florida.


Peter J. Tsamis
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myffamilies.com
Copies Furnished To:


Mar 14, 2016
STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES

## RESPONDENT.



## FINAL ORDER

Pursuant to notice and agreement, Hearing Officer Patricia C. Antonucci convened hearing in the above-captioned matter on January 28, 2016 at approximately 10:00 a.m. All parties and witnesses appeared via teleconference.

## APPEARANCES

For the 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), through its contracted peer review organization, eQHealth Solutions, Inc., to terminate Petitioner's Prescribed Pediatric Extended Care (PPEC) services. Respondent bears the burden of proving, by a preponderance of the evidence, that said termination is proper.

FINAL ORDER (Cont.)
15F-08675
Page 2 of 12

## PRELIMINARY STATEMENT

Hearing was previously scheduled to convene on December 1, 2015 at 1:00 p.m. On that date, Petitioner failed to appear; however, Petitioner's father contacted the Office of Appeal Hearings on or about December 3, 2015 to state that he had not received the Notice of Hearing until December 2, 2015. Hearing was thus rescheduled, via notice to both parties.

At hearing on January 28, 2016, the minor Petitioner was not present, but was represented by his father. Respondent was represented by Selwyn Gossett, Medical/Health Care Program Analyst, on behalf of AHCA. Respondent presented one additional witnesses: Ellyn Theophilopoulos, M.D., Physician Reviewer with eQHealth Solutions (eQHealth).

Respondent's Exhibits 1 through 9, inclusive, were admitted into evidence. Administrative Notice was taken of Fla. Stat. § 409.905, Fla. Admin. Code R. 59G1.001, Fla. Admin. Code R. 59G-1.010, Fla. Admin. Code R. 59G-4.260, and pertinent pages of the September 2013 Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook (PPEC Handbook).

## FINDINGS OF FACT

1. The Petitioner is a 5-year old male, born in 2011. His diagnoses include failure to thrive and feeding aversions. He has history of reactive airway disease, for which he uses a nebulizer, as needed. He is ambulatory and verbal, but is not yet potty trained, and must be prompted to use the toilet. The Petitioner receives speech therapy (ST) to assist in treating his food aversion.

FINAL ORDER (Cont.)
15F-08675
Page 3 of 12
2. At some point prior to 2014, the Department of Children and Families (DCF) became involved with Petitioner and he was placed into medical foster care. Petitioner is now in the custody of his father, and DCF is no longer involved.
3. Petitioner is and has been eligible to receive Medicaid services at all times relevant to these proceedings.
4. On or about July 28, 2015, Petitioner's PPEC provider submitted a request on behalf of the Petitioner, to continue his previously authorized PPEC services into his new certification period, spanning August 6, 2015 through February 1, 2016.
5. This prior service authorization request, along with information and documentation required to make a determination of medical necessity, was submitted to AHCA's peer review organization (PRO). The PRO contracted by AHCA to review PPEC requests is eQHealth Solutions, Inc. (eQHealth).
6. On July 31, 2015, the PRO reviewed Petitioner's request for services and all supporting documentation. By letter dated July 31, 2015, the PRO notified Petitioner's provider of its decision to terminate PPEC, stating, in pertinent part:

PR Principal Reason - Denial: Requested services are denied because the clinical information does not support the medical necessity.
7. Although no clinical rationale was included in eQHealth's denial letter, said rationale is contained within its Outpatient Review History. Said History specifies that eQHealth will approve 90 days of PPEC to allow for Petitioner's transition to alternate care, but that the remainder of his requested services are denied because " $[\mathrm{t}] \mathrm{he}$ patient appears to no longer required skilled nursing services and does not meet the medical

FINAL ORDER (Cont.)
15F-08675
Page 4 of 12
complexity requirement of PPEC services. The additional services are deemed excessive."
8. The July 31, 2015 letter sent to Petitioner notes only:

The reason for the denial is that the services are not medically necessary as defined in 59G-1.010 (166), Florida Administrative Code (F.A.C.), specifically the services must be:
Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.
Reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.
9. On or about October 15,2015 , Petitioner requested a hearing to challenge this denial.
10. As Petitioner's request for hearing was received prior to the end of his certification period, his PPEC services have continued, pending the outcome of this appeal.
11. At hearing, Dr. Theophilopoulos testified based upon her review of Petitioner's request for services, in conjunction with his Plan of Care, PPEC Assessment, and care coordination and progress notes.
12. Petitioner's most recent Plan of Care reflects that he is totally dependent on others for activities of daily living (ADL) care, with current diagnoses including failure to thrive, dysphagia, asthma, chronic lung disease, deformities of skull/face/jaw, and food aversion. Petitioner is noted to have developmental and speech delay, and torticolis. He was born at 27 weeks gestation and spent four months in intensive care, thereafter. He remains incontinent and is at the third percentile of growth for his age. While he requires precautions/monitoring, the only interventions indicated on the Plan (other than

FINAL ORDER (Cont.)
15F-08675
Page 5 of 12
therapies) are the administration of as-needed medications/nebulizer, diaper changes, and repositioning. The Plan instructs that, due to his aversion, Petitioner must be fed pureed food or formula over a long period of time (one hour), with increased foods as tolerated. The Plan further indicates that he receives ST , as well as physical therapy (PT) and occupational therapy (OT) to promote steadier ambulation and reduce falls, while at PPEC.
13. Per Dr. Theophilopoulos, Petitioner's PPEC Assessments and notes reflect that Petitioner has no history of seizures, tube placement, or dependence upon mechanical devices. His ADLs are mostly age-appropriate, and while Dr. Theophilopoulos agrees that Petitioner requires therapeutic services and assistance with toilet training, she does not feel these needs indicate a medical necessity for continuation of PPEC. She recommends that Petitioner look into intensive feeding therapy centers, through his managed care plan.
14. Petitioner's father agrees that the Petitioner does not need full medical assistance, but notes that Petitioner has thrived at PPEC and progressed "leaps and bounds" since he started receiving the service, as the Petitioner trusts the PPEC providers. His father is concerned that Petitioner is still over-friendly and vulnerable to strangers, and that he still does not eat well, weighing only 33.6 pounds. The father testified that he, himself, has received training in Petitioner's care. However, Petitioner begins projectile vomiting when fed food other than formula. The father is worried about a potential lapse in service or Petitioner's resistance to change during a transition to regular day care. He has conferred with Petitioner's managed care plan and believes therapies will be coordinated upon Petitioner's transition to an "Explore K-8" program.

FINAL ORDER (Cont.)
15F-08675
Page 6 of 12
However, he remains concerned that Petitioner will "clam up" and regress when exiting PPEC, and lose weight, as he did when PPEC first began. The father further notes that the nearest intensive feeding therapy center is several hours away.
15. It is Dr. Theophilopoulos's opinion that at this time, Petitioner does not require skilled nursing interventions on a regular basis, as his conditions have stabilized. Dr. Theophilopoulos opined that Petitioner's feeding/swallowing aversion should continue to be addressed through ST, which Petitioner can receive as a distinct service, outside of the PPEC setting.
16. The Agency noted that because Petitioner is enrolled with a medical managed care plan through Children's Medical Services (CMS), he should have a CMS case manager or RN coordinator, who can assist Petitioner's father in finding appropriate services to supplement what Petitioner receives in a day care/school setting, and to address any other outstanding needs.

## CONCLUSIONS OF LAW

17. By agreement between AHCA and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction to conduct this hearing, pursuant to Florida Statutes Chapter 120.
18. Respondent, the Agency for Health Care Administration, administers the Medicaid Program. Legal authority governing the Florida Medicaid Program is found in Chapter 409 of the Florida Statutes and in Chapter 59G of the Florida Administrative Code.

FINAL ORDER (Cont.)
15F-08675
Page 7 of 12
19. The September 2013 Florida Medicaid Prescribed Pediatric Extended Care

Services Coverage and Limitations Handbook (PPEC Handbook) has been
promulgated into rule by Fla. Admin. Code R. 59G-4.260.
20. This is a Final Order, pursuant to $\S 120.569$ and $\S 120.57$, Fla. Stat.
21. This hearing was held as a de novo proceeding, in accordance with Fla. Admin.

Code R. 65-2.056.
22. The burden of proof in the instant case is assigned to Respondent, who seeks to terminate Petitioner's PPEC services. The standard of proof in an administrative hearing is preponderance of the evidence. (See Fla. Admin. Code R. 65-2.060(1).)
23. 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....
(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.-The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.
24. Page 1-1 of the PPEC Handbook notes that, "[t]he purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) Services Program is to enable recipients under the age of 21 years with medically complex conditions to receive medical and therapeutic care at a non-residential pediatric center."

FINAL ORDER (Cont.)
15F-08675
Page 8 of 12
25. On page 2-1 - 2-2, the PPEC Handbook lists the requirements for PPEC services.

To receive reimbursement for PPEC services, a recipient must meet all of the following criteria:

- Be Medicaid eligible.
- Diagnosed with a medically-complex or medically fragile condition as defined in Rule 59G-1.010, F.A.C.
- Be under the age of 21 years.
- Be medically stable and not present significant risk to other children or personnel at the center.
- Require short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care due to a medically-complex condition.

26. Fla. Admin. Code R. 59G-1.010 defines "medically complex" and "medically fragile" as follows:
(164) "Medically complex" means that a person has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention. (165) "Medically fragile" means an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, e.g., requires total parenteral nutrition (TPN), is ventilator dependant, or is dependent on a heightened level of medical supervision to sustain life, and without such services is likely to expire without warning. (emphasis added)
27. Consistent with the law, AHCA's agent, eQHealth, performs service authorization reviews under the Prior Authorization Program for Medicaid recipients in the state of Florida. Once eQHealth receives a PPEC service request, its medical personnel conduct file reviews to determine the medical necessity of requested services, pursuant to the authorization requirements and limitations of the Florida Medicaid Program.
28. Fla. Admin. Code Rule 59G-1.010(166) defines medical necessity, as follows:

FINAL ORDER (Cont.)
15F-08675
Page 9 of 12
"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.
6. As the petitioner is under the age of 21, a broader definition of medically necessary applies, to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) requirements. Both EPSDT and Medical Necessity requirements (both cited, above) have been considered in the development of this

Order.
30. EPSDT augments the Medical Necessity definition contained in the Florida Administrative Code via the additional requirement that all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of problems be addressed by the appropriate services.
31. United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in Moore v.

Reese, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, (which involved a dispute over private duty nursing):
(1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.
(2) A state Medicaid plan must include "reasonable standards ... for determining eligibility for and the extent of medical assistance" ... and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.
(3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."
(4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."
(5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to provide medically unnecessary, albeit desirable, EPSDT services. However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."
(6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and my present its own evidence of medical necessity in disputes between the state and Medicaid patients (citations omitted).
32. In the instant case, PPEC is requested to treat and ameliorate the supervisory and monitoring needs which Petitioner's health conditions require. As such, in a general sense, PPEC is in keeping with Fla. Admin. Code R. 59G-1.010(166)(1).

FINAL ORDER (Cont.)
15F-08675
Page 11 of 12
Because PPEC is a recognized Medicaid service, it is consistent with generally accepted medical standards, per Fla. Admin. Code R. 59G-1.010(166)(3).
33. More specifically, however, Fla. Admin. Code R. 59G-1.010(166) also requires that any authorized service not be in excess of a patient's needs, be furnished in a manner not intended for convenience, and be a service for which no equally effective and less-costly treatment is available. In order for PPEC to fulfill these criteria, the Petitioner must meet the requirements for PPEC, as provided in the PPEC Handbook. 34. There is little evidence to suggest that the Petitioner is dependent upon 24-hour per day medical or nursing care, or that he is dependent upon life-sustaining medical intervention or equipment, such that he would properly be deemed "Medically Complex" or "Medically Fragile." His need for supervision, general monitoring, slow feeding, and precautions do not constitute a need for "intermittent continuous therapeutic interventions or skilled nursing care."
35. Tellingly, there is currently no skilled therapy or intervention provided to Petitioner at the PPEC site. While the PPEC program is "hosting" ST, OT, and PT services, these services, as well as any other needed therapy, can be authorized as a distinct service, outside the PPEC environment. Petitioner is encouraged to pursue coordination of same, through CMS.
36. When jointly considering the requirements of both ESPDT and Medical Necessity, along with a review of the totality of the evidence and legal authority, the undersigned concludes that Respondent has met its burden of proof to terminate PPEC.
37. Petitioner's father is further encouraged to coordinate with AHCA and Petitioner's CMS case manager or RN coordinator, to determine Petitioner's options for an intensive

FINAL ORDER (Cont.)
15F-08675
Page 12 of 12
feeding therapy program, and any other services necessary to supplement day
care/school-provided services in meeting Petitioner's needs. Should Petitioner request
a service and receive a notice denying same, he will retain the right to appeal
that/those, specific denial(s).

## DECISION

Based upon the foregoing, Petitioner's appeal is hereby DENIED.

## NOTICE OF RIGHT TO APPEAL

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


Mar 03, 2016

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

PETITIONER,
Vs.
AGENCY FOR HEALTH CARE ADMINISTRATION, CIRCUIT: 11 DADE
UNIT: AHCA
and
SUNSHINE STATE HEALTH PLAN, INC.
RESPONDENTS.

## FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on December 15, 2015 at 1:00 p.m. and on January 28, 2016 at 10:00 a.m.

APPEARANCES
For the Petitioner:


For the Respondent AHCA: Monica Otalora, Senior Program Specialist
For Sunshine State Health Plan, Inc.: Mamie Joeveer, Esq.

## STATEMENT OF ISSUE

At issue is the Petitioner's request for various Long-Term Care (LTC) plan services, including adult diapers, a shower chair, and the nutritional supplement Glucerna. The Petitioner bears the burden of proof in this matter by a preponderance of the evidence.

## PRELIMINARY STATEMENT

Appearing as witnesses for the Respondent were Dr. John Carter, Medical Director; India Smith, Grievance and Appeals Coordinator; Karel Fernandez, Case Manager; Rolande Francois, Case Manager Supervisor, and Mayra Infantone, LTC Director, from Sunshine Health Plans, which is Petitioner's managed care plan.

Also present for the hearing was a


Sunshine State Health Plan, Inc. (a/k/a Sunshine Health Plans) is included as an additional party to this proceeding pursuant to its Motion to Intervene.

## FINDINGS OF FACT

1. The Petitioner is an adult Medicaid recipient who was enrolled in the Statewide Medicaid Managed Care (SMMC) - Long Term Care (LTC) plan. She receives services under the plan from Sunshine Health.
2. 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

FINAL ORDER (Cont.)
15F-08980
PAGE -3
contract. Managed Care Organizations such as Sunshine Health provide services to Medicaid recipients pursuant to a contract with AHCA.
3. The hearing was convened to discuss three potential issues - adult diapers, a shower chair, and the nutritional supplement Glucerna.
4. Petitioner's son stated he did not request a hearing on the Glucerna, and that it was requested by his mother's physician without his consent. Accordingly, this issue was not addressed during the hearing.
5. Regarding the shower chair, this item was initially denied by Sunshine since it may have been available to the Petitioner through Medicare coverage. Once Medicare denied this item to the Petitioner, it was subsequently approved by Sunshine. Since this item has now been approved by Sunshine, there is no further action which can be taken by the hearing officer on that issue.
6. The hearing was reconvened to discuss on-going issues regarding the shower chair, including Petitioner's son's claim that it had not yet been delivered. Ms. Francois from Sunshine stated the Petitioner's son had been uncooperative with the provider of the chair regarding the measurements needed for the chair. Petitioner's son stated the provider told him that the chair could not be used or delivered if the bathroom had a tub rather than a shower. He also stated other providers told him there are no measurements needed to obtain a shower chair, only a doctor's prescription.
7. Despite these on-going issues related to delivery of the shower chair, there is no further relief or remedy which can be offered by the hearing officer. The extent of the hearing officer's authority would be to render a decision as to whether or not the initial

FINAL ORDER (Cont.)
15F-08980
PAGE -4
denial of the shower chair was correct or not. Since the shower chair has already been approved by Sunshine, this renders the issue moot for hearing purposes. Petitioner's son's complaints are more in the nature of customer service issues which cannot be addressed by the hearing officer.
8. Regarding the issue of the diapers, Petitioner's son confirmed his mother is currently receiving the correct diapers. His main concern appears to be his claim that Sunshine is overpaying the supplier of the diapers and he believes this should be investigated as a fraudulent activity. In addition, he is complaining that his mother received the wrong diapers for a period of time earlier in the year 2015 and had to go without diapers for several months (this issue was addressed in prior fair hearing proceedings).

## 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.

FINAL ORDER (Cont.)
15F-08980
PAGE -5
12. After considering the evidence and testimony presented, the hearing officer concludes that the issues for the hearing are now moot and there is no remedy or action which can be offered or taken by the hearing officer. The Petitioner did not request a hearing on the Glucerna, the shower chair has been approved by Sunshine, and the Petitioner has been receiving the correct diapers. The hearing officer cannot address the customer service issues related to the shower chair or conduct investigations of alleged fraud.

## 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 $\qquad$ 03 day of $\qquad$ March 2016,
in Tallahassee, Florida.

FINAL ORDER (Cont.)
15F-08980
PAGE -6


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

Copies Furnished To:
PETITIONER
RHEA GRAY, AREA 11, AHCA FIELD OFFICE MANAGER

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

APPEAL NO. 15F-09110
PETITIONER, Vs.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES CIRCUIT: 06 PASCO UNIT: 883CF

CASE NO.

RESPONDENT.

## FINAL ORDER

Pursuant to notice, hearing officer Brandy Ricklefs convened a telephonic administrative hearing in the above-referenced matter on December 16, 2015 at 9:28 a.m.

## APPEARANCES

For the petitioner:


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

## STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny her application for Medicaid dated October $5^{\text {th }}, 2015$. The petitioner carries the burden of proving her case by a preponderance of the evidence.

FINAL ORDER
15F-09110
PAGE - 2

## PRELIMINARY STATEMENT

By way of a Notice of Case Action dated October $26^{\text {th }}, 2015$, the respondent informed the petitioner that her application for Medicaid was denied. The reason stated on the notice is "you or a household member do not meet the citizenship requirement." [Sic.] On October $27^{\text {th }}, 2015$, the petitioner filed a timely appeal to challenge the respondent's action.

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

The respondent submitted a total of 127 pages which were entered into the record as Respondent's Exhibits 1 through 11.

The record was held open until the close of business January $8^{\text {th }}, 2016$ to allow the petitioner to submit evidence. Within the allowed time frame, the petitioner submitted 126 pages which were entered into the record as Petitioner's Composite 1. The record was closed at the close of business January $8^{\text {th }}, 2016$.

Due to unforeseen circumstances, the appeal was necessarily reassigned to the undersigned hearing officer. On February $16^{\text {th }}, 2016$, the undersigned issued a Notice of Transfer of Hearing Officer stating that the undersigned would review the record of December $16^{\text {th }}, 2015$ and issue a Final Order based on the merits therein. The notice allowed either party to raise any objection to this procedure within seven (7) days. As of the close of business of February $24^{\text {th }}, 2016$ neither party contacted the undersigned with any objection. Therefore, the undersigned will proceed as stipulated.

## FINDINGS OF FACT

1. On October $5^{\text {th }}, 2015$, the petitioner applied for Medicaid for herself. As part of the application process, the respondent is required to explore and verify all technical, income, and asset-related factors of eligibility.
2. The petitioner, 72 years of age, was born in Mexico.
3. On October $7^{\text {th }}, 2015$, the respondent issued to the petitioner a Notice of Case Action (Respondent's Exhibit 6) requesting of the petitioner, the following:

Proof of INS status
Proof of [m]edical emergency in September as verified by a [d]octor/hospital official

The notice informs the petitioner of the various means by which she can provide the requested information. The notice establishes a deadline of October $19^{\text {th }}$, 2015, and advises that failure to provide the requested information will result in the respondent's inability to determine the petitioner's eligibility. In this event, the petitioner's application would be denied.
4. On October $26^{\text {th }}, 2015$, the respondent issued to the petitioner a Notice of Case Action informing her that her Medicaid application of October $5^{\text {th }}, 2015$ was denied. The reason given on the notice is "You or a household member do not meet the citizenship requirement."
5. On November $13^{\text {th }}, 2015$, the petitioner supplied tax returns from the years 1990, 1993, and 1996, thereby verifying that the petitioner was residing in the United States at least during those years. The petitioner also supplied an Authorization for Parole of an Alien under section 212(d)(5) (Respondent's Exhibit 3).

FINAL ORDER
15F-09110
PAGE-4
6. On November $24^{\text {th }}, 2015$, the respondent initiated a search to verify the petitioner's status with Homeland Security using the Systematic Alien Verification for Entitlements (SAVE) system. The response received from the search indicated that the petitioner was granted a status of Lawful Permanent Resident, Employment Authorized on October $2^{\text {nd }}, 2015$. The petitioner's country of origin was indicated as being Mexico, and the class of admission (COA) is IR0, which signifies that the petitioner is the parent of a United States citizen.
7. The respondent's contention is that the petitioner is ineligible for Medicaid due to a five-year ban from the date of entry (in this case, October $2^{\text {nd }}, 2015$ ) for Lawful Permanent Residents to receive public assistance benefits.

## 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 $\S 409.285$, 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. § 435.406, explains Medicaid Citizenship and alienage requirements and in part states:
(a) The agency must provide Medicaid to otherwise eligible residents of the United States who are-
(2)(i) Except as specified in 8 U.S.C. 1612(b)(1) (permitting States an option with respect to coverage of certain qualified aliens), qualified aliens as described in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641) (including qualified

FINAL ORDER
15F-09110
PAGE - 5
aliens subject to the 5-year bar) who have provided satisfactory documentary evidence of Qualified Alien status, which status has been verified with the Department of Homeland Security (DHS) under a declaration required by section 1137(d) of the Act that the applicant or beneficiary is an alien in a satisfactory immigration status.
(ii) The eligibility of qualified aliens who are subject to the 5 -year bar in 8 U.S.C. 1613 is limited to the benefits described in paragraph (b) of this section.
(b) The agency must provide payment for the services described in § 440.255(c) of this chapter to residents of the State who otherwise meet the eligibility requirements of the State plan (except for receipt of AFDC, SSI, or State Supplementary payments) who are qualified aliens subject to the 5-year bar or who are non-qualified aliens who meet all Medicaid eligibility criteria, except non-qualified aliens need not present a social security number or document immigration status.
11. The United States Code at 8 U.S.C. § 1641 Definitions, states in part:
(a) In general. Except as otherwise provided in this chapter, the terms used in this chapter have the same meaning given such terms in section 101(a) of the Immigration and Nationality Act [8 U.S.C. 1101(a)].
(b) Qualified alien For purposes of this chapter, the term "qualified alien" means an alien who, at the time the alien applies for, receives, or attempts to receive a Federal public benefit, is-
(1) an alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act [8 U.S.C. 1101 et seq.],
(2) an alien who is granted asylum under section 208 of such Act [8 U.S.C. 1158],
(3) a refugee who is admitted to the United States under section 207 of such Act [8 U.S.C. 1157],
(4) an alien who is paroled into the United States under section 212(d)(5) of such Act [8 U.S.C. 1182(d)(5)] for a period of at least 1 year...(emphasis added)
12. The United States Code at 8 U.S.C. § 1613 Five-year limited eligibility of
qualified aliens for Federal means-tested public benefit, states in part:
(a) In general. Notwithstanding any other provision of law and except as provided in subsections (b), (c), and (d) of this section, an alien who is a qualified alien (as defined in section 1641 of this title) and who enters the United States on or after August 22, 1996, is not eligible for any Federal means-tested public benefit for a period of 5 years beginning on the date of the alien's entry into the United States with a status within the meaning of the term "qualified alien". (Emphasis added.)

FINAL ORDER
15F-09110
PAGE-6
13. The Department's Program Policy Manual, CFOP 165-22, Passage
1440.0110 Parolees (MSSI, SFP), states the following:

Parolees under Section 212(d)5 for at least one year; Noncitizens granted temporary parole status for a total period of at least one year by the Attorney General under Section 212(d)(5) of the Immigration and Nationality Act (INA) are eligible for on the factor of noncitizen status. Verification for this status includes:

1. USCIS Form I-94 indicating that the individual has been paroled under this section of the INA, or
2. other conclusive documentation of this status.

Note: If the USCIS document does not reflect at least a one-year period, the eligibility specialist must institute secondary verification.
Note: These individuals are subject to the five-year ban if the entry date is after 8/22/96.
14. In accordance with the above authorities, non U.S. citizens must have a qualified alien status to be eligible for Medicaid benefits.
15. The evidence establishes that petitioner entered the U.S. on August $19^{\text {th }}$, 1997 as a Parolee. In careful review of the cited authorities and evidence, the undersigned concludes the respondent was incorrect in its action to deny the petitioner's Medicaid application on the basis of non-citizenship. Although the petitioner is currently a LPR, the evidence shows that she had a prior qualified alien status as she was granted parolee status on August $19^{\text {th }}, 1997$ for at least one year and has completed the five-year ban from that date.
16. Therefore, after careful review of the evidence and controlling authorities, the undersigned concludes that the petitioner is a qualified alien and meets the noncitizenship requirement for Medicaid eligibility. Accordingly, the case is hereby remanded to the respondent. The respondent will, within ten days from the date of this order, continue the eligibility determination process on all other qualifying factors. The

FINAL ORDER
15F-09110
PAGE-7
petitioner may need to cooperate in this process. The respondent will preserve the petitioner's original application date of October $5^{\text {th }}, 2015$. Once an eligibility determination is made, the respondent will issue a new Notice of Case Action informing her of the outcome, and the notice will include appeal rights to be exercised should the petitioner disagree with the outcome.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is GRANTED in part, and remanded to the respondent for corrective action as indicated above.

## 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 $\qquad$ 03 day of March , 2016,
in Tallahassee, Florida.


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:

STATE OF FLORIDA
Mar 14, 2016
DEPARTMENT OF CHILDREN AND FAMILIES Office of Appeal Hearings OFFICE OF APPEAL HEARINGS


APPEAL NO. 15F-09148
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 12, 2016, at 10:35 a.m.
APPEARANCES

For the Petitioner:


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.

FINAL ORDER (Cont.)

## PRELIMINARY STATEMENT

Present as witnesses for the respondent from Better Health were Dianna Anda, Grievance and Appeals Manager, and Dr. Marlin Osorio, Medical Director. Also present as witnesses for the respondent from DentaQuest were Dr. Susan Hudson, Dental Consultant, and Nicholas Calderon, Grievance and Appeals Supervisor.

The record was left open twenty-five days for petitioner to submit additional information. This information was submitted within the time frame allotted. The record was left open seven additional days for respondent to provide a response. Respondent was then given an additional thirteen days to provide a response. The respondent provided a response after the deadline.

The respondent submitted into evidence Respondent Exhibits 1 through 3. 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 seventeen years of age. She was enrolled in the Medicaid MMA (Managed Medical Assistance) Program with Better Health. In January 2016, the petitioner enrolled with Molina as her MMA Plan. Better Health 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 is contracted by Better Health to provide dental services and perform prior authorization reviews.

FINAL ORDER (Cont.)
15F-09148
PAGE -3
2. On September 29, 2015, DentaQuest received a prior authorization request from the petitioner's treating dental surgeon for the removal of four wisdom teeth, tooth numbers 1, 16, 17 and 32. On October 1, 2015, DentaQuest reviewed this request and provided an Authorization Determination notice to the petitioner's dental provider. The removal of tooth numbers 17 and 32 were approved (lower quadrant) and removal of tooth numbers 1 and 16 were denied.
3. The notice indicated that the request for procedure code D7240 was denied for the two upper quadrant teeth. The determination reason indicated "there is no sign of infection or other medical reasons for tooth removal." Procedure code D9999, unspecified adjunctive procedure by report, was also denied. The notice indicated "please resubmit with a narrative describing this treatment and/or a narrative regarding medical necessity."
4. On October 27, 2015, DentaQuest sent the petitioner notice 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;

The requested service is not a covered service.

FINAL ORDER (Cont.)
15F-09148
PAGE -4
5. The respondent's dental physician witness indicated DentaQuest reviewed the information submitted and there is no sign of infection or other medical reasons for tooth removal that would meet the criteria for the service request to be approved.
6. The petitioner's representative indicated the petitioner has a new dental provider. She requested that DentaQuest send her or the new dentist provider an approval letter for the teeth removal that was approved. DentaQuest agreed to send another approval letter. She argued the petitioner has a lot of pain associated with her dental problems. She also argued that she would like all of the dental procedures be approved so that they could be done all at once.
7. The information provided by the petitioner while the record was left open is a letter dated September 29, 2015 that appears to be (digitally) signed by the petitioner's treating surgeon dentist. It states "teeth number 1, 16, 17 and 32 are impacted. There is evidence of pericoronitis at all areas producing periodontal problems at adjacent teeth. Extraction of wisdom teeth advised." The respondent provided a response, after the deadline, in which they indicated that the petitioner did not provide new information and that she had changed her plan.

## CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285 of the Florida Statues. This order is the final administrative decision of the Department of Children and Families under Section 409.285 of the Florida Statutes.
9. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 652.056.

FINAL ORDER (Cont.)
15F-09148
PAGE -5
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 (November 2011) is incorporated by reference in Chapter 59G-4 Florida Administrative Code and states on page 1-2:

Children's Dental Services
The children's dental program provides full dental services for all Medicaid eligible children age 20 and below.
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.

FINAL ORDER (Cont.)
15F-09148
PAGE -6
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. Section 409.905 of the Florida Statutes, 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

FINAL ORDER (Cont.)
15F-09148
PAGE -7
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 1 and 16 , upper quadrant.
18. For the case at hand, the respondent argued after review of the information submitted for the request, including X-rays, DentaQuest found no evidence of infection or pathology that would meet criteria for the service to be approved. However, the petitioner testified she is in pain based on her dental problems. Additionally, the

FINAL ORDER (Cont.)
15F-09148
PAGE -8
petitioner's treating dental surgeon provided an unrefuted statement indicating all of the petitioner's wisdom teeth are impacted and need to be surgically removed.
19. After considering the evidence and all of the authorities set forth above, including the Early and Periodic Screening, Diagnosis, and Treatment Services (EPDST) requirements, the hearing officer concludes the petitioner has met her burden of proof and the Agency's action in denying the request for the removal of tooth numbers 1 and 16 is incorrect.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is GRANTED in part to the extent that procedure code D7240 for teeth 1 and 16 is now approved.

## NOTICE OF RIGHT TO APPEAL

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

FINAL ORDER (Cont.)
15F-09148
PAGE -9
DONE and ORDERED this 14 day of __March , 2016, in Tallahassee, Florida.


## 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

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

APPEAL NO. 15F-09275

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 this matter on January 19, 2016 at 1:39 p.m.

## APPEARANCES

For the Petitioner:
For the Respondent:


Linda Latson, Registered Nurse Specialist, Agency for Health Care Administration

## STATEMENT OF ISSUE

The Petitioner is appealing the Agency for Health Care Administration's (AHCA's) decision, through DentaQuest, to deny the Petitioner's requests for dental procedures D7240 (removal of impacted tooth) for tooth 1 and 16, D9220 (general anesthetic-first 30 minutes) and D9221 (general anesthetic-each additional 15 minutes).

FINAL ORDER (Cont.)
15F-09275
PAGE - 2
Because the issue under appeal involves requests for services, the Petitioner bears the burden of proof.

## PRELIMINARY STATEMENT

Diana Anda, Grievance and Appeals Supervisor, and Dr. Jeanette Rios, Medical Director, appeared as Respondent's witness from Petitioner's managed care plan Better Health. Appearing as Respondent's witnesses from DentaQuest were Heidi Penderanda, Grievance and Appeals Specialist, and Dr. Susan Hudson, Dental Consultant.

Respondent submitted a 30-page document, which was entered into evidence and marked Respondent Exhibit 1. Petitioner submitted a 5-page document, which was entered into evidence and marked Petitioner Exhibit 1.

The initial prior authorization requests were submitted on September 25, 2015 and included requests for removal of teeth \#1, \#16, \#17, and \#32. These requests were all denied on September 29, 2015. However, on November 2, 2015, DentaQuest reversed its denial of removal of tooth \#17 and \#32. Removal of tooth \#1 and \#16 remain at issue at the time of hearing.

Petitioner was having his braces removed within two weeks from the hearing, so the record was held open until February 19, 2016 for petitioner to provide updated information on the condition of tooth \#1 and \#16 and for DentaQuest to complete an updated review of the request for extraction of these teeth.

Petitioner provided the updated information on February 9, 2016 and the document was entered into evidence and marked Petitioner Exhibit 2. Respondent
provided the results of DentaQuest's updated review on February 22, 2016, which was entered into evidence and marked Respondent Exhibit 2.

## 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 16 year-old Medicaid recipient enrolled with Better Health, a Florida Health Managed Care provider.
2. Better Health requires prior authorization for services related to dental care and has subcontracted with DentaQuest to perform prior authorization requests.
3. On September 25, 2015, DentaQuest received a prior authorization request from Petitioner's dentist for the following procedure codes: D7240 extraction of impacted tooth covered by bone, Tooth 1 and 16; D9220 (general anesthetic-first 30 minutes); and D9221 (general anesthetic-each additional 15 minutes).
4. On September 29, 2015, DentaQuest sent a Notice of Action to the Petitioner advising the requests for removal of tooth \#1 and tooth \#16 were denied as not medically necessary.
5. On October 28, 2015, Petitioner submitted an appeal with Better Health. On November 2, 2015, the initial denial for extraction of tooth \#1 and tooth \#16 was upheld since these teeth exhibit no pathology and there appears to be space for them to erupt over time.
6. On November 5, 2015, Petitioner filed a timely request for a fair hearing.
7. Petitioner read into the record a letter from his dentist, which states in relevant part:
[Petitioner] is nearing completion of his orthodontic treatment. Upon review of his last panoramic radiograph all the third molars are impacted and require removal. Removal of the third molars will alleviate any pain the patient is experiencing and will help prevent lower incisor crowding in the future.
8. Petitioner's mother explained that her son is experiencing significant pain in his mouth which is interfering with his school attendance and studies. She also feels tooth \#1 and \#16 should be removed at the same time as teeth \#17 and \#32 to prevent her son from having to return at a later date to have tooth \#1 and \#16 removed.
9. DentaQuest's dentist explained the x-rays submitted by her dentist do not show any pathology or problem with tooth 1 and 16 erupting through the gums. There is plenty of space for them. DentaQuest reviewed the updated information submitted by the Petitioner containing x-rays and dentist recommendation and provided the following:

DentaQuest reviewed the additional information received from MFH [Medicaid Fair Hearing] ${ }^{1}$, contacted the dental provider to obtain the doctor's narrative and determined to uphold the denial since no sign of infection, pathology, or medical reason for removal. Also there appears to be sufficient space for $1 \& 16$ to erupt over time.

## CONCLUSIONS OF LAW

10. By agreement between the Agency for Health Care Administration and the Department of Children and Families, the Agency for Health Care Administration has
[^2]FINAL ORDER (Cont.)
15F-09275
PAGE - 5
conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant
to Chapter 120.80 Florida Statutes.
11. This proceeding is a de novo proceeding pursuant to Florida Administrative Code R.65-2.056.
12. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Florida Administrative Code Rule 652.060(1).
13. Florida Statutes 409.971 - 409.973 establishes the requirement for Medicaid recipients to be enrolled in the statewide managed medical assistance program and the minimum benefits the managed care plans shall cover. Dental services are one of the mandatory services that must be provided.
14. Section 409.912, Fla. Stat. also provides that the Agency may mandate prior authorization for Medicaid services.
15. Fla. Admin. Code R. 59G-1.010 defines "prior authorization" as:
(226) "Prior authorization" means the approval by the Medicaid office for a Medicaid provider, or by a prepaid health plan for its affiliated providers, to deliver Medicaid covered medical or allied care, goods, or services in advance of the delivery of the care, goods, or services.
16. Fla. Admin. Code R. 59G-1.010 (166) provides...
"Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.
6. 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.
18. Because the Petitioner is under twenty-one-years-old, the requirements of Early
and Periodic Screening, Diagnostic, and Treatment services (EPSDT) must be considered. Section 409.905 of the Florida Statutes, 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.
19. While the Petitioner provided updated medical information in support of his request to have his teeth removed, Respondent reviewed the updated information and contacted Petitioner's dental provider for the doctor's narrative. Respondent then determined there was no medical necessity for removing tooth \#1 or tooth\#16. There is no pathology or infection indicated and there is sufficient room for them to erupt through the gums. Respondent's decision meets the ESPDT requirements as cited above.
20. After careful review of the relevant authorities and the evidence in this matter, the undersigned concludes Petitioner has not met her burden to show that

Respondent's denial is 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.

FINAL ORDER (Cont.)
15F-09275
PAGE-8

DONE and ORDERED this _11_ day of _March_, 2016,
in Tallahassee, Florida.

$$
\begin{aligned}
& \text { Hanceffer } \\
& \text { Warren Hunter } \\
& \text { Hearing Officer } \\
& \text { Building 5, Room } 255 \\
& 1317 \text { Winewood Boulevard } \\
& \text { Tallahassee, FL 32399-0700 } \\
& \text { Office: 850-488-1429 } \\
& \text { Fax: 850-487-0662 } \\
& \text { Email: Appeal.Hearings@myflfamilies.com }
\end{aligned}
$$

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

Mar 28, 2016
STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES OFFICE OF APPEAL HEARINGS

## PETITIONER,

Vs.
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 18 Brevard
UNIT: AHCA

RESPONDENT.
l

## FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative
hearing in the above-styled matter on February 15, 2016, at approximately 3:30 p.m.


## STATEMENT OF ISSUE

At issue is whether or not Respondent's termination of Petitioner's receipt of the prescription drug Suboxone was correct. The burden of proof is assigned to Respondent.

## PRELIMINARY STATEMENT

Petitioner represented herself at the hearing. Lissette Knott, Program
Administrator, represented and appeared as a witness for Respondent, the Agency for

FINAL ORDER (Cont.)
15F-09481
PAGE-2
Health Care Administration ("AHCA" or "Agency"). The following individuals were present as witnesses for Respondent:

- Stephanie Shupe - Regulatory Research Coordinator - Staywell
- Erika Hatchman - Pharmacy Appeals Manager - Staywell

Petitioner gave oral testimony, but did not move any exhibits into evidence at the hearing. Respondent's Exhibits 1 through 15 were entered into evidence at the hearing. The record was held open for Respondent to submit additional evidence. Respondent submitted additional evidence, entered as Exhibit 16. Administrative notice was taken 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 26 -year-old female. She is enrolled with $\square$ as her Managed Medical Assistance (MMA) plan.
 authorization and a renewal request is required every three (3) to (6) months. Petitioner said she has been taking $\square$ for a few years, and that she has been clean and not had a relapse for six (6) years.

received a Drug Evaluation Review ("DER") from Petitioner's primary care physician on November 5, 2015. (Respondent's Exhibit 4). The request was for a renewal of Under the section entitled "Explanation," Petitioner's physician stated:

Please review attached documentation. We are requesting renewal of patient's authorization for $\quad$ She reports that she is doing well with

FINAL ORDER (Cont.)
15F-09481
PAGE-3
our treatment plan and continues to show compliance with the program. She follows up as directed, submits to regular urine drug screens as well as continued lifestyle changes to maintain a supportive environment. She still experiences intermittent withdrawal type symptoms. She denies any relapse in treatment and would like to continue until is able to taper down further in dose. She continues to attend NA/AA meetings on a weekly basis at least $2-3 x$ weekly. She has been fully counseled on her recent noncompliant urine drug screens. She voices understanding that she has breached her contract with her positive result of THC substance. She understands that any future positive of illicit substances will result in her discharge from treatment program.
4. On November 6, 2015, issued a Notice of Action denying the request for the (Respondent's Exhibit 5). The Notice states:

We made our decision because:
Other authority: The request could not be approved. The reason you did not meet criteria is you filled
per claims history. We do not approve concurrent use with short or long acting narcotic.

The facts that we used to make our decision are: The criteria are the Pharmacy \& Therapeutics (P\&T) approved Prior Authorization (PA) Protocol for , AND Policy \& Procedure C20RX150 which states WellCare follows P\&T approved PA Protocol.
5. Petitioner filed an appeal with which was received on November 7, 2015. issued an Appeal Denial Upheld Notice on November 9, 2015. (Respondent's

Exhibit 11). The Notice states:
On 11/7/2015, we received a request for an appeal...
It was reviewed by a board-certified doctor on (date). He/she was not a part of the first review.

This doctor's findings were given to our Appeal Review Committee. Members met on 11/9/2015. They were:

- Medical Director(s) of varied specialties: Psychiatry, DO
- Pharmacist(s) (Pharm D or RPh)

FINAL ORDER (Cont.)
15F-09481
PAGE - 4
They have looked at your records. This includes your original Drug Evaluation Review (DER), DER denial reason, medical records, prescription refill claims, FDA recommendations, industry guidelines, plan preferred drug list and the appeal documents.

These items were reviewed against the Pharmacy \& Therapeutics (P\&T) approved Prior authorization (PA) Protocol for

AND Policy and Procedure C20RX-137 which states WellCare follows P\&T approved PA Protocol. There was no documentation submitted to show the member has a negative drug screening test.

After this review, we have decided that we will not pay for this medication.
6. When asked what constitutes concurrent use of two substances, Ms. Hatchman said they look back at the prior review period of three (3) to six (6) months. Ms. Hatchman said the denial was not based on lack of medical necessity, only on the prior authorization criteria.
7. AHCA maintains a Preferred Drug List ("PDL"). $\square$ is not on the PDL and there is no preferred drug in its class. Ms. Shupe said Staywell covers whatever drug in its class that is requested as long as the criteria are met. The prior authorization criteria for both initial use and continued use of $\square$ is contained in Respondent's Exhibit
16. For continued use, all of the following criteria must be met for approval:

1. Must be compliant with pharmacologic therapy.
2. Must provide progress notes since last approval detailing the patient's response to treatment and progress towards goals.
3. Prescriber must address relapse if it occurred.
4. Must not have concurrent use of opioids, tramadol, carisprodol, or illicit substances (review prescription claims history since the last approval to ensure abstinence of these medications).
5. Must provide all urine drug screen tests since last approval.
6. Must provide documentation of compliance with non-pharmacologic therapy (counseling or group therapy).
7. Ms. Hatchman said Petitioner meets all of the criteria, with the exception of number four (4), which is due to the concurrent use of the hydrocodone/acetaminophen and the

FINAL ORDER (Cont.)
15F-09481
PAGE - 5
positive test for THC. She also stated Petitioner's physician included the paragraph under "Explanation" section in the DER for her July 2015 review, acknowledging her positive THC test, and that Staywell went ahead and approved the for the period of July 6, 2015 through October 10, 2015 because he said it wouldn't be an issue going forward. Petitioner was able to refill her $\square$ prescription on October 7, 2015, after having filled the hydrocodone/acetaminophen, because the authorization for the was still active.
9. Petitioner said she has always had a positive THC result and her physician has always known about it and said it wouldn't be a problem. The substance abuse program Petitioner participates in sets the standards for continuing in the program, including whether or not to allow someone to continue in the program despite a positive test for an illicit substance. The November 6, 2015 Notice of Action issued by did not mention anything about the THC. The Case Notes for the appeal states there was a positive THC drug screen on October 13, 2015 and the Appeal Denial Upheld Notice states there was no documentation submitted of a negative drug screen, as quoted above.
10. Petitioner had significant dental work performed in September of 2015, where she had eight (8) teeth extracted. Her dental provider prescribed her 40 tablets of the hydrocodone/acetaminophen to help with the pain from the dental work. Per her claims history, Petitioner filled the prescription on September 15, 2015. (Respondent's Exhibit 10). Petitioner testified she only took the medication for three (3) or four (4) days.

FINAL ORDER (Cont.)
15F-09481
PAGE-6
11. Petitioner said the has been very helpful for her and her family and she is very grateful for receiving it. Ms. Hatchman said she can submit a new request with medical records for reauthorization.

## 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, $7^{\text {th }}$ 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 spendingcontrol 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.

FINAL ORDER (Cont.)
15F-09481
PAGE - 8
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.
6. Section 409.912 of the Florida Statutes requires AHCA to create a PDL. Suboxone is not on the PDL and therefore requires prior authorization. The prior authorization criteria for $\square$ s contained in Respondent's Exhibit 16, and $\square$ only disputes Petitioner's compliance with number four (4).
7. The prior authorization criteria for clearly states that there cannot be concurrent use of opioids or illicit substances in order for

FINAL ORDER (Cont.)
15F-09481
PAGE-9
also clearly states that the prescription claims history and drug screens from the last approval should be reviewed to ensure abstinence of use.
24. It appears only caught the THC use after the appeal was filed, however, Petitioner admitted her drug screens have always tested positive for THC.
25. Petitioner's claims history shows she filled the prescription for hydrocodone/acetaminophen during her last approval period. She admits to taking the medication for three (3) or four (4) days after her dental work. While it may seem quite an overstatement to call three (3) or four (4) days of taking an opioid pain medication after having eight (8) teeth removed "concurrent use," the prior authorization criteria requires abstinence. $\square$ policy says they will not approve $\square$ if there is concurrent use of a short or long acting narcotic.
26. Since it is undisputed that Petitioner did not completely abstain from opioid use during the July 6, 2015 to October 10, 2015 approval period, and it is undisputed Petitioner's drug screens have always tested positive for THC, the undersigned concludes properly applied the prior authorization criteria and has met its burden of proof to show it was correct to terminate Petitioner's
27. Petitioner said the has been very helpful and that she has been clean for six (6) years. She is strongly encouraged to make sure she strictly follows the prior authorization criteria and to submit a new request for the as soon as she qualifies.

## DECISION

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

FINAL ORDER (Cont.)

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 28 day of March , 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@myfIfamilies.com

Copies Furnished To: Petitioner<br>Judy Jacobs, Area 7, AHCA Field Office

Mar 10, 2016
STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES OFFICE OF APPEAL HEARINGS

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 11, 2016 at 11:30 a.m.

APPEARANCES
For the Petitioner:


For the Respondent: Marielisa Amador, Data Analyst, Agency for Health Care Administration (AHCA).

## STATEMENT OF ISSUE

At issue is whether the Respondent's partial denial of the Petitioner's request for adult day care (ADC) services 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 Dr. Marc Kaprow, Medical Director for United Healthcare, and Christian Laos, Senior Compliance Analyst for United Healthcare, which is Petitioner's managed health care plan.

Petitioner did not submit any documents as evidence for the hearing.
Respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Exhibits: Exhibit 1 - Statement of Matters; Exhibit 2 - Denial Notice; Exhibit 3 - Grievance System Screenshots; and Exhibit 4 - Medical Assessment Form.

Also present for the hearing was a Spanish language interpreter, Richard Interpreter Number 763, from Propio Language Services.

## FINDINGS OF FACT

1. The Petitioner is eighty-two (82) years old and resides with his wife, who is seventy-two (72) years old. He has been diagnosed with His wife suffers from kidney problems and has had three recent surgeries.
2. The Petitioner is a Medicaid recipient who was enrolled in the Statewide Medicaid Managed Care (SMMC) - Long Term Care (LTC) plan. He receives services under the plan from United Healthcare.
3. The Agency For Health Care Administration (AHCA) is responsible for management of the managed long-term care plan contracts; statewide policy decisions

FINAL ORDER (Cont.)
15F-09522
PAGE -3
and interpretation of all federal and state laws; and rules and regulations governing the contract. Managed Care Organizations such as United Healthcare provide services to Medicaid recipients pursuant to a contract with AHCA.
4. United Healthcare sent a notice to Petitioner dated September 4, 2015 stating his request for five (5) days of adult day care weekly was denied and three (3) days weekly would be approved. This notice stated, in part:

Adult day health care is for helping you with activities of daily living. Adult day care is for socialization. Being alone in your home is not, in and of itself, a reason for adult day health care. Based on our evaluation you need 3 days of adult day care weekly. The health plan will cover this. The health plan will not cover the other days you asked for. The other days are in excess of your needs. Days in excess of your needs are not medically necessary.
5. The Petitioner's wife stated her husband's adult day care services should be increased to 5 days weekly because she has her own health problems and she usually goes to her own doctor appointments twice per week. She stated there is no one else available to supervise her husband when she goes out.
6. The Respondent's witness, Dr. Kaprow, stated that the partial denial of the requested services was appropriate because the services already approved for the Petitioner should be sufficient to meet his needs. In addition to the 3 days weekly of adult day care (including transportation to the facility), the Petitioner receives 14 hours weekly of personal care assistance, 1 hour weekly of homemaker services, and consumable medical supplies such as adult pull-up diapers and wipes. Dr. Kaprow noted that during the case manager's visit to the Petitioner in November 2015, his daughter and grandson were also in the home visiting him. Dr. Kaprow also stated that

FINAL ORDER (Cont.)
15F-09522
PAGE -4
respite care hours could possibly be approved if the Petitioner's wife has to attend her doctor appointments and needs someone to watch her husband that day.

## 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 proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.
9. The standard of proof in an administrative hearing is a preponderance of the evidence, in accordance with Rule 65-2.060 (1), Fla. Admin. Code. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, $7^{\text {th }}$ Ed.).
10. Fla. Stat. $\S 409.979$ 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).
11. As stated in the Findings of Fact, the Petitioner is eligible and he was enrolled in the Long Term Care Program.

FINAL ORDER (Cont.)
15F-09522
PAGE -5
12. The Petitioner requested a fair hearing because he believes his adult day care services under the Program should be increased by United Healthcare to 5 days weekly.
13. Covered services under the AHCA contract for LTC plans include Adult Day

Care services, among other services.
14. Adult Day Health Care services are defined in the contract as:

Services furnished in an outpatient setting which encompass both the health and social services needed to ensure optimal functioning of an enrollee, including social services to help with personal and family problems and planned group therapeutic activities. Adult day health care includes nutritional meals. Adult day health care provides medical screening emphasizing prevention and continuity of care... . Nursing services, which include periodic evaluation, medical supervision and supervision of self-care activities directed toward activities of daily living and personal hygiene, are also a component of this service.
15. The Florida Medicaid Program is authorized by Chapter 409, Florida

Statutes, and Chapter 59G, Florida Administrative Code. 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;

FINAL ORDER (Cont.)
15F-09522
PAGE -6
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. After considering the evidence and testimony presented, the hearing officer concludes the Petitioner has not met the burden of proof in demonstrating his adult day care services should be increased to 5 days weekly. He currently receives 3 days weekly of adult day care services in addition to 15 hours weekly of assistance in his home (personal care assistance and homemaker service). Petitioner's wife stated she usually goes to her own doctor appointments 2 times per week. Accordingly, the currently approved services should be sufficient to meet the Petitioner's 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

FINAL ORDER (Cont.)
15F-09522
PAGE -7

Petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this $\qquad$ day of March 2016, in Tallahassee, Florida.


Apr 15, 2016
Office of Appeal Hearings Dept. of Children and Families

APPEAL NO. 15F-09553
PETITIONER,
Vs.
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 15 Palm Beach
UNIT: AHCA

## RESPONDENT.

## FINAL ORDER

Pursuant to notice, a telephonic administrative hearing was first convened on January 8, 2016 at 11:03 a.m. The parties reconvened on March 30, 2016 at 9:01 a.m.

## APPEARANCES



## ISSUE

Whether respondent's denial of an out of network/out of state second medical opinion was proper. The burden of proof was assigned to the petitioner. The standard of proof in an administrative hearing is by a preponderance of the evidence.

## PRELIMINARY STATEMENT

When convening on January 8, 2016, petitioner had not received the respondent's proposed evidence. To facilitate petitioner's review, the matter was

FINAL ORDER (Cont.)
15F-09553
PAGE - 2
continued to February 1, 2016. On February 1, 2016 petitioner's request for a continuance was granted. The matter was rescheduled for March 8, 2016. Due to the lack of availability of a witness from Sunshine Health, respondent's request for a continuance was granted. The matter was then rescheduled for March 30, 2016.

Petitioner was present on January 8, 2016, only. At time of hearing, petitioner entered no exhibits into evidence.

Ms. Sanchez appeared as both the representative and witness for the respondent. Present from Sunshine Health were Dr. Ernest Bertha, Medical Director and India Smith, Grievance and Appeals Coordinator. Respondent's exhibits " 1 " and " 2 " were accepted into evidence. Administrative notice was taken of the Florida Medicaid Provider General Handbook (Provider Handbook).

The record was left open through April 6, 2016 for petitioner to provide a letter from Dr. Robert Nickeson. Information was timely received and entered as petitioner's exhibit " 1 ".

The record was also left open through April 6, 2016 for respondent to provide pages nine through eleven of the evidence package. Information was timely received and entered as respondent's exhibit " 3 ".

Neither party wished to provide a written response to post hearing submissions.

## 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 18 years of age. At all times relevant to this proceeding, she was Medicaid eligible.

FINAL ORDER (Cont.)
15F-09553
PAGE-3
2. Petitioner's Medicaid services are through respondent's Statewide Managed Medical Assistance (MMA) Program. Sunshine Health is the managed care entity selected by the petitioner to provide medical services.
3. Individuals must use providers affiliated with their managed care plan. When certain conditions exist, an out of network provider can be considered.
4. Petitioner is diagnosed with a rare

The disease has caused skin and muscle inflammation. As a result, petitioner experiences fatigue; pain; rashes; muscle weakness; and joint swelling.

6. Due to the complexity of petitioner's condition, requested petitioner be evaluated by s medical group in the Washington D.C. area. Dr.
$\square$ group is affiliated with the National Institute of Health (NIH).
7. is not enrolled in Sunshine Health's provider network.
8. for an out of network provider outlined petitioner's medical status and medication history. Petitioner's muscle weakness required use of a wheelchair for a seven month period. also referenced a diagnosis of both
9. provided no documentation to support the requested service was not available through either an in-state physician or a physician affiliated with Sunshine Health.

FINAL ORDER (Cont.)
15F-09553
PAGE-4
10. On November 2, 2015 Sunshine Health issued a Notice of Action denying the request to be evaluated by The notice stated the request was not medically necessary. The notice also stated:

The request for a second opinion at a non-participating physician's office is denied. The member needs to use providers that are in the network.

Request to use a Specialist that is not part of the Sunshine Health Plan, is denied.

Sunshine health Plan has participating Specialists, for your second opinion.
11. On November 17, 2015 petitioner's mother contacted the Office of Appeal Hearings and timely requested a fair hearing.
12. Petitioner's representatives argue dermatomyositis is so rare, most physicians are not familiar with the disease.
13. Petitioner kept the appointment with $\square$ in November 2015. $\square$ did not charge for the consultation. While in the Washington D.C. area, petitioner was also evaluated by a
14. Respondent asserts there has been no contact from the parents regarding specialists in the Sunshine Health network. This information can be found online by calling the customer service department, or speaking with a case manager.

## 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 § 120.80, Fla. Stat.

FINAL ORDER (Cont.)
15F-09553
PAGE-5
16. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R.

65-2.056.
17. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at $1201,7^{\text {th }}$ Ed.).
18. As the petitioner is under 21 years of age, Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements are applicable. 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 ...
19. 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].
20. The Findings of Fact establish an out of network provider can be approved when certain conditions are satisfied. Such is supported by Title 42 of the Code of Federal Regulations (CFR); Chapter IV; Subchapter D; which states:
§457.495 State assurance of access to care and procedures to assure quality and appropriateness of care.

FINAL ORDER (Cont.)
15F-09553
PAGE-6
(c) Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition.
21. The definition of "medically necessary" is found in the Fla. Admin. Code R. 59G-
1.010, which states, in part:
(166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider...
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.
6. Regarding out of state services, respondent's Provider Handbook is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code R. 59G-5.020 and states:

Page 2-35:
Florida Medicaid reimburses for non-emergency services when the recipient receives the services at an out of state location, if those services cannot be obtained in Florida and if Medicaid prior authorizes the service.

Services received by a recipient in an out of state location cannot be post authorized.

A Florida Medicaid enrolled primary care or specialist physician may refer a Medicaid recipient for out-of-state care to obtain medically-necessary services that cannot be provided in Florida. The physician must request and obtain prior authorization before the recipient receives out-of-state services.

This is not the same authorization as the MediPass primary care provider's authorization number. Florida Medicaid physicians may not authorize out-of-state services; they may only request authorization for the services.

If the recipient is insured by a third party, Health Maintenance Organization, or Provider Service Network, the request for out-of-state services must be directed to those insurers.

Page 2-36:
The out-of-state prior authorization request must include:
A completed Out-of-State Prior Authorization Request Form, 20000016, filled out by the recipient's Florida Medicaid enrolled primary care or specialist physician;
$\square$ Documentation that justifies the medical necessity for the service, such as medical history, lab reports, etc.;
$\square$ A separate letter from the requesting physician indicating the need for out-of-state home health services if applicable;
Contact information for the requesting physician;
$\square$ A referral from a specialty hospital or subspecialist in the area specific to the recipient's diagnosis certifying the requested service is not available in Florida;
The Current Procedural Terminology (CPT) codes for the procedure(s) being requested;
$\square$ The name and address of the out-of-state provider; $\square$ The name and telephone number of the out-of-state provider's contact person.

## Page 2-42:

Florida Medicaid will reimburse out-of-state providers who provide services under the following circumstances:
$\square$ An emergency arising from an accident or illness that occurs while the recipient is out of state;

FINAL ORDER (Cont.)
15F-09553
PAGE - 8
The recipient's health will be endangered if the care and services are postponed until returning to Florida;

The child is a non-Title-IV-E Florida foster or adoption subsidy child living out of state and is covered under the Florida Medicaid program; or $\square$ Florida Medicaid determines, on the basis of medical advice, that the needed medical services or necessary supplementary resources are more readily available in another state and prior authorizes the out-of-state services.
23. To secure out an out of state appointment, petitioner must demonstrate each component of medical necessity has been satisfied. Additionally, all criteria required by the Provider Handbook must be satisfied.
24. In this appeal, the greater weight of evidence has not demonstrated the service cannot be provided either in Florida or through Sunshine Health's in-state provider network. Definitive certification of such was not provided by a rheumatologist.
25. Petitioner's request for out of state services was not based on an accident or illness while out of the state. As such, the requested treatment is not related to emergency medical care.
26. Petitioner's unique medical diagnosis is noted. Regardless, before an out of network provider can be accessed it must be documented the service cannot be obtained in Florida.
27. The undersigned has considered all evidence; testimony; EPSDT; and Medical Necessity criteria. As such, the petitioner has not met the required evidentiary standard in this matter. The greater weight of evidence does not demonstrate 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;

FINAL ORDER (Cont.)
15F-09553
PAGE-9
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 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 $\qquad$ day of Abril 2016,
in Tallahassee, Florida.

## Zrank Douston

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@myfffamilies.com

Copies Furnished To:
PETITIONER
JUUY JACUBS, AREA /, AHCA FIELD OFFICE

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

Mar 15, 2016


PETITIONER,
Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES CIRCUIT: 13 Hillsborough UNIT: 883DT

APPEAL NO. 15F-09730

CASE NO.

RESPONDENT.

## FINAL ORDER

The undersigned convened a telephonic administrative hearing in the abovereferenced matter on January 29, 2016 at 9:16 a.m. All parties appeared from different locations. One continuance was granted to the petitioner.

## APPEARANCES

For Petitioner:


For Respondent: Signe Jacobson, Economic Self Sufficiency Specialist II

## STATEMENT OF ISSUE

At issue is whether respondent's action to deny petitioner's request for retroactive SSI-Related Medicaid benefits for the months of December 2014; May 2015; and August 2015 is correct. The burden of proof is assigned to the petitioner by the preponderance of the evidence.

FINAL ORDER (Cont.)
15F-09730
PAGE-2

## PRELIMINARY STATEMENT Petitioner was not present and was represented by owner of who testified. Petitioner submitted no exhibits at the

 hearing. Respondent was represented by Signe Jacobson with the Department of Children and Families (hereafter "DCF", "Respondent" or "Agency"). Ms. Jacobson testified. Respondent submitted nine exhibits, which were accepted into evidence and marked as Respondent's Exhibits " 1 " through " 9 ".
## FINDINGS OF FACT

1. On September 25, 2015, the petitioner submitted an application for Medicaid benefits. The application listed petitioner as disabled; as a 58 year old female; as applying for retro Medicaid benefits for the months of December 2014, May 2015, and August 2015; and as not having applied for Supplemental Security Income (SSI) in the last ninety days.
2. On December 2, 2015, the Department of Health Division of Disability

Determination (hereafter "DDD") determined petitioner not disabled using the denial code N32. N32 means "Non-pay-Capacity for substantial gainful activity - other work, no visual impairment". The Disability Determination and Transmittal form (Respondent's Exhibit 5) had "Hankerson 9/14 same allegations" handwritten on the document and listed petitioner's diagnoses as Back Disorder and Affective Disorder.
3. On December 3, 2015, the respondent mailed petitioner a Notice of Case Action indicating petitioner's November 25, 2015 Medicaid application was denied as "You or a member(s) of your household do not meet the disability requirement. No household members are eligible for this program".

FINAL ORDER (Cont.)
15F-09730
PAGE-3
4. State of Florida SSA State On-Line Query (Respondent's Exhibit 4) indicated petitioner applied for SSI on November 18, 2015; however, the Query did not indicate petitioner's SSI application was denied by the Social Security Administration (SSA). Respondent argued the SSA State On-Line Query did not verify petitioner's previous September 2014 SSA denial; however, respondent maintains petitioner's previous SSI application was denied by SSA in September 2014. The respondent did not submit any evidence indicating petitioner's SSI application was denied by SSA.
5. Petitioner argued she submitted an SSI application to SSA on December 2, 2015 with the following diagnoses: $\square$ She also argued she suffers from chronic back pain and has had facial reconstructive surgery and back surgery. Petitioner further argued she was not aware her SSI application was denied by SSA.
6. Respondent determined petitioner not eligible for Medicaid benefits as she has no children under the age of eighteen living with her, is not pregnant; and is under the age of 65 .
7. Respondent explained petitioner would be eligible to receive retroactive Medicaid benefits for December 2014; May 2015; and August 2015 if DDD determines her disabled as the requested retroactive months precede one or three months from a Medicaid application.
8. Petitioner requested DDD completes an independent disability review on her as DDD did not consider her diagnosis when it determined she was not disabled. Furthermore, the respondent did not submit any evidence indicating SSA denied

FINAL ORDER (Cont.)
15F-09730
PAGE-4
petitioner's SSI application; therefore, there is no evidence to support DDD's adoption of
a SSI denial.

## 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
$\S 409.285$, Fla. Stat. This order is the final administrative decision of the Department of
Children and Families under $\S 409.285$, Fla. Stat.
10. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 652.056.
11. 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...
12. According to the above authority, to be eligible for Family-Related Medicaid benefits, petitioner must have a minor child under age 18 living in the household with her or she must be pregnant. Since petitioner does not have a minor child under age 18 living in the household and since she is not pregnant, she does not meet the technical requirements to be eligible for Family-Related Medicaid benefits.
13. 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

FINAL ORDER (Cont.)
15F-09730
PAGE - 5
for aged and disabled individuals (or couples), as provided in 42 U.S.C. § 1396a(m).
For an individual less than 65 years of age to receive Medicaid benefits, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R.
$\S 416.905$ which states, in part:
(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see § 416.960(b)) or any other substantial gainful work that exists in the national economy.
14. Pursuant to the above authority, to be eligible for SSI-Related Medicaid, petitioner must be deemed disabled by DDD as she is under the age of 65 and is currently not considered disabled by the SSA.
15. 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 $\S 435.912$ 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 $\S 435.909$.
(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...

FINAL ORDER (Cont.)
15F-09730
PAGE-6
(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:
(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...
16. Petitioner argued she applied for SSI on December 2, 2015 and the respondent argued she applied for SSI on November 18, 2015. DDD indicated petitioner's SSI application was denied in September 2014 pursuant to code N32. On September 25, 2015, the petitioner applied for Medicaid benefits with the respondent. Respondent then determined petitioner not to be disabled and denied her application for SSI-Related Medicaid benefits as DDD adopted SSA's denial decision.
17. Pursuant to the above authority, an independent disability determination must be made by a State Agency if an individual applies for both SSI and State Medicaid and an SSI disability determination has not been made within 90 days of the date of the State Medicaid application.
18. In careful review of the cited authorities and evidence, the undersigned concludes petitioner has met her burden of proof to indicate the respondent incorrectly denied her September 25, 2015 application for retroactive SSI-Related Medicaid benefits for the months of December 2014; May 2015; and August 2015.
19. Respondent was incorrect to deny petitioner's September 25, 2015 application for retroactive SSI-Related Medicaid benefits for the months of December 2014; May 2015; and August 2015 as the evidence indicates DDD incorrectly adopted a SSA's denial decision. There was no evidence presented to show that SSA had denied

FINAL ORDER (Cont.)
15F-09730
PAGE-7
petitioner's SSI disability application in September 2014. Therefore, the undersigned remands the case to the respondent for further development. Respondent is hereby ordered to complete an independent disability review on petitioner in accordance with the controlling legal authorities. Respondent is to issue a Notice of Case Action when the review is completed; the notice should include appeal rights.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is GRANTED and REMANDED to the Department for further development as explained in the conclusions. Once the new review is completed, the respondent is to issue written notice, to include appeal rights.

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this $\qquad$ day of March $\qquad$

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

APPEAL NO. 15F-09769
PETITIONER,
Vs.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 07 Volusia
UNIT: 88325

## RESPONDENT.

CASE NO.


## PRELIMINARY STATEMENT

The hearing was originally scheduled to convene on January 12, 2016 at 10:15
a.m. On December 31, 2015, the petitioner contacted the hearing officer and requested an in-person hearing. The petitioner's request was granted and rescheduled to March 2, 2016.

Appearing as an observer for the petitioner was his mother,
Evidence was submitted and entered as the Respondent Exhibit 1 through Respondent Exhibit 3.

No evidence was submitted by the petitioner.

## FINDINGS OF FACT

1. On October 7, 2015, the petitioner completed an application to recertify for Medicaid for himself. The petitioner receives $\$ 882$ in Social Security income.
2. The Department calculated the MN budget by including the petitioner's gross monthly Social Security income in the amount of $\$ 882$. The total gross income was subtracted by the unearned income disregard in the amount of $\$ 20$ to result in $\$ 862$ 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 $\$ 682$.
3. The petitioner does not dispute the income included in the Department's calculations. The petitioner argues that his income is not enough to cover his expenses.

FINAL ORDER (Cont.)
15F-09769
PAGE-3
4. The petitioner does not agree with being enrolled in the MN program and argues that he needs help. The petitioner contends that he would like to be accepted into a medical treatment program at a clinic located in $\square$ but is not in the correct Medicaid program to be accepted.
5. The petitioner is covered under Medicare Part A and Part B. The petitioner did not provide any evidence or testimony to show that he is currently receiving any institutional care, hospice, or home and community based services.
6. The Department explained that the petitioner was previously receiving fullcoverage Medicaid until November 2012; his Social Security income was less. The Department explained that the petitioner is receiving Qualified Medicare Beneficiary (QMB) benefits.

## CONCLUSIONS OF LAW

7. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285 , Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.
8. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
9. 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

FINAL ORDER (Cont.)
15F-09769
PAGE -4
also eligible for Medicaid covered institutional care services, hospice services or home and community based services.
10. The above controlling authorities 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, 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.

## DECISION

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

## NOTICE OF RIGHT TO APPEAL

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

FINAL ORDER (Cont.)
15F-09769
PAGE -5

DONE and ORDERED this $\qquad$ 05 day of April 2016, in Tallahassee, Florida.


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

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

Office of Appeal Hearings Dept. of Children and Farnilies

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 February 16, 2016 at 10:36 a.m.

## APPEARANCES

For the Petitioner:

For the Respondent:
Dianna Chirino,
Senior Human Services Program Specialist, Agency for Health Care Administration

## STATEMENT OF ISSUE

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

- D7240-Removal of impacted tooth...for tooth 1 and 16;
- D7241-Removal of impacted tooth-completely bony, with unusual surgical complications...for tooth 17;
- D9630-Other drugs and/or medicines;

FINAL ORDER (Cont.)
15F-09865
PAGE - 2

- D9230-Inhalation of nitrous oxide/analgesia anxiolysis; and
- D9242:Intravenous moderate sedation/analgesia each additional 15 minutes.

Because the issue under appeal involves requests for services, the Petitioner carries the burden of proof.

## PRELIMINARY STATEMENT

Mindy Aikman, Grievance and Appeals Specialist, appeared as Respondent's witness from Petitioner's managed care plan, Humana. Appearing as Respondent's witnesses from DentaQuest were Nicolas Calderon, Grievance and Appeals Supervisor and Dr. Susan Hudson, Dental Consultant.

Respondent submitted a 30-page document, which was entered into evidence and marked Respondent Exhibit 1.

Petitioner submitted a 5-page document, which was entered into evidence and marked Petitioner Exhibit 1.

## FINDINGS OF FACTS

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

1. Petitioner is an 18 year-old Medicaid recipient enrolled with Humana, a Florida Health Managed Care provider.
2. Humana requires prior authorization for services related to dental care and has subcontracted with DentaQuest to perform the prior authorization requests.
3. DentaQuest received a prior authorization request from Petitioner's dentist on October 29, 2015 for the following procedure codes: D7240-extraction of impacted tooth covered by bone, Tooth 1 and 16; D9630-other drugs and/or medicines (for the 3 teeth

FINAL ORDER (Cont.)
15F-09865
PAGE - 3
to be extracted); D7241-extraction of impacted tooth with complications, Tooth 17;
D9230-relaxation gas and D9242-I.V. sedation-each additional 15 minutes.
4. DentaQuest sent a Notice of Action to the Petitioner on November 19, 2015
advising all the requests were denied as not medically necessary.
5. DentaQuest also sent a Notice of Action to the provider on November 19, 2015 and gave the determination reason for each denied procedure as follows:

Procedure:
D7240-removal of impacted
Tooth 1 and 16

D7241-removal of impacted tooth with complications

D9630-other drugs and/or medicines

D9230-inhalation of nitrous oxide

D9242-intravenous moderate sedation.

Determination Reason:
There is no sign of infection or other medical reason for tooth removal.

The x-rays do not support the code requested. A less severe extraction code would be considered. Please review the ADA code you requested and resubmit with the appropriate extraction code.

Service is not covered.

Nitrous oxide is covered as part of the approved anesthesia benefit.

Anesthetic services are only covered when the associated services are approved.
6. Petitioner filed a timely request for a fair hearing on December 2, 2015.
7. Petitioner explained that her dentist advised her that when she had her braces removed last year she needed to have her wisdom teeth removed within three to five weeks. She takes over-the-counter medication to relieve the pain in her mouth, but it

FINAL ORDER (Cont.)
15F-09865
PAGE-4
causes her to have gastric pain in her stomach. Petitioner has not spoken to her dentist since receiving the denial notice in November 2015.
8. DentaQuest's dentist explained the x-rays submitted by her dentist do not show any infection or problem with Tooth 1 and 16 erupting through the gums. There is plenty of space for them. DentaQuest agrees that Tooth 17 needs to be extracted but Petitioner's dentist needs to submit the less severe procedure code for extracting Tooth 17. DentaQuest's decisions as outlined in its November 2015 Notice of Action to Petitioner's dentist were reiterated by the dental consultant.

## 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 of the 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.
14. 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:
15. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
16. 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;
17. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
18. 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
19. 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 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. In addition to the Handbook, Respondent also publishes a Dental General Fee Schedule that lists all the procedure codes covered by Medicaid. If a procedure code is not on the list it is not covered by Medicaid. The current Dental General Fee Schedule does not list procedure code D9630-Other drugs and/or medicines.
18. 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 section 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.
19. While the Petitioner asserted her dentist opined that her three wisdom teeth -1 , 16 and 17 - needed to be extracted, the medical expert from DentaQuest provided credible testimony that only Tooth 17 needs to be extracted, based on the x-rays submitted by the Petitioner's dentist. Furthermore, the evidence shows Petitioner's dentist should submit a less severe extraction code for Tooth 17. Based on the totality of the evidence, the undersigned finds the Petitioner failed to meet her burden.

FINAL ORDER (Cont.)
15F-09865
PAGE - 7
Respondent's review for medical necessity meets the ESPDT requirements as noted above.

## 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 $\qquad$ 07 day of $\qquad$ March 2016,
in Tallahassee, Florida.


Warren Hunter
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myfffamilies.com

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

Mar 01, 2016

PETITIONER,
Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pinellas
UNIT: 88269

CASE NO.

## RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on January 5, 2016 at 10:01 a.m. All parties appeared telephonically from different locations.

## APPEARANCES

For the petitioner:
For the respondent: Ed Poutre, Economic Self Sufficiency Specialist II.

## STATEMENT OF ISSUE

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

## PRELIMINARY STATEMENT

On November 30, 2015, the Department sent the petitioner Notice of Case Action (NOCA) informing him that his application dated November 2, 2015 for Medicaid was

FINAL ORDER (Cont.)
15F-09915
PAGE - 2
denied because "you or a member(s) of your household do not meet the disability requirement." The petitioner timely appealed this action on December 2, 2015.

The petitioner presented no evidence for the undersigned to consider. The Department presented a total of 73 pages of evidence for the undersigned to consider, which were entered into the record as Respondent's Exhibits 1 through 8. The record was closed on January 5, 2016.

## FINDINGS OF FACT

1. On November 2, 2015, the petitioner applied for Medicaid for himself. He is 40 years old and lives with his wife. The petitioner claimed to be disabled. On November 16, 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 had also filed a disability application with the Social Security Administration (SSA), which was denied on September 10, 2015. The petitioner appealed this denial and it is currently pending for a hearing with an Administrative Law Judge (ALJ).
3. On November 25, 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 N32, which is non-pay- capacity for substantial gainful activity-other work, no visual impairment. The primary diagnosis was
5. On November 30, 2015, the Department sent the petitioner a NOCA informing him that he was ineligible for Medicaid.
6. The petitioner reported his conditions to be
7. The SSA denial letter gave the following explanation for its denial:

8. All of the conditions the petitioner reported during the hearing were reported to the SSA and described in the above 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 § 409.285, Fla. Stat. 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

FINAL ORDER (Cont.)
15F-09915
PAGE-4
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 $\S 435.912$ 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

FINAL ORDER (Cont.)
15F-09915
PAGE - 5
(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 $\S 435.912$ 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 he had reported his conditions to the SSA. SSA denied the petitioner's disability claim on September 10, 2015 because it determined he was not disabled under its 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 September 10, 2015 and denying the petitioner's Medicaid disability application.

FINAL ORDER (Cont.)
15F-09915
PAGE -6

## 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 _ 01 day of _ March 2016,
in Tallahassee, Florida.

LBrandyricklep
Brandy Ricklefs
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myfffamilies.com

Vs.

## CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 18 Brevard

## RESPONDENT.

## APPEAL NO. 15F-09953

## FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 9, 2016, at 10:30 a.m.

## APPEARANCES

For the Petitioner:
For the Respondent:
Lisa Sanchez, Medical Health Care Program Analyst, Agency for Health Care Administration (AHCA).

## STATEMENT OF ISSUE

At issue is the Agency's decision, through Prestige Health Choice, to deny the petitioner's request for reimbursement of a dental procedure received through an out-ofnetwork provider. The petitioner carries the burden of proving her case by a preponderance of the evidence.

FINAL ORDER (Cont.)

## PRELIMINARY STATEMENT

Present as a witness for the respondent was Michelle Narcisse, Grievance and Appeals Coordinator with Prestige Health Choice.

The respondent submitted into evidence Respondent Exhibits 1-3. The petitioner submitted into evidence Petitioner Exhibit 1.

The record was left open for seven days for respondent to provide additional information. The respondent provided a response within the time frame allotted. The record was left open seven additional days for petitioner to provide any responses if chosen. The petitioner did not provide a response

## 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 Brevard County, Florida and is a Medicaid recipient. She is enrolled in the Medicaid MMA (Managed Medical Assistance) Program with Prestige Health Choice (Prestige). Prestige Health Choice is a Managed Care Organization that has been authorized by AHCA to make prior authorization decisions for individuals enrolled in the Medicaid MMA Program.
2. On or about June 24, 2015, the petitioner received a dental cleaning procedure at $\square$ is not a network provider for Prestige. The petitioner paid an out-of-pocket cost of $\$ 152$ for this procedure. She requested reimbursement for the procedure from Prestige shortly after.
3. The respondent witness from Prestige indicated they did not receive a Prior Service Authorization request from any dental provider for the above noted procedure.

FINAL ORDER (Cont.)
15F-09953
PAGE - 3
On September 2, 2015, Prestige sent the petitioner a Resolution of Grievance Letter regarding her request for reimbursement which states in part:

Your grievance was reviewed and it was determined last year a one time exception was made to reimburse you when vou decided to go out of network, with the understanding that sout of network. You were advised at that time out of network services are not Covered. You chose to go back tc again when in network providers are available in your area for a routine cleaning and were provided to you. Out of network services are not covered unless in emergency circumstances and/or authorization is obtained prior to receiving the services. Routine cleanings are not considered emergency services and you did not reach out to Prestige in regards to getting an authorization prior to obtaining out of network services. Unfortunately, Prestige will not reimburse you for this bill by an out of network provider.
4. In 2014, the petitioner received the same dental treatment from the out-ofnetwork dental provider. The petitioner requested direct reimbursement for her out of pocket payment to the dental provider. Prestige originally denied the petitioner's request for reimbursement. The petitioner appealed that decision. During that appeal process, Prestige subsequently approved the petitioner's request for reimbursement. The Prestige witness indicated the petitioner was advised at that time that the reimbursement was a one-time only exception. The petitioner disputes that she was advised this from Prestige.
5. The petitioner argued that Prestige has a very limited amount of providers in her county that perform teeth cleaning. She argued the one Prestige provider she was told to go see for dental procedures tried to extort money from her previous to the service being rendered. She argued that she has on numerous occasions called Prestige to report her situation with dental providers and has tried to receive information

FINAL ORDER (Cont.)
15F-09953
PAGE -4
about suitable providers. She argued that a staff member of Prestige told her that she could go have dental work completed by an out-of-network provider.
6. The Prestige witness indicated there is no record in 2015 of a staff member from Prestige telling petitioner she could have this dental procedure completed by an out-of-network provider. She indicated that all telephone calls made to and from Prestige are recorded and if the petitioner can provide the date and time of the alleged incident she would do further research to determine if the incident occurred. She indicated that if a staff member told the petitioner she could receive services from an out-of-service provider, then the reimbursement request will be approved. She also indicated the petitioner was mailed a list of in network dental providers.
7. The petitioner indicated the dates of these occurrences were May 19, 2015 through May 21, 2015 and also August 25, 2015. The record was left open for the respondent witness to do research and to provide a response concerning any decision based on this research.
8. The respondent witness from Prestige indicated she researched information from a previous Prestige dental provider and a May 19, 2015 telephone call made to Prestige by petitioner and found no evidence that the petitioner was told she could receive dental treatment from an out of network dental provider. She also indicated that she would attempt to help the petitioner with her 2016 dental needs by offering transportation to a Prestige dental provider in another county.
9. During the hearing, the Prestige witness indicated that she contacted to inquire if they wished to be a Prestige dental provider and was told no.

She also indicated under certain circumstances an out-of-network dentist procedure
could be approved if an emergency dental procedure was warranted. She indicated a dental cleaning would not meet the definition of an emergency dental procedure. She reiterated that Prestige's denial of the petitioner's request for reimbursement for her out of pocket payment to an out of network dental procedure remains correct.

## 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, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.
11. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
12. In accordance with Fla. Admin. Code R. 65-2.060 (1), the party having the burden shall establish its position by a preponderance of the evidence, to the satisfaction of the hearing officer.
13. The Florida Medicaid program is administered by the respondent and governed by Title XIX of the Social Security Act, Title 42 of the Code of Federal Regulations, Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code.
14. Federal Medicaid Regulation 42 C.F.R. § 447.25 "Direct payments to certain beneficiaries for physicians' or dentists' services" states in part:
(a) Basis and purpose. This section implements section 1905(a) of the Act by prescribing requirements applicable to States making direct payments to certain beneficiaries for physicians' or dentists' services.
(b) State plan requirements. Except for groups specified in paragraph (c) of this section, a State may make direct payments to beneficiaries for physicians' or dentists' services. If it does so, the State plan must-
(1) Provide for direct payments; and
(2) Specify the conditions under which payments are made.
15. Section 409.912 of the Florida Statutes sets standards for purchasing cost-
effect health care and states in relevant part:
Cost-effective purchasing of health care.-The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care ...
16. Florida Administrative Code R. 59G-5.110 "Claims Payment" sets standards for direct payments to recipients and states in relevant part:
(1)(a) The agency provides eligible individuals with access to Medicaid services and goods by direct payment to the Medicaid provider upon submission of a payable claim to the fiscal agent contractor. Except as provided for by law or federal regulation, payments for services rendered or goods supplied shall be made by direct payment to the provider except that payments may be made in the name of the provider to the provider's billing agent if designated in writing by the provider. Direct payment may be made to a recipient who paid for medically necessary, Medicaidcovered services received from the beginning date of eligibility (including the three-month retroactive period) and paid for during the period of time between an erroneous denial or termination of Medicaid eligibility and a successful appeal or an agency determination in the recipient's favor [emphasis added].

The services must have been covered by Medicaid at the time they were provided. Medicaid will send payment directly to the recipient upon submission of valid receipts to the Agency for Health Care Administration. All payments shall be made at the Medicaid established payment rate in effect at the time the services were rendered. Any services or goods the recipient paid before receiving an erroneous determination or services for which reimbursement from a third party is available are not eligible for reimbursement to the recipient.

FINAL ORDER (Cont.)
15F-09953
PAGE -7
17. The Florida Medicaid Provider General Handbook (July 2012) is
incorporated by reference in Chapter 59G-5, Fla. Admin. Code and 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.
18. Page 1-30 of the Florida Medicaid Provider General Handbook sets
standards for HMOs (managed care organizations) and states in part:

## HMO Limitations

An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service.

## Exemptions from HMO Authorization

## All services may be prior authorized by the HMO plan except for the

 following:- Emergency services;
- Family planning services regardless of whether the provider is a plan provider;
- The diagnosis and treatment of sexually transmitted diseases and other communicable diseases such as tuberculosis and human immunodeficiency rendered by county health departments;
- OB/GYN services for one annual visit and the medically-necessary follow up care for a condition(s) detected at that visit (the recipient must use a plan provider for these services);
- Chiropractic, podiatry, and some dermatology services (the recipient must use a plan provider for these services); and
- Immunizations by county health departments [emphasis added].

FINAL ORDER (Cont.)
15F-09953
PAGE -8
19. Page 1-30 of the Florida Medicaid Provider General Handbook, Optional Services, further explains "[o]ther services that plans may provide include dental services, transportation, nursing facility and home and community-based services. Plans may also provide services under their contracts that Medicaid does not cover, such as over-the-counter drugs."
20. The Florida Medicaid Dental Services Coverage and Limitations Handbook (November 2011) is incorporated by reference in Chapter 59G-4, Fla. Admin. Code and states on pages 2-38:

Some procedures must be authorized prior to being provided to the recipient. All requests for prior authorization (PA) of dental procedures must be submitted on the dental "Prior Authorization Request for Treatment Authorization" form (DPA 1041). Medicaid will notify the provider in writing of the disposition of the request.
21. As shown in the Findings of Fact, the Agency denied the petitioner's request for reimbursement of a dental procedure she received by an out-of-network provider.
22. For the case at hand, the petitioner received dental treatment by an out-ofnetwork dental provider in June 2015. No prior authorization for the dental treatment was submitted to Prestige. The petitioner paid the dental bill for this treatment and requested reimbursement from Prestige. The request was denied. The respondent witness indicated under certain circumstances, such as if a Prestige staff member advised petitioner she could receive the services from an out-of-network provider or if the dental procedure was an emergency, a direct reimbursement would be provided.
23. However, the evidence provided does not indicate that the petitioner met either of the above noted circumstances. Additionally, as required by the above Rule, the evidence presented does not show that the Agency made an erroneous denial or

FINAL ORDER (Cont.)
15F-09953
PAGE -9
termination of Medicaid eligibility in this case to allow for direct reimbursement to the petitioner for the requested dental bills. Based on these facts, the hearing officer agrees with the respondent's arguments.
24. 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 decision to deny the petitioner's request for reimbursement of a dental procedure received through an out-of-network provider 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.

FINAL ORDER (Cont.)
15F-09953
PAGE -10
DONE and ORDERED this __11_day of _ March , 2016, in Tallahassee, Florida.

| Rolvert 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: Petitioner
Judy Jacobs, Area 7, AHCA Field Office

Mar 01, 2016

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

PETITIONER,
Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 18 Seminole
UNIT: 55207

## RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 1:00 p.m. on January 13, 2016.

## APPEARANCES

For the Petitioner:


For the Respondent:
Anthony Barresi, ACCESS Supervisor

## STATEMENT OF ISSUE

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

## PRELIMINARY STATEMENT

By notice dated November 13, 2015, the respondent (or the Department) notified petitioner she was denied Medicaid. Petitioner timely requested a hearing to challenge the denial.

FINAL ORDER (Cont.)
15F-09995
PAGE-2
petitioner's mother, appeared as a witness for petitioner. Banish
White, ACCESS Economic Self-Sufficiency Specialist II, 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 through end of business day on January 13, 2016, for the respondent to submit an additional exhibit.

The exhibit was received timely and entered as Respondent Exhibit " 5 ". Petitioner also submitted an exhibit, entered as Petitioner Exhibit "1". The record was closed on January 13, 2016.

## FINDINGS OF FACT

1. On October 30 , 2015, the petitioner (age 27) submitted a Food Assistance application.
2. On November 9, 2015, the Department interviewed the petitioner; petitioner did not mention she was disabled.
3. On November 12, 2015, the petitioner submitted another application to add Cash Assistance and Family Medicaid. Neither application indicates that the petitioner is disabled or pregnant. Medicaid is the only issue.
4. To be eligible for Family Medicaid, petitioner must have minor children living in the home or be pregnant. To be eligible for Adult Medicaid, petitioner must be age 65 or older or considered blind or disabled by the Social Security Administration (SSA) or the Department's Division of Disability (DDD).
5. Petitioner does not have minor children, is not pregnant, is not age 65 or older, and has not been considered blind or disabled by the SSA or DDD.

FINAL ORDER (Cont.)
15F-09995
PAGE-3
6. The Department did not complete a disability interview with the petitioner due to petitioner not indicating she was disabled on the applications nor during the Department interview.
7. The Department processed both applications (October 30, 2015 and November 12, 2015) on November 12, 2015.
8. On November 13, 2015, the Department mailed the petitioner a Notice of Case Action notifying she was denied Medicaid; "Reason; You or a member(s) of you household do not meet the disability requirement."
9. Petitioner asserts that she is disabled because she "is on methadone" and she cannot afford to purchase the methadone.
10. Petitioner's mother testified that petitioner has a behavior health condition and is on a substance abuse maintenance program. Petitioner's mother believes Medicaid has an "exclusion clause" that qualifies a person with behavioral health condition for Medicaid, when the condition limits the person's ability to function and work; which applies to her daughter.
11. Petitioner submitted a letter from Health Insurance Marketplace, dated December

2, 2015, that states in part:
Understanding Your Eligibility Results...
5. Getting help with the cost of special health care needs

Does Medicaid cover special health care needs?
Yes. You may qualify to get coverage for more health services And pay less for care if you have special health care needs, like if you: Have a medical, mental health or substance abuse condition that limits the ability to work or go to school...

FINAL ORDER (Cont.)
15F-09995
PAGE-4
12. Respondent's representative suggested the petitioner submit another Medicaid application and indicate she is disabled so the Department can determine disability Medicaid eligibility.
13. Petitioner responded that she submitted another Medicaid application on December 15,2015 ; eligibility determination has not been completed.

## 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
$\S 409.285$, 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. 652.056.
16. Medicaid eligibility is based on Federal Regulations. There are two categories of Medicaid that the Department determines eligibility for: (1) Family-Related Medicaid for parents and children, and pregnant women, and (2) Adult-Related (referred to SSIRelated Medicaid) for disabled adults and adults 65 or older.
17. Florida Administrative Code R. 65A-1.703 Family-Related Medicaid Coverage Groups in part states:
(1) The department provides mandatory Medicaid coverage for individuals, families and children described in Section 409.903, F.S., Section 1931 of the Social Security Act and other relevant provisions of Title XIX of the Social Security Act. The optional family-related Title XIX and Title XXI coverage groups served by the department are stated in each subsection of this rule...
(5) Medicaid for pregnant women...

FINAL ORDER (Cont.)
15F-09995
PAGE - 5
18. The evidence submitted establishes that petitioner has no children and is not pregnant. Therefore, petitioner is not eligible for Family-Related Medicaid.
19. The evidence also establishes that petitioner is not age 65 or older and petitioner did not indicate on her applications or during the Department interview that she is disabled. Therefore, the Department did not consider petitioner for SSI-Related Medicaid.
20. In careful review of the cited authorities and evidence, the undersigned concludes the respondent is correct in denying petitioner Medicaid.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the respondent's action is affirmed.

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this $\qquad$ 01 day of March , 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@myffamilies.com


Vs.
PETITIONER,

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 PALM BEACH
UNIT: 88701
CASE NO. 1446956555

RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on January 25, 2016 at 1:36 p.m. All parties appeared telephonically from different locations.

## APPEARANCES

For the Petitioner:

For the Respondent:
Stacy Ann Mills, supervisor

## STATEMENT OF ISSUE

At issue is the amount of Food Assistance Program (FAP) benefits the petitioner was approved to receive. The petitioner carries the burden of proof in the FAP appeal.

The petitioner is also appealing the denial of full Medicaid and enrollment in the Medically Needy Program with an estimated share of cost (SOC). He is seeking full Medicaid. The petitioner caries the burden of proof in the Medicaid appeal.

FINAL ORDER (Cont.)
15F-10015, 16F-01466, 02048
PAGE -2

## 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. The record was held open until February 8, 2016, for the petitioner to provide verification of his medical premium to the respondent and for the respondent to update the petitioner's case and provide updated budgets, new Notice of Case Action and the FAP application. Additional time was allowed to both parties to provide the information. The Department provided one exhibit on March 1, 2016 and one exhibit on March 3, 2016 which were accepted into evidence and marked as Respondent's Composite Exhibits 2 and 3. The exhibits consisted of Running Record Comment (CLRC), new Notice of Case Action, FAP budgets, Medicaid budget, and the petitioner's application. The petitioner did not provide any exhibits. The record was closed on March 3, 2016.

## FINDINGS OF FACT

1. On September 10, 2015, the petitioner submitted an application for FAP and Cash Assistance benefits. He was the only household member. He listed expenses for telephone, water and electricity. The petitioner receives Social Security Disability Income (SSDI) of \$1,806. The Department processed his application and determined he was eligible for $\$ 16$ monthly in FAP benefits. To determine the FAP benefits for November 2015, ongoing, the respondent counted the petitioner's gross monthly income of $\$ 1,806$. It subtracted $\$ 155$ resulting in a total adjusted income of $\$ 1,651$. The shelter cost of $\$ 700$ was added to the utility standard of $\$ 345$ to get the total shelter/utility cost of $\$ 1,045$. Fifty percent of the adjusted net income ( $\$ 825.50$ ) is the

FINAL ORDER (Cont.)
15F-10015, 16F-01466, 02048
PAGE -3
standard shelter. This was subtracted from the total shelter/utility, resulting to $\$ 219.50$.
This was subtracted from the adjusted income $(\$ 1,651)$ resulting in $\$ 1,431.50$ as the Food Assistance adjusted income. The maximum net income limit for a household size of one is $\$ 981$. As the petitioner's adjusted income was more than the maximum monthly net income limit, the Department determined the petitioner was only eligible for the minimum allotment of $\$ 16$.

| SSDI income | $\$ 1,806$ |
| :--- | ---: |
| Total household income | $\$ 1,806$ |
| Standard deduction for a <br> household of 1 | $(\$ 155)$ |
| Excess medical expenses) | 0.00 |
| Adjusted income after <br> deductions | $\$ 1,651$. |
| Shelter costs | $\$ 700$ |
| Standard utility Allowance | $\$ 345$ |
| Total rent/utility cost <br> Shelter standard (50\% adjusted <br> income) | $\$ 825.50$ |
| Excess shelter deduction | $\$ 219.50$ |
| Adjusted income <br> Excess Shelter Deduction | $\$ 1,651$ |
| Adjusted income after shelter <br> deduction | $\$ 1,431.50$ |

2. By notice dated September 14, 2015, the respondent mailed a Notice of Case Action informing the petitioner that his September 10, 2015 application for FAP benefits was approved. He was approved for $\$ 11$ for September 2015, a prorated month and $\$ 16$ for October 2015 ongoing. The same notice informed him that he was eligible for Medically Needy Medicaid coverage.

FINAL ORDER (Cont.)
15F-10015, 16F-01466, 02048
PAGE -4
3. On November 5, 2015, the petitioner submitted a recertification application for SSI-Related Medicaid benefits. The Department determined he was eligible he was for the Medically Needy Program with a share of cost.
4. To determine the petitioner's SSI-Related Medicaid benefits, the respondent determined the petitioner's gross income of $\$ 1,806$. The respondent compared it to the income limit for one person which is $\$ 864$ and found the petitioner exceeded the income limit for full Medicaid benefits. The respondent proceeded to enroll him in the Medically Needy Program with SOC based on his income.
5. The respondent performed the following budget calculations when it determined the petitioner's estimated SOC. It determined the petitioner's monthly gross income was $\$ 1,806$. A $\$ 20$ unearned income disregard was subtracted resulting to $\$ 1,786$ as the petitioner's countable income. The Medically Needy Income Limit of \$180 for household size of one was subtracted resulting to $\$ 1,606$ as the petitioner's SOC.
6. On December 8, 2015, the petitioner requested a hearing to challenge the Department's action to enroll him in the Medically Needy Program.
7. At the hearing, the petitioner reported his household expenses as follows: rent expense of $\$ 700$, utilities telephone of $\$ 200$ and medical insurance of $\$ 130$. He is not currently receiving Medicare Part A or B but will be eligible in July 2016. He also requested that his FAP benefits be reviewed.
8. The respondent updated the petitioner's case with his medical insurance premium of $\$ 131.36$, medical expenses of $\$ 1,081.27$ and allowed a total medal cost of $\$ 1,212.63$ as a deduction in the FAP budget. The petitioner's FAP benefits increased

FINAL ORDER (Cont.)
15F-10015, 16F-01466, 02048
PAGE -5
after the Department updated the FAP budget. The Department's calculation for
February 2016 ongoing is as follows.

| SSDI income | $\$ 1,806$ |
| :--- | ---: |
| Total household income <br> Standard deduction for a <br> household of 1 | $\$ 1,806$ |
| Excess medical expenses <br> (\$131.36+\$1,081.27-\$35) | $(\$ 155)$ |
| Adjusted income after <br> deductions | $\$ 1,177.63$ |
| Shelter costs <br> Standard utility Allowance | $\$ 473.37$. |
| Total rent/utility cost <br> Shelter standard (50\% adjusted <br> income) | $\$ 1,045$ |
| Excess shelter deduction | $\$ 236.68$ |
| Adjusted income <br> Excess Shelter Deduction | $\$ 808.32$ |
| Adjusted income after shelter <br> deduction | $\$ 873.37$ |

9. The petitioner's adjusted income is zero therefore he is eligible for the maximum FAP allotment for a one person household.
10. The respondent provided a new Notice of Case Action informing the petitioner that his FAP benefits will increase to $\$ 194$ for April 2016 through August 31, 2016. The

Department supplemented February 2016 and March FAP benefit in the amount of $\$ 178$ each month. The same notice informed the petitioner that his Medically Needy application was approved. The petitioner's SOC remained at \$1,606 for February 2016, March 2016 and ongoing.

FINAL ORDER (Cont.)
15F-10015, 16F-01466, 02048
PAGE -6
11. The petitioner argues that he cannot purchase medication with the money he is getting from his disability. He also asserts that his doctors do not accept Medically Needy SOC Medicaid.

## CONCLUSION 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.

## The FAP benefits issue will be addressed first.

14. 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...
15. 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

FINAL ORDER (Cont.)
15F-10015, 16F-01466, 02048
PAGE -7
care deduction, (5) child support deduction, (6) standard utility allowance, and shelter expenses.
16. 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.
17. 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 $\S 273.9(\mathrm{~d})(3)$, 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...
(iii) To determine the amount of the prorated allotment, the State agency shall use either the appropriate Food Stamp Allotment Proration Table provided by FNS...

FINAL ORDER (Cont.)
15F-10015, 16F-01466, 02048
PAGE -8
18. The Department's Field Guide Handouts/Proration Factors Chart, Cash \& FS, $06 / 18 / 2012$, lists the proration factor of 0.700 as the factor that corresponds to day 10 . As the petitioner applied on September 10, 2015, the Department issued a prorated amount of $\$ 11$ in FAP benefits for September 2015 ( $0.70 \times \$ 16=\$ 11$ rounded down).
19. Federal regulations at 7 C.F.R. §273.10(e)(vi) (B) addresses Food Assistance Minimum Benefit and state: " (B) Except as provided in paragraphs (a)(1), (e)(2)(ii)(B), and $(e)(2)(v i)(C)$ of this section, one- and two-person households shall be provided with at least the minimum benefit.".
20. Federal Regulations at 7 C.F.R. §273.2 (8) (ii) addresses changes, it states:

Changes reported during the certification period shall be subject to the same verification procedures as apply at initial certification, except that the State agency shall not verify changes in income if the source has not changed and if the amount has changed by $\$ 50$ or less, unless the information is incomplete, inaccurate, inconsistent or outdated.
21. Federal Regulations at 7 C.F.R. §273.12 (c) states in relevant part:
(1) Increase in benefits. (i) For changes which result in an increase in a household's benefits, other than changes described in paragraph (c)(1)(ii) of this section, the State agency shall make the change effective no later than the first allotment issued 10 days after the date the change was reported to the State agency. For example, a \$30 decrease in income reported on the 15th of May would increase the household's June allotment. If the same decrease were reported on May 28, and the household's normal issuance cycle was on June 1, the household's allotment would have to be increased by July.
22. The above-cited regulation explains changes that result in an increase in benefits shall be effective the first allotment following the reported change. The Department updated FAP benefits to reflect the petitioner's medical expenses resulting in an increase of FAP benefits to the maximum monthly amount of \$194 for February 2016 ongoing. The reported change was effective January 25, 2016 (at the hearing)

FINAL ORDER (Cont.)
15F-10015, 16F-01466, 02048
PAGE -9
therefore, the petitioner's FAP for September 2015 through January 2016 remained at \$11 for September 2015 and \$16 for October 2015 through January 2016.
23. The above-cited regulation describes the eligibility process and defines
deductions. The Standard Utility Allowance and the petitioner's rent expense make up the petitioner's total shelter cost. The petitioner was credited with a standard deduction and an excess shelter deduction (which included the Standard Utility Allowance) for the FAP budgets November through January 2016, an excess medical deduction given for February 2016 ongoing as the petitioner reported his medical expenses at the hearing. There is no indication the petitioner was eligible for any other deductions as he received the maximum FAP amount for an assistance group size of one for February 2016 ongoing. The was no medical expenses reported on the petitioner's September 10, 2015, application therefore the Department's calculation of the petitioner's FAP benefits for November 2016 was correct.
24. In accordance with the federal regulations, the Food Assistance standards for income and deductions appear in the Policy Manual, at Appendix A-1. The 200\% Federal Poverty level (FPL) for a household size of one prior to October 2015 was $\$ 1,605$. A one-person assistance group's net income limit was $\$ 973$, the standard deduction was $\$ 155$ and the standard utility allowance was $\$ 337$. Effective October 2015, the 200\% Federal Poverty level (FPL) for a household size of one is $\$ 1,962$. 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 and the minimum allotment is $\$ 16$.

FINAL ORDER (Cont.)
15F-10015, 16F-01466, 02048
PAGE -10
25. After considering the evidence, the testimony, and the appropriate authorities cited above, the hearing officer did not find the petitioner eligible for any additional FAP benefits. The undersigned also determined the petitioner's FAP benefits of $\$ 11$ for November 2015 and $\$ 16$ for December 2015 and January 2016 is correct.

## Medicaid Benefits will now be addressed

26. The Department determined the petitioner's Medicaid benefits under the SSI Related Program.
27. 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.
28. 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.
29. The Policy Manual, at Appendix A-9, lists the MEDS-AD income limit as $\$ 864$ for an individual effective July 2015.
30. 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 MEDSAD income limit for an individual is $\$ 864$. The petitioner does not have Medicare benefits but his income of $\$ 1,786$ (after $\$ 20$ unearned disregards) exceeds the income limit for full Medicaid benefits therefore, eligibility is not found for full Medicaid benefits.

FINAL ORDER (Cont.)
15F-10015, 16F-01466, 02048
PAGE -11
The undersigned further concludes Medically Needy eligibility must be explored for the petitioner.

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

31. 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.
32. 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.
33. 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.
34. 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.
35. 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..."
36. 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.
37. Fla. Admin. Code R. 65A-1.716 (2), Income and Resource Criteria, sets forth the

Medically Needy Income Level for one person at \$180.
38. The Policy Manual at passage 2440.0102, Medically Needy Income Limits
(MSSI) states:
When the assistance group has met the technical eligibility criteria and the asset limits, it is enrolled. There is no income limit for enrollment. The assistance group is income eligible (entitled to Medicaid) once income is less than or equal to the Medically Needy Income Level (MNIL) or medical bills equal the amount by which his income exceeds the MNIL. Once medical bills are equal to this surplus income, referred to as share of cost, the assistance group is eligible.

FINAL ORDER (Cont.)
15F-10015, 16F-01466, 02048
PAGE -13
The eligibility specialist must determine eligibility for Medically Needy any time the assistance group's income exceeds the income limits for another full Medicaid Program.
39. The above states the SOC is determined by subtracting a $\$ 20$ unearned disregard, the Medically Needy Income Limit (MNIL) and medical insurance premium from the family's income. The hearing officer determined the petitioner's SOC by subtracting the $\$ 20$ unearned disregard, MNIL of $\$ 180$, and the petitioner medical insurance premium of $\$ 131.36$ from his monthly income of $\$ 1,806$, which resulted in a SOC of \$1,474 effective February 2016 and ongoing. The undersigned found that the petitioner has medical insurance premium which the Department failed to include in his Medically Needy SOC budget. The petitioner is found eligible for a lower SOC than the Department determined.
40. The undersigned also concludes the respondent's actions to deny full-coverage Medicaid is a correct action; however, the undersigned finds the Department erred when it determined the petitioner's SOC. The petitioner's Medicaid insurance premium was not used to determine the petitioner's SOC. The undersigned determined the petitioner SOC is $\$ 1,474.64$. The Department is to take corrective action and include the petitioner's medical insurance premium in the determination of the petitioner's SOC.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal for FAP benefits is denied and the Department's action is upheld.

The appeal is denied for full Medicaid benefits and the respondent's action is upheld.

FINAL ORDER (Cont.)

The appeal related to the Medically Needy Program is granted. The petitioner is eligible for a lower SOC.

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 31 day of March , 2016,
in Tallahassee, Florida.
Christine Gepaul Marine
Christian 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: Petitioner
Once oi Economic Self Sufficiency

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

## FILED

Mar 11, 2016
Office of Appeal Hearings
Dept. of Children and Families

APPEAL NO. 15F-10035
PETITIONER,
Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES CIRCUIT: 06 Pinellas
UNIT: 88274
CASE NO.

RESPONDENT.

## FINAL ORDER

Pursuant to notice, hearing officer Brandy Ricklefs convened an administrative hearing by phone in the above-referenced matter on January 6, 2016 at 1:33 p.m.

APPEARANCES
For Petitioner:
For Respondent: Ed Poutre, Economic Self Sufficiency Specialist II

## STATEMENT OF ISSUE

At issue is whether the respondent's action to deny petitioner's request for retroactive Qualified Medicare Beneficiary (QMB) Medicaid benefits for the months of September 2015 and October 2015 is correct. The burden of proof is assigned to the petitioner by the preponderance of the evidence.

FINAL ORDER (Cont.)

## PRELIMINARY STATEMENT

Petitioner was present and testified. Petitioner submitted no exhibits at the hearing. Respondent was represented by Ed Poutre with the Department of Children and Families (hereafter "DCF", "Respondent" or "Agency"). Respondent submitted one exhibit, which was accepted into evidence and marked as Respondent's Composite Exhibit "1".

Due to unforeseen circumstances, the appeal was necessarily reassigned to the undersigned. On February 19, 2016, the undersigned issued an Order Transferring Hearing Officer stating the undersigned would review the entire record, including the evidence presented at the hearing and the electronic recording of the hearing and issue a Final Order based on the merits therein. The notice allowed either party to raise any objections to this procedure within seven (7) days. As of the close of business on February 26, 2016, neither party contacted the undersigned with any objections. Therefore, the undersigned will proceed as stipulated.

## FINDINGS OF FACT

1. On June 28, 2013, the petitioner submitted an interim contact letter for the Qualified Medicare Beneficiary (QMB) Medicaid program.
2. On June 16, 2014, the respondent mailed petitioner a Notice of Case Action indicating "it is time to review your case to find out if you are still eligible...If you do not complete your review by July 1, 2014, your Medicaid may end."
3. On July 30, 2014, the respondent extended petitioner's QMB Medicaid benefits for an additional year.

FINAL ORDER (Cont.)
15F-10035
PAGE - 3
4. On August 18, 2015, the respondent mailed petitioner a Notice of Case Action indicating petitioner's QMB Medicaid benefits would end on August 31, 2015 as "Your Medicaid for this period is ending. We did not receive all the information requested to determine eligibility".
5. On November 6, 2015, the petitioner submitted an application for QMB Medicaid benefits. Respondent determined petitioner eligible for QMB Medicaid benefits for the certification period of November 1, 2015 through October 31, 2016.
6. On November 13, 2015, the respondent mailed petitioner a Notice of Case Action indicating her QMB Medicaid benefits were reviewed and she is eligible for QMB Medicaid benefits.
7. On December 9, 2015, the petitioner requested a hearing as she is seeking the approval of QMB Medicaid benefits for the months of September 2015 and October 2015.
8. Respondent argued petitioner is not eligible for QMB Medicaid benefits for the months of September 2015 and October 2015 as QMB Medicaid benefits cannot be retroactively approved.
9. Petitioner argued she was unable to complete an application for QMB Medicaid benefits until November 2015 as she was ill and in the hospital during the months of July 2015 and August 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

FINAL ORDER (Cont.)
15F-10035
PAGE - 4
§ 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 Florida Administrative Code R. 65-2.056.
12. The Fla. Admin. Code R. 65A-1.702 Special Provisions, states in part:
(9) Retroactive Medicaid. Retroactive Medicaid is based on an approved, denied, or pending application for ongoing Medicaid benefits.
(a) Retroactive Medicaid eligibility is effective no later than the third month prior to the month of application for ongoing Medicaid if the individual would have been eligible for Medicaid at the time of application for Medicaid covered services. A request for retroactive Medicaid can be made for a deceased individual by a designated representative or caretaker relative filing an application for Medicaid assistance. The individual or his or her representative has up to 12 months after the date of application for ongoing Medicaid to request retroactive Medicaid eligibility. However, Qualified Medicare Beneficiaries (QMB's) are not eligible for retroactive Medicaid benefits under the QMB coverage group as indicated in 42 U.S.C. § 1396a(e)(8).
(12) Limits of Coverage.
(a) Qualified Medicare Beneficiary (QMB). Under QMB coverage, individuals are entitled only to Medicare cost-sharing benefits, including payment of Medicare premiums...
13. Pursuant to the above authority, retroactive Medicaid benefits are effective no later than the third month prior to an application for ongoing Medicaid benefits; however, QMB Medicaid benefits cannot be approved retroactively from an application for ongoing Medicaid benefits. On November 6, 2015, the petitioner submitted an application for QMB Medicaid benefits. Respondent approved petitioner QMB Medicaid benefits effective November 1, 2015 and ongoing. Since QMB Medicaid benefits cannot be approved retroactively, the respondent was correct in not approving petitioner QMB Medicaid benefits for the months of September 2015 and October 2015.

FINAL ORDER (Cont.)
15F-10035
PAGE-5
14. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner did not meet the burden of proof to indicate the respondent incorrectly denied her request for Qualified Medicare Beneficiary Medicaid benefits for the months of September 2015 and October 2015.

## DECISION

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

## NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the 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 $\qquad$ day of $\qquad$ , 2016,
in Tallahassee, Florida.

Mary Gane 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@myffamilies.com
Copies Furnished To:
Petitioner
Office of Economic Self Sufficiency

Mar 07, 2016

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

PETITIONER,
Vs.
CASE NO.
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-referenced matter on February 9, 2016, at 2:30 p.m.

## APPEARANCES

For the Petitioner:


For the Respondent: Lisa Sanchez, Medical Healthcare Program Analyst, Agency for Health Care Administration (AHCA).

## STATEMENT OF ISSUE

At issue is the Agency action, through Sunshine Health, in denying the petitioner's request for Home Health Aide services 24 hours per day seven days per week. The petitioner carries the burden of proof in this matter.

## PRELIMINARY STATEMENT

Present as a witness for the petitioner was he petitioner's sister.

Present as witnesses for the respondent from Sunshine Health were Tracey Thomas, Appeals Coordinator II; Mary Sigmore, Case Manager; Dr. John M. Carter, Long-Term Care Medical Director; and Stephanie Gunning, Case Manager Supervisor. Present as an observer was Mario McDonnough with Sunshine Health.

The respondent submitted into evidence Respondent Exhibit 1 through 3.

## FINDINGS OF FACT

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

1. The petitioner is a Long-Term Care (LTC) Medicaid recipient living in Cocoa, Florida. She is forty years of age and lives at home. Sunshine Health is a Managed Care Organization that has been authorized by AHCA to make prior service authorization decisions for individuals enrolled in Medicaid LTC Programs.
2. The petitioner is paralyzed and needs wound care.
3. On September 29, 2015, the petitioner's provider requested Home Health Aide services 24 hours per day, seven days per week.
4. On October 19, 2015, Sunshine Health denied the petitioner's request and mailed the petitioner a Notice of Action stating:
...After our review, this service has been denied, as of October 15, 2015...
We made this decision because:

FINAL ORDER (Cont.)
15F-10066
PAGE -3
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.

Other authority.
Request for Home Health Aide for 24 hours per day 7 days a week is DENIED. The provider's request contains no medical prescription and no medical records that explain the medical need for this request.
5. On January 11, 2016, after the petitioner requested a review of the decision and a fair hearing, Sunshine Health approved 8 hours of personal care services per day 7 days per week for the petitioner. On February 3, 2016, Sunshine Health further reviewed the determination and approved another 8 hours per day 7 days per week, for a total of 16 hours per day 7 days per week.
6. The respondent's medical director witness indicated, as of the date of this hearing, the petitioner or her provider still has not provided a prescription or medical information to Sunshine Health for the requested services.
7. The petitioner indicated that she was approved at one time for $24 / 7$ care, but indicated that it stopped because her provider was not (apparently) being paid for the service that they provided to the petitioner. The respondent's case manager witness indicated at no time did Sunshine Health approve a request for $24 / 7$ care services. The respondent's representative and the medical director witness indicated the petitioner's prior request/approval of services may have been Medicare related, as Medicare will approve such services. The petitioner was advised to contact Medicare.
8. The petitioner argued that she still needs $24 / 7$ care as she cannot turn herself on her own every two hours as needed to prevent her current wound from getting

FINAL ORDER (Cont.)
15F-10066
PAGE -4
worse. Her sister argued that the petitioner's mother lives in the house and is unable to provide any help for the petitioner. She also indicated that other members of the petitioner's household must go to work during the daytime.
9. The medical director witness indicated that he is aware the petitioner has severe care issues, but based on the assessment as provided to the petitioner and the fact that other individuals live in the petitioner's home, 16 hours per day 7 days per week is the correct medically necessary amount of hours of (personal) care services that petitioner needs for her care.

## 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, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under section 409.285, Florida Statutes.
11. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
12. In accordance with Fla. Admin. Code R. 65-2.060 (1), the party having the burden shall establish his/her position by a preponderance of the evidence, to the satisfaction of the hearing officer.
13. 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:
14. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

FINAL ORDER (Cont.)
15F-10066
PAGE -5
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.
14. As shown in the Findings of Fact, the Agency, through Sunshine Health, initially denied the petitioner's request for Home Health Aide services 24 hours per day, seven days per week. However, Sunshine Health, as of February 4, 2016, approved 16 hours per day 7 days per week of services for the petitioner.
15. For the case at hand, the respondent's medical director witness agreed in spite of Sunshine Health not having received necessary information from the petitioner's provider, Sunshine Health determined the petitioner is in need of personal care services based on her medical situation. Additionally, the amount of hours recently approved are based on the petitioner's household member's ability to provide care for the petitioner.
16. Though the petitioner argued she is in need of around the clock care she did not meet her burden of proof to show that the service was 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. There was no medical information or prescription for services supplied to Sunshine Health by petitioner or her provider.

FINAL ORDER (Cont.)
15F-10066
PAGE -6
17. After careful review of the evidence submitted and the relevant laws set forth above, the undersigned concludes the Agency's action in denying petitioner's request for Home Health Aide services 24 hours per day seven days per week. is correct. 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 $\qquad$ day of $\qquad$ 2016,
in Tallahassee, Florida.


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

Copies Furnished To: Petitioner
Judy Jacobs, Area 7, AHCA Field Office

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

Apr 26, 2016

Vs.
AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 07 Volusia
UNIT: AHCA
RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on April 6, 2016 at 10:06 a.m.

## APPEARANCES

For the Petitioner: pro se

For the Respondent: Selwyn Gossett, medical healthcare analyst with AHCA

## STATEMENT OF ISSUE

Whether the respondent was correct to deny the petitioner's request for a computer tomography (CT) scan of the lumbar spine (lower 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

FINAL ORDER (Cont.)
15F-10068
PAGE - 2
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 25, 2015, Molina informed the petitioner that his request for a CT scan of the lumbar spine was denied. The notice reads in pertinent part: "your requested services are not medically necessary because the services...must meet accepted medical standards..."

The petitioner timely requested a hearing on December 3, 2015.
There were no additional witnesses for the petitioner. The petitioner did not submit documentary evidence.

The respondent presented four witnesses from Molina: Dr. Mark Bloom, medical director; Alice Kuiros, associate vice president of government contracts; Bonnie Blitz, director of healthcare services; and Elvis Leiva, manager of healthcare services. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

## FINDINGS OF FACT

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

1. The petitioner (age 54) is a Florida Medicaid recipient. The petitioner is enrolled with Molina HMO. The petitioner's medical history includes diabetes, bipolar disorder, and numerous broken bones.

FINAL ORDER (Cont.)
15F-10068
PAGE - 3
2. The petitioner visited his treating physician on November 6, 2015 due to lower back pain. An x-ray showed changes to the petitioner's spine which the treating physician concluded required a sharper diagnostic image. On November 17, 2015, the physician requested authorization from Molina for a CT scan of the petitioner's lower back. The request reads in pertinent part: "Patient....[c]omplains of low back pain and right sided sciatica pain. No numbness, tingling, weakness or loss of bowel/bladder function....Molina denied the lumbar MRI....[w]e are shooting for a CT scan now."
3. All Medicaid goods and services must be medically necessary. Specified goods and services require prior authorization that is performed by the respondent, a contracted HMO or other designee.
4. Molina denied the petitioner's request as not medically necessary on November 25, 2015 because it determined that the requested treatment was not consistent with generally accepted professional standards, specifically InterQual criteria (InterQual). InterQual is a nationally recognized treatment guideline used throughout the medical community.
5. Dr. Mark Bloom, Molina medical director, explained that in cases involving unspecified back pain, InterQual criteria requires patients first undergo 4 to 6 weeks of physical therapy in conjunction with oral anti-inflammatory medication. These treatments have shown to be effective in alleviating back pain. CT scans and more advanced imaging scans are only appropriate if these less invasive treatments fail. The petitioner has not participated in physical therapy.

FINAL ORDER (Cont.)
15F-10068
PAGE-4
6. The petitioner argued that he cannot participate in physical therapy due to a left ankle injury for which he receives daily hyperbolic therapy. He has an open wound on the ankle which makes it impossible for him to participate in physical therapy. The petitioner argued further that if his treating physician, who knows his complete medical history, believes that a CT scan is necessary, Molina should approve the scan without question.
7. On rebuttal, Dr. Bloom explained that InterQual guidelines do not include exceptions because a patient has other unrelated impairments. The primary purpose of CT scans is to determine if a patient requires surgery or to rule out surgery. The wound on the petitioner's ankle requires daily treatment. Back surgery is contra-indicated until the ankle injury no longer requires daily hyperbolic therapy. Oral medications can be prescribed to ease the petitioner's back pain in the interim, while his ankle injury heals. When appropriate, the petitioner should undergo physical therapy and anti-inflammatory medication to address his back pain. Only if those treatments fail would it be appropriate for the petitioner to undergo a CT scan.

## CONCLUSIONS OF LAW

8. By agreement between the AHCA and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Section 120.80, Florida Statutes.
9. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.
10. 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.
12. The standard of proof in an administrative hearing is by a preponderance of the evidence (See Fla. Admin. Code R. 65-2.060(1)). The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, $7^{\text {th }}$ Ed.).
13. The Florida Medicaid Program is authorized by Chapter 409 Florida Statutes and Fla. Admin. Code Chapter 59G.
14. 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:
15. Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
16. 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;
17. Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational;
18. 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,
19. 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 respondent denied the petitioner's request for a lumbar spine CT scan because nationally accepted medical guidelines require less invasive treatments be attempted first, specifically physical therapy and oral anti-inflammatory medication. Pain control medications can be used to address the petitioner's back pain until he is medically fit for physical therapy.
21. The petitioner argued that he is not a candidate for physical therapy due to an open ankle wound. In addition, the recommendation of his treating physician should carry greater weight than the opinion of a reviewing physician.
22. Dr. Bloom, the only expert witness to testify during the hearing, opined that a preemptive CT scan is not consistent with generally accepted professional medical standards and therefore is prohibited by Medicaid rule.
23. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the petitioner did not meet his burden in this matter. The petitioner did not prove by a preponderance of the evidence that it is medically necessary, as the term is defined in Medicaid rule, for him to receive a CT scan of the lumbar spine.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied. The respondent's action is affirmed.

FINAL ORDER (Cont.)
15F-10068
PAGE-7

## 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 April_, 2016,
in Tallahassee, Florida.


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

Copies Furnished To
Petitioner
Debbie Stokes, Area 4, AHCA Field Office Manager

Mar 03, 2016

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 12, 2016 at 8:30 a.m.

## APPEARANCES

For the Petitioner:

For the Respondent:

Petitioner's mother
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 November 16, 2015 through April 30, 2016, was correct. Respondent bears the burden of proof in this matter by a preponderance of the evidence.

## PRELIMINARY STATEMENT

The Petitioner did not submit any documents as evidence for the hearing.
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 Notices; Exhibit 4 - Supporting Documentation (therapy reports and records).

Appearing as a witness for the Petitioner was his occupational therapist, Beatriz Cadiz.

Appearing as a witness for the Respondent was Rakesh Mittal, M.D., PhysicianConsultant with eQHealth Solutions, Inc.

Also present for the hearing was a Spanish language interpreter, Rene Interpreter No. 723, from Propio Language Services.

## FINDINGS OF FACT

1. The Petitioner's OT service provider, Renascence Therapy Center (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.

FINAL ORDER (Cont.)
15F-10076
PAGE-3
The submission included, in part, information about the Petitioner's medical conditions;
his functional limitations; and other pertinent information related to the household.
3. eQHealth Solutions' personnel had no direct contact with the Petitioner, his
family, or his physicians. All pertinent information was submitted by the provider directly to eQ Health Solutions.
4. The medical information submitted by the provider contained, in part, the following information in regard to the Petitioner:

- 11 years old
- Diagnosis includes developmental delay, and ADHD

5. The Petitioner is also currently receiving speech therapy and physical therapy services through the Medicaid Program.
6. The Petitioner resides with his mother, older sister, and twin brother (who has the same diagnosis).
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 Exercises
- Perceptual Motor Training
- Fine Motor Coordination Treatment
- Activities of Daily Living Training
- Sensory Integration
- Motor Control Exercises
- Strengthening Exercises
- Neurodevelopment Treatment

FINAL ORDER (Cont.)
15F-10076
PAGE-4
8. A physician at eQHealth Solutions, who is board-certified in pediatrics, reviewed the submitted information and partially denied the requested OT services (approving two hours weekly rather than three hours weekly). The rationale for the decision was: "Based on the deficits and goals [that] have been documented: Partial Approval: Occupational Therapy 4 units $2 x$ week." A notice of this determination was sent to all parties on November 19, 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 requested by the provider.
10. A second physician-reviewer at eQHealth reviewed the submitted information and upheld the initial decision to approve 2 hours weekly of occupational therapy. A notice of this reconsideration decision was sent to all parties on November 23, 2015. The Petitioner thereafter requested a fair hearing and this proceeding followed.
11. The Petitioner's therapist testified that the Petitioner may regress in his skills if the therapy is reduced to 2 hours weekly. She also stated his therapy plan includes educational goals as well as ADL (activities of daily living) goals. Petitioner's mother also believes he will regress if his services are reduced.
12. The Respondent's witness, Dr. Mittal, testified that the reduction in the Petitioner's OT services is appropriate because he has been receiving therapy for at least 4 years and he has achieved 50-80\% of his short-term goals.
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

FINAL ORDER (Cont.)
15F-10076
PAGE - 5
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 $\S 120.57$.
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 Respondent since the Petitioner had been previously approved for three hours weekly of OT service and the Respondent is seeking to reduce these services to two hours weekly. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at $1201,7^{\text {th }}$ 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

FINAL ORDER (Cont.)
15F-10076
PAGE - 6
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 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 ...

[^3]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.
2. 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:
3. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
4. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
5. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
6. 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
7. 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.
8. 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 two hours 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

FINAL ORDER (Cont.)
15F-10076
PAGE - 10
a prescription does not automatically mean the requirements of medical necessity have been satisfied.
32. The Respondent's witness, Dr. Mittal, stated he believes services can be reduced at this time since the Petitioner has been receiving occupational therapy for at least the past 4 years and he has achieved $50 \%-80 \%$ of his therapy goals.
33. The Petitioner's therapist and mother believe he will regress in his skills if his therapy is reduced at this time.
34. After considering all the documentary evidence and witness testimony presented, the undersigned concludes that the Respondent has met its burden of proof in demonstrating the occupational therapy should be reduced to 2 hours weekly at this time. The therapy reports submitted indicate the Petitioner has been making good, although slow, progress in his therapy sessions. He has also met at least $50 \%$ of each therapy goal listed in his plan of care. If there is a regression in skills in the future, the Petitioner may submit a request for an increase in therapy hours at that time.

## 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

FINAL ORDER (Cont.)
15F-10076
PAGE - 11
the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the 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 $\qquad$ 03 day of $\qquad$ , 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 TC PETITIONER
RHEA GRAY, AREA 11, AHCA FIELD OFFICE MANAGER

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

## FILED

Apr 06, 2016

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 15 Palm Beach
UNIT: 88585

RESPONDENT.
$\qquad$

## FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative
hearing in the above matter on March 25, 2016 at 8:38 a.m.
APPEARANCES
For Petitioner:

For Respondent: Susan Williams
Senior Pharmacist

## ISSUE

At issue is whether respondent's denial of the prescribed medication was proper. The burden of proof is assigned to the petitioner. The burden of proof in an administrative hearing is by a preponderance of the evidence.

## PRELIMINARY STATEMENT

A hearing was first scheduled for February 1, 2016 by Hearing Officer GopaulNarine. The Department of Children and Families (DCF) was the respondent.

FINAL ORDER (Cont.)

Petitioner failed to appear at the February 1, 2016 hearing.
It was thereafter determined the Agency for Healthcare Administration was the proper respondent. The matter was then re-assigned to the undersigned.

On March 25, 2016 petitioner entered no exhibits into evidence.
Ms. Williams appeared as both a representative and witness for the respondent. Also present was Lisa Sanchez, Medical Health Care Program Analyst. Respondent's exhibit "1" was accepted into evidence. Administrative notice was taken on § 409.912, Fla. Stat.; Fla. Admin. Code R. 59G-4.250; and the Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook (Drug Handbook).

## 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. DCF determines Medicaid eligibility.
2. Through June 30, 2015 petitioner was eligible for Medicaid's Statewide Managed Medical Assistance (MMA) Program. Humana was petitioner's MMA provider.
3. On July 1, 2015 petitioner's status changed. He then became eligible for Medicaid's Medically Needy Program.
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 of the month when allowable medical expenses equal a designated share of cost. The entire process starts over the following month.
5. DCF determines the monthly share of cost.

FINAL ORDER (Cont.)
15F-10091
PAGE-3
6. Since July 2015 petitioner's share of cost has ranged from $\$ 758.00$ per month to $\$ 208.00$ per month.
7. All requests for prescribed medication must be in compliance with respondent's Drug Handbook.
8. The Drug Handbook establishes a Preferred Drug List (PDL). The PDL contains medications for all therapeutic classes. Medications appearing on the PDL must first be prescribed. If unsuccessful, medications not on the PDL can be considered.
9. In December 2015 Dr. Dana Richard submitted, on petitioner's behalf, a prior authorization for The request was submitted to respondent's medication contractor, Magellan Medicaid Administration (Magellan).
10. $\square$ is not included on the PDL.
11. The request for $\square$ contained no prescription; diagnosis; or clinical documentation of unsuccessful trials with PDL medications.
12. In December 2015 Magellan issued a Notice of Prior Authorization

Determination. The notice stated, in part: "In accordance with FL Medicaid, the patient must have documentation of the trials and failures on preferred long acting narcotic analgesic agents (i.e. before the non-preferred medication may be considered."
13. On December 8, 2015 petitioner contacted the Office of Appeal Hearings and requested a fair hearing.
14. When enrolled in the MMA Program, on June 15, 2015 Humana approved petitioner's request for

FINAL ORDER (Cont.)
15F-10091
PAGE-4
15. Magellan contacted the physician's office and verbally requested trial information and copies of authorization requests submitted to Humana.
16. No information regarding trials with medications listed on the PDL was provided to Magellan.
17. Prior authorization information previously submitted to Humana was not provided to Magellan.

## CONCLUSIONS OF LAW

18. 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.
19. This is a final order pursuant to § 120.569 and $\S 120.57$, Fla. Stat.
20. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R.

65-2.056.
21. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at $1201,7^{\text {th }}$ Ed.).
22. The Drug Handbook has been promulgated into rule by reference in Fla. Admin.

Code R. 59G-4.250.
23. The Drug Handbook, on page 2-2, requires a medication to be medically necessary.
24. Fla. Admin. Code R. 59G-1.010(166) provides the following definition:
(a) "Medical necessary" or "medical necessity" means that medical or allied care, goods or services furnished or ordered must meet the following conditions:

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

Page 2-4:
The Preferred Drug List (PDL) is a listing of prescription products recommended by the Pharmaceutical and Therapeutics (P\&T) Committee for consideration by AHCA as efficacious, safe, and cost effective choices when prescribing for Medicaid patients.

Products included on the PDL must be prescribed first unless the patient has previously used these products unsuccessfully or the prescriber submits documentation justifying the use of a none-PDL product.

Non- PDL drugs may be approved for reimbursement upon prior authorization.

Page 2-5:
Approval of reimbursement for alternative medications that are not listed on the preferred drug list shall be considered if listed products have been tried without success within the previous twelve months. The step-therapy prior authorization may require the prescriber to use medications in a similar drug class or that are indicated for a similar medical indication unless contraindicated in the Food and Drug Administration labeling. The trial period between the specified steps may vary according to the medical indication. A drug product may be approved without meeting the steptherapy prior authorization criteria if the prescribing physician provides the

FINAL ORDER (Cont.)
15F-10091
PAGE-6
agency with additional written medical or clinical documentation that the product is medically necessary because:

- There is not a drug on the preferred drug list which is an acceptable clinical alternative to treat the disease or medical condition; or
- The alternatives have been ineffective in the treatment of the beneficiary's disease; or
- Based on historic evidence and known characteristics of the patient and the drug, the drug is likely to be ineffective; or
- The number of doses has been ineffective.

26. The Findings of Fact establish $\square$ is not on respondent's PDL.
27. The Findings of Fact establish trial information with PDL medications was not
provided. The prescribing physician provided no medical or clinical documentation as to why is medically necessary.
28. Persuasive evidence in support of
 was not presented. As such, the following conditions of medical necessity have not been satisfied:
29. 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;
30. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
31. 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, ...
32. To assist in the understanding of 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.
30. The Florida Medicaid Provider General Handbook (Provider Handbook)
continues by stating, in part:

FINAL ORDER (Cont.)
15F-10091
PAGE-7
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 ...

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 ...
31. Petitioner's Medicaid status is determined by DCF on a monthly basis. Had
been approved, Medicaid would pay for the medication only when the
monthly share of cost had been satisfied.
32. The only issue before the undersigned is whether the denial of
proper. Petitioner has not demonstrated, by the required evidentiary standard, that respondent's action in this matter was incorrect. All matters concerning Medicaid eligibility should be further addressed with DCF.
33. Petitioner has not met the required evidentiary standard in this matter. As such, respondent's action is proper.

## DECISION

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

## NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with

FINAL ORDER (Cont.)
15F-10091
PAGE-8
the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees 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 $\qquad$ 06 day of $\qquad$ , 2016, in Tallahassee, Florida.


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

Copies Furnished To:

Mar 07, 2016

## 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 February 2, 2016, at 10:40 a.m.

## APPEARANCES

For the Petitioner:


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

## STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the Agency for Health Care Administration incorrectly denied her request for removal of her two upper wisdom teeth?

FINAL ORDER (Cont.)
15F-10137
PAGE-2

## PRELIMINARY STATEMENT

 the petitioner's mother, appeared on behalf of the petitioner, Elaneor Gordon ("petitioner"), who was not present. 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: Mindy Aikman, Grievance and Appeals Specialist with Humana; Jackelyn Salcedo, Complaints and Grievances Specialist with DentaQuest; and Susan Hudson, D.M.D., Dental Consultant with DentaQuest.

The respondent introduced respondent's Exhibits "1" through " 9 ", inclusive, at the hearing. The exhibits were accepted into evidence and marked accordingly.

The hearing officer took administrative notice of the following Florida Statutes and Florida Administrative Code Rules: Section 409.910, Florida Statutes; Section 409.962, Florida Statutes; Section 409.963, Florida Statutes; Section 409.964, Florida Statutes; Section 409.965, Florida Statutes; Section 409.973, Florida Statutes, Rule 59G-1.001, Florida Administrative Code; Rule 59G-1.010, Florida Administrative Code; and Rule 59G-4.060, Florida Administrative Code. The hearing officer also took administrative notice of the Florida Medicaid 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:

FINAL ORDER (Cont.)
15F-10137
PAGE - 3

1. Petitioner is an 18-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 Humana. Humana is a health maintenance organization ("HMO") contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in Florida.
4. Petitioner's effective date of enrollment with Humana was July 1, 2014.
5. Humana provides certain dental benefits to its members. With regard to its members under age 21, these benefits include the surgical extraction of wisdom teeth when such medical intervention is determined to be medically necessary.
6. Humana has contracted DentaQuest to be its dental vendor. DentaQuest completes prior authorization reviews of requests for dental services submitted to it by Humana members.
7. On or about November 20, 2015, the petitioner's dental provider submitted a prior authorization request (Resp. Exhibit 4) to DentaQuest for the following services:
8. D9220 - general anesthetic - first 30 minutes;
9. D9221 - general anesthesia - each additional 15 minutes;
10. D9221 - general anesthesia - each additional 15 minutes;
11. D7240 - extraction of impacted tooth covered by bone, Tooth 1;
12. D7230 - extraction of impacted tooth with some bone, Tooth 16;
13. D7240 - extraction of impacted tooth covered by bone, Tooth 17;
14. D7240 - extraction of impacted tooth covered by bone, Tooth 32.
15. Teeth \# 1, 16, 17, and 32 are an individual's wisdom teeth. They are the last teeth on both the left and right sides of a person's top and bottom jaw.
16. In a Notice of Action dated November 24, 2015, DentaQuest denied the petitioner's request for services. The Notice of Action (Resp. Exhibit 6) states, in part:

We determined that your requested services are not medically necessary because the services do not meet the reason(s) checked below: (See Rule 59G-1.010)

X Must be needed to protect life, prevent significant illness or disability, or alleviate severe pain.
X Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs.
$X$ Must meet accepted medical standards and not be experimental or investigational.
$X$ The requested service is not a covered benefit.
10. The Notice of Action (Resp. Exhibit 6) goes on to explain:

The facts that we used to make our decision are:

- Your dentist has asked for anesthesia (a medicine to make you sleep) for a service that has been denied. Therefore, the request to make you sleep is also denied. We have told your dentist this also. Please talk to your dentist about other treatment options.
- We cannot approve this request to remove your tooth because the information that your dentist sent shows that your teeth are not bad enough to be removed and show no sign of infection or pain. We have told your dentist this also. Please talk to your dentist about your choices to treat your teeth.

The DentaQuest guideline or policy used to support this decision was:

- DentaQuest Clinical Criteria for Surgical Extraction

11. DentaQuest will not approve the extraction of asymptomatic wisdom teeth. DentaQuest will, however, approve the extraction of wisdom teeth if there is evidence of pathology, infection, malpositioning, or excessive cavities.
12. On December 21, 2015, the Dental Consultant appearing as a witness for the respondent completed an internal review of DentaQuest's decision to deny the extraction of all four wisdom teeth. The Dental Consultant determined there was reason to remove Teeth 17 and 32 and overturned that portion of the denial along with the

FINAL ORDER (Cont.)
15F-10137
PAGE - 5
denial for the sedation associated with those two teeth. However, the Dental Consultant upheld the denial for the extraction of Teeth 1 and 16 explaining "these teeth do not exhibit pathology, malpositioning or infection. (Resp. Exhibit 8)
13. The decision to overturn the denial associated with the extraction of Teeth 17 and 32 was communicated to the petitioner's dentist in a form called an Authorization Determination, which was dated December 21, 2016. (Resp. Exhibit 9)
14. The petitioner is experiencing pain associated with the eruption of her wisdom teeth.
15. The Progress Note accompanying the Dental Claim Form submitted to DentaQuest by the petitioner's dentist (Resp. Exhibit 4) indicates the petitioner is experiencing pain in her mouth but does not indicate which tooth or teeth are causing the pain.
16. The Dental Consultant appearing as a witness for the respondent testified there is no evidence of pathology or infection in the petitioner's upper wisdom teeth. She explained the teeth are already almost into the mouth and in-line with the existing teeth; there is no evidence of malpositioning.
17. It is the position of the petitioner's representative that, since the petitioner will be sedated for the removal of two of her wisdom teeth, it makes sense to remove the remaining two teeth at the same time.

## CONCLUSIONS OF LAW

18. By agreement between the Agency for Health Care Administration and the Department of Children and Families, the Agency for Health Care Administration has

FINAL ORDER (Cont.)
15F-10137
PAGE - 6
conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80, Fla. Stat.
19. This is a final order pursuant to § 120.569 and $\S 120.57$, Fla. Stat.
20. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
21. 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.
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, $7^{\text {th }}$ Ed.).
23. The Florida Medicaid program is authorized by Chapter 409, Fla. Stat. and Chapter 59G, Fla. Admin. Code. The Medicaid program is administered by respondent.
24. 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...
25. 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:

FINAL ORDER (Cont.)
15F-10137
PAGE-7

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.
6. 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.
27. The United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in Moore v. Reese, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the
following guiding principles in its opinion, which involved a dispute over private duty nursing:
[A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.
(2) A state Medicaid plan must include "reasonable standards ... for determining eligibility for and the extent of medical assistance" ... and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.
(3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."
(4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."
(5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to provide medically unnecessary, albeit desirable, EPSDT services. However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."
(6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and may present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)) (emphasis added).
28. Consistent with these requirements, the state is obligated to provide services to recipients under 21 years of age, but only to the extent such services are medically necessary. The definition of medical necessity for

FINAL ORDER (Cont.)
15F-10137
PAGE-9
services provided under the EPSDT benefit is established by the state and the state is authorized to establish the amount, duration, and scope of such services.
29. Section 409.913, Fla. Stat. governs the oversight of the integrity of the Florida Medicaid Program. Section (1)(d) sets forth the "medical necessity or medically necessary" standards, and states in pertinent part as follows
"Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice....

Section (1)(d) goes on the further state:
...For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.
30. Section (1)(d) highlights that the Agency makes the final decision regarding whether or not a requested service is medically necessary; however, the hearing officer is the final decision making authority for the Agency. See § 120.80, Fla. Stat.
31. The Florida Medicaid Provider General Handbook - July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Chapter 59G-5.020. The Handbook states the following on Page 1-27:

Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.

Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.

Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.
32. 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."
33. 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-forservice."
34. The Dental Services Coverage and Limitations Handbook - November 2011 is incorporated by reference in the Medicaid Service Rules by Fla. Admin. Code Rule 59G-4.060.
35. The Dental Services Coverage and Limitations Handbook addresses

Covered Child Services (Ages under 21) on Page 2-3 and states as follows:
The Medicaid children's dental services program may provide reimbursement for diagnostic services, preventive treatment, restorative, endodontic, periodontal, surgical procedures and extractions, orthodontic treatment, and full and partial dentures (fixed and removable) for recipients under age 21.

The removal of wisdom teeth falls under the category of surgical procedures and extractions.

FINAL ORDER (Cont.)
15F-10137
PAGE-11
36. The Dental Services Coverage and Limitations Handbook describes Oral Surgery Services on Page 2-13. It explains as follows:

Oral surgery services include extractions as well as surgical and adjunctive treatment of diseases, injuries, deformities, and defects of the oral and maxillofacial regions.
37. The DentaQuest criteria for the approval of extractions (Resp. Exhibit 7) explain oral surgery may be approved if there is documentation to support the surgery is medically necessary. It explains there must be "evidence of diagnosed pathology or demonstrable need ... rather than anticipated future pathology.
38. Humana policy and DentaQuest policy regarding oral surgery is not more restrictive than that of the Agency for Health Care Administration.
39. In the present case, there is no evidence of pathology or infection in the petitioner's upper wisdom teeth. Similarly, there is also no evidence of malpositioning. Although the petitioner is experiencing pain in her mouth, there is no documentation to support this pain is being caused by the eruption of her upper wisdom teeth. Therefore, the petitioner does not meet the established criteria for the removal of her upper wisdom teeth at this time.
40. After careful review of the testimony and evidence presented in this case, along with the relevant laws set forth above, the undersigned concludes the petitioner has not demonstrated by a preponderance of the evidence the respondent incorrectly denied her request for the removal of her wisdom teeth.

## DECISION

The petitioner's appeal is hereby DENIED.

## NOTICE OF RIGHT TO APPEAL

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

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


Peter J. Tsamis
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To:
Petitioner
Don Fuller, Area 6, AHCA Field Office Manager

Mar 09, 2016

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
vs.

## AGENCY FOR HEALTH CARE ADMINISTRATION

CIRCUIT: 05 Hernando
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 approximately 10:09 a.m. All parties and witnesses appeared via teleconference.


## STATEMENT OF ISSUE

At issue is a decision by Respondent, the Agency for Health Care Administration (AHCA), through its contracted health plan, United Healthcare Community Plan ("United"), to deny portions of Petitioner's request for dental services. Just prior to hearing, Petitioner's request for a filling (CPT code D2330) was approved; however, United decided to uphold its denial of the remainder of her request. Petitioner bears the burden of proving, by a preponderance of the evidence, that this denial is improper.

FINAL ORDER (Cont.)
15F-010167
Page 2 of 9

## PRELIMINARY STATEMENT

At hearing, Respondent was represented by Selwyn Gossett, AHCA Medical/Health Care Program Analyst, who presented three witnesses from Petitioner's health plan, United: Susan Frishman, Senior Compliance Analyst; Lori Eubanks, Dental Account Manager; and Brittany Vo, D.D.S., Dental Consultant. Petitioner appeared as her own representative, and proffered no other witnesses.

Petitioner's request for a filling was approved prior to hearing, and the plan sent confirmation of this approval to both Petitioner and her dental provider. As such, this order will only address the remaining issues, which include denial of Petitioner's request for a crown, filling/tooth build up, and deep gum cleaning.

Respondent's Exhibits 1 through 8, inclusive, were accepted into evidence. Administrative Notice was taken of Florida Administrative Code Rules 59G-1.001 and 1.010, as well as the Florida Medicaid Dental Services Coverage and Limitations Handbook (November 2011), and accompanying Fee Schedule.

## FINDINGS OF FACT

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

1. Petitioner is a Medicaid recipient over 21 years of age. Prior to meeting with her current dental provider, it had been six years since she saw a dentist. She has broken and damaged teeth, and needs work done on same. She is diagnosed with and is concerned that the condition of her teeth will interfere with her ability to eat and maintain her blood sugar. She seeks services and procedures in preparation for full and partial dentures (upper and lower, respectively).

FINAL ORDER (Cont.)
15F-010167
Page 3 of 9
2. Petitioner testified that she has encountered difficulty locating a dental provider who participates with United, as most of United's participating providers belong to Coastal Dental. Per Petitioner, Coastal Dental mainly provides dental services to children.
3. On or about December 3, 2015, Petitioner's dentist submitted a prior authorization request to United, requesting the following services:
D2750 Crown Tooth 30

D2950 Filling Tooth 30
D4342 Deep Gum Cleaning LR
D4342 Deep Gum Cleaning LL
D2330 Tooth Colored Plastic Filling Tooth 23 (subsequently approved)

Along with the request, the provider submitted xrays and a "Periodontal Status Chart." No other information or medical records accompanied the request for services.
4. Via notice dated December 4, 2015, United informed Petitioner and her provider that the request was denied because these procedures are not a covered benefit and/or are not covered for Medicaid recipients over 21 years of age.
5. Per United, the dental plan covers regular cleanings, but not deep cleanings. Crowns and a "filling" such as D2950, which constitutes core buildup of a tooth, are also not covered procedures. While the plan does cover certain procedures in preparation for dentures, such as bone adjustments or tor removal, particularly absent any additional information from Petitioner's providers, the procedures requested do not fit within coverage under the category of denture preparation.

FINAL ORDER (Cont.)
15F-010167
Page 4 of 9
6. At hearing, Dr. Vo testified that the xrays provided by Petitioner's dentist do not even show the tooth for which the crown and buildup procedures are requested (i.e., tooth 30). Additionally, Dr. Vo stated that even for plans under which deep cleaning is a covered benefit (though it is not covered under Petitioner's plan), such cleaning is not offered to patients unless they demonstrate a score of ' 5 ' on two to three teeth.

Petitioner's Periodontal Status Chart does not reflect this level of scoring.
7. Per coverage information submitted by United (Attachment I Exhibit I-A -

Effective Date: July 15, 2015), adult dental services include:
Two (2) exams per year; two (2) x-rays per year; two (2) cleanings per year, maximum nine (9) amalgam fillings: one (1), two (2) and three (3) surface(s), three (3) fillings each every thirty-six (36) months; one (1), two (2) and three (3) surface(s), three (3) fillings each every thirty-six (36) months; Comprehensive LTC enrollees excluded.

Per additional information, provided by United (AHCA Contract FP025, Exhibit II-A,
Section V.A.1.a. (8), "Dental Services"),
(a) The Managed Care Plan shall provide Dental Services to enrollees under the age of twenty-one (21), emergency dental services to enrollees age twenty-one (21) and older, and denture and denture-related services and oral and maxillofacial surgery services to all enrollees. The Managed Care Plan shall provide medically-necessary, emergency dental procedures to alleviate pain or infection to enrollees age twenty-one (21) and older. Emergency dental care... is limited to a problem focused oral evaluation, necessary radiographs in order to make a diagnosis, extractions, and incision and drainage of an abscess. Full and removable partial dentures and denture-related services are also covered services for enrollees age twenty-one (21) and older.... The Managed Care Plan shall provide medically necessary oral and maxillofacial surgery for all eligible Medicaid recipients regardless of age.
8. Petitioner is unable to afford the requested procedures, out-of-pocket, and is afraid that she will be unable to get her dentures without same. She also seeks

FINAL ORDER (Cont.)
15F-010167
Page 5 of 9
assistance in locating a new provider, who may be able to assist with alternate services and/or procedures.
9. Dr. Vo recommended that Petitioner contact a dental school in her area to obtain a second opinion and/or to determine if the school can provide a more affordable option for the dental work Petitioner's seeks. She encouraged Petitioner to coordinate with her United case manager to find alternative, participating providers.

## CONCLUSIONS OF LAW

10. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing, pursuant to Chapter 120.80, Florida Statutes.
11. This is a final order, pursuant to Fla. Stat. § 120.569 and 120.57.
12. This hearing was held as a de novo proceeding, in accordance with Fla. Admin. Code R. 65-2.056.
13. In accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof is assigned to the Petitioner. The standard of proof in an administrative hearing is preponderance of the evidence, as provided by Fla. Admin. Code R. 65-2.060(1).
14. Section 409.912, Florida Statutes, notes that AHCA shall purchase goods and services for Medicaid recipients in the most cost-effective manner possible, consistent with the delivery of quality medical care. 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.

FINAL ORDER (Cont.)
15F-010167
Page 6 of 9
15. The July 2012 Florida Medicaid Provider General Handbook ("Provider Handbook") is incorporated by reference in Fla. Admin. Code R. 59G-5.020(1). In accordance with Florida law, the Provider Handbook discusses managed care coverage, stating on page 1-27:

Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.

Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.

Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.
16. Page 1-30 of the Provider Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."
17. According to page 2-3 of the Florida Medicaid Dental Services Coverage and Limitations Handbook ("Dental Handbook"), Medicaid covers some dental services for adults over 21. The Dental Handbook is promulgated into law by Fla. Admin. Code R. 59G-4.060(2). According to the Dental Handbook, Medicaid will cover dentures and denture-related procedures, as well as:
...medically-necessary emergency dental procedures to alleviate pain and/or infection for eligible adults... Emergency dental care shall be limited to emergency problem-focused evaluations, necessary radiographs to make a diagnosis, extraction, and incision and drainage of abscess.
18. The question thus becomes whether Petitioner's request for services is either consistent with those covered in preparation for dentures, or a medically-necessary
emergency dental procedure, to alleviate pain and/or infection. Fla. Admin. Code R.
59G-1.010(166), defines medical necessity, as follows:
"Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.
6. Per the Dental Handbook, crowns, core buildups, and deep gum cleanings are not covered benefits for adults over 21, under fee-for-service Medicaid. The HMO may provide services beyond what Medicaid provides, but in this case, the HMO does not cover the requested procedures (see contractual language cited in paragraph 7 , above). In terms of medical necessity, absent clear documentation or testimony from Petitioner's provider to show that any/all of the requested procedures are necessary to alleviate pain or infection, or to prepare Petitioner's mouth for dentures, the undersigned must rely upon Dr. Vo's opinion that the services constitute neither emergency procedures nor "denture-related" services.

FINAL ORDER (Cont.)
15F-010167
Page 8 of 9
20. After careful review of the relevant authorities, testimony, and the evidence in this matter, the hearing officer concludes that Petitioner has not met her burden to show that Respondent's denial is improper.
21. Petitioner is encouraged to coordinate with United to obtain contact information for alternate providers, and to request that said providers furnish United will all pertinent medical records and supporting documentation when requesting coverage of any service or procedure. Should Petitioner request any services in the future, and be denied same, she will be notified in writing of her right to appeal that/those specific denial(s).

## 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.

FINAL ORDER (Cont.)
15F-010167
Page 9 of 9
DONE and ORDERED this $\qquad$ day of $\qquad$ 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:
Petitioner
Debble Stokes, Area 4, AHCA Field Office Manager

Mar 03, 2016

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

## PETITIONER,

Vs.

## 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 February 17, 2016, at 4:00 p.m. All parties appeared telephonically from different locations.

## APPEARANCES

For the petitioner:
For the respondent: Dotlin Williamson, economic self-sufficiency supervisor.

## STATEMENT OF ISSUE

At issue is whether the respondent's actions denying full Medicaid benefits for petitioner and her enrollment in the Medically Needy (MN) Program with an estimated share of cost (SOC) are correct. The petitioner carries the burden of proof by the preponderance of evidence.

FINAL ORDER (Cont.)

## PRELIMINARY STATEMENT

The petitioner did not provide any evidence for the undersigned to consider. The respondent submitted a composite exhibit, which were marked 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. On October 27, 2015, the petitioner submitted an online application to continue Food Assistance (FA) and Medicaid benefits for herself, her 5 year-old child. On that application, the petitioner reported that she is employed earning $\$ 844.41$ biweekly and receives (\$243) child support for her son. Petitioner intends to file taxes with her child as a tax dependent.
2. The petitioner reported the following monthly expenses: $\$ 1,917$ mortgage, \$163.44 for water/sewer, \$163.44 for trash removal, \$150 for telephone, \$270 for electricity and \$178 for aftercare.
3. The Department determined the child's eligibility for full Medicaid benefits because the household income was below the income limit for children in its age group for a standard filing unit size of two. The petitioner was enrolled in the Medically Needy (MN) Program with an estimated SOC.
4. The petitioner was seeking full Medicaid for herself. To begin the budgeting process for the petitioner for the Medically Needy Program, the Department added petitioner checks together to arrive at $\$ 1,688.82$ (\$844.41 X 2). This amount was considered to be petitioner's modified adjusted gross income (MAGI). To determine

FINAL ORDER (Cont.)
15F-10191
PAGE -3
Medicaid eligibility for the petitioner, the household income of $\$ 1,688.82$ was compared to the income limit for an adult with a household size of two, $\$ 241$. As the income exceeded the maximum limit, she was found ineligible for full Medicaid benefits. Since the petitioner was determined ineligible for full Medicaid, the respondent enrolled her in the Medically Needy Program with an estimated SOC.
5. To determine the estimated SOC the Medically Needy Income Level (MNIL) of $\$ 387$ for a standard filing unit size of two was subtracted from the $\$ 1,688.82$ gross monthly household income, resulting to the petitioner estimated SOC of \$1,301 effective December 2015. A Notice of Case Action was sent to the petitioner on December 16, 2015, informing her of the outcome, see Respondent's Composite Exhibit 1, pages 8 through 21. On December 10, 2015, the petitioner requested a hearing challenging her Medicaid denial and her enrollment in the Medically Needy Program.
6. 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 biweekly incomes are multiplied by two for the Medicaid eligibility determination. 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.
7. The petitioner did not dispute the income amount used by the Department in the eligibility process. She asserted that she has been dealing with her dad's recent death and is going through a lot. She stated that she is in poor health and needs constant medical care. She acknowledged that she understands the benefits provided by the

FINAL ORDER (Cont.)
15F-10191
PAGE -4
respondent are income-based, but believes that it is not fair to exclude household expenses in that equation. The petitioner maintains she cannot meet her share of cost on a monthly basis without going to the emergency room. Petitioner believes her income is not enough to buy health insurance for herself, as she has too many expenses. She is seeking full Medicaid to access regular gynecological care.
8. 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

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 $\S 409.285$, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under $\S 409.285$, Fla. Stat.
10. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 652.056.
11. 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.
12. 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 $\S 435.956$ (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.
13. The Department's Program Policy Manual, CFOP 165-22 (The Policy Manual) at
2230.0400 Standard Filing Unit (MFAM) states:

For tax filers, the Standard Filing Unit (SFU) is the tax filing group for the tax year in which eligibility is being determined. Eligibility is determined by each individual using the tax filing group's income. Individuals cannot receive Medicaid benefits under more than one coverage group, but can have their income included in more than one SFU.
For individuals who neither file a federal tax return nor are claimed as a tax dependent (non-filers), the Standard Filing Unit consists of the individual and, if living with the individual, their spouse, their natural,

FINAL ORDER (Cont.)
15F-10191
PAGE -6
adopted, and step children under age 19 , or 19 and 20 if in school fulltime.
14. In accordance with the above controlling authorities, the Medicaid household
group is the petitioner and her 5 year-old child (two members). The findings show the
Department determined the petitioner's eligibility with a household size of two to determine her eligibility for Medicaid.
15. 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 MAGIbased methodologies in the applicable Title of the Act, but not to determine eligibility for a particular eligibility group.
16. 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 selfemployment to obtain the Modified Adjusted Gross Income.
Step 3 - Deduct the appropriate standard disregard. This will give the countable net income.
Step 4 - Compare the total countable net income to the coverage group's income standard.
If less than or equal to the income standard* for the program category, STOP, the individual is eligible. If greater than the income standard for the program category, continue to Step 5.
Step 5 - Apply a MAGI deduction (5\% of the FPL based on SFU size). If the $5 \%$ disregard would make the individual eligible, include the disregard. Otherwise the individual is ineligible for Medicaid.
Individuals determined ineligible for Medicaid will be enrolled in Medically Needy and referred, as appropriate, to Florida KidCare and/or the Federally Facilitated Marketplace (FFM).
17. The Policy Manual at Appendix A-7 indicates the Family-Related Medicaid Income Limit as $\$ 241$ and a Standard Disregard of $\$ 146$ for an adult with a child between 1-5 years old to be eligible for full Family-Related Medicaid Program. It also indicates the MNIL to be $\$ 387$.
18. In accordance with the above controlling authorities, the undersigned reviewed the Medicaid eligibility for the petitioner. Step 1: The total income counted in the budget is $\$ 1,688.82(\$ 844.41 \times 2)$. Step 2: There are no deductions provided as there was no tax return. Step 3: The total income of $\$ 1,688.82$ less the standard disregard of $\$ 146$ is $\$ 1,542.82$. Step 4: The balance of $\$ 1,542.82$ is greater than the income limit of $\$ 241$
for the mother with only a 5 year-old child to receive full Medicaid for herself. Step 5:

FINAL ORDER (Cont.)
15F-10191
PAGE -8
With no MAGI disregard applied, the countable balance remains $\$ 1,542.82$. This amount was greater than the income limit of $\$ 241$. The undersigned concludes that the petitioner is ineligible for full Medicaid. The undersigned further concludes Medically

Needy eligibility must be explored.
19. 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.
20. 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.
21. Effective January 2015, Appendix A-7 indicates that for the parent of a child between 1 and 5 years old the MNIL is $\$ 387$.
22. To determine petitioner's SOC the respondent determined the petitioner's
household monthly to be $\$ 1,688.82$. The Medically Needy Income Level of $\$ 387$ for a standard filing unit size of two was subtracted resulting to the petitioner estimated SOC of $\$ 1,301$ effective November 2015.

FINAL ORDER (Cont.)
15F-10191
PAGE -9
23. The hearing officer found that no exception to these calculations. It is concluded that a more favorable share of cost could not be determined. Eligibility for full Medicaid was not found. The petitioner has failed to meet her burden that she is eligible for full Medicaid.

## DECISION

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

FINAL ORDER (Cont.)
15F-10191
PAGE-10
DONE and ORDERED this _ 03 day of _ March , 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
Email: Appeal.Hearings@myffamilies.com

Copies Furnished To:
Petitioner
Otilce or Economic Self Sufficiency

Mar 22, 2016

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

Office of Appeal Hearings
Dept. of Children and Families

APPEAL NO. 15F-10206
PETITIONER,
Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES CIRCUIT: 07 St. Johns
UNIT: 88778

RESPONDENT.
CASE NO.


FINAL ORDER (Cont.)
15F-10206
PAGE -2

The Department later revised its calculations based on new information provided by the petitioner's wife during the hearing and reduced the patient responsibility to \$2192.24.

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

## PRELIMINARY STATEMENT

The hearing originally convened on January 28,2016 at 1:30 p.m. The petitioner presented evidence that required the recalculation of the amount of the patient responsibility. The hearing was scheduled to reconvene on February 12, 2016 at 1:30 pm.

The respondent submitted evidence that was entered as the Respondent Exhibits 1 through 2. No evidence was submitted by the petitioner or his representative.

The record was left open until 5:00 p.m. on February 16, 2016 to allow the respondent to submit additional evidence. Evidence was provided and entered as the Respondent Exhibit 3.

## FINDINGS OF FACT

1. The petitioner (age 79) is residing in a nursing facility. The petitioner's spouse (community spouse) lives in her own home in the community. In determining eligibility for the ICP program, the respondent takes into consideration the income of the institutionalized spouse. The Department calculated the petitioner's income at \$2655.20, which included his Social Security income in the amount of \$1327 and retirement income in the amount of $\$ 1328.20$. The petitioner's wife's income was calculated at $\$ 2194.02$, which is from her employment with the

The Department included, in its calculations of her income, paystubs dated October 15, 2015 in the amount of $\$ 1361.82$ and October 30, 2015 in the amount of $\$ 832.20$. The paystubs were added together to result in $\$ 2194.02$.
2. On November 10, 2015, the petitioner's spouse applied for ICP Medicaid on the petitioner's behalf. The petitioner was approved for ICP Medicaid with a patient responsibility in the amount of $\$ 2549.20$.
3. The petitioner's wife is 56 years old. The Department's Institutional Budget Sheet included the petitioner's wife's total gross income of \$2194.02. The Department determines the community spouse income allowance by a budgeting procedure that considers shelter and utility expenses as well as the community spouse's income. The community spouse's reported monthly property taxes in the amount of $\$ 220$. The home is paid for where the community spouse resides. The Department included in its calculations the Food Assistance Program's (FAP) standard utility allowance (SUA) in the amount of $\$ 345$. Total shelter costs allowed was $\$ 565$.
4. To determine how much of petitioner's income the community spouse can keep, a calculation is performed using a spousal impoverishment Minimum Monthly Maintenance Income Allowance (MMMIA) of \$1991 (Respondent Exhibit 2). The MMMIA was multiplied by $30 \%$ to result in $\$ 597$ in excess shelter standard. The excess shelter standard was subtracted from the total shelter costs to result in $\$ 0$ excess shelter costs. The excess shelter cost was added to the MMMIA (\$1991) to result in a subtotal of $\$ 1991$ for the Community Spouse Allowance. The Community Spouse Allowance was subtracted by the community spouse's gross income in the amount of

FINAL ORDER (Cont.)
15F-10206
PAGE -4
\$2194.02 (Respondent Exhibit 2) to result in a total Community Spouse Income Allowance in the amount of $\$ 0$.
5. The petitioner's wife disputed the income from , stating that the pay for October 15, 2015 is not representative of her regular pay because it included back payments.
6. The Department recalculated the patient responsibility based on updated paystubs provided by the petitioner's wife. The Department contends that the petitioner provided updated paystubs dated January 15, 2016 and January 29, 2016 in the amounts of $\$ 817.02$ each. These paystubs were multiplied by two to result in $\$ 1634.04$ gross monthly pay.
7. The MMMIA was multiplied by $30 \%$ to result in $\$ 597$ in excess shelter standard. The excess shelter standard was subtracted from the total shelter costs to result in $\$ 0$ excess shelter costs. The excess shelter cost was added to the MMMIA (\$1991) to result in a subtotal of $\$ 1991$ for the Community Spouse Allowance. The Community Spouse Allowance was subtracted by the community spouse's gross income in the amount of $\$ 1634.04$ to result in a total Community Spouse Income Allowance in the amount of $\$ 356.96$.
8. In order to become eligible for ICP Medicaid, the applicant must be within the income and asset limits. The petitioner was approved to receive ICP Medicaid. Once an individual is approved to receive ICP Medicaid, the respondent determines a patient responsibility. Patient responsibility is the portion of the individual's income that must be

FINAL ORDER (Cont.)
15F-10206
PAGE -5
paid to the nursing facility. When there is a community spouse, some or all of the individual's income can be diverted to help the community spouse meet her needs.
9. Petitioner's husband's Social Security and retirement income total to a gross monthly income in the amount of $\$ 2654.20$. The gross income was deducted by the $\$ 500$ deposited into a qualified income trust to result in a total countable income of $\$ 2154.20$. The $\$ 2154.20$ countable income was within the income standard of $\$ 2199$. The $\$ 105$ personal need allowance was subtracted from the countable income to result in a subtotal of $\$ 2549.20$. The Community Spouse Income Allowance in the amount of $\$ 356.96$ was subtracted from the subtotal of $\$ 2549.20$ to result in a patient responsibility in the amount of $\$ 2192.24$ retroactive to September 2015 (Respondent Exhibit 3). This is the amount he must pay the nursing facility each month for his care.
10. The petitioner's wife does not agree with the revised patient responsibility amount. The petitioner's wife would like more of her husband's income to be diverted to her. The petitioner's wife explained that she does not have any out of the ordinary expenses other than a Home Depot credit card expense to pay for a tractor. The petitioner's wife pays a health insurance premium and requested additional time to provide proof of the expense.
11. The Department contends that the proof of health insurance premiums was not provided, post-hearing, but can be submitted at any time to make a change.
12. The petitioner's wife expressed during the reconvened hearing that she did not want to leave the record open to allow additional time to provide proof of the premiums as she is going back and forth to the hospital with her husband and does not

FINAL ORDER (Cont.)
15F-10206
PAGE -6
have time. The petitioner's wife explained that the petitioner is in the hospital at this time but will be released today. The petitioner's wife explained that the nursing facility informed her that she would have to pay an unpaid balance before they will allow her husband to be readmitted into the facility. The petitioner argues that she is not able to pay for her expenses with only $\$ 356.96$ of her husband's income. The petitioner's wife pointed out that during the summer she is not working.
13. The Department explained that the petitioner's wife can report when she stops working during the summer in order to receive more of her husband's income.

## CONCLUSIONS OF LAW

14. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.
15. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
16. Florida Admin. Code R.65A-1.701 defines patient responsibility as, "(t)hat portion of an individual's monthly income which the department determines must be considered as available to pay for the individual's institutional care..."
17. Florida Admin. Code R. 65A-1.7141, SSI-Related Medicaid Post Eligibility Treatment of Income, defines allowable deductions from income to determine patient responsibility and states:

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

Cystic Fibrosis waiver, Individual Budgeting (iBudget), or Statewide Medicaid Managed Care Long-Term Care (SMMC-LTC) Program, the Department determines the individual's patient responsibility. "Patient responsibility" is the amount the Agency for Health Care Administration (AHCA) must reduce its payments to a medical institution and intermediate care facility or payments for home and community based services provided to an individual towards their cost of care. Patient responsibility is based on the amount of income remaining after the following deductions are applied pursuant to 42 CFR § 435.725 and 42 CFR § 435.726. This process is called "post eligibility treatment of income".
(1) For institutional care services and Hospice, the following deductions are applied to the individual's income to determine patient responsibility in the following order:
(a) A Personal Needs Allowance (PNA) of \$105. Individuals residing in medical institutions and intermediate care facilities shall have $\$ 105$ of their monthly income protected for their personal need allowance.
(e) The community spouse income allowance. The Department applies the formula and policies under $\S 1924$ of the Social-Security Act, and Rule 65A1.716, F.A.C., to compute the community spouse income allowance after the institutionalized spouse is determined eligible for institutional care benefits.
(f) The community spouse's excess shelter and utility expenses. The amount by which the sum of the spouse's expenses for rent or mortgage payment (including principal and interest), taxes and insurance and, in the case of a homeowner's association, condominium or cooperative, required maintenance charge, for the community spouse's principal residence and utility expense exceeds thirty percent of the amount of the Minimum Monthly Maintenance Needs Allowance (MMMNA) is allowed. The utility expense is based on the current Food Assistance Program's standard utility allowance as referenced in subsection 65A-1.603(2) F.A.C.
18. Florida Admin. Code R. 65A-1.716 Income and Resource Criteria states:
(5)(c) Spousal Impoverishment Standards.

1. State's Resource Allocation Standard. The amount of the couple's total countable resources which may be allocated to the community spouse is equal to the maximum allowed by 42 U.S.C. § 1396r-5.
2. State's Minimum Monthly Maintenance Income Allowance (MMMIA).

The minimum monthly income allowance the department recognizes for a community spouse is equal to 150 percent of the federal poverty level for a family of two.
3. Excess Shelter Expense Standard. The community spouse's shelter
expenses must exceed 30 percent of the MMMIA to be considered excess shelter expenses to be included in the maximum income allowance: MMIA $\times 30 \%=$ Excess Shelter Expense Standard. This standard changes July 1 of each year.
4. Food Assistance Program Standard Utility Allowance. The amount specified in Rule 65A-1.603, F.A.C.
5. Cap of Community Spouse Income Allowance. The MMMIA plus excess shelter allowance cannot exceed the maximum amount allowed under 42 U.S.C. § 1396r-5. This standard changes January 1 of each year.
19. Florida Admin. Code R. 65A-1.603 Food Assistance Program Income and

Expenses lists the current standard Food Stamp utility allowance and states in relevant part:
(2) Standard Utility Allowance. A standard utility allowance (SUA) of \$345 must be used by AGs who incur, or within the eligibility period expect to incur, heating or cooling expenses separate and apart from their rent or mortgage and by AGs who receive direct or indirect assistance authorized under the Low Income Home Energy Assistance Act of 1981. Actual utility expenses are not allowed. Any additional utility expenses, including the telephone standard, are not used.
20. 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. § $1396 r-5$ 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 [sic] in the community and in amounts that they could not be expected to be paid from amounts already recognized for maintenance and/or amounts held in resources [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.
21. 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 revised calculations increased the amount of the petitioner's income ( $\$ 356.96$ ) to be diverted to the community spouse, causing the patient responsibility to be reduced from $\$ 2549.20$ to $\$ 2194.24$, retroactive to September 1, 2015. In a situation where proof is provided to show that an exceptional circumstance has caused a significant inadequacy, the diversion amount to the community spouse can be increased, resulting in a lower patient responsibility amount and a greater amount paid by Medicaid to the nursing facility.
22. The above authority explains that In order to be considered to have an exceptional circumstance for the hearing officer to establish a higher income allowance through the fair hearing process, a couple must present proof that an exceptional circumstance has caused unavoidable extreme financial duress for the community

FINAL ORDER (Cont.)
15F-10206
PAGE -11
spouse. In this case, the petitioner's wife argues that the amount of her husband's income that goes to her is not enough to take care of her expenses. However, the undersigned concludes that the petitioner's wife's Home Depot bill does not meet the threshold of an exceptional or unavoidable circumstance. 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 the burden of proof.
23. Based on these authorities, the undersigned concludes that the respondent's calculations in determining the community spouse income allowance in the amount of $\$ 356.96$ and the petitioner's patient responsibility in the amount of $\$ 2194.24$ beginning September 2015 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 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 $\qquad$ 22 day of $\qquad$ 2016, in Tallahassee, Florida.


Paula Ali
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myffamilies.com

Copies Furnished To: $\begin{aligned} & \text { Petitice of Economic Self Sufficiency }\end{aligned}$

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

Mar 11, 2016
Office of Appeal Hearings
Dept. of Children and Families

> APPEAL NO.

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 23, 2016, at 2:30 p.m.

## APPEARANCES

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

## STATEMENT OF ISSUE

At issue is the Agency decision, through Sunshine Health, to deny the petitioner's request for 16 hours per day, 7 days per week, of personal care services (PCS). The petitioner carries the burden of proving her case by a preponderance of the evidence.

FINAL ORDER (Cont.)
15F-10233
PAGE -2

## PRELIMINARY STATEMENT

Present as witnesses for the respondent were Tracey Thomas, Appeals
Coordinator; Dr. John Carter, Long Term Care Medical Director; Renaco Quijada, Supervisor of Case Management; Andrea Metcoss, Supervisor of Case Management; Maida Infantone, Director of Case Management Services; Janey Lunney, Case Manager; and Chantel Pierre, all from Sunshine Health.

The respondent submitted into evidence Respondent Exhibits 1 through 3. 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 a nursing home in Broward County, Florida. She has been living in a nursing home for two years. She is ninety-two years of age and has multiple medical problems.
2. The petitioner is enrolled in the Long-Term-Care (LTC) Program through Sunshine Health. Sunshine Health is a Managed Care Organization that has been authorized by AHCA to make prior authorization decisions for individuals enrolled in Medicaid LTC Programs.
3. On July 16, 2015, the petitioner's representative requested that the petitioner be approved for 16 hours per day 7 days per week of PCS services to reside in her home for when the petitioner is voluntarily discharged from the nursing home. The petitioner's representative indicated he has not discussed the discharge of the petitioner from the nursing home with anyone at the nursing home.

FINAL ORDER (Cont.)
15F-10233
PAGE -3
4. On July 23, 2015, Sunshine Health denied the petitioner's request for the 16 hours per day 7 days per week of PCS services and mailed the petitioner a Notice of Action indicating:

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.

Your case manager looked at your care needs and has recommended the best placement is in an Assisted Living Facility. You living at home without family support would not be safe.
5. Recently, based on the petitioner's request for this appeal, Sunshine Health sent a "Transition Team" to visit the petitioner. After an analysis and an assessment of the petitioner's situation, Sunshine Health agreed that the petitioner could be safely transitioned to the petitioner's son's home, as the petitioner's needs could be met in the home environment. The amount of care hours that would be approved for the petitioner are 42 hours per week or 6 hours per day. It should be noted that the above decision was finalized by Sunshine Health on the date of this hearing and that no notice was provided.
6. The petitioner's representative did not agree with the above noted new decision.
7. The petitioner ambulates in a wheelchair and wears diapers for incontinence. The case manager supervisor for the respondent indicated the petitioner does need help with all her ADL's (activities of daily living) except for eating. The petitioner can eat independently. This witness also indicated that the petitioner's representative request

FINAL ORDER (Cont.)
15F-10233
PAGE -4
would amount to PCS being on standby in the petitioner's representative's home.
Based on this, Sunshine Health would approve the hours of care for the petitioner to be provided two hours in the morning, two hours in the afternoon, and two hours in the evening. The Sunshine Health physician indicated the amount of care hours to be approved would be the correct medically necessary amount of care to meet the petitioner's needs.
8. Additionally, the witness indicated she has attempted to get accurate information from the petitioner's representative about his work hours. The petitioner's representative indicated he is a salesman and has no clear work schedule but works six days per week.
9. The petitioner's representative argued that even though he is the petitioner's caretaker, based on his job, he will not be able to provide much care for the petitioner. He argued the petitioner needs constant supervision and will need 16 hours per day of care as requested.
10. The respondent's medical director witness indicated that Sunshine Health's new decision to approve the total of 42 hours per week for the petitioner is the correct medically necessary amount that will meet the petitioner's needs if she transfers to her son's home.

## CONCLUSIONS OF LAW

11. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

FINAL ORDER (Cont.)
15F-10233
PAGE -5
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. 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.
6. As shown in the Findings of Fact, Sunshine Health denied the petitioner's request for 16 hours per day 7 days per week of PCS and approved the petitioner for 42 hours per week, or 6 hours per day of services, on the day of this hearing, all contingent

FINAL ORDER (Cont.)
15F-10233
PAGE -6
on the petitioner being discharged from the nursing home and moving into her son's home.
16. For the case at hand, the respondent argued based on the petitioner's medical needs, she would need help with most of her ADL's. So approving 6 hours per day of care split in three segments would be the correct medically necessary amount of hours. The respondent indicated that the request for 16 hours per day 7 days per week of PCS is not individualized, specific, consistent with symptoms or diagnosis of illness or injury and would be in excess of the patient's needs. The hearing officer agrees with the respondent's arguments noted above. In addition, the evidence shows the petitioner is not discharged from the nursing home. The controlling legal authorities make clear that Medicaid services cannot be in excess of the patient's needs.
17. After careful review of the evidence submitted and the relevant laws set forth above, the undersigned concludes the Agency's decision to partially approve the request for PCS in the amount of 6 hours per day 7 days per week is correct. The Petitioner has not met her burden to show that Respondent's decision was improper.

## DECISION

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

FINAL ORDER (Cont.)
15F-10233
PAGE -7

## 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 $\qquad$ day of $\qquad$ , 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

PETITIONER,
Vs.
AGENCY FOR HEALTH CARE ADMINISTRATION CIRCUIT: 11 DADE
UNIT: AHCA

## RESPONDENT.

APPEAL NO.



FINAL ORDER (Cont.)
15F-10237
PAGE - 2

## PRELIMINARY STATEMENT

The Petitioner submitted letters and medical records as evidence for the hearing, which were marked Petitioner Exhibits 1 and 2.

The Respondent submitted the following documents into evidence, which were marked as Respondent Exhibit 1: fair hearing summary, notice of action, and medical review criteria.

Appearing as witnesses for the Respondent were Tracy Thomas, Appeals Coordinator, Dr. David Gilchrist, Medical Director, and Leslie Miranda, Program Specialist, for Sunshine Health Plans, which is the Petitioner's managed health care plan.

## FINDINGS OF FACT

1. The Petitioner is a fifty-two (52) 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 through Sunshine Health.
2. The Agency for Health Care Administration (AHCA) is responsible for management of the managed care plan contracts; statewide policy decisions and interpretation of all federal and state laws; and rules and regulations governing the contract. Managed Care Organizations such as Sunshine Health provide services to Medicaid recipients pursuant to a contract with AHCA.

FINAL ORDER (Cont.)
15F-10237
PAGE - 3
3. The Petitioner is

Her other medical
issues include high
She lives with her mother, who is seventy-two (72) years of age and has her own medical issues, such as knee replacement surgery, herniated disks, and a rotator cuff tear in her shoulder.
4. On or about December 7, 2015, Petitioner's home health services provider submitted an authorization request to Sunshine for continuation of approval of three home health aide visits daily.
5. On or about December 14, 2015, Sunshine informed the Petitioner by written notice that her request for home health aide visits had been partially denied. Sunshine approved one home health aide visit daily. The denial was based on medical necessity criteria. Sunshine subsequently modified its decision and approved two home health visits daily.
6. The Petitioner had been previously receiving three home health aide visits daily for approximately the past seven years. She has been covered by Sunshine since July 1, 2015 and was previously covered by other health plans.
7. The Petitioner testified she should continue receiving three home health aide visits daily because she needs assistance throughout the day. The aide helps her with bathing, grooming, feeding, dressing, and transferring from her bed to her wheelchair. The aide currently helps her in the morning, afternoon, and evening. The Petitioner weighs 180 pounds and she stated her mother is unable to assist her with most of her needs. Her mother does assist with her urinary catheterizations, which must be done every four hours to help her avoid urinary tract infections.

FINAL ORDER (Cont.)
15F-10237
PAGE-4
8. The Respondent's witnesses, Ms. Thomas and Dr. Gilchrist, testified that the home health aide visits were reduced due to medical necessity criteria, known as InterQual criteria, and that the maximum number of visits under that criteria is two visits daily. Dr. Gilchrist further explained that the maximum number of visits is one visit daily for someone with an available caregiver and two visits daily for someone with no available caregiver. In the Petitioner's case, it was determined she had no available caregiver since her mother is unable to provide assistance due to her own medical conditions. Therefore, Sunshine made the decision to approve two visits daily, rather than the one visit originally approved. Dr. Gilchrist also explained that the Petitioner was previously receiving three visits daily through Sunshine because the prior home health provider, Univita, was providing extra benefits to some plan members.
9. The AHCA representative, Ms. Chirino, stated that Medicaid guidelines provide for a maximum of three home health aide visits daily, but it is up to the health plan to determine medical necessity for those visits.
10. Home health services under the Medicaid State Plan in Florida are provided in accordance with the Respondent's Home Health Services Coverage and Limitations Handbook ("Home Health Handbook"), effective October, 2014. In addition, all Medicaid services are provided in accordance with the Respondent's Provider General Handbook, effective July, 2012.

FINAL ORDER (Cont.)
15F-10237
PAGE - 5

## CONCLUSIONS OF LAW

11. 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.
12. This is a final order pursuant to Fla. Stat. § 120.569 and $\S 120.57$.
13. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
14. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the Respondent since it is seeking a reduction in Petitioner's services. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, $7^{\text {th }}$ Ed.).
15. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the Respondent. The Home Health Handbook is incorporated by reference in Chapter 59G-4, Florida Administrative Code.
16. The Home Health Handbook, on page 2-18, describes home health aide visits as follows

Home health aide services help maintain a recipient's health or facilitate treatment of the recipient's illness or injury. The following are examples of home health aide services reimbursed by Medicaid:

- Assisting with the change of a colostomy bag
- Assisting with transfer
- Reinforcing a dressing
- Assisting the individual with prescribed range of motion exercises that have been taught by the RN
- Measuring and preparing prescribed special diets

FINAL ORDER (Cont.)
15F-10237
PAGE - 6

- Providing oral hygiene
- Bathing and skin care
- Assisting with self-administered medication

Home health aides must not perform any services that require the direct care skills of a licensed nurse.
17. The Home Health Handbook, on page 2-15, also states the following concerning home health visits:

Home health visits are limited to a maximum of three intermittent visits per day for non-pregnant adults age 21 and older. The visits can be any combination of licensed nurse and home health aide visits.

The minimum length of time between home health visits provided to a recipient on the same day must be at least one hour.
18. When a Medicaid recipient receives their services through a managed care plan or HMO, the Provider General Handbook states the following:

An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service.
19. AHCA's MMA model contract also contains the following provision:

The Managed Care Plan shall comply with provisions of the Medicaid Home Health Services Coverage and Limitations Handbook. In any instance when compliance conflicts with the terms of this Contract, the Contract prevails. In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those in the Medicaid Home Health Services Coverage and Limitations Handbook.
20. 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 Petitioner's home health visits from three visits daily to two visits daily. The Petitioner has previously received three visits daily for many years and her medical conditions have not substantially changed. Although a

FINAL ORDER (Cont.)
15F-10237
PAGE - 7
plan can make a medical necessity determination to reduce services, the testimony indicates that the criteria used by Sunshine can result in a maximum of two visits daily regardless of the individual's circumstances. Medicaid guidelines allow for a maximum of three home health visits daily. The criteria used by Sunshine are, in essence, imposing a limitation on home health visits which is more stringent than the Medicaid Handbook provisions.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is GRANTED, and the Petitioner shall continue receiving three home health visits daily.

## 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 $\qquad$ day of $\qquad$ 2016,
in Tallahassee, Florida.

FINAL ORDER (Cont.)
15F-10237
PAGE - 8


Fax: 850-487-0662
Copies Furnished To: PETITIONER
RHEA GRAY, AHCA AREA 11, FIELD OFFICE MANAGER

Mar 08, 2016

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

APPEAL NO. 15F-10255
PETITIONER,
Vs.
FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 PINELLAS
UNIT: 88326

CASE NO.

## RESPONDENT.

## FINAL ORDER

Pursuant to notice, Hearing Officer Brandy Ricklefs convened a telephonic administrative hearing in the above-referenced matter on January $26^{\text {th }}, 2016$ at 11:00 a.m.

## APPEARANCES

For the Petitioner:
the petitioner's mother. The petitioner was not present at the hearing.

For the Respondent: Signe Jacobson, Economic Self-Sufficiency Specialist II.

## STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to enroll him in the Medically Needy program with an assigned share of cost, as opposed to authorizing full-coverage Medicaid. The petitioner carries the burden of proving his position by a preponderance of the evidence.

FINAL ORDER (Cont.)
15F-10255
PAGE 2

## PRELIMINARY STATEMENT

Due to unforeseen circumstances following the hearing, the appeal was necessarily transferred to the undersigned hearing officer. On February $18^{\text {th }}, 2016$, an Order Transferring Hearing Officer was issued to both parties. The order stated that the undersigned would review the record of January $26^{\text {th }}, 2016$ and issue a Final Order based on the merits therein. The order allowed either party to raise any objection to this procedure within seven (7) days. As of the close of business February $25^{\text {th }}, 2016$, neither party contacted the undersigned with any objection. Therefore, the undersigned will proceed as stipulated.

The petitioner did not submit any documents for the hearing officer's consideration. The respondent submitted a total of 83 pages which were entered into the record as Respondent's Exhibits 1 through 8. (Page 17 of the exhibits was excluded, is it was not related to the issue under appeal.)

The record was held open until the close of business February $2^{\text {nd }}, 2016$ to allow the respondent to submit additional information. During the allowed time frame, 4 pages of documents consisting of the Department's Policy Manual were entered into the record as Respondent's Exhibit 9, and administrative note was made of the policy at issue. (An additional two pages were not moved into evidence, as they merely indicated that a bill tracking procedure was initiated post-hearing, and did not directly relate to the issue under appeal.)

By way of a Notice of Case Action dated October 9th, 2015, the respondent informed the petitioner that his application dated September $14^{\text {th }}, 2015$ was approved, and that he was enrolled in the Medically Needy program with an assigned share of cost

FINAL ORDER (Cont.)
15F-10255
PAGE 3
(SOC) of $\$ 550$ effective September 2015 and ongoing. On December $11^{\text {th }}, 2015$, the petitioner filed a timely appeal to challenge the respondent's action.

## FINDINGS OF FACT

1. The petitioner applied for Medicaid on September 14 ${ }^{\text {th }}, 2015$. As part of the application process, the respondent is required to explore and verify all factors of eligibility which include, but are not limited to, all sources and amounts of countable income.
2. The petitioner, 38 years of age, is a disabled single-person household.
3. The petitioner's sole source of income is Social Security Disability in the monthly amount of $\$ 750$, less a deduction of $\$ 155$ for Child Support. The petitioner does not pay a premium for Medicare, as this expense is paid for by the Qualified Medicare Beneficiary (QMB) program.
4. The respondent's contention is that the petitioner's income of $\$ 750$ exceeds the income limit of $\$ 180$ for an individual. Therefore, the next step is to determine a share of cost. Accordingly, the respondent subtracted from the petitioner's income of \$750, a standard deduction of $\$ 20$, leaving an adjusted countable income figure of $\$ 730$. From this amount, the respondent subtracted the Medically Needy Income Limit (MNIL) of $\$ 180$, yielding a share of cost of $\$ 550$.
5. During the hearing, the question arose as to whether or not the petitioner's child support payments could be deducted from his income, thereby lessening the amount of income to be considered in calculating his SOC. The respondent agreed to research policy on this issue after the hearing, and to advise the petitioner and the hearing officer of its findings. During the period in which the record was held open, the

FINAL ORDER (Cont.)
15F-10255
PAGE 4
respondent supplied a copy of the Department's Policy Manual CFOP 165-22, Chapter
1840.0102 (Deductions from Gross Income) that states as follows:

Some deductions withheld from gross income must be included as income [emphasis added]. Examples of these deductions include:
...9. child support if not redirected irrevocably from the source.
6. The petitioner contends that without full-coverage Medicaid, he is unable to receive both his necessary doctor's treatments and medications due to difficulties in finding providers who understand and agree to providing services under the Medically Needy 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 §
120.80, Fla. Stat. This order is the final administrative decision of the Department of

Children and Families under § 409.285, Fla. Stat.
8. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code
R. 65-2.056.
9. Fla. Admin. Code 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."
10. FI. Admin. Code 65A-1.702, Special Provisions states in part:
"(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."
11. FI. Admin. Code 65A-1.710, SSI-Related Medicaid Coverage Groups states
in part:
(5) Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. $\S \S$ 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 longterm care services.
12. FI. Admin. Code 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...
(3) When Income Is Considered Available for Budgeting. The department counts income when it is received, when it is credited to the individual's account, or when it is set aside for their use, whichever is earlier.
(4)(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,

FINAL ORDER (Cont.)
15F-10255
PAGE 6
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.
13. The hearing officer affirms the respondent's consideration of $\$ 750$ in determining the petitioner's eligibility for Medicaid. The hearing officer reviewed the guidelines, and finds nothing that allows consideration of the petitioner's deduction of child support for this process.
14. The regulations state that in order to qualify for full-coverage Medicaid, a qualified individual's income must not exceed the income limit. If an individual's income exceeds the limit, a share of cost will be determined.
15. According to the Department's Policy Manual CFOP 165-22, Appendix A-9, the income limit for a disabled individual is $\$ 733$. As the petitioner's income of $\$ 750$ exceeds this amount, the undersigned concludes that the petitioner is ineligible for fullcoverage Medicaid. The next step is to determine a share of cost.
16. Following the guidelines cited above, the hearing officer will address the assigned share of cost. The total income received is the petitioner's Social Security Disability in the monthly amount of $\$ 750$. From this amount, the hearing officer subtracted the unearned income disregard of $\$ 20.00$, leaving a countable unearned income balance of $\$ 730$. Subtracted from this figure was the Medically Needy Income Level for one person, of $\$ 180$, leaving a share of cost of $\$ 550$. This is the share of cost for which the respondent determined the petitioner to be eligible. The hearing officer affirms this determination.

FINAL ORDER (Cont.)
15F-10255
PAGE 7
17. The petitioner's concerns were considered. However, the hearing officer must make a ruling based on all applicable regulations. Based on a review of the evidence in its totality, the hearing officer concludes that the respondent's action to enroll the petitioner in the Medically Needy program with a share of cost of $\$ 550$ is correct.

## 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 08 day of _March , 2016,
in Tallahassee, Florida.


Justin Enfinger
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.hearings@myFLfamilies.com
Copies Furnished To:
Petitioner
Ottice of Economic Self Sufficiency

Mar 15, 2016
STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES OFFICE OF APPEAL HEARINGS

PETITIONER,
Vs.
AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 14 Washington
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 10:17 a.m.

## APPEARANCES

For the Petitioner:


For the Respondent: Diane Soderland, registered nurse specialist with AHCA

## STATEMENT OF ISSUE

Whether the respondent was correct to deny the petitioner's request for home accessibility adaptation services (installation of water tight shower stall). The burden of proof was assigned to the petitioner.

FINAL ORDER (Cont.)

## 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. Humana American Eldercare (Humana) is the contracted health care organization in the instant case.

By notice dated November 23, 2015, Humana informed the petitioner that her request for home accessibility adaptation services (installation of water tight shower stall) was denied. The notice reads in pertinent part: "you do not need this service to treat or support a health problem."

The petitioner timely requested a hearing on December 15, 2015.

witness on her behalf. The petitioner submitted documentary evidence which was admitted to the record as Petitioner's Composite Exhibit 1.

The respondent presented two witnesses from Humana: Dr. Teresita Hernandez, medical director of the Long Term Care Program (LTCP) and Stacey Larsen, clinical guidance analyst. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

The record was held open until close of business on March 2, 2016 for the submission of additional evidence. Evidence was received from both parties and admitted as Respondent's Composite Exhibit 2 and Petitioner's Composite Exhibit 2.

FINAL ORDER (Cont.)

## 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 90) is a Florida Medicaid recipient. The petitioner is enrolled with Humana HMO. The petitioner is enrolled in Humana's LTCP. LTCP provides home health goods and services to individuals who would otherwise require nursing home placement.
2. The petitioner's diagnoses includ

She also has a history of
urinary tract infections. The petitioner ambulates with a cane or rollator. She feeds and takes medications by mouth. She is incontinent of bladder and bowel; she wears adult diapers. The petitioner needs verbal prompting, supervision, and some physical assistance to complete the activities of daily living.
3. The petitioner lives on the property of her niece and POA. The petitioner lives in a mobile home provided by the Federal Emergency Management Agency (FEMA). The mobile home is located behind the niece's home; the two dwellings are connected by a covered walkway with railings.
4. Humana LTCP provides the petitioner 33 hours of home health care weekly, 5 meals per week, 2 boxes of wet wipes per month, 1 box of gloves per month, and 80 adult diapers every two months.
5. In November 2015, the petitioner's POA requested home adaptations; a ramp and a water tight shower stall. The POA's request explained that it is difficult for the

FINAL ORDER (Cont.)
15F-10272
PAGE-4
petitioner to climb up and down the home steps to attend medical appointments. A ramp would be beneficial. The request explained that the walk-in shower in the petitioner's only bathroom was not water tight and did not have a tile floor. The shower leaks water into the bathroom when used, creating a fall hazard and causes water damage to the bathroom floor and walls. The petitioner had been using the POA's tub shower next door, but can no longer lift her leg over the side of the tub due to her degenerative arthritis.
6. Humana approved the ramp, but denied the water tight shower stall. Humana explains its decision in the case notes of the petitioner's file:

Due member's , member's ADLs will likely continue to decline until she is bed bound. Member is total assist in bathing, so putting her in the shower will not dramatically improve her quality of life. Member's needs can be met with bed baths, which she is now receiving. Shower modifications denied. A ramp is required for member to be safely transported to Dr. appointments. Ramp is approved...
7. Humana's decision was based on a case manager's visit to the petitioner's home and a comprehensive assessment, known as a 701B assessment. The 701B assessment is a snapshot of the petitioner's functional, behavioral, and physical status, as well as in-home supports. The 701B assessment used to make the decision under challenge was completed on November 13, 2015.
8. The 701B assessment reads in pertinent part:

Member requires total assistance with bathing...[t]oilets, transfers, and ambulates with assistive devices. Member uses cane or rollator for ambulation. Her bathroom in her FEMA trailer is handicap accessible with grab bars, shower chair and high commode; however, the shower is lacking a stall bottom. The floor of the shower is not separated from the bathroom floor, so it doesn't drain properly and if used, becomes a hazard.

FINAL ORDER (Cont.)
15F-10272
PAGE - 5

Also the shower handle is not properly sealed, causing water damage if the shower is used. At this time, member is getting sponge baths.
9. Dr. Hernandez, LTCP medical director with Humana, argued that given the progressive nature of the petitioner's $\quad$, her inability to assist with bathing, and the fact that her bathing needs are being adequately addressed with bed baths, it is not necessary that she take full showers. The shower modification is not medically necessary.
10. The petitioner's nieces disputed the accuracy of her functioning level set forth in the 701B assessment. The petitioner does not receive bed baths. She is alert and oriented and physically capable of bathing herself with visual supervision. She will not allow the home health aide to give her bed baths. She becomes agitated and verbally aggressive if the caregiver attempts to give her bed baths. The caregivers do not want to physically restrain the petitioner and have stopped trying to give her bed baths. The petitioner cleans herself at the bathroom sink; she also uses wet wipes. She does not fully clean herself, as a result she experiences bouts of itching which she scratches and causes sores. The sores are slow to heal due to her diabetes. She also has recurring urinary tract infections because she does not adequately clean her genitals.
11. The petitioner's nieces argued that her home should be equipped with a functioning shower to meet her basic health and hygiene needs. It is no longer safe for her to use the niece's tub shower. The niece's bathroom is not large enough for a shower transfer seat or an assistive device that could held the petitioner step over the side of the tube. In addition, due to her age and degenerative health issues, she should

FINAL ORDER (Cont.)
not have to go next door to clean herself. She needs a safe and functioning shower in her own home.
12. At the POA's request, the Humana case manager completed another 701B assessment on February 8, 2016 and noted that the petitioner is capable of assisting with her baths.

## 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 Section 120.80, Florida Statutes.
14. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.
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, $7^{\text {th }}$ Ed.).
18. The Florida Medicaid Program is authorized by Chapter 409 Florida Statutes and Fla. Admin. Code Chapter 59G.

FINAL ORDER (Cont.)
15F-10272
PAGE-7
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 patient's needs;
3. Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational;
4. Be reflective of the level of service that can safely be furnished, for which no equally effective and more conservative or less costly treatment is available statewide; and,
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. . .
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods or services medically necessary, or a medical necessity, or a covered service.
6. Section 409.98, Florida Statutes, addresses Long-term care plan benefits. Home accessibility adaptation is a covered service.
7. The respondent denied the petitioner's request for a home accessibility adaptation, a water tight shower stall. The respondent concluded that bed baths were adequate because the petitioner required total assistance with bathing/showering.
8. The evidence proves that the petitioner is capable of assisting with her baths/showers. Currently she is not bathing or showering because her shower stall is

FINAL ORDER (Cont.)
15F-10272
PAGE - 8
not water tight. She can no longer safely use the shower tub next door. She refuses bed baths because she is physically capable of bathing herself. The petitioner is using wet wipes and washing herself in the bathroom sink. She is not cleaning herself properly, as a result she has skin sores and recurring urinary tract infections.
23. After careful review, the undersigned concludes that a functioning shower is necessary to prevent the petitioner from contracting a serious illness; is not in excess of the petitioner's needs; is consistent with generally accepted professional standards regarding health and hygiene; is reflective of the level of service that can be safely provided for which there is no equally effective service (bed baths are not equivalent to showers); and is not for the convenience of the petitioner or her caregivers. The undersigned concludes that it is medically necessary for the petitioner to have a functioning water tight shower stall in her home.
24. The undersigned concludes that the respondent's decision in this matter was incorrect.

## DECISION

The appeal is GRANTED. The respondent is ordered to approve the home accessibility adaptation service (water tight shower stall).

## NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The

FINAL ORDER (Cont.)
15F-10272
PAGE-9
petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 15 day of March , 2016,
in Tallahassee, Florida.


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

Mar 14, 2016

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

APPEAL NO. 15F-10273
PETITIONER,
Vs.
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 19 St. Lucie
UNIT: AHCA
RESPONDENT.
$\qquad$ 1

## FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 5, 2016 at 8:35 a.m.

## APPEARANCES

For Petitioner:

For Respondent: Lisa Sanchez Medical Health Care Program Analyst

## ISSUE

Whether the denial of petitioner's reimbursement request for the purchase of was proper. The amount is $\$ 121.95$. The burden of proof was assigned to the petitioner.

## PRELIMINARY STATEMENT

Petitioner's exhibit " 1 " was accepted into evidence.
Ms. Sanchez appeared as both a representative and witness for the respondent.

FINAL ORDER (Cont.)
15F-10273
PAGE-2
Aikman Grievance and Appeals Specialist. Respondent's exhibits "1" and "2" were accepted into evidence. Administrative Notice was taken of the Florida Medicaid Provider General Handbook.

The record was held open through February 12, 2016 for petitioner to provide prescription information related to A response was not received.

The record was held open through February 17, 2016 for the respondent to provide further information on a reference number provided by the petitioner and a list of medications considered as controlled substances. Information was received and entered as respondent's exhibit " 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. Petitioner's birth date is $\square$ At all times relevant to this proceeding, she was Medicaid eligible.
2. Petitioner's medical services are through respondent's Statewide Managed Medical Assistance (MMA) Program. Humana is the managed care entity which provides petitioner's MMA services.
3. Petitioner's diagnosis includes


FINAL ORDER (Cont.)
15F-10273
PAGE - 3
5. As some pharmacies carry limited supplies of $\square$, the medication is prescribed to be filled every 15 days.
6. Agency for Healthcare Administration policy allows a combined total of four refills of controlled substances during a 30 day period.
7. Relevant dates for petitioner's refills are:

8. On November 4, 2015 petitioner requested the pharmacy refill her prescription. When processing the request, the refill was denied by Humana. The rationale received by the pharmacy was "EXCEEDS MAX ALLOWED FILLS".
9. On November 5, 2015 the petitioner returned to the pharmacy and paid $\$ 121.95$ for a refill of
10. On or about December 5, 2015 petitioner requested reimbursement from Humana.
11. On December 9, 2015 Humana issued a Notice of Action. The notice references a Direct Member Reimbursement (DMR) and states the request is denied.
12. On December 15, 2015 the Office of Appeal Hearings received Petitioner's timely request for a Fair Hearing.
13. Petitioner argues she was told by a Humana representative, during a phone conversation on December 15, 2015, she would be reimbursed. A reference number of 17800921 was provided.

FINAL ORDER (Cont.)
15F-10273
PAGE-4
14. Respondent argues four refills for a controlled substance were processed between October 8, 2015 and November 4, 2015. As 30 days had not elapsed since the refill on October 8,2015 , the refill at issue could not be processed until November 7, 2015. Additionally, the reference number provided by the petitioner is not known by Humana.

## 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 $\S 120.569$ and $\S 120.57$, 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 $1201,7^{\text {th }}$ Ed.).
19. The Florida Medicaid program is authorized by Fla. Stat. ch 409 and Fla. Admin.

Code R. 59G. The Medicaid program is administered by the respondent.
20. The Florida Medicaid Provider Handbook (Provider Handbook) is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Chapter 59G-4. In accordance with the above Statute, the Handbook states on page 1-27:

Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.

FINAL ORDER (Cont.)
15F-10273
PAGE-5

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.
21. In this instant appeal, Humana is the health maintenance organization which provides petitioner's MMA services.
22. Page 1-28 of the Provider Handbook lists HMO covered services. The service list includes prescribed drug services.
23. Federal Medicaid Regulations found at 42 C.F.R. § 447.25 "Direct payments to certain beneficiaries for physicians' or dentists' services" states in part:
(a) Basis and purpose. This section implements section 1905(a) of the Act by prescribing requirements applicable to States making direct payments to certain beneficiaries for physicians' or dentists' services.
(b) State plan requirements. Except for groups specified in paragraph (c) of this section, a State may make direct payments to beneficiaries for physicians' or dentists' services. If it does so, the State plan must-
(1) Provide for direct payments; and
(2) Specify the conditions under which payments are made.
24. Fla. Admin Code R 59G-5110, "Claim Payments" provides information regard the conditions under which direct payments can be made:
(1)(a) The agency provides eligible individuals with access to Medicaid services and goods by direct payment to the Medicaid provider upon submission of a payable claim to the fiscal agent contractor. Except as provided for by law or federal regulation, payments for services rendered or goods supplied shall be made by direct payment to the provider except that payments may be made in the name of the provider to the provider's billing agent if designated in writing by the provider. Direct payment may be made to a recipient who paid for medically necessary, Medicaidcovered services received from the beginning date of eligibility (including the three-month retroactive period) and paid for during the period of time between an erroneous denial or termination of Medicaid eligibility and a successful appeal or an agency determination in the recipient's favor [Emphasis Added]. The services

FINAL ORDER (Cont.)
15F-10273
PAGE-6
must have been covered by Medicaid at the time they were provided. Medicaid will send payment directly to the recipient upon submission of valid receipts to the Agency for Health Care Administration. All payments shall be made at the Medicaid established payment rate in effect at the time the services were rendered. Any services or goods the recipient paid before receiving an erroneous determination or services for which reimbursement from a third party is available are not eligible for reimbursement to the recipient.
25. The above authority states direct payments are made to a Medicaid provider upon submission of a payable claim. Additionally, direct payment can be made to a Medicaid recipient who paid for medically necessary and covered services during the period of an erroneous denial of Medicaid eligibility coupled with a successful appeal or agency determination in the recipients favor.
26. Neither testimony nor evidence establishes the petitioner experienced an erroneous denial of Medicaid eligibility. Rather, the Findings of Fact establish Petitioner was Medicaid eligible at all times relevant to this proceeding.
27. Respondent's Summary of Drug Limitations are found at: http://ahca.myflorida.com/medicaid/Prescribed Drug/pdf/Summary of Dr ug Limitations 2016-01-29 v27.pdf
28. Regarding schedule II -V controlled substances, a maximum of four refills every 30 days is allowed. The only exception is six refills every 30 days for individuals diagnosed with sickle cell anemia or cancer.
29. No evidence was presented that Petitioner is diagnosed with either sickle cell anemia or cancer.
30. It is noted that Petitioner's is prescribed twice per month as opposed to one 30 day supply. The problems filling a 30-day

FINAL ORDER (Cont.)
15F-10273
PAGE-7
supply is also noted. Regardless, the prescribed refill frequency has impacted petitioner's ability to fill those medications classified as controlled substances.
31. Compelling evidence establishing the validity of the reference number provided by the petitioner was not presented.
32. The petitioner has not demonstrated, 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 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.

FINAL ORDER (Cont.)
15F-10273
PAGE-8
DONE and ORDERED this 14 day of _March , 2016, in Tallahassee, Florida.


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

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


PETITIONER,
Vs.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 07 Volusia
UNIT: 88264

## RESPONDENT.

APPEAL NO. 15F-10285

CASE NO.


The record was held open until 5:00 p.m. on February 3, 2016 to allow the petitioner and the respondent to provide additional evidence. Evidence was submitted and entered as the Respondent Exhibit 3 and the Petitioner Exhibit 1.

## FINDINGS OF FACT

1. On November 13, 2015, the petitioner applied for the Medicare Savings Plan (MSP). The Department considered in the MSP budget the petitioner's gross monthly Social Security income in the amount of $\$ 1874$.
2. The Department's budget included income in the amount of $\$ 1873.20$ minus the $\$ 20$ unearned income disregard, for a total countable income of $\$ 1853.20$. The income limit for the Ql1 program is $\$ 1325$ for an individual. The Department determined that the petitioner was ineligible for the Q11 program due to her income exceeding the income limit for the program.
3. The petitioner disputes the Department's denial of the Ql1 program. The petitioner believes she is entitled to receive benefits under the (Qualified Medicare Beneficiary (QMB) program because her countable income should only be $\$ 1099$ after the Department deducts the $\$ 20$ unearned income standard deduction, the $\$ 180 \mathrm{MNIL}$, and the $\$ 573$ for her medical costs.
4. The Department explained that the petitioner is enrolled in the Medically Needy (MN) program with a share of cost (SOC) in the amount of $\$ 1099$.
5. The petitioner argues that she is automatically eligible for the Low Income Subsidy (LIS) program because she is a member of a federally recognized American Indian tribe and therefore should be deemed eligible for the QMB program. The

FINAL ORDER (Cont.)
15F-10285
PAGE -3
petitioner believes that her disabled daughter should be included as a member of the standard filing unit and that her household size should be two persons, rather than a one person household for the QMB program. The petitioner's daughter does not receive Supplemental Security Income (SSI) or Social Security disability income but was determined by the Department to be exempt from participating in the Food Assistance Program (FAP) work program due to her disability. The petitioner believes she qualifies for the QMB program if the Department includes her daughter and income of $\$ 1099$. The petitioner would like for her Medicare premium to be paid for her so that she may receive all of her income.
6. The Petitioner Exhibit 1 includes a letter from the petitioner arguing that she was informed by the Agency for Health Care Administration (AHCA) that her monthly income should be recalculated to include her burial expense of $\$ 1500$. The petitioner explained in the letter that her burial expense in the amount of $\$ 1500$ should be calculated at $\$ 125$ per month (\$1500/12). The $\$ 1853$ should be reduced by the $\$ 125$, which would reduce her countable income to $\$ 1728$, which is under the Ql1 income limit of $\$ 1793$ for a couple (including her disabled adult child).
7. The petitioner believes the LIS program considered her household to consist of two persons; therefore, the Department should do the same. The petitioner believes she was denied the QMB because there is a glitch in the system that is not allowing the Department to catch up with the other systems. The Petitioner Exhibit 1 includes the "Summary of Indian Provisions in the Patient Protection and Affordable Care Act-H.R. 3590 P.L. 111-148" (Summary). The Summary was enacted March 23, 2010 and
explains the provisions relating to Indian Health programs and the reauthorization of the
Indian Health Care Improvement Act (IHCIA). The Summary explains in part:

## SEC. 1402. REDUCED COST-SHARING FOR INDIVIDUALS

ENROLLING IN QUALIFIED HEALTH PLANS. The standard out-of-pocket maximum limits ( $\$ 5,950$ for individuals and $\$ 11,900$ for families) would be reduced to one-third for those between 100-200 percent of poverty, onehalf for those between 200-300 percent of poverty, and to two-thirds for those between 300-400 percent of poverty. The plan's share of total allowed costs of benefits would be increased to 90 percent for those between 100-150 percent of poverty (i.e., the individual's liability is limited to 10 percent on average) and to 80 percent for those between 150-200 percent of poverty (i.e., the individual's liability is limited to 20 percent on average). The cost-sharing assistance does not take into account benefits mandated by States.
Sec. 1402(d) SPECIAL RULES FOR INDIANS.-
(1) INDIANS UNDER 300 PERCENT OF POVERTY.-If an individual enrolled in any qualified health plan in the individual market through an Exchange is an Indian (as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d))) whose household income is not more than 300 percent of the poverty line for a family of the size involved, then, for purposes of this section-
(A) such individual shall be treated as an eligible insured; and
(B) the issuer of the plan shall eliminate any cost-sharing under the plan.
(2) ITEMS OR SERVICES FURNISHED THROUGH INDIAN HEALTH

PROVIDERS.-If an Indian (as so defined) enrolled in a qualified health plan is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services(A) no cost-sharing under the plan shall be imposed under the plan for such item or service; and
(B) the issuer of the plan shall not reduce the payment to any such entity for such item or service by the amount but for subparagraph (A).
(3) PAYMENT.-The Secretary shall pay to the issuer of a qualified health plan the amount necessary to reflect the increase in actuarial value of the plan required by reason of this subsection.

## Indian Provisions

Subtitle K-Protections for American Indians and Alaska Natives SEC. 2901. SPECIAL RULES RELATING TO INDIANS.
(a) NO COST-SHARING FOR INDIANS WITH INCOME AT OR BELOW 300 PERCENT OF POVERTY ENROLLED IN COVERAGE THROUGH A STATE EXCHANGE.-For provisions prohibiting cost sharing for Indians enrolled in any qualified health plan in the individual market through
an Exchange, see section 1402(d) of the Patient Protection and Affordable Care Act.
(b) PAYER OF LAST RESORT.-Health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations (as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) shall be the payer of last resort for services provided by such Service, tribes, or organizations to individuals eligible for services through such programs, notwithstanding any Federal, State, or local law to the contrary.
(c) FACILITATING ENROLLMENT OF INDIANS UNDER THE EXPRESS LANE OPTION.-Section 1902(e)(13)(F)(ii) of the Social Security Act (42 U.S.C. 1396a(e)(13)(F)(ii)) is amended-
(1) in the clause heading, by inserting "AND INDIAN TRIBES AND TRIBAL ORGANIZATIONS" after "AGENCIES"; and
(2) by adding at the end the following:
"(IV) The Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (as defined in section 1139(c))."
(d) TECHNICAL CORRECTIONS.-Section 1139(c) of the Social Security Act (42 U.S.C. 1320b-9(c)) is amended by striking "In this section" and inserting "For purposes of this section, title XIX, and title XXI". SEC. 2902. ELIMINATION OF SUNSET FOR REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.
(a) REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN
INDIAN HOSPITALS AND CLINICS.-Section 1880(e)(1)(A) of the Social Security Act (42 U.S.C.
8. The Department explained that the petitioner may file an application for the Indian Exemption through the marketplace at https://www.healthcare.gov//american-indian-alaska-native/exemption/; it is not done through DCF.
9. The Respondent Exhibit 3 includes a copy of the email from Jamie Franz, the Senior Management Analyst Supervisor for its Office of Economic Self Sufficiency Customer Information Support Services (CISS) unit with DCF. Jamie Franz explained in the email that the petitioner may be exempt from paying healthcare fees, such as the Medicare Part B premiums, due to her status as a member of a federally recognized

FINAL ORDER (Cont.)
15F-10285
PAGE -6

American Indian tribe by applying for the exemption through the aforementioned website. Jamie Franz explained in the email that the petitioner may also claim the exemption paid by claiming it on her federal income tax return.
10. The aforementioned website includes information listed below:

Medicaid and the Children's Health Insurance Program (CHIP) are available to qualifying federally recognized American Indians and Alaska Natives. These programs provide better access to services that a local Indian health clinic might not be able to provide.
You can apply for Medicaid or CHIP even if you filed for an exemption from the shared responsibility payment.
To learn how to apply for these programs, visit our Medicaid \& CHIP page. Your Medicaid and CHIP rights and protections If you're eligible for services from the Indian Health Service, tribal programs, or urban Indian programs (known as I/T/Us), including Contract Health Services:

- You don't have to pay Medicaid premiums or enrollment fees.
- You don't have to pay out-of-pocket costs like copayments, coinsurance, and deductibles for Medicaid services.

11. The Department explained that the petitioner's daughter may be included in her Medicaid case if she were a minor child. The Department further explained that the MSP programs only include individuals and their spouses; not their adult children. The Department only considers an individual's gross unearned income and the income deduction in the amount of $\$ 20$ for the standard disregard in the determination of eligibility for the MSP programs. The Department explained that the petitioner is not eligible for its QMB, SLMB, or Q11 programs based on her countable income.
12. The Department also explained that the rules and requirements for the Food Assistance Program (FAP) are different from its Medicaid programs and cannot be applied to the QMB program.

## CONCLUSIONS OF LAW

13. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.
14. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
15. 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 (Ql1). Under Ql1 coverage, individuals are only entitled to payment of their Medicare Part B premium. (This is coverage for individuals who would be eligible for QMB or SLMB coverage except their income exceeds limits for those programs.)...
16. Fla. Admin. Code R. 65A-1.701 Definitions provides for definitions related to the SSI-Related Medicaid programs and explains in relevant part:
(11) Eligible Couple: An eligible individual and their eligible spouse. See definition for spouse.
(32) Spouse:
(a) For SSI-related programs MEDS-AD Demonstration Waiver, Medically Needy, Emergency Medicaid for Aliens, Qualified Medicare Beneficiary,

Special Low-Income Medicare Beneficiary, Working Disabled (WD), and Protected Medicaid Coverage purposes: A person's husband or wife as defined at 20 C.F.R. § 416.1806.
17. The above authority explains that a couple is defined as an individual and his or her spouse. A spouse is defined as a husband or a wife. In this case, the petitioner argues that her disabled adult daughter should be included in the QI1 budget.

However, the above controlling authority explains that only an individual and his or her spouse is to be included as a couple. Therefore, the undersigned concludes that the Department was correct to not include the petitioner's disabled adult daughter in the Q/1 assistance group to determine her eligiblity for the program.
18. Fla. Admin. Code R.65A-1.713 "SSI-Related Medicaid Income Eligibility

## Criteria," states:

(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
(b) For QMB, income must be less than or equal to the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.
(g) For SLMB, income must be greater than 100 percent of the federal poverty level but equal to or less than 120 percent of the federal poverty level.
(j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. Q11 is eligible only for payment of the Part B Medicare premium through Medicaid.
(4) Income Budgeting Methodologies. To determine eligibility SSI budgeting methodologies are applied except where expressly prohibited by 42 U.S.C. § 1396 (2000 Ed., Sup. IV) (incorporated by reference), or another less restrictive option is elected by the state under 42 U.S.C. § 1396a(r)(2) (2000 Ed., Sup. IV) (incorporated by reference). When averaging income, all income from the most recent consecutive four weeks shall be used if it is representative of future earnings. A longer
period of past time may be used if necessary to provide a more accurate indication of anticipated fluctuations in future income.
(a) For MEDS-AD Demonstration Waiver, Protected Medicaid, Medically Needy, Qualified Working Disabled Individual, QMB, SLMB, QI1, and to compute the community spouse income allocation for spouses of ICP individuals, the following less restrictive methodology for determining gross monthly income is followed:

1. When income is received monthly or more often than once per month the monthly income from that source shall be computed by first determining the weekly income amount and then multiplying that amount by 4. A five-week month shall not be treated any differently than a fourweek month.
2. When unearned income is received less often than monthly the total amount will be prorated over the period it is intended to cover. If prorating income adversely affects the client it will be counted in the month received and not prorated.
3. When earned income is received less often than monthly, the department counts the total amount in the month received and does not prorate.
(c) Medically Needy. The amount by which the individual's countable income exceeds the Medically Needy income level, called the "share of cost", shall be considered available for payment of medical care and services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical costs. If countable income exceeds the Medically Needy income level the department shall deduct allowable medical expenses in chronological order, by day of service. Countable income is determined in accordance with subsection 65A-1.713(2), F.A.C. To be deducted the expenses must be unpaid, or if paid, must have been paid in the month for which eligibility is being determined or incurred and paid during the three previous calendar months to the month for which eligibility is being determined but no earlier than the three retroactive application months. The paid expense may not have been previously deducted from countable income during a period of eligibility. Medical expenses reimbursed by a state or local government not funded in full by federal funds, excluding Medicaid program payments, are allowable deductions. Any other expenses reimbursable by a third party are not allowable deductions. Examples of recognized medical expenses include:
4. 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

FINAL ORDER (Cont.)
15F-10285
PAGE -10
personal care services in the home prescribed by a recognized member of the medical community.
19. The above authority explains that an individual must have income that is within the income limits established by the federal and state law as well as the Medicaid State plan to receive SSI-related Medicaid coverage. An individual may qualify for the QMB program if his income is less than or equal to the federal poverty level after applying exclusions to the income. The SLMB program requires income to be greater than $100 \%$ of the federal poverty level but equal to or less than $120 \%$ of the federal poverty level. An individual 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 QI1. The above authority also explains the different budgeting procedures for the QI1 and Medically Needy (MN) programs. The petitioner believes that the QI1 budgeting should be the same as that of the Medically Needy program. However, the above authority requires a different budgeting method for each program. Therefore, the undersigned concludes that the Department was correct to not apply the MN budgeting procedures to the Ql1 program.
20. The Policy Manual, Appendix A-9 sets forth the income standards effective April 2015 as $\$ 1325$ for an individual and $\$ 1793$ for a couple for the Q11 program. This income limit is based on $135 \%$ of the federal poverty level and changes annually.
21. 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" for the MSP programs.

FINAL ORDER (Cont.)
15F-10285
PAGE -11

The Department deducted $\$ 20$ from the petitioner's gross income in the amount of
$\$ 1873.20$ to arrive at $\$ 1853.20$ countable income.
22. The Policy Manual, passage1640.0514 Burial Exclusion Policy (MSSI, SFP)
states,
An individual and the individual's spouse may set aside funds of up to $\$ 2,500$ each for burial expenses. These funds are excluded as assets as long as the individual shows that they are clearly designated as being set aside for burial. This is true even if the case has been closed as long as the funds continue to be designated for burial. The funds must be separately identifiable (not commingled with other funds) unless the asset cannot be separated or it is unreasonable to require it. The individual (or deemed individual) must provide a written statement defining:

1. the amount of funds set aside,
2. for whose burial the funds are set aside, and
3. the form in which the funds are held.

The individual and the individual's spouse must be given the opportunity to designate funds for burial at the time of application and at review if the maximum amount is not already designated. These funds may be excluded regardless of whether the exclusion is needed to allow eligibility. The $\$ 2,500$ limit is not reduced by the value of excluded life insurance policies or irrevocable burial contracts (emphasis added).
23. The above authority explains that an individual is allowed to designate funds for burial expenses up to $\$ 2500$. These funds are to be considered as an exclusion to assets. In this case, the petitioner argues that she should be allowed as a deduction to her income, funds set aside for burial expenses. Therefore, the undersigned concludes that the Department was correct to not consider the petitioner's burial expense as a deduction to reduce her countable income.
24. The petitioner argues that she is automatically eligible for the QMB program due to her status as an American Indian. The undersigned was unable to locate any authorities that would allow the Department to approve the petitioner under any of the

MSP programs due to her being a member of a federally recognized American Indian tribe. Therefore, based on the above findings of facts and conclusions of law, the undersigned concludes that the Department was correct in its denial of the petitioner's application for the Q11 program.
25. The petitioner may wish to apply for an exemption related to her status as a member of a federally recognized American Indian tribe as directed in the aforementioned website.

## DECISION

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

## NOTICE OF RIGHT TO APPEAL

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

FINAL ORDER (Cont.)
15F-10285
PAGE -13

DONE and ORDERED this _11 day of __ March , 2016, in Tallahassee, Florida.


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

Copies Furnished To:
Office of Economic Self Sufficiency

Mar 04, 2016
Office of Appeal Hearings
STATE OF FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES OFFICE OF APPEAL HEARINGS

## 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 11, 2016 at 11:34 a.m.

## APPEARANCES

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

## STATEMENT OF ISSUE

At issue is the Agency's action in denying Petitioner's request for approval of a renewal prescription for

Because the last payment for the medication was made in May 2015 and the request for approval of a renewal prescription was submitted in October 2015, the burden of proof is assigned to the Petitioner.

## PRELIMINARY STATEMENT

Appearing as witnesses from Staywell Managed Medical Assistance(MMA) were Alexandria Hicks, Regulatory Research Coordinator; Lauren Barnes, Manager for Pharmacy Operations; and Robert Walker, Regulatory Research Coordinator.

The Respondent entered a 121-page document into the record, which was marked Respondent Exhibit 1. Respondent's Request for Additional Information was returned by Petitioner's doctor and was entered into evidence and marked Respondent Exhibit 2.

The record was held open until January 25, 2016 for Respondent to provide the date was removed from the preferred drug list and for the Petitioner to provide the date the petitioner's prescription for it expired. The information from the Respondent was received in an email on January 14, 2016 and was entered into evidence and marked Respondent Exhibit 3.

The Petitioner provided her response on January 25, 2016, which was accompanied by a letter from Petitioner's doctor. The nine-page document was entered into evidence and marked as Petitioner Exhibit 1.

## FINDINGS OF FACT

1. The Petitioner is a 15 year-old Medicaid recipient who enrolled with managed care provider Staywell effective March 1, 2015. She is diagnosed with suspect with asymmetry.
2. A request to continue use of submitted by Petitioner's Ophthalmologist on October 19, 2015.
3. Staywell sent Petitioner a Notice of Action on October 20, 2015 advising the request was denied and provided the reason for the decision:

The drug that you have requested is not on the preferred drug list. We reviewed your medication history and/or your prescriber's supporting documentation (or medical records). You have not had previous trial and failure on preferred drug(s):
4. Petitioner's provider submitted a Medicaid Medication Appeal Request on

October 22, 2015 providing the following clinical reason for the appeal:
Pediatric patient requires continuation of current therapy to prevent glaucomatous vision loss and maintain stability of intraocular pressure.
5. On November 20, 2015, Staywell up held the denial:
[A]fter review of...original DER [Drug Evaluation Review], DER denial reason, prescription refill claims, FDA recommendations and/or industry guidelines, PDL/plan formulary, prior authorization or utilization management criteria(if applicable), and the appeal documents.
6. Petitioner filed a timely request for a fair hearing on December 7, 2015.
7. Petitioner has been using for six years, since she was nine years old.
8. was previously on the PDL (preferred
drug list) and was removed from the list in February 2015.
9. In response to a November 20, 2015 Request for Additional Information from Staywell, the Petitioner's Ophthalmologist responded:

The enrollee/patient is a child for whom the other listed options on formulary would be inappropriate therapy. She requires Betoptic (it is medically necessary) to treat the enrollee's condition (glaucoma suspect).
10. Respondent advised that trial and failure on at least 2 formulary alternative(s) was necessary before granting approval of a non-formulary medication.
11. Although was removed from the PDL in February 2015, Staywell covered refills for the medication on March 12, 2015 and April 9, 2015 in compliance with the 60 day continuance of services requirement for new managed care plan enrollees. Additionally, a one-time override was processed for a refill on May 19, 2015.
12. The record was held open until January 25, 2016 for the following information:

- Copy of response from Petitioner's Ophthalmologist to Respondent's request for additional information (Respondent);
- Date when Betoptic was removed from the PDL.(Respondent);
- Date prescription for expired and number of refills authorized. (Petitioner)

13. A copy of response from Petitioner's Ophthalmologist was received on January

11, 2016. This document was entered into evidence and marked Respondent Exhibit 2.
An email from the AHCA representative was received on January 14, 2016 advising that


February 4, 2015. This email was entered into evidence and marked Respondent Exhibit 3.
14. A nine-page response from the Petitioner was received on January 25, 2016 and was marked as Petitioner Exhibit 1. A new prescription for was written May 19, 2015 with a refill prescription written October 27, 2015. Included in the exhibit is a January 12, 2016 letter from Petitioner's doctor, that states in part:

15. As noted above, the generic
 was removed from the Preferred Drug List which also impacted any brand names for the medication such as


## 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, Florida Statutes
17. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
18. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence.
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. 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:
21. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
22. 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;
23. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
24. 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;
25. 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...

## 21. AHCA's Prescribed Drug Coverage, Limitations, and Reimbursement Handbook

(Handbook), dated July 2014 and incorporated in Florida Administrative Code Rule
59G-4.250, states the following for Health Maintenance Organizations (HMO) on page
1-4 :
HMO prescribed drug services are defined the same as for the Medicaid fee-for-service program and include all legend drug products covered by fee-for-service Medicaid as defined in Chapter 2 of this handbook, Legend Drugs. Medicaid's contract with HMOs states that Medicaid HMOs may use prior authorization and/or step therapy to encourage compliance with the preferred drug list.
A Medicaid HMO is required to cover any product that is required to be covered under the fee-for-service Medicaid program as specified in section 1927 of Title XIX of the Social Security Act. If a product meets the definition of a covered service under that section there must be a provision to make it available through the HMO and through fee-for-service.
22. On page 2-4 of the Handbook, the Preferred Drug List is explained under
covered services, 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 in selected therapeutic classes will be presented to the P \& T Committee with their relevant clinical efficacy and relative net cost positions. The P \& T Committee will recommend the most cost effective drugs in each therapeutic category to AHCA for consideration for inclusion on the PDL. A minimum of two products per therapeutic class, if available, will be recommended. 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. Please see the following section of this handbook for explanation of the prior authorization process for non-PDL products.

Non-PDL drugs may be approved for reimbursement upon prior authorization. A step-therapy process that requires initial use of PDL products before authorization of non-PDL products will then permit prior authorization (PA) for non-listed drugs. Oral contraceptives and HIVIAIDSrelated anti-retroviral products are covered, and are exempt from PDL requirements. Mental health drugs are not exempt from PDL requirements. Nursing home residents and waiver program participants are not exempt from PDL requirements.
[emphasis added]
23. Page 2-12 of the Handbook, "How Non-PDL Requests are Processed" states:

Medications on the Preferred Drug List must have been tried within the twelve months prior to the request for a non-PDL alternative product. Certain step-therapy prior authorization protocols require the prescriber to use medications in a similar drug class or for a similar medical indication unless contraindicated in the federal Food and Drug Administration labeling. Reimbursement for a drug product may be approved without meeting the step-therapy prior authorization criteria if the prescribing physician provides written medical or clinical documentation that the product is medically necessary because:

- There is not an acceptable clinical alternative on the PDL to treat the disease or medical condition; or
- The PDL alternatives have been ineffective in the treatment of the recipient; or
- The number of doses has been ineffective, or based on historic evidence and known characteristics of the patient the PDL drug is likely to be ineffective.

24. 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 Statutes section 409.905, Mandatory Medicaid services, provides that Medicaid services for children must 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.
25. Respondent denied Petitioner's request for Betoptic Ophthalmic Suspension $0.25 \%$ (Betaxolol) because it is no longer on the Preferred Drug List (PDL) and proof of trial use of at least two alternative medications on the PDL was not submitted.
26. Petitioner has been using $\quad$ for six years, since she was nine years old, and her doctor provided an explanation of the risks to her vision if her eye medication is changed.
27. After considering the evidence and all of the appropriate authorities set forth in the findings above, including EPSDT requirements, the undersigned finds the Petitioner's evidence, including the documentation from her doctor, sufficiently


## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal
is GRANTED and the Agency action 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 $\qquad$ 04 day of $\qquad$ , 2016,
in Tallahassee, Florida.


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

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

Mar 01, 2016

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

APPEAL NO. 15F-10329
PETITIONER,
Vs.
CASE NO
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 01 Santa Rosa
UNIT: 88113
RESPONDENT.

## FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned on January 27, 2016 at approximately 1:30 p.m.,


APPEARANCES
For the Petitioner: usband of Ruth Stolle

For the Respondent: Julie Mount, Economic Self-Sufficiency Specialist Supervisor, Department of Children and Families

## ISSUE

At issue is the amount of the Community Spouse Monthly Income Allowance.
Petitioner's husband is seeking to have his income allowance increased to maintain the level of support of the household.

FINAL ORDER (Cont.)
15F-10329
PAGE -2

## PRELIMINARY STATEMENT

The Petitioner submitted a packet of information that was entered into evidence and marked as Petitioner's Exhibits " 1 " through " 5 ". The Respondent submitted a packet of information that was entered into evidence and marked as Respondent's Exhibit "1". The Petitioner brought a six-minute video of the home and property which was not watched and not admitted into evidence.

## FINDINGS OF FACT

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

1. The petitioner currently lives in a nursing home and was found eligible by the Department to receive Institutional Care Program (ICP) Medicaid services. The Department determined the petitioner has a patient responsibility as part of her stay in a nursing home.
2. The petitioner's husband lives in his home and has been designated as the "community spouse" in regards to the petitioner's eligibility for the ICP Program.
3. At hearing, the Respondent explained how the community spouse allowance is calculated. Respondent stated that the latter steps in the budgeting process were not applied in this instance because the gross countable income of the Community Spouse (petitioner's husband) is more than two times the level of the MMMNA (Minimum Monthly Maintenance Needs Allowance), which precludes the application of income disregards in the budgeting process.
4. The applicable MMMNA amount is $\$ 1,991.00$ per month. His gross countable income is $\$ 4,675.80$ per month.

FINAL ORDER (Cont.)
15F-10329
PAGE -3
5. The Petitioner's husband did not argue the fact that the Department determined his Community Spouse Income Allowance to be zero. He is requesting that the amount be increased.
6. Petitioner's doctor states the he requires assistance with housekeeping and yard maintenance on an ongoing basis. He paid $\$ 2,820$ in 2015 for housekeeping services. He pays his grandson $\$ 75$ per week for yard maintenance, which comes to $\$ 3,600$ per year (Petitioner's Exhibit 3).
7. The Petitioner argued that a seven year history of major household expenses provided substantiation of his need for a portion of his wife's income to meet household needs. Over that seven year period $\$ 47,000$ of major expenses were accrued (Petitioner's Exhibit 2). This amount averaged over a seven-year period is $\$ 534.10$ in expenses per month.
8. The Petitioner's Exhibit 4 is a summary of deposits and expenses for 2015. This details his net income deposited into his checking account plus other deposits. From this total, he deducts the cash used to pay for housekeeping and lawn maintenance and payments to the nursing facility and concludes that $\$ 4,096.92$ is needed monthly to cover other monthly household expenses. He further illustrates his need for an increase is his Spousal Allowance with a breakdown on monthly expenses versus income. Concluding that when considering his income alone, there is a total monthly deficit of $\$ 391.65$ monthly.

## 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 §

FINAL ORDER (Cont.)
15F-10329
PAGE -4
409.285 Fla. Stat. This order is the final administrative decision of the Department of

Children and Families under § 409.285, Fla. Stat.
10. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-
2.056.
11. Fla. Admin. Code R. 65A-1.713 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. § $1396 a(r)(2)(2000$ 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.
3. 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. § $1396 r-5$ 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

FINAL ORDER (Cont.)
15F-10329
PAGE -6
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.
13. 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 $\$ 0.00$ of the petitioner's income is diverted to the community spouse, causing the patient responsibility to be $\$ 1,695.48$. 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.

FINAL ORDER (Cont.)
15F-10329
PAGE -7
14. A couple must present proof that an exceptional circumstance has caused unavoidable extreme financial duress for the community spouse. The petitioner asserts the cost of his household major expenses such as his history of incidental expenses over the past seven years (a new roof, work on the septic tank, hot tub repairs, carpeting and flooring replacement, etc.), in addition to housekeeping, and lawn maintenance should be considered for an increase in the spousal diversion amount. However, the undersigned concludes that lawn maintenance, and housekeeping does not meet the threshold of an exceptional or unavoidable circumstance. Also the major expenses summarized by the Petitioner are not likely to be repeated in the immediate future. The petitioner has not presented the undersigned with an exceptional circumstance, either temporary or long term, causing a significant financial inadequacy for him 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 the 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

FINAL ORDER (Cont.)
15F-10329
PAGE -8
the court fees 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 _ March 2016,
in Tallahassee, Florida.


Gregory Watson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myffamilies.com

Copies Furnished To: Petitioner
Office of Economic Self Sufficiency

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

Vs.
CASE NO.
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 12 Manatee
UNIT: AHCA
RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on January 27, 2016 at 11:05 a.m.

## APPEARANCES

For the Petitioner:
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 medicatior Petitioner held the burden of proof by a preponderance of the evidence in this matter.

## PRELIMINARY STATEMENT

The Agency for Healthcare Administration (AHCA or Agency) is responsible for administering Florida's Medicaid Program.

FINAL ORDER (Cont.)
15F-10332
PAGE-2
Petitioner represented himself and presented no witnesses. Serving as Respondent's witnesses were Robert Walker (Regulatory Research Coordinator with Staywell), Lauren Barnes (Manager of Pharmacy Operations with Staywell) and Stephanie Shupe (Regulatory Research Coordinator with Staywell).

Respondent submitted eleven exhibits during the hearing, marked and entered as Respondent's Exhibits 1 through 11, into evidence. The record was left open until Friday January 29, 2016 to receive the criteria Respondent relied on in making its decision. The criteria was received before the record closed and was entered as Respondent's Exhibit 12. The hearing officer took administrative notice of Florida Statutes 409.910, 409.962 through 409.965, and 409.973. Administrative notice was also taken of Florida Administrative Code Rules 59G-1.001, 1.010, and 4.250, as well as the Florida Medicaid Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook, and the Florida Medicaid Preferred Drug List.

## 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 diagnosed with $\square$ His physician suggested a medication called Petitioner was not tested for
2. Petitioner's treating physician submitted a preauthorization request to the Agency for on November 24, 2015. The physician provided a drug screen, RNA levels, clinical notes, and lab results to support the preauthorization request. The prior authorization request did not include a

FINAL ORDER (Cont.)
15F-10332
PAGE-3
3. The Agency reviewed the submitted documentation and denied the request. The denial notice dated November 25, 2015, stated that "The request could not be approved
and went on to list the required scores and criteria that must be met to approve the In response to the denial, Petitioner requested a fair hearing.
4. The Agency denied the preauthorization request for because Petitioner's condition must meet certain criteria to be approved for that particular drug. Based on the Agency's review of the submitted medical records, his condition does not meet the specific criteria for

## CONCLUSIONS OF LAW

5. The Department of Children and Families Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 120.80, Florida Statutes.
6. Florida Medicaid State Plan is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The program is administered by the Agency.
7. This hearing was held as a de novo proceeding pursuant to Florida Administrative Code Rule 65-2.056.
8. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Florida Administrative Code Rule 652.060(1).
9. Section 409.912, Florida Statutes (2015) provides that AHCA shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent

FINAL ORDER (Cont.)
15F-10332
PAGE-4
with the delivery of quality medical care. 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.
10. 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.
11. The Agency has the authority to manage its prior authorization process, including establishing criteria for approval. It established specific criteria for The Medicaid drug criteria for $\quad$ equires evidence (through liver biopsy, Fibroscan, FibroTest, or APRI score) showing at least Stage 3 or 4 hepatic fibrosis for approval. Respondent's Exhibit 12. Petitioner has not had any testing to show his current stage of fibrosis, so he does not meet the established criteria for
12. Petitioner had the burden of proof in this case. Petitioner did not meet his burden of proof to show that he met the criteria for this drug. He is encouraged to complete testing to find out his and re-submit his request with the required information. If his results show he is $\square$, he is encouraged to work with his physician and the Agency to find an alternative medication that will meet his needs.
13. 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.

FINAL ORDER (Cont.)
15F-10332
PAGE - 5

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the

Petitioner's appeal is hereby DENIED and the Agency's action is AFFIRMED.

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this $\qquad$ day of $\qquad$ , 2016,
in Tallahassee, Florida.

| Wemelle Wluray |
| :--- |
| 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 |

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

APPEAL NO. 15F-10342
APPEAL NO. 15F-10343
APPEAL NO. 16F-01860

CASE NO.


FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES CIRCUIT: 15 PALM BEACH UNIT: 88701

RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 24, 2016, at 11:22 a.m.

## APPEARANCES

For the Petitioner:


For the Respondent:
SueJay Collins, supervisor

## STATEMENT OF ISSUE

1. At issue is the amount of Food Assistance (FA) benefits approved at recertification. The petitioner carries the burden of proof by a preponderance of evidence in this appeal.
2. The petitioner is also appealing the Department's action to deny her full Medicaid benefits and instead enroll her into the Medically Needy Share of Cost Program. The petitioner has the burden of proof by a preponderance of evidence in this appeal.

FINAL ORDER (Cont.)
15F-10342, 10343, 16F-01860
PAGE -2
3. Also at issue is the denial of the Medicare Savings Program. The petitioner has the burden of proof by a preponderance of evidence in this 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 Exhibit 1 and Petitioner's Exhibit 2. The record was held open until March 7, 2016. Additional time was allowed. No additional exhibits were received. The record was closed on March 12, 2016.

## FINDINGS OF FACT

1. On November 18, 2015, the petitioner submitted a recertification application for FAP benefits, SSI-Related Medicaid and the Medicare Saving Plan. She listed herself as the only household member. The petitioner receives monthly Social Security Disability Income (SSDI) of $\$ 1,410.90$. She pays Medicare Part B of $\$ 104.90$. She has household expenses for rent of $\$ 828$, electricity of $\$ 100$, telephone of $\$ 55$ and water of \$50. She listed medical expenses for Palm Tran of \$57, medical insurance for Humana of $\$ 17$ and Walgreens of $\$ 57$.
2. The Department processed the application and determined eligibility. To determine the FA benefits for January 2016 ongoing, the Department used the total monthly household gross income of $\$ 1,410$. A standard deduction of $\$ 155$ and an excess medical expense of $\$ 168.90$ was subtracted was to get the adjusted income of $\$ 1,086.10$. The utility allowance of $\$ 345$ added to the shelter cost of $\$ 828$ resulting in a total shelter/utility cost of $\$ 1,173$. Fifty percent of the adjusted income (\$543.05) is the

FINAL ORDER (Cont.)
15F-10342, 10343, 16F-01860
PAGE - 3
standard shelter. This was subtracted from the total shelter, which resulted in the excess shelter deduction of $\$ 629.95$. It was subtracted from the adjusted income $(\$ 1,086.10)$ to equal the Food Assistance adjusted income of $\$ 456.15$. The maximum net income limit for a household of one is $\$ 981$. As the petitioner's Food Assistance adjusted income was lower than the maximum net income limit, the respondent proceeded to calculate the benefit reduction. The Food Assistance adjusted net income was multiplied by $30 \%$ to equal $\$ 137$ (rounded up). The benefit reduction was subtracted from the maximum allotment of $\$ 194$ for a one-person assistance group, resulting to $\$ 57$ as the petitioner's monthly FA benefits.
3. On November 25, 2015, the respondent sent a Notice of Case Action informing the petitioner that her FAP benefits will stay the same. The same notice informed her that her application for Medically Needy benefits was approved. The notice also informed her that she was enrolled in the Medically Needy Program with an estimated share of cost (SOC) for November 2015 and December 2015. This notice also informed her that her application for Medicare Saving Plan (MSP) was denied. The reason given for the denial was that her income was too high for the program.
4. The Department reviewed the petitioner's income and found that her income of $\$ 1,390.90$ was over the maximum income limit of $\$ 1,337$ to be eligible for the Medicaid Savings Plan (\$1,410.90 less \$20).
5. To determine the petitioner's SSI-Related Medicaid benefits, the respondent determined the petitioner's gross income of $\$ 1,410$. The respondent determined the petitioner was not eligible for full Medicaid as she was receiving Medicare benefits. The

FINAL ORDER (Cont.)
15F-10342, 10343, 16F-01860
PAGE -4
respondent proceed to enroll her in the Medically Needy Program with a share of cost (SOC) based on her income.
6. The respondent performed the following budget calculations when it determined the petitioner's estimated SOC. It determined the petitioner's monthly gross income was $\$ 1,410$. A $\$ 20$ unearned income disregard was subtracted resulting to $\$ 1,390$ as the petitioner's countable income. The Medically Needy Income Limit of \$180 for household size of one was subtracted resulting to $\$ 1,210$ as the petitioner's SOC. The respondent then allowed a deduction of the Medicare premium of $\$ 104.90$, resulting to \$1,105 as the petitioner's recurring SOC.
7. The petitioner asserts her doctor's co-payments for September 2015, October 2015, November 2015 and December were $\$ 175$ or an average $\$ 43$ per month.
8. The petitioner argued that no doctors will see her because she has a SOC Medicaid. She also argued that her monthly income is not enough to pay for medical expenses and also purchase food as she is on a special diet.
9. The respondent acknowledged that it did not send a pending notice for the petitioner to provide verification of her medical expenses.

## 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 $\S 409.285$, 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. 652.056.

FINAL ORDER (Cont.)
15F-10342, 10343, 16F-01860
PAGE -5

## The FAP benefits issue will be addressed first:

12. 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 eligibility standards for the Food Stamp Program...
(b)(2) Unearned income shall include, but not be limited to:
(i) Assistance payments from Federal or federally aided public assistance programs, such as supplemental security income (SSI)...
(ii) Annuities; pensions; retirement, veteran's, or disability benefits; worker's or unemployment compensation including any amounts deducted to repay claims for intentional program violations as provided in §272.12; old-age, survivors, or social security benefits; strike benefits; foster care payments for children or adults who are considered members of the household...
d) Income deductions. Deductions shall be allowed only for the following household expenses:
(1) Standard deduction...
(3) Excess medical deduction...
(6) Shelter costs...
(ii) Excess shelter deduction. Monthly shelter expenses in excess of 50 percent of the household's income after all other deductions in paragraphs (d)(1) through (d)(5) of this section have been allowed. If the household does not contain an elderly or disabled member, as defined in §271.2 of this chapter, the shelter deduction cannot exceed the maximum shelter deduction limit established for the area...
(iii) Standard utility allowances...
13. The above-cited regulation explains the petitioner is required to meet the net
income standard and SSDI income is included as income in the determination. The above regulation sets forth specific potential deductions in the FAP budget.
14. It further states at 7 C.F.R. §273.10(e) Calculating net income and benefit levels:
(1) Net monthly income. (i) To determine a household's net monthly income, the State agency shall:
(A) Add the gross monthly income earned by all household members and the total monthly unearned income of all household members, minus income exclusions, to determine the household's total gross income...

FINAL ORDER (Cont.)
15F-10342, 10343, 16F-01860
PAGE -6
(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.
(ii) In calculating net monthly income, the State agency shall use one of the following two procedures:
(A) Round down each income and allotment calculation that ends in 1 through 49 cents and round up each calculation that ends in 50 through 99 cents; or...
(2)(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...
15. The FAP standards for net income, deductions and maximum allotment appear in the Department's Program Policy Manual CFOP 165-22, (The Policy Manual) at Appendix A-1. Effective October 1, 2015, the 200\% Federal Poverty level (FPL) for a household size of one is $\$ 1,962$. A one-person assistance group's net income is $\$ 981$, the Standard Utility Allowance is $\$ 345$, and the standard deduction is $\$ 155$. The same reference shows the maximum FAP benefits for one person as $\$ 194$ effective October 2014.

FINAL ORDER (Cont.)
15F-10342, 10343, 16F-01860
PAGE - 7
16. 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. 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).
2. 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.
3. Dentures, hearing aids, and prosthetics.
4. Eyeglasses or contact lenses prescribed by a physician skilled in eye disease or by the optometrist.
5. 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.
6. 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)
17. 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

FINAL ORDER (Cont.)
15F-10342, 10343, 16F-01860
PAGE -8
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.
18. The above allows transportation costs, prescription drugs, over-the-counter
medications and medical insurance as deductions in the FAP budget.

## The Medicaid issue will now be addressed.

19. The Department determined the petitioner's Medicaid benefits under the SSI

Related Program.
20. 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.

FINAL ORDER (Cont.)
15F-10342, 10343, 16F-01860
PAGE -9
21. 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.
22. The Policy Manual at Appendix A-9, lists the MEDS-AD income limit as $\$ 864$ for an individual effective July 2015.
23. 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 MEDSAD income limit for an individual is $\$ 864$. The petitioner is receiving Medicare Part B paid by the state; therefore, she is ineligible for full Medicaid. The undersigned further concludes Medically Needy eligibility must be explored for the petitioner. The Department was correct to explore Medically Needy program for the petitioner.

## The denial of the Medicare Savings Program will now be addressed:

24. Fla. Admin. Code R. 65A-1.702 Special Provisions explains the MSPs and in part states:
(12) Limits of Coverage.
(a) Qualified Medicare Beneficiary (QMB). Under QMB coverage, individuals are entitled only to Medicare cost-sharing benefits, including payment of Medicare premiums.
(b) Special Low-Income Medicare Beneficiary (SLMB). Under SLMB coverage, individuals are entitled only to payment of the Part B Medicare premium. If eligible, AHCA shall pay the premium for up to three months retroactive to the month of application...
(d) Part B Medicare Only Beneficiary (Ql1). Under Ql1 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.)...

FINAL ORDER (Cont.)
15F-10342, 10343, 16F-01860
PAGE -10
25. 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. Q11 is eligible only for payment of the Part B Medicare premium through Medicaid...
26. The Policy Manual at Appendix A-9, identifies MSP income standards for a couple as follows:

July 2015
QMB, SLMB QI1
\$990 \$1,188 \$1,337
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". The $\$ 20$ disregard is deducted from the petitioner's $\$ 1,410$ to arrive at $\$ 1,390$ countable income. The total countable income exceeds all of the MSP income standards therefore the petitioner is not eligible for the MSP.
28. In careful review of the cited authorities, evidence and testimonies, the undersigned concludes that the respondent erred when it calculated the petitioner's FAP benefits for November 2015, ongoing. The undersigned found the respondent did not credit the petitioner with all of her medical deductions. The Department did not pend the petitioner to verify her medical expenses. The FAP appeal is therefore

FINAL ORDER (Cont.)
15F-10342, 10343, 16F-01860
PAGE -11
returned to the Department to allow the petitioner an opportunity to verify her medical expenses (medical insurance, transportation, drugs, over the counter medications).
29. The undersigned found the Department correctly denied the petitioner Medicaid benefits and instead enrolled her in the Medically Needy Program with a monthly share of cost.
30. The petitioner was correctly denied the MSPs as her total countable income exceeded the established income standards.

## DECISION

1. Based upon the foregoing Findings of Fact and Conclusions of Law the FAP appeal is granted and remanded to the Department's to take corrective action and for consideration of the petitioner's medical expenses, protecting her application dated November 2015. The Department is to issue any additional FAP benefits the petitioner may be eligible for, not duplicating benefits already received and to issue a new notice to include appeal rights.
2. The appeal for full Medicaid benefits is denied. The respondent's action is upheld.
3. The appeal for eligibility in the Medicare Saving Plan is denied and the Department'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.

FINAL ORDER (Cont.)

## 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 petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this $\qquad$ day of March , 2016, in Tallahassee, Florida.


Christian 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: Petitioner
Office of Economic Self Sufficiency

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

Mar 15, 2016
Office of Appeal Hearings Dept. of Children and Farnilies

APPEAL NO. 15F-10358

PETITIONER,
Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 05 Hernando
UNIT: 88004

## RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 1:35 p.m. on February 3, 2016.

## APPEARANCES

For the Petitioner:

For the Respondent:

Cindy Sarver, 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 December 3, 2015, the respondent (or the Department) notified the petitioner his November 18, 2015, application was approved for MN with a $\$ 1,662$ SOC. Petitioner timely requested a hearing to challenge enrollment in the MN Program.

FINAL ORDER (Cont.)
15F-10358
PAGE-2

Petitioner submitted one exhibit, entered as Petitioner Exhibit "1". Respondent submitted four exhibits, entered as Respondent Exhibits "1" through "4". The record was closed on February 3, 2016.

## FINDINGS OF FACT

1. On November 18, 2015, petitioner submitted a Food Assistance, Cash Assistance and SSI-Related Medicaid application for himself. The application indicates petitioner is disabled and receives $\$ 1,863$ from Social Security. Medicaid is the only issue.
2. The Department verified that petitioner receives $\$ 1,967$ Social Security Disability Income (SSDI). And the Social Security Administration deducts $\$ 104.90$ from his check to pay his Medicare premium.
3. To be eligible for full Medicaid petitioner's income cannot exceed the $\$ 864$ Medicaid income standard. Petitioner's $\$ 1,967$ SSDI exceeds $\$ 864$. The next available program is MN with a SOC .
4. The Department determined petitioner's SOC as follows:

| $\$ 1,967$ | SSDI |
| :--- | :--- |
| $-\$ 20$ | unearned income disregard |
| $-\$ 104$ | Medicare premium (90 cents dropped) |
| $-\$ 180$ | MN Income Level (MNIL) for a household size of one |
| $\$ 1,662.00$ | SOC |

5. On December 3, 2015, the Department mailed petitioner a Notice of Case Action, notifying his November 18, 2015, application was approved and he was enrolled in MN with a $\$ 1,662$ SOC.
6. Petitioner said he has many medical issues and needs full Medicaid for at least three to six months.

## 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. The 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:
(a) For MEDS-AD Demonstration Waiver, income cannot exceed 88 percent of the federal poverty level...
(h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses...
(4)(c) Medically Needy. The amount by which the individual's countable income exceeds the Medically Needy income level, called the "share of cost", shall be considered available for payment of medical care and services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical costs. If countable income exceeds the Medically Needy income level the department shall deduct allowable medical expenses in chronological order, by day of service...To be deducted the expenses must be unpaid, or if paid, must have been paid in the month for which eligibility is being determined or incurred and paid during the three previous calendar months to the month for which eligibility is being determined but no earlier than the three retroactive application months...
10. The above authority explains to be eligible for full Medicaid; income cannot exceed

88 percent of the federal poverty level (FPL). And MN provides coverage for individuals who do not qualify for full Medicaid due to income.

FINAL ORDER (Cont.)
15F-10358
PAGE-4
11. The Department's Program Policy Manual, CFOP 165-22, appendix A-9 identifies $\$ 864$ as 88 percent of the FPL for a household size of one.
12. Petitioner's $\$ 1,967$ SSDI exceeds the $\$ 864$ income standard to be eligible for full Medicaid. Therefore, petitioner is not eligible for full Medicaid.
13. 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..."
14. The Fla. Admin. Code R. 65A-1.716 sets forth the MNIL at $\$ 180$ for a family size of one.
15. Federal Regulation at 42 C.F.R. $\S 436.831$ (e) Determination of deductible incurred expenses in part states "1) Expenses for Medicare and other health insurance premiums..."
16. In accordance with the above authorities, respondent deducted $\$ 20$ unearned income, $\$ 180$ MNIL and $\$ 104$ Medicare premium from petitioner's $\$ 1,967$ SSDI to arrive at $\$ 1,662$ SOC .
17. In carefully review of the cited authorities and evidence, the undersigned concludes the respondent is correct in approving petitioner in the MN Program with a $\$ 1,662$ monthly SOC.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the respondent's action is affirmed.

FINAL ORDER (Cont.)
15F-10358
PAGE - 5

## 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 petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this $\qquad$ 15 day of $\qquad$ , 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@myfIfamilies.com

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


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 referenced matter on February 1, 2016 at 8:35 a.m.

APPEARANCES

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

## STATEMENT OF ISSUE

At issue is the Agency's denial of Petitioner's request for continued acute inpatient rehabilitation services. Because the matter at issue involves a termination of services, Respondent carries the burden of proof.

FINAL ORDER (Cont.)
15F-010363
PAGE -2

## PRELIMINARY STATEMENT

Appearing as Respondent's witnesses from petitioner's managed medical assistance plan, Molina Healthcare, were Dr. Mark Bloom, Chief Medical Officer; Bonnie Blitz, Nurse Director of Healthcare Services; Carlos Galvez, Government Contract Specialist; Elvis Leiva, Manager of Healthcare Services; and Alice Quiros, Associate Vice President of Government Contracts.

Respondent submitted three documents which were entered into evidence and marked Respondent Exhibit 1, 2 and 3.

## FINDINGS OF FACT

1. The Petitioner is a 55 year-old recipient of the Medicaid program. Petitioner suffered a stroke and was admitted to Health Central Hospital. She was discharged from Health Central Hospital to an acute care rehabilitation facility, Colonial Lakes Health Care for intense therapy. Petitioner is alert but unable to care for herself because of limited use of her right arm and leg.
2. Molina Healthcare (Molina) approved the acute rehabilitation services from November 21, 2015 through December 5, 2015.
3. On December 10, 2015, a Notice of Action was sent to the petitioner and the provider advising the acute rehabilitation services were denied as of December 8, 2015 providing, in part, the following explanation:

The asked for Acute Rehabilitation Hospital admission on 12/6/15 and beyond is not approved. Using standard and accepted rules a Molina Healthcare doctor has looked at this request. We see that you have been in the rehabilitation hospital recovering from a stroke. The records are

FINAL ORDER (Cont.)
15F-010363
PAGE -3
showing that you are no longer making progress in your recovery. We do not cover inpatient stays if you are not able to benefit from the therapy there and are no longer making much improvement. You could continue therapy as an outpatient now according to the rules.
4. Petitioner submitted a request for a fair hearing on December 21, 2015 and requested continued services. In order to receive continued benefits, the request needed to have been filed within ten days of Molina's notice or no later than December 20, 2015.
5. The Chief Medical Officer for Molina explained that petitioner made improvement after her initial acute rehabilitation but she is now making slow progress.
6. While petitioner has regained some movement in her right arm and right leg, she does not have control of her right foot. She is unable to walk and is receiving total care.
7. Petitioner's mother disagreed with the assessment of her daughter's lack of progress. She stated her daughter is making progress on a daily basis and can now stand with someone to support her. She explained her daughter would not be able to care for herself at home because she is unable to ambulate and is wearing diapers.
8. Nurse notes dated December 3, 2015 state that activities of daily living (ADLs) were completed and medications given as ordered for pain relief. Petitioner feeds herself after "setup" but otherwise receives total care, including staff propelling her in a wheelchair.
9. Petitioner feels the electro therapy is the most helpful in her recovery and would not be available if she is discharged from the acute rehabilitation center.

FINAL ORDER (Cont.)
15F-010363
PAGE -4
10. The Chief Medical Director explained that the therapy Petitioner received at the acute rehabilitation center would be provided as an outpatient. He agreed Petitioner currently needs total care which suggests she may need placement in a care facility until she is able to care for herself.

## CONCLUSIONS OF LAW

11. 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.
12. This is a final order pursuant to Fla. Stat. $\S 120.569$ and $\S 120.57$. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
13. The Florida Medicaid Program is authorized by Chapter 409, Fla. Stat. and Chapter 59G, Fla. Admin. Code. The Medicaid Program is administered by the respondent.
14. Fla. Admin. Code 59G-1.010 states in part:
(166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
(a) Meet the following conditions:
15. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
16. 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;
17. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
18. 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 [emphasis added].
> (b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service...[emphasis added]
19. Respondent has determined that petitioner's slow improvement from inpatient therapy services justifies providing the therapy services in an outpatient setting.
20. The mother asserts the petitioner needs to continue to receive inpatient therapy services until her daughter is able to care for herself when discharged from the hospital.
21. Respondent agrees petitioner will need additional services when discharged, possibly a nursing home or adult living facility until she is able to care for herself.
22. After considering the evidence and all of the appropriate authorities set forth in the findings above, the undersigned concludes that the respondent has met its burden of proof.

## DECISION

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

FINAL ORDER (Cont.)
15F-010363
PAGE -6

## 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 $\qquad$ 01 day of $\qquad$ 2016,
in Tallahassee, Florida.


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

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

APPEAL NO. 15F-10367

## 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 26, 2016 at 10:00 a.m.

## APPEARANCES

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

## STATEMENT OF ISSUE

At issue is whether the Respondent's denial of the Petitioner's request for a gastric bypass surgery was correct. The Petitioner bears the burden of proving her case by a preponderance of the evidence.

FINAL ORDER (Cont.)
15F-10367
PAGE - 2

## PRELIMINARY STATEMENT

The Petitioner submitted medical records as evidence for the hearing, which were marked as Petitioner Exhibit 1.

The Respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Exhibits: Exhibit 1 - Statement of Matters and Authorization Request; Exhibit 2 - Denial Notice; Exhibit 3 - Medical Records; and Exhibit 4 - Medical Review Documents.

Appearing as witnesses for the Respondent were Dr. Merlin Osorio, Medical Director, and Lourdes Gayo, Director of Member Services, from Simply Healthcare, which is the Petitioner's managed health care plan.

Also present for the hearing were two Spanish language interpreters

## FINDINGS OF FACT

1. The Petitioner is an adult Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) - Managed Medical Assistance (MMA) plan. She receives services under the plan from Simply Healthcare.
2. On or about December 8, 2015, the Petitioner's treating physician (hereafter referred to as "the provider"), requested prior authorization from Simply Healthcare to perform a gastric bypass surgical procedure on the Petitioner. Simply Healthcare denied this request on December 14, 2015 based on medical necessity criteria. The denial notice stated the following:

FINAL ORDER (Cont.)
15F-10367
PAGE - 3
Your request for gastric bypass was not approved. There is insufficient documentation of a structured medically supervised weight loss program for at least 6 months to show a diligent attempt to lose weight.
3. The Petitioner has been diagnosed with

is seeking the gastric bypass procedure as a means of achieving weight loss.
4. The Respondent's witness, Dr. Osorio, testified that the applicable medical necessity criteria for this type of surgery require there be documentation that the patient has tried and failed a medically supervised weight loss program for at least six months prior to approval of the surgery. Dr. Osorio also stated the medical records submitted by the Petitioner's treating physician refer to various diet programs, but there is no supporting documentation such as diet logs detailing what foods were being consumed by the patient.
5. The Petitioner believes her request for the gastric bypass should be approved because she has tried different diets and exercise but is still gaining weight. She states she is 100 pounds overweight and has difficulty walking due to pain in her knee. She also states she consulted a nutritionist in 2013 to obtain a diet plan.
6. Services under the Medicaid State Plan in Florida are provided in accordance with the Respondent's Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July, 2012.

## CONCLUSIONS OF LAW

7. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Fla. Stat. § 120.80
8. This is a final order pursuant to Fla. Stat. § 120.569 and $\S 120.57$.

FINAL ORDER (Cont.)
15F-10367
PAGE-4
9. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
10. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the Petitioner. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at $1201,7^{\text {th }}$ Ed.).
11. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the Respondent. The Medicaid Handbook referred to above is incorporated by reference in Fla. Admin. Code R. 59G-4.001.
12. The Medicaid Handbook and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:
"Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
(a) Meet the following conditions:

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

FINAL ORDER (Cont.)
15F-10367
PAGE - 5
13. Although the Petitioner testified she has done all she can to try to lose weight, she must also satisfy each of the remaining components of the rule's requirements concerning medical necessity. Respondent's medical expert testified that medical necessity guidelines require a documented trial and failure of a medically supervised weight loss program, and this was not established in the Petitioner's pre-authorization request. Although the Petitioner's treating physician has requested the gastric bypass, this does not in itself establish that this service is medically necessary according to the rule provisions outlined above.
14. Petitioner has not established by a preponderance of the evidence that her requested gastric bypass procedure is medically necessary as defined by Fla. Admin. Code R. 59G-1.010(166). The submitted medical records do not contain sufficient documentation of a supervised weight loss program. After considering the evidence and relevant authorities set forth above, the undersigned concludes that the Petitioner has not met her burden of proof in establishing that the Respondent's action was incorrect.

## DECISION

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

## NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the Petitioner disagrees with this decision, the Petitioner may seek a judicial review. To begin the

FINAL ORDER (Cont.)
15F-10367
PAGE -6
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 $\qquad$ 14 day of March 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:

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

Mar 14, 2016

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 February 8, 2016 at approximately $1: 30$ p.m.

## APPEARANCES

For Petitioner:

For Respondent: Lisa Sanchez
Medical/Health Care Program Analyst
Agency for Health Care Administration

## STATEMENT OF ISSUE

At issue is whether or not Respondent's partial approval of Petitioner's request for 40 hours per week of home health services was correct. Petitioner requested 40 hours and 30 hours were approved. The burden of proof is assigned to Petitioner.

FINAL ORDER (Cont.)
15F-10369
PAGE - 2
 her at the hearing. Lisa Sanchez, Medical/Health Care Program Analyst, represented and appeared as a witness for Respondent, the Agency for Health Care Administration ("AHCA" or "Agency"). Respondent presented the following witnesses:

- Dr. Sloan Karver - Long Term Care Medical Director - UnitedHealthcare
- Christian Laos - Senior Compliance Analyst - UnitedHealthcare

Petitioner's representative gave oral testimony, but did not move any exhibits into evidence. Respondent's Exhibits 1 through 6 were entered into evidence. The undersigned took administrative notice of the July 2012 Florida Medicaid Provider General Handbook.

## FINDINGS OF FACT

1. Petitioner is a 102-year-old female. Petitioner receives both Medicare and Medicaid. She is enrolled with UnitedHealthcare ("United") as both her Managed Medical Assistance ("MMA") plan and her Long Term Care ("LTC") plan.
2. Petitioner is unable to walk and has digestive problems, including and Her grandson testified she has many food intolerances, resulting in gas, cramps, and 10 to 12 bowel movements per day. He has to transfer her to and from the toilet each time.
3. Petitioner requires total assistance with all her Activities of Daily Living ("ADLs") and Instrumental Activities of Daily Living ("IADLs"). She lives with her 75-year-old daughter and her 51-year-old grandson. Her grandson is her primary caregiver. Her daughter

FINAL ORDER (Cont.)
15F-10369
PAGE - 3
used to assist more with her care, but is unable to due to her own age and physical decline.
4. On October 22, 2016, Petitioner's Case Manager, Stephanie Noriega, completed an LTC Assessment, where she recommended services for Petitioner, and provided a range of recommended minutes per day for each service. Dr. Karver then subsequently approved a certain amount of services. For example, in section 3.1, regarding bathing, ecommended a range of 31-50 minutes per day, and Dr. Karver approved 45 minutes per day. (Respondent's Exhibit 5).
5. The sum total of the minimum amount of time for each recommended service, based upon the range provided by for each service, is 2,625 minutes per week, which is 43.75 hours per week. The sum total of the maximum amount of recommended time is 3,045 minutes per week, which is 50.75 hours per week. Dr. Karver approved 1,847 minutes per week, which is 30.78 hours per week. At hearing, Dr. Karver agreed to round up and approve 31 hours per week, instead of the previously approved 30 hours.
6. Petitioner requested 40 hours per week of home health services, specifically 15 hours of Personal Care, 15 hours of Homemaking, and 10 hours of Companion Care. On October 28, 2015, United issued a Notice of Action, Respondent's Exhibit 3, partially approving the request. The Notice stated, in pertinent part:

You asked for 40 hours of care at home a week.
Your care plan for help is based on how much help you need. Needs in Florida Medicaid are defined by the law. For a service to be needed it must treat a problem. It must also be common practice. It must also be just for you. It must also not be in excess of your needs. It must also be safe. It must also be the least costly treatment in the state that meets your needs.

FINAL ORDER (Cont.)
15F-10369
PAGE-4
It must also not be for the convenience of you or another person. The fact that a doctor orders a service does not make it needed or covered.

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

The numbers of minutes approved were added together. Additional minutes were added to round up to the next hour if needed. The hours were approved as a total amount of time. Hours are not required to be used for a specific task. You are able to use these hours in addition to any help from relatives or other resources.

The total number of hours approved is 30 hours per week.
7. Dr. Karver was concerned Petitioner's grandson was incorrectly under the impression that the 40 hours would definitely be approved. only makes recommendations, but Dr. Karver makes the final approval decision. She stated the approved hours could be broken down however desired in order to meet Petitioner's needs. It does not have to be a set amount of Personal Care, Companion Care, and Homemaking services. Petitioner's grandson can work with her case manager regarding what specific services are needed.
8. Petitioner's grandson stated he currently takes care of her up to 18 hours in a given day. He said family will come help when he's out shopping or running errands, but they live 30 minutes away.
9. Dr. Karver said the family should consider putting Petitioner in a nursing home or assisted living facility. Petitioner's grandson said they have considered it, but that her mind is clear and she has adamantly refused. She said if she dies she wants to die at home.

FINAL ORDER (Cont.)

## 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 § 120.80, Fla. Stat.
11. This hearing was held as a de novo proceeding, in accordance with Florida Administrative Code Rule 65-2.056.
12. This is a Final Order, pursuant to Sections 120.569 and 120.57, Fla. Stat.
13. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, $7^{\text {th }}$ Ed.).
14. Legal authority governing the Florida Medicaid Program is found in Fla. Stat. Chapter 409, and in Chapter 59G of the Florida Administrative Code. Respondent, AHCA, is the single state agency that administers the Medicaid Program.
15. 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...."
16. 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.
17. 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.
18. Page 1-2 of the Home Health Handbook defines "Home Health Services," stating:

FINAL ORDER (Cont.)
15F-10369
PAGE-6
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.
19. The definition of "medically necessary" is found in Fla. Admin. Code R.59G-1.010,
which states, in part:
(166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
(a) Meet the following conditions:

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

20 rovided a wide range of recommended time, anywhere between 43.75
hours per week and 50.75 hours per week. Petitioner's request of 40 hours per week is less than the minimum recommended time. The 30 approved hours are 13.75 hours less than the minimum recommended time.

FINAL ORDER (Cont.)
15F-10369
PAGE-7
21. It is undisputed that Petitioner requires total assistance with all of her ADLs and IADLs. It may also be true that Petitioner would be better suited for a nursing home or assisted living facility at this time. However, Petitioner wishes to remain at home.
22. The Florida Statutes require AHCA to provide home and community-based services for long-term care, using a managed care model. The limitation on the services provided is that they must be medically necessary.
23. In the instant-matter, Dr. Karver, on behalf of United, determined that the requested 40 hours is in excess of Petitioner's needs. The undersigned disagrees. Considering that ninimum recommendation is more than Petitioner requested, as well as her grandson's testimony and the entire record in this case, the undersigned concludes Petitioner has met her burden of proof to show that the 40 hours of home health services are not in excess of her needs and are medically necessary.

## DECISION

Based upon the foregoing, Petitioner's appeal is GRANTED. Respondent is directed to provide Petitioner with the requested 40 hours per week of home health services.

## NOTICE OF RIGHT TO APPEAL

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

FINAL ORDER (Cont.)
15F-10369
PAGE - 8
DONE and ORDERED this $\qquad$ day of $\qquad$ , 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: Petitioner
Judy Jacobs, Area 7, AHCA Field Office

Mar 04, 2016
STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES OFFICE OF APPEAL HEARINGS

PETITIONER,
Vs.
CASE NO.
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 19 ST. LUCIE
UNIT: AHCA

## RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in Ft.
Pierce, Florida on February 15, 2016 at 10:39 a.m.

## APPEARANCES

For the Petitioner:

For the Respondent:
Linda Latson
Registered Nurse Specialist

## ISSUE

Whether the denial of petitioner's request for 12 additional hours of personal care services per week was proper. The burden of proof was assigned to the petitioner.

## PRELIMINARY STATEMENT

Petitioner was present and represented by her daughter. Petitioner's exhibits "1" and " 2 " were accepted into evidence.

Ms. Latson appeared as both a representative and witness for the respondent. Also present from the Agency for Healthcare Administration was Lisa Sanchez, Medical Health Care Program Analyst. Present telephonically from Sunshine Health were: India Smith, Grievance and Appeals Coordinator; Dr. John Carter, Medical Director; Jodie Munez, Long Term Care Case Manager Supervisor; Teresa Barron-Gornto, Long Term Care Manager; and Carolyn Smith, Long Term Care Director of Case Management. Respondent's exhibit "1" was accepted into evidence.

The record was held open through February 22, 2016 for respondent to provide information regarding the Participant Directed Option (PDO); services available through the Long Term Managed Care Program (LTMC Program); and whether a notice was required prior to ending personal care services. PDO information and services in the LTMC Program were timely provided and entered as respondent's exhibits " 2 " and " 3 ".

The record was held open through February 29, 2016 for the petitioner to respond in writing to post hearing submissions. A response 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 is 87 years of age and resides with her daughter. The daughter is also petitioner's representative in this matter.
2. The daughter is employed. Her work scheduled is 9:00 a.m. to 5:00 p.m.; Monday through Friday.
3. Petitioner was, at all times relevant to this proceeding, Medicaid eligible. She is enrolled in respondent's LTMC Program.

FINAL ORDER (Cont.)
15F-10379
PAGE-3
4. Respondent administers Florida's Medicaid Program and contracts with Health Maintenance Organizations (HMOs) to provide comprehensive, cost-effective medical services to Medicaid recipients in the LTMC Program.
5. Respondent does not have a promulgated Coverage and Limitations Handbook for the LTMC Program. LTMC services are defined by contract.
6. Since September 1, 2013 petitioners' LTMC services have been provided by Sunshine Health.
7. Petitioner is also enrolled in respondent's PDO Program. The program allows family members to be paid for caregiver services.
8. Petitioner's diagnoses include Petitioner also has
resulted in a one month hospitalization.
9. Petitioner requires assistance with all activities of daily living (bathing; dressing; eating; transferring; and walking). She is incontinent of bladder and bowel.
10. Petitioner was approved for 18 hours of personal care and 18 hours of homemaker services each week. For approximately one year, the services were provided by petitioner's daughter/representative.
11. The services were provided twice a day in three hour increments; six days per week.
12. On October 14, 2015, Sunshine Health received a request for additional personal care hours. On November 12, 2015 Sunshine Health issued a Notice of Action denying

FINAL ORDER (Cont.)
15F-10379
PAGE - 4
an additional 33 hours per week of personal care services. Sunshine Health determined the requested hours were not medically necessary.
13. In response to the notice of November 12, 2015, petitioner's representative requested an internal appeal. On December 1, 2015 Sunshine Health issue correspondence upholding the original denial. The correspondence stated, in part:

This case was reviewed by Sunshine Health's Medical Director, who is Board Certified in Emergency Medicine \& 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 an additional 33 hours of personal care per week. The member needs assistance with all activities of daily living and needs total assistance with all instrumental activities of daily living except for using the telephone. She is currently receiving 18 hours of personal care and 18 hours of home making care per week for a total of 36 hours per week. Based on the needs of the Comprehensive Assessment (701B) dated October 13, 2015, it was calculated the member is currently receiving more hours than needed.
14. On December 17, 2015 petitioner's representative timely contacted the Office of Appeal Hearings and requested a fair hearing. The hearing request states, in part: "Sunshine was paying her for 6 hrs . of caretaker services per day. Requested additional 2 hours. Sunshine has denied saying they cannot pay for her services due to conflict of interest."
15. Petitioner states an additional 33 service hours per week was never requested.

Rather, an additional 12 hours per week was requested. Respondent states confusion existed due to a change in case managers.
16. The parties stipulated an additional 12 hours per week of personal care services is the issue before the undersigned. Regarding 12 additional hours, respondent's position was unchanged.

FINAL ORDER (Cont.)
15F-10379
PAGE-5
17. An issue arose with the PDO Program concerning the petitioner's representative signing her own time sheet. Due to petitioner's cognitive status, she was unable to sign timesheets. The last time petitioner's representative was paid for providing personal care service/homemaker services was in October 2016.
18. At an unspecified date in January or February 2016, personal care/homemaker services were replaced with Adult Day Care (ADC) services. Personal care/homemaker services have not been received since at least February 1, 2016.
19. Sunshine Health did not issue a notice ending services. Respondent argues services were placed on hold due a conflict of interest concerning the representative signing her own time sheet. At that time, Adult Day Care was approved. Personal care/ homemaker services would be available if provided by someone other than petitioner's representative. In such an instance, the representative would sign that person's timesheet.
20. Respondent asserts the representative signing the timesheet is a conflict of interest. As such, this is the primary reason for denial.
21. Petitioner now attends the ADC program Monday through Friday from 9:00 a.m. to 5:00 p.m.
22. Petitioner argues she thought personal care would continue in addition to the Adult Day Care. Personal care assistance is still needed in the mornings and evenings.
23. The representative's step-daughter and a neighbor have provided assistance to the petitioner. Their assistance is not through the PDO program.

## CONCLUSIONS OF LAW

24. 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.
25. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R.

65-2.056.
26. The standard of proof in an administrative hearing is by a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at $1201,7^{\text {th }}$ Ed.).
27. 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.
28. Sunshine Health is the managed care entity providing petitioner's LTMC services.
29. Regarding the LTMC Program, Sunshine Health and the respondent entered into a contractual relationship. The contract defines required services.
30. Definitions for the LTMC Program are found on respondent's website at:
http://www.fdhc.state.fl.us/medicaid/statewide mc/pdf/Contracts/2015-1101/Exhibit II-B-Long-term Care LTC Program 2015-11-01.pdf
31. Definitions include:
(2) Adult Day Health Care - Services provided pursuant to Chapter 429, Part III, F.S. Services furnished in an outpatient setting which encompass both the health and social services needed to ensure optimal functioning of an enrollee, including social services to help with personal and family
problems and planned group therapeutic activities. Adult day health care includes nutritional meals. Meals are included as a part of this service when the patient is at the center during meal times. Adult day health care provides medical screening emphasizing prevention and continuity of care, including routine blood pressure checks and diabetic maintenance checks. Physical, occupational and speech therapies indicated in the enrollee's plan of care are furnished as components of this service. Nursing services, which include periodic evaluation, medical supervision and supervision of self-care services directed toward activities of daily living and personal hygiene, are also a component of this service. The inclusion of physical, occupational and speech therapy services, and nursing services as components of adult day health services does not require the Managed Care Plan to contract with the adult day health provider to deliver these services when they are included in an enrollee's plan of care. The Managed Care Plan may contract with the adult day health care provider for the delivery of these services or the Managed Care Plan may contract with other providers qualified to deliver these services pursuant to the terms of this Contract.
(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.
32. Florida Medicaid, which includes the LTMC Program, only covers those services determined to be medically necessary. See § 409.905 (4) (c), Fla. Stat.
33. 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;

FINAL ORDER (Cont.)
15F-10379
PAGE - 8
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider...
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.
34. Analysis is first directed to personal care and homemaker services placed on hold by Sunshine Health. In regard to this action, the Findings of Fact establish no notice was issued.
35. 42 C.F.R. states, in part:
§431.201 Definitions.
Action means a termination, suspension, or reduction of Medicaid eligibility or covered services...

Notice means a written statement that meets the requirements of §431.210.
§431.206 Informing applicants and beneficiaries.
(b) The agency must, at the time specified in paragraph (c) of this section, inform every applicant or beneficiary in writing-
(1) Of his right to a hearing;
(2) Of the method by which he may obtain a hearing; and
(3) That he may represent himself or use legal counsel, a relative, a friend, or other spokesman.
(c) The agency must provide the information required in paragraph (b) of this section-(1) At the time that the individual applies for Medicaid;
(2) At the time of any action affecting his or her claim; [Emphasis Added]
§431.210 Content of notice.
A notice required under § 431.206 (c)(2), (c)(3), or (c)(4) of this subpart must contain-
(a) A statement of what action the State, skilled nursing facility, or nursing facility intends to take;
(b) The reasons for the intended action;
(c) The specific regulations that support, or the change in Federal or State law that requires, the action;
(d) An explanation of-
(1) The individual's right to request an evidentiary hearing if one is available, or a State agency hearing; or
(2) In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and
(e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested.
§431.213 Exceptions from advance notice.
The agency may send a notice not later than the date of action if-
(a) The agency has factual information confirming the death of a beneficiary;
(b) The agency receives a clear written statement signed by a beneficiary that-
(1) He no longer wishes services; or
(2) Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;
(c) The beneficiary has been admitted to an institution where he is ineligible under the plan for further services;
(d) The beneficiary's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address (See $\S 431.231$ (d) of this subpart for procedure if the beneficiary's whereabouts become known);
(e) The agency establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;
(f) A change in the level of medical care is prescribed by the beneficiary's physician; ...

FINAL ORDER (Cont.)
15F-10379
PAGE - 10
36. Sunshine Health's placing personal care and homemaker services on hold represents a suspension of services. As such, an action was taken which required issuance of a notice.
37. An exception to advance notice was not established by the respondent.
38. Due to the lack of notice, petitioner was unable to exercise rights associated with the services being continued pending the outcome of the fair hearing process ${ }^{1}$.
39. A notice suspending personal care and homemaker services should have been issued by Sunshine Health.
40. Analysis is next directed as to whether the need for 12 additional hours of personal care services has been demonstrated.
41. Respondent's notice of November 12, 2015 states the denial was based on medically necessity. At time of hearing, respondent argued the representative's signature of time sheets reflected a conflict of interest. This denial rationale was not contained in the notices of November 12, 2015 or December 1, 2015. Respondent continued to argue that 12 hours of personal care represents a conflict of interest. 42. The Findings of Fact establish petitioner has dementia and requires assistance with all activities of daily living. The definition for adult day care includes assistance with personal care during the hours of attendance. Petitioner attends adult day care from 9:00 to 5:00 each weekday.

43 Respondent's notice of December 1, 2015 does not dispute petitioner requires assistance with all activities of daily living. The notice also identifies total assistance is needed with most instrumental activities of daily living.

[^4]FINAL ORDER (Cont.)
15F-10379
PAGE - 11
44. Respondent argues personal care was placed on hold due to a conflict of interest regarding timesheet signatures. This argument does not refute the need for personal care assistance. Rather, the argument is process-based.
45. The issue before the undersigned is not who can provide personal care services.

Rather, the issue focuses on whether the need for 12 hours of personal care has been demonstrated.
46. The Findings of Fact establish petitioner's representative works each weekday from 9:00 a.m. to 5:00 p.m.
47. Testimony regarding the need for personal care either before or after the representative's work schedule is found to be credible.
48. Petitioner's representative has met the required evidentiary standard. Personal care services at 12 hours per week has been demonstrated to satisfy each criterion of medical necessity.
49. Regarding the lack of notice, respondent cannot be ordered to reinstate services for a time period which has passed.
50. Should personal care services be, at a future date, suspended due to PDO timesheet requirements, a Notice of Action is to be issued to the petitioner.

FINAL ORDER (Cont.)
15F-10379
PAGE - 12

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, petitioner's
appeal is GRANTED. Respondent is to approve 12 hours of personal care services per
week.

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this $\qquad$ day of $\qquad$ March , 2016,
in Tallahassee, Florida.


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

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

PETITIONER,
Vs.
AGENCY FOR HEALTH
CARE ADMINISTRATION (AHCA)
CIRCUIT: 04 Duval
UNIT: AHCA
RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter at the Department of Children and Families Regional Program Office in Jacksonville, Florida on March 2, 2016 at 10:25 a.m.

## APPEARANCES

For the Petitioner:

For the Respondent: Sheila Broderick, registered nurse specialist with AHCA

## STATEMENT OF ISSUE

Whether the respondent was correct to deny the petitioner's request for dental implants. 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 October 7, 2015, United informed the petitioner that her request for dental implants through Medicaid was denied. The notice reads in pertinent part: " $[t]$ he requested service is not a covered benefit."

The petitioner requested reconsideration.
By notice dated November 17, 2015, United informed the petitioner that the original denial decision was upheld.

The petitioner timely requested a hearing on December 17, 2015.
The petitioner was present and testified. The petitioner's daughter, appeared as a witness on her behalf. The petitioner submitted documentary evidence which was admitted to the record as Petitioner's Composite Exhibit 1.

The respondent presented three witnesses from United: Susan Frishman, senior compliance analyst; Lauri Eubanks, account manager; and Dr. Brittany Vo, dental consultant. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

The record was held open until close of business on the day of the hearing for the submission of additional evidence. Evidence was received from the respondent and admitted as Respondent's Composite Exhibit 2. The petitioner requested additional time to submit her evidence. The deadline was extended until close of business on

FINAL ORDER (Cont.)
15F-10381
PAGE - 3

March 4, 2016. The petitioner did not submit additional evidence and did not request another deadline extension. The record was closed on March 4, 2016.

## FINDINGS OF FACT

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

1. The petitioner (age 51) is a Florida Medicaid recipient. The petitioner is enrolled with United HMO. The petitioner's medical diagnoses include

2. All Medicaid goods and services must be medically necessary. Specified goods and services require prior authorization that is performed by the respondent, a contracted HMO or other designee.
3. The petitioner is toothless. She visited a dentist in late 2015 for dentures. The dentist determined that the petitioner required oral surgery in order to receive dentures and referred her to an oral surgeon. The oral surgeon filed a prior service authorization request with United for two dental implants (procedure code D6010) in October 2015.
4. The surgeon's clinical notes read in pertinent part:
[Petitioner] is a very pleasant 51 y[ear] o[ld] female who presents to our clinic today...for mandibular vestibuloplasty. Patient is completely edentulous [toothless] and reports smoking 1 pack per day.

FINAL ORDER (Cont.)
15F-10381
PAGE-4
[Patient unable] to comfortably wear mandibular [lower] denture. Patient would benefit from implant retained mandibular [lower] denture.
5. United determined that requested dental implants were a non-covered benefit and denied the service request.
6. The petitioner argued that dental implants are medically necessary due to which has weakened bones throughout her body, including her lower jaw bone. Her lower jaw bone is not strong enough to support dentures. She requires dental implants in her lower jaw which would attach to the denture and hold it firmly in place.
7. The petitioner has been wearing a temporary upper denture for seven years; only an upper denture, she does not have a lower denture. She has not been able to replace the temporary upper denture with a permanent set of full dentures because she has no source of income. The temporary upper denture frequently falls out even when the petitioner uses a sealing bond. The petitioner cannot eat chewy or hard foods because the pain is too great. She is able to eat only soft foods which do not require significant chewing. Because of the restricted diet necessitated by her dental condition, the petitioner is under weight. Her overall health has suffered because she does not intake the recommended amount of daily vitamins and minerals. She is embarrassed in social situations because she is afraid her denture will fall out while talking or eating. She suffers from depression because of her situation.
8. Dr. Vo, dental consultant with United, argued that all Medicaid covered dental services are published in a Dental Fee Schedule by procedure code. The requested
procedure code, D6010 -Implant, is not included on the Dental Fee Schedule and therefore is not a covered service.
9. Dr. Vo argued further that even if the requested procedure was covered, the request would have been denied because the clinical information does not prove that a dental implant is medically necessary. The petitioner's oral surgeon wrote that she would "benefit" from dental implants. He did not write that the implants were "medically necessary."
10. On cross examination, Sheila Broderick, registered nurse specialist with AHCA, testified that the Dental Fee Schedule is not an all-inclusive list of covered dental services. The schedule does not contain every covered dental service because Medicaid rules allow for individualized services based on the clinical judgement of the treating dental expert.

## CONCLUSIONS OF LAW

11. By agreement between the AHCA and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Section 120.80, Florida Statutes.
12. This is a final order pursuant to Sections120.569 and 120.57, Florida Statutes
13. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
14. In accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof was assigned to the petitioner.

FINAL ORDER (Cont.)
15. The standard of proof in an administrative hearing is by a preponderance of the evidence (See Fla. Admin. Code R. 65-2.060(1)). The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at $1201,7^{\text {th }}$ Ed.).
16. The Florida Medicaid Program is authorized by Chapter 409 Florida Statutes and Fla. Admin. Code Chapter 59G.
17. Fla. Admin. Code R. 59G-1.010(166) explains that medical or allied care, goods, or services furnished or ordered must meet the definition of medically necessary or medical necessity, and defines medical necessity as:
"Medical necessary" or "medical necessity" means that medical or allied care, goods, or services furnished or ordered must:
(a) Meet the following conditions:

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

FINAL ORDER (Cont.)
15F-10381
PAGE-7
18. 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. ...

## 19. The Florida Medicaid Dental Handbook (Dental Handbook) addresses

covered adult services, ages 21 and over, on page 2-3:
The adult dental program provides for the reimbursement of full and removable partial dentures. Extractions and other surgical procedures essential to the preparation of the mouth for dentures are reimbursable if the patient is to receive dentures.
20. The Dental Handbook defines oral surgery on page 2-13 and expounds on covered services:

Oral surgery services include extractions as well as surgical and adjunctive treatment of diseases, injuries, deformities, and defects of the oral and maxillofacial [face or jaw bone] regions.

For recipients 21 years and older, Medicaid covers extractions and other surgical procedures essential to the preparation of the mouth for dentures.
21. The authorities cited above explain that oral surgery needed to prepare a patient's mouth for dentures is covered in the Medicaid Adult Dental Program.
22. The petitioner's oral surgeon requested authorization to place dental implants in her lower jaw in order to prepare her mouth for dentures. The petitioner suffers from
23. The respondent denied the implant surgery as a non-covered dental benefit.
24. The controlling legal authorities state that oral surgery, including surgery to the face or jaw bone, required to prepare a patient for dentures is a covered service in the Medicaid Adult Dental Program. The undersigned concludes that the respondent's denial decision in this matter was incorrect. The requested dental implant surgery is covered by Medicaid because it is preparing the petitioner's mouth for dentures.
25. The respondent argued that it would have also denied the service request because the oral surgeon wrote that the petitioner would "benefit" from the implant surgery; he did not use the words "medically necessary."
26. The undersigned concludes that the respondent's interpretation of the controlling legal authorities is too restrictive. The rules do not specify that requests must include the words "medically necessary." However, the supporting clinical evidence must be prove that requested services are medically necessary.
27. The evidence proves that the requested dental surgery is necessary due to serious illness, are not in excess of the petitioner's needs; are consistent with generally accepted professional standards regarding health; are reflective of the level of service that can be safely provided for which there is no equally effective service; and are not for the convenience of the petitioner. The undersigned concludes that is medically necessary for the petitioner to receive the requested dental implants.

FINAL ORDER (Cont.)
28. After carefully reviewing the evidence and the controlling legal authorities, the undersigned concludes that the petitioner met her burden of proof in this matter. The respondent's decision in this matter was incorrect.

## DECISION

The appeal is GRANTED. The respondent is ordered to approve the dental implant surgery.

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this _14 day of __ March , 2016,
in Tallahassee, Florida.


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

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

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

Mar 11, 2016


PETITIONER,
Vs.
AGENCY FOR HEALTH
CARE ADMINISTRATION (AHCA)
CIRCUIT: 01 Escambia
UNIT: AHCA
RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 10, 2016 at 10:05 a.m.

## APPEARANCES

For the Petitioner: $\square$ mother of petitioner

For the Respondent: Cindy Henline, medical health care analyst with AHCA

## STATEMENT OF ISSUE

Whether it is medically necessary for the petitioner to have a bilateral mastectomy. 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

FINAL ORDER (Cont.)
PAGE - 2
with numerous health care organizations to provide medical services to its program participants. Humana Health of Florida (Humana) is the contracted health care organization in the instant case.

By notice dated November 11, 2015, Humana informed the petitioner that his request for a $\quad$ through Medicaid was denied. The notice reads in pertinent part:

Based on a review of part of your medical records it is noted that you have a diagnosis of Your record does not show that you meet Medicaid Criteria for a mastectomy.

The petitioner timely requested a hearing to challenge the denial decision on December 17, 2015.

There were no additional witnesses for the petitioner. The petitioner did not submit exhibits.

The respondent presented several witnesses from Humana: Dr. Ian Nathanson, medical director; Stacey Larson, clinical guidance analyst; and Mindy Aikman, grievance and appeals specialist. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1. Administrative notice was taken of Practitioner Services Coverage and Limitation Handbook (April 2014).

## 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:

FINAL ORDER (Cont.)
15F-10384
PAGE - 3

1. The petitioner (age 17) is a Florida Medicaid recipient. The petitioner is enrolled with Humana HMO. The petitioner's medical diagnoses include and
2. All Medicaid goods and services must be medically necessary. Specified goods and services require prior authorization that is performed by the respondent, a contracted HMO or other designee.
3. The petitioner's treating physician filed a prior authorization request with

Humana to perform a bilateral mastectomy on October 17, 2015.
4. The treating physician's clinical notes read in pertinent part:

He's here in referral for evaluation of He has noted enlargement of the breasts since about 2 years ago. He says the breasts slowly enlarged. He started playing football, lost weight, and the breasts did not get smaller. He was bullied on the football team about the breasts, and he eventually quit. He has seen endocrinology about the problem and they recommended he see a surgeon. He has some occasional pain at the site, at odd times, and due to anything special. He is very embarrassed by the appearance, and avoids PE class or sports because of it.

I discussed the diagnosis with the patient and his mother. I told him that the excess tissue can be removed, but it doesn't have to be removed for fear of cancer or serious illness. There are risks of surgery including infection, bleeding, scarring, saucerization, a poor cosmetic effect, fluid accumulation, drains postop, and other unanticipated complications that might occur. He and his mother both think he needs the surgery. It's currently interfering with his life, keeping him from participating in PE class or sports. We will schedule during Christmas holidays.
5. Humana determined that the breast tissue was mostly due to the petitioner's weight. At the time of the request he weighed 237 pounds, height 5'5". The notes of the reviewing physician read: "With the information submitted, this procedure is mostly

FINAL ORDER (Cont.)
15F-10384
PAGE-4
cosmetic nature [sic]. Unable to support the medical necessity of the requested service with the clinical information submitted by the provider."
6. Humana denied the petitioner's request on November 11, 2015.
7. The petitioner's mother argued that the surgery should be authorized because the petitioner is embarrassed about the size of his breasts. He is teased by other kids. The teasing makes him feel depressed. He has verbalized thoughts of suicide. The petitioner has lost approximately 20 pounds, the weight loss did not reduce the size of his breast.
8. The petitioner continues to do well in his academic classes, he makes good grades and would like to be a doctor someday. He quit football because other children teased him, but he participates in other school activities, like ROTC.
9. Dr. Nathanson, medical director with Humana of Florida, opined that there is no medical reason for the petitioner to have this surgery. The breast tissue is not cancerous or causing the petitioner physical illness. Medicaid rules prohibit provision of services for purely cosmetic reasons. Dr. Nathanson also noted that there is no record that the petitioner received extended psychiatric services to address his feelings about being teased because of his appearance.

## CONCLUSIONS OF LAW

10. By agreement between the AHCA and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Section 120.80, Florida Statutes.
11. This is a final order pursuant to Sections 120.569 and 120.57 Florida Statutes.
12. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
13. In accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof was assigned to the petitioner.
14. The standard of proof in an administrative hearing is by a preponderance of the evidence (See Fla. Admin. Code R. 65-2.060(1)). The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at $1201,7^{\text {th }}$ Ed.).
15. The Florida Medicaid Program is authorized by Chapter 409 Florida Statutes and Fla Admin. Code Chapter 59G.
16. Fla. Admin. Code R. 59G-1.010(166) explains that medical or allied care, goods, or services furnished or ordered must meet the definition of medically necessary or medical necessity, and defines medical necessity as:
"Medical necessary" or "medical necessity" means that medical or allied care, goods, or services furnished or ordered must:
(a) Meet the following conditions:
17. Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
18. 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;
19. Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational;
20. 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,
21. 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. 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, Florida Statues, Mandatory Medicaid services, defines Medicaid services for children to include:

## (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT

 SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems...18. The cited Medical Necessity authority explains that Medicaid goods and services cannot be in excess of the patient's needs. EPSDT expands the Medical Necessity definition and requires provision of all services determined necessary for the treatment, correction, or amelioration of the identified medical illness.
19. The respondent denied the petitioner's request for a bilateral mastectomy. The respondent concluded that the size of the breast tissue was mostly due to the petitioner's weight and the required procedure was for cosmetic reasons.

FINAL ORDER (Cont.)
15F-10384
PAGE-7
20. The petitioner's mother argued that he should receive the surgery due feelings of depression caused by the teasing of other children and the fact the recent weight loss did not reduce the size of the petitioner's breasts.
21. Dr. Nathanson, the only expert witness to testify during the hearing, opined that there is no medical reason for the petitioner to have the surgery. The breast tissue is not cancerous or causing the petitioner any physical illness. In addition, the clinical notes of the petitioner's treating physician also conclude that there is no medical reason for the surgery.
22. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the petitioner did not meet his burden in this matter. The petitioner did not prove by a preponderance of the evidence that is medically necessary that he have a

## 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.

FINAL ORDER (Cont.)
15F-10384
PAGE-8

DONE and ORDERED this $\qquad$ 11 day of March 2016, in Tallahassee, Florida.


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

Copies Furnished Tc Petitioner
Marshall Wallace, Area 1, AHCA Field Office Manager

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

Mar 16, 2016

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 29, 2016 at 1:30 p.m.

## APPEARANCES

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

## STATEMENT OF ISSUE

At issue is whether the Respondent's reduction of the Petitioner's home health aide services was correct. Respondent bear the burden of proving its case by a preponderance of the evidence.

## PRELIMINARY STATEMENT

The Petitioner did not submit any documents as evidence for the hearing.
The Respondent submitted the following documents into evidence, which were marked as Respondent Exhibit 1: fair hearing summary, notice of action and related documents, medical review criteria, and medical records.

Appearing as witnesses for the Respondent were India Smith, Grievance and Appeals Coordinator, Dr. Ernest Bertha, Medical Director, and Leslie Miranda, Program Specialist, for Sunshine Health Plans, which is the Petitioner's managed health care plan.

However, the Petitioner was
able to proceed with the hearing in English.

## FINDINGS OF FACT

1. The Petitioner is a sixty-five (65) year old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) - Managed Medical Assistance (MMA) plan. He receives services under the plan through Sunshine Health.
2. The Agency for Health Care Administration (AHCA) is responsible for management of the managed care plan contracts; statewide policy decisions and interpretation of all federal and state laws; and rules and regulations governing the contract. Managed Care Organizations such as Sunshine Health provide services to Medicaid recipients pursuant to a contract with AHCA.

FINAL ORDER (Cont.)
15F-10385
PAGE - 3
3. The Petitioner lives alone and utilizes a cane for ambulation. His medical issues


He has experienced heart attacks in the past and has difficulty breathing.
4. On or about September 29, 2015, Petitioner's home health services provider submitted an authorization request to Sunshine for continuation of approval of three hours of home health aide services daily.
5. On or about October 12, 2015, Sunshine informed the Petitioner by written notice that his request for home health aide services had been denied because that service was only for individuals under age 21. Petitioner then followed the grievance/appeal process with Sunshine.
6. Sunshine subsequently modified its decision and approved ten (10) home health aide visits every two (2) weeks. Sunshine sent the Petitioner a written notice of this decision on December 3, 2015, which stated: "[o]ur decision is based on the additional medical documentation received for review, clinical judgment, standards of practice, and Sunshine Health Guideline."
7. The Petitioner testified he was previously receiving three hours daily of home health services, which consisted of the aide coming to his home once per day for those three hours. The aide helps him shower, brush his teeth, change his diapers, and cleans the home. He stated he needs assistance from the aide every day.
8. The Respondent's witness, Dr. Bertha, explained that the Petitioner was previously receiving three hours daily of home health services through Sunshine because the prior home health provider was providing services to some plan members to which they were not entitled. He stated the Petitioner is currently approved for 10

FINAL ORDER (Cont.)
15F-10385
PAGE-4
home health visits every 2 weeks, and one home health visit can be up to 2 hours of service.
9. Ms. Miranda, also with Sunshine, stated that the Petitioner's condition has worsened and he has had two recent hospitalizations.
10. Home health services under the Medicaid State Plan in Florida are provided in accordance with the Respondent's Home Health Services Coverage and Limitations Handbook ("Home Health Handbook"), effective October, 2014. In addition, all Medicaid services are provided in accordance with the Respondent's Provider General Handbook, effective July, 2012.

## CONCLUSIONS OF LAW

11. 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.
12. This is a final order pursuant to Fla. Stat. § 120.569 and $\S 120.57$.
13. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
14. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the Respondent since it is seeking a reduction in Petitioner's services. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, $7^{\text {th }}$ Ed.).
15. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered

FINAL ORDER (Cont.)
15F-10385
PAGE - 5
by the Respondent. The Home Health Handbook is incorporated by reference in
Chapter 59G-4, Florida Administrative Code.
16. The Home Health Handbook, on page 2-18, describes home health aide visits as follows

Home health aide services help maintain a recipient's health or facilitate treatment of the recipient's illness or injury. The following are examples of home health aide services reimbursed by Medicaid:

- Assisting with the change of a colostomy bag
- Assisting with transfer
- Reinforcing a dressing
- Assisting the individual with prescribed range of motion exercises that have been taught by the RN
- Measuring and preparing prescribed special diets
- Providing oral hygiene
- Bathing and skin care
- Assisting with self-administered medication

Home health aides must not perform any services that require the direct care skills of a licensed nurse.
17. The Home Health Handbook, on page 2-15, also states the following concerning home health visits:

Home health visits are limited to a maximum of three intermittent visits per day for non-pregnant adults age 21 and older. The visits can be any combination of licensed nurse and home health aide visits.

The minimum length of time between home health visits provided to a recipient on the same day must be at least one hour.
18. Sunshine was correct in its determination that hourly home health services are only for individuals under age 21 pursuant to the provisions of the Home Health Handbook. Since the Petitioner is over age 21, the appropriate service for him is home health visits. Therefore, Sunshine was correct in transitioning the Petitioner from hourly home health services to home health visits.

FINAL ORDER (Cont.)
15F-10385
PAGE-6
19. However, 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 Petitioner's home health services to 10 visits every 2 weeks. The evidence presented establishes that the Petitioner's condition has worsened and he needs at least one home health visit daily to help him change his diapers and take a shower. He should receive one visit daily rather than 10 visits every 2 week period.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is GRANTED, in part, and the Petitioner shall receive one (1) home health visit daily.

## NOTICE OF RIGHT TO APPEAL

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

FINAL ORDER (Cont.)
15F-10385
PAGE-7
DONE and ORDERED this $\qquad$ day of March , 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: PETITIONER

Mar 17, 2016

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

Office of Appeal Hearings Dept. of Children and Families


PETITIONER,

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES CIRCUIT: 07 St. Johns
UNIT: 88324

## RESPONDENT.

CASE NO.


## PRELIMINARY STATEMENT

Evidence was submitted and entered as the Respondent Exhibits 1-3 and the Petitioner Exhibit 1.

The record was held open until 5:00 p.m. on February 17, 2016 to allow the petitioner and respondent to submit additional evidence. Evidence was received and entered as the Respondent Exhibit 3 and the Petitioner Exhibit 2.

## FINDINGS OF FACT

1. On September 14, 2015, the petitioner's representative applied for SSIRelated Medicaid on the petitioner's behalf. The Department's Data Exchange Inquiry system revealed that the petitioner held three joint bank accounts located at Suntrust with his girlfriend and power-of-attorney, LA.
2. The Respondent Exhibit 2, pages one, two, and three, includes the Data Exchange Inquiry screens, which show there was a joint bank account ending with 9680 at Suntrust with balances of $\$ 2456.79$ for September 2015 and $\$ 2048.96$ for October 2015;a Suntrust, account ending with 7849, with balances of $\$ 4989.71$ for September 2015 and $\$ 5987.58$ for October 2015; and another Suntrust account ending with 5244 with a balance of $\$ 8033.77$ for September 2015 and $\$ 0$ for October 2015.
3. On December 17, 2015, the Department denied the petitioner's application on its contention that his assets exceeded the asset limit.
4. The petitioner's representative contends that the petitioner was not given an opportunity to rebut the ownership of the joint bank accounts prior to denying the petitioner's application in December 2015.
5. On January 26, 2016, the Department sent to the petitioner's representative the "Decision Pending/Request for Verification." The "Decision Pending/Request for Verification" states: "Please contact this office by 02/05/2016 so that we can discuss your request...Assets: Verify Assets for all accounts that you wish to rebut or dispute. Full bank statements for all account for 08/2015-10/2015. Accounts ending in 59167849, 177275244 possibly suntrust accounts." The "Decision Pending/Request for Verification" also requests "Verify $\quad$ had no income from 08/01/2015-10/31/2015 by 2 letters from friends or relatives living out of home. (Letters should be signed listing address \& phone to be valid) Authorized rep in home is not a valid source" (Respondent Exhibit 2).
6. The petitioner's representative argues that she provided two letters from two collateral contacts on February 9, 2016 and February 10. 2016 to verify the petitioner had no income for the periods in question. The Petitioner Exhibit 2 includes letters from two collateral contacts. One of the letters from CP states that she has known the petitioner for the last three years and that he lived with LA, who paid all of the household expenses and provided a home for him free of charge. The other letter is from MM, who has known the petitioner for the last four years. MM states in the letter that the petitioner was not working and lived with LA, who provided a home for him and paid all of the expenses.
7. The petitioner's representative argues that the petitioner's girlfriend does not wish to provide bank statements for the requested months because she does not want the Department involved in her personal business. The petitioner's representative was
given the opportunity, post-hearing, to provide the requested bank statements for the periods in question but none were provided.
8. The petitioner's representative argues that the petitioner's girlfriend provided a letter stating that the jointly-owned accounts were for convenience purposes only and that the petitioner was on the accounts in case of an emergency. The petitioner's girlfriend also provided a letter stating that the petitioner has been living in her home for the past four years and that she paid all of the bills. The petitioner's girlfriend also stated in the letter that the petitioner has not supported the household as he has not worked since November 2014 (Respondent Exhibit 2, page 18).
9. The petitioner's representative argues that the petitioner was on a ventilator in the hospital from August 2015 until his demise on October 21, 2015 and could not access any of the funds in the account. The petitioner's representative believes the Department should grant a hardship in this case and not count the bank accounts as an asset.
10. It is the Department's contention that in order to successfully rebut the petitioner's ownership of the assets in question, the petitioner's girlfriend would also have to provide proof from the financial institution that the funds deposited into the accounts did not belong to the petitioner. The Department contends that the petitioner's girlfriend would need to provide correspondence from the financial institutions to verify the source of the funds being deposited into the accounts, as it is unclear if the funds being deposited belong to the petitioner or to his girlfriend.

## CONCLUSIONS OF LAW

11. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.
12. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
13. The Fla. Admin. Code R. 65A-1.712, SSI-Related Medicaid Resource

Eligibility Criteria, sets forth: "(1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is the

SSI limit specified in Rule 65A-1.716, F.A.C..."
14. The Fla. Admin. Code R. 65A-1.716 sets forth:
(3) The resource limits for the Medically Needy program are as follows:

Monthly
Asset
Family
Level
Size
\$5,000
15. The Fla. Admin. Code R. 65A-1.303 Assets states:
(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.
16. The Fla. Admin. Code R. 65A-1.712 SSI-Related Medicaid Resource Eligibility Criteria states in part:
(a) Resources of a comatose applicant (or recipient) are excluded when there is no known legal guardian or other individual who can access and expend the resource(s).
17. The above authorities explain that the asset limit for an individual in the Medically Needy program is $\$ 5000$. An asset is considered to be countable if the asset is available to a representative who is able to make the asset available to the individual and that an asset owned by an individual who is in a coma can be excluded if there is no other person who is able to access the asset. In this case, the petitioner's representative argues that the petitioner was on a ventilator during his stay at the hospital until his demise and had no access to the joint accounts. The findings show that the accounts in question were jointly owned with the petitioner's girlfriend, who had access to the funds but was uncooperative in providing the requested documentations from the financial institutions. Therefore, the undersigned concludes that the Department was correct to consider the joint bank accounts in question as available to the petitioner as assets due to his girlfriend's ability to access the bank accounts.
18. The Department's Program Policy Manual, passage 1640.0302.04 Proof Needed to Rebut Ownership (MSSI, SFP) explains the rebuttal process and states:

When an individual has unrestricted access to the funds in a joint account but does not consider himself an owner of part or all of the account funds, you must advise the individual that:

1. the funds are presumed to be his; and
2. he may rebut the presumption of ownership by presenting proof the funds belong to someone else.

To rebut the presumption of ownership, the individual must provide the following information:
First, the individual must provide a written statement and corroborating evidence from the financial institution(s) and other sources to substantiate:

1. any claims about ownership of the funds or interest from the funds;
2. the reasons for establishing the joint account;
3. whose funds were deposited into the account;
4. who made withdrawals from the account; and
5. information on how withdrawals were spent.

Second, the individual must provide a written statement from the joint owner(s) explaining their understanding of the ownership of the account(s); that is, claims of ownership, why the account was set up, who deposited funds, withdrew funds and used the account.

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.
19. The above authority explains that the rebuttal process involves two steps.

The first step includes providing written statements and corroborating evidence from the financial institution to verify the owner of the funds and who made the withdrawals. The second step involves providing a written statement from the joint owner explaining the reason the account was set up as well as who deposited, withdrew, and used the funds in the account. The evidence must clearly support the individual's claim that he or she is not joint owner of the funds in the accounts in order to obtain a successful rebuttal of the ownership of the asset.
20. In this case, the petitioner is deceased and the petitioner's representative is seeking Medicaid coverage for the months of August 2015 through October 2015. The petitioner's representative believes the Department should consider a hardship in this
case as the petitioner was on a ventilator and had no access to the funds in the jointlyowned accounts. The findings show that the petitioner's assets exceeded the asset limit for the SSI-Related Medicaid program amount for the periods in question and that the petitioner's representative did not provide verifications from the financial institutions to successfully rebut the petitioner's ownership of the assets in question. Based on the findings of fact and conclusions of law, the undersigned concludes that the petitioner did not meet his burden to prove that he did not own the assets in question. The undersigned concludes that the Department was correct to include as assets the jointly owned accounts and deem the petitioner ineligible for SSI-Related Medicaid for the retroactive months of August 2015 through October 2015.

## 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 17 day of $\quad$ March , 2016,
in Tallahassee, Florida.


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

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

APPEAL NO. 15F-10421
PETITIONER,
Vs.
AGENCY FOR HEALTH CARE ADMINISTRATION CIRCUIT: 01 SANTA ROSA
UNIT: AHCA
RESPONDENT.


## FINAL ORDER

Pursuant to notice, a telephonic administrative hearing was convened on
February 9, 2016 at 1:09 p.m.
APPEARANCES
For the Petitioner:

For the Respondent:
Cindy Henline Medical Healthcare Program Analyst

## ISSUE

Whether respondent's denial of petitioner's request for home health aide visits by a skilled nurse was proper. As home health visits are an initial service request, the burden of proof was assigned to the petitioner.

## PRELIMINARY STATEMENT

Present for the petitioner was Robin May, Social Worker. Petitioner's exhibit "1" was accepted into evidence.

FINAL ORDER (Cont.)

Ms. Henline appeared as both a representative and witness for the respondent. Present for the respondent from Humana were Stacey Larsen, Clinical Guidance Analyst; Mindy Aikman, Grievance and Appeals Specialist; and Dr. Ian Nathanson, Medical Director. Respondent's exhibit "1" and "2" were accepted into evidence.

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

## FINDINGS OF FACT

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

1. Petitioner is 52 year old female. She resides with a minor aged son.
2. Petitioner was Medicaid eligible at all times relevant to this proceeding,
3. Petitioner's medical services are provided through respondent's Managed Medical Assistance (MMA) Program.

4 Humana is the managed care entity providing petitioner's MMA services.
5. Petitioner's diagnoses include
6. Due to chronic airway obstruction, petitioner utilizes a portable oxygen system.
7. Petitioner experiences difficulties completing many activities of daily living. In particular, bathing; nail care; and some accepts of dressing.
8. Due to petitioner is unable to wear shoes.

Additionally, she can stand only for short periods of time.

FINAL ORDER (Cont.)
15F-10421
PAGE - 3
9. Petitioner self-administers all medications.
10. A prior authorization was submitted on petitioner's behalf for three home health
visits per day; 7 days a week by a skilled nurse (See respondent's Exhibit "2").
11. On October 7, 2015 Human issued a Notice of Action denying the request as not being medically necessary. The notice stated, in part:

The facts that we used to make our decision are: The request for in home nursing care has been received. Based on a review of part of your medical record it is noted that you have a diagnosis of Your record does not show that you meet Medicaid Criteria tor in home nursing care.
12. Upon receipt of the above notice, petitioner requested an internal appeal with Humana.
13. A second reviewer thereafter considered all submitted information and, on

November 9, 2015, upheld the original decision.
14. On December 22, 2015 petitioner timely requested a fair hearing.
15. Petitioner argues home health visits of three times a day was not her intent. Due to her multiple medical issues she needs assistance with personal care and would also benefit from occupational therapy. A skilled nurse could provide education on her numerous medications.
16. Respondent argues no skilled nursing services are required by the petitioner.

As such, personal care by a skilled nurse is not medically necessary.
17. Respondent also argues:

- Occupational therapy was not requested.
- Education related to medication should be provided by the prescribing physician.

FINAL ORDER (Cont.)
15F-10421
PAGE-4

## CONCLUSIONS OF LAW

18. 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.
19. This is a final order pursuant to $\S 120.569$ and $\S 120.57$, Fla. Stat.
20. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R.

65-2.056.
21. The standard of proof in an administrative hearing is by a preponderance of the evidence. (See Fla. Admin. Code R. 65-2060(1).) The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at $1201,7^{\text {th }}$ Ed.).
22. The Florida Medicaid program is authorized by Chapter 409, Fla. Stat. and Chapter 59G, Fla. Admin. Code. The Medicaid program is administered by respondent.
23. 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...
(c) The agency may not pay for home health services unless the services are medically necessary ...
24. The definition of medically necessary 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.
6. The Home Health Services Handbook has been promulgated into rule by Florida

Administrative Code Rule 59G-4.130(2) and provides the following relevant requirements:

Page 2-12:
Medicaid reimburses the following services provided to eligible recipients age 21 and older:

- Licensed nurse and home health aide visits
- Limited durable medical equipment and supplies
- Limited therapy evaluations

Page 2-15:
Home health visits are limited to a maximum of three intermittent visits per day for non-pregnant adults age 21 and older. The visits can be any combination of licensed nurse and home health aide visits.

The minimum length of time between home health visits provided to a recipient on the same day must be at least one hour.

Page 2-16:
Home health nurse visit services must be all of the following:

- Provided through home health visits
- Medically necessary
- Furnished by an RN or an LPN
- Ordered by the attending physician and specified in the physician approved POC

Page 2-17:
The following are examples of nursing services reimbursable by Medicaid:

- Administration of intravenous medication
- Administration of intramuscular injections, hypodermoclysis, and subcutaneous injections only when not able to be self-administered appropriately
- Insertion, replacement, and sterile irrigation of catheters
- Colostomy and ileostomy care, excluding care performed by recipients
- Treatment of decubitus ulcers when:
- deep or wide without necrotic center
- deep or wide with layers of necrotic tissue
- infected and draining
- Treatment of widespread infected or draining skin disorders
- Administration of prescribed heat treatment requiring observation by licensed nursing personnel to adequately evaluate the recipient's progress
- Restorative nursing procedures (including related teaching and adaptive aspects of nursing), which are a part of active treatment and require the presence of licensed nurses at the time of performance
- Nasopharyngeal, tracheotomy aspiration, ventilator care
- Levin tube and gastrostomy feedings (excluding feedings performed by the recipient, family, parent or legal guardian)
- Complex wound care requiring packing, irrigation, and application of an agent prescribed by the physician

Medicaid does not reimburse skilled nursing services solely for the purposes of monitoring medication compliance or assisting with selfadministered medication.

Page 2-18:
Home health aide services help maintain a recipient's health or facilitate treatment of the recipient's illness or injury. The following are examples of home health aide services reimbursed by Medicaid:

- Assisting with the change of a colostomy bag
- Assisting with transfer
- Reinforcing a dressing
- Assisting the individual with prescribed range of motion exercises that have been taught by the RN
- Measuring and preparing prescribed special diets
- Providing oral hygiene
- Bathing and skin care
- Assisting with self-administered medication

Home health aides must not perform any services that require the direct care skills of a licensed nurse.

Medicaid reimburses home health aide visits when they are either of the following:

- A home health aide visit that is associated with a skilled nursing service ...
- A home health aide visit that is not associated with a skilled nursing service...

26. The above Handbook identifies two types of visits associated with Home Health

Services: a home health visit associated with skilled nursing and a home health visit not associated with skilled nursing.
27. Neither evidence nor testimony establishes that petitioner meets any of the criteria for a home health visit by a skilled nurse as enumerated on page 2-17 of the Home Health Services Handbook.
28. It is noted that the Home Health Services Handbook specifically excludes medication monitoring or assistance with self-administered medication as part of a skilled nursing visit.

FINAL ORDER (Cont.)
15F-10421
PAGE - 8
29. The issue before the undersigned is whether the denial of skilled nursing visits was proper. The greater weight of evidence does not establish that skilled nursing visits are medically necessary.
30. Petitioner has not met the required evidentiary standard establishing respondent's denial was improper. The following conditions of medical necessity have been satisfied for home health visits by a skilled nurse:
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;
31. If desired, petitioner can pursue whether home health aide visits not associated with skilled nursing is appropriate. Requirements are found in the Home Health Services Handbook. A link to respondent's Coverage and Limitations Handbooks can be found at:

## http://www.fdhc.state.fl.us/Medicaid/index.shtml

32. Occupational therapy is not an issue before the undersigned. The Therapy

Services Coverage and Limitations Handbook can be reviewed regarding this matter.

## DECISION

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

FINAL ORDER (Cont.)
15F-10421
PAGE -9

## 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 $\qquad$ day of March 2016,
in Tallahassee, Florida.


Frank Houston
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myfIfamilies.com

Copies Furnished To:

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

PETITIONER,
Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 88999
RESPONDENT. 1

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on February 4, 2016 at 9:45 a.m.

## APPEARANCES

For the petitioner:

For the respondent: Lori Winfield, ACCESS Supervisor.

## STATEMENT OF ISSUE

Petitioner is appealing the respondent's action to deny petitioner's application for Institutional Care Program (ICP) Medicaid benefits. Petitioner carries the burden of proof by the preponderance of evidence.

FINAL ORDER (Cont.)
15F-10427
PAGE - 2

## PRELIMINARY STATEMENT

The petitioner submitted an on-line application on October 27, 2015 for ICP Medicaid benefits; however, there was no notice submitted by the respondent to the undersigned informing the petitioner that he was denied for these benefits. Instead, the respondent mailed a Notice of Case Action to the petitioner on November 23, 2015 notifying him that he was denied for the Medically Needy (MN) Program with a share of cost. Petitioner's representative timely requested a hearing to challenge the denial.

Petitioner was not present. The petitioner's representative presented one exhibit, which was entered into evidence as Petitioner's Exhibit "1". The respondent presented two exhibits, which were entered into evidence as Respondent's Exhibits "1" and " 2 ". The record was held open until close of business on February 8, 2016 for submission of additional evidence from the respondent. Additional evidence was received from the respondent on February 4, 2016 and entered into evidence as Respondent's Exhibit " 3 ". The record closed on February 8, 2016.

## FINDINGS OF FACT

1. 

facility since 2010. Petitioner's ICP Medicaid benefits ended on June 30, 2015.
Petitioner's authorized representative i
2. Prior to the action under appeal, the petitioner, through his authorized representative submitted an interim contact letter for Qualified Medicare Beneficiary (QMB) and ICP Medicaid benefits on February 27, 2015. During the pending period, the respondent discovered a checking account under the petitioner's name from the Department's "Data Exchange Inquiry Asset Verification" system. The data showed an

FINAL ORDER (Cont.)
15F-10427
PAGE - 3
account ending in 5798 from BB\&T with a current balance of $\$ 4,692.00$ since November 2014.
3. The ICP Medicaid benefits ended on June 30, 2015 due to exceeding the asset limit. No Notice of Case Action was submitted by the respondent regarding the ICP Medicaid benefits ending on June 30, 2015.
4. On October 27, 2015, the petitioner, through his authorized representative, submitted an application for ICP Medicaid benefits and retroactive ICP coverage for July, August, and September 2015. During the eligibility determination period, the respondent mailed the petitioner a pending notice, on November 2, 2015, requesting bank statements for the BB\&T checking account for the periods of July through September 2015; due no later than November 12, 2015.
5. On November 23, 2015, the respondent mailed the petitioner a Notice of Case Action informing him that the application was denied for the Medically Needy Program with a share of cost.
6. The petitioner's representative explained that when the petitioner came to the Nursing Home facility, he was homeless and lacked the ability to make his own decisions due to being incompetent. The representative was not aware of an account with BB\&T until the case was denied.
7. The respondent explained that because the petitioner's BB\&T bank account showed a current balance of $\$ 4,692.00$ since November 2014, it exceeded the $\$ 2,000$ asset limit for an individual to qualify for ICP; therefore, he was denied eligibility. Additionally, the respondent explained there are no exceptions found in the Department's policy to support not counting financial institution accounts with no legal restrictions as an asset.

FINAL ORDER (Cont.)
15F-10427
PAGE-4
8. The representative, has submitted a new application on January 12, 2016. The respondent has issued a pending notice requesting verification of the BB\&T bank account. At the time of the hearing, that application was still pending.

## 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. 652.056.
11. In accordance with Fla. Admin. Code R. 65A-1.716 (5), the SSI-Related Medicaid resource limit for an individual is $\$ 2,000$. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, Appendix A-9 sets forth $\$ 2,000$ as the ICP income limit for an individual when the monthly income exceeds $\$ 856$. The findings show petitioner's monthly income exceeds this amount. Therefore, $\$ 2,000$ is the applicable asset limit.
12. The Code of Federal Regulations at 20 C.F.R. $\S 416.1201$ states, in 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).
(b) Liquid resources. Liquid resources are cash or other property which can be converted to cash within 20 days, excluding certain nonwork days
as explained in $\S 416.120$ (d). Examples of resources that are ordinarily liquid are stocks, bonds, mutual fund shares, promissory notes, mortgages, life insurance policies, financial institution accounts (including savings, checking, and time deposits, also known as certificates of deposit) and similar items. Liquid resources, other than cash, are evaluated according to the individual's equity in the resources. (See § 416.1208 for the treatment of funds held in individual and joint financial institution accounts).
13. 20 C.F.R. § 416.1208, explains how funds held in financial institution accounts are counted:
(a) General. Funds held in a financial institution account (including savings, checking, and time deposits, also known as certificates of deposit) are an individual's resource if the individual owns the account and can use the funds for his or her support and maintenance. We determine whether an individual owns the account and can use the funds for his or her support and maintenance by looking at how the individual holds the account. This is reflected in the way the account is titled.
(b) Individually-held account. If an individual is designated as sole owner by the account title and can withdraw funds and use them for his or her support and maintenance, all of the funds, regardless of their source, are that individual's resource. For as long as these conditions are met, we presume that the individual owns 100 percent of the funds in the account.
This presumption is non-rebuttable. (emphasis added)
14. Fla. Admin. Code R. 65A-1.303 addresses assets and states in relevant part:
(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.

FINAL ORDER (Cont.)
15F-10427
PAGE-6
15. The Policy Manual, CFOP 165-22, passage 1640.0320 explains Legally

Incompetent Individuals (MSSI, SFP) and states:
Under the Florida Guardianship Law, only a guardian of the property is authorized to dispose of assets on behalf of a legally incompetent individual. Until a legal guardian is assigned, real property owned by a legally incompetent individual is not available.
Liquid assets (for example, patient fund accounts and checking accounts) are included as available if the individual has free access to the funds. If a legal guardian must petition the court in order to dispose of the individual's property, the asset is still included for the individual. The fact that the guardian must petition the court does not make the property an unavailable asset.
1640.0321 Assets Unavailable - Circumstances Beyond Control (MSSI, SFP).
Assets unavailable due to circumstances beyond the individual's control are not considered in the determination of eligibility.
The individual must present convincing evidence to prove the asset is unavailable to him due to circumstances beyond his control. The eligibility specialist will make an independent assessment of the availability based on the evidence presented. Additional guidance can be requested from the Region or Circuit Program Office, Circuit Legal Counsel, or Headquarters through the Region or Circuit Program Office.
16. Fla. Admin. Code R. 65A-1.712 (1) states: "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 fact of resources for that month."
17. Based on the above authority, at any time during a month under review (in this case, application dated October 27, 2015), petitioner would meet the ICP asset eligibility requirement should his asset level be equal to or below $\$ 2,000$. The findings establish petitioner's liquid assets included a BB\&T checking account, which showed a current balance of $\$ 4692.00$ since November 2014. No evidence was presented to establish that the value of this asset was equal to or less than $\$ 2,000$ during the review period.

FINAL ORDER (Cont.)
15F-10427
PAGE-7
18. The petitioner's representative claimed the asset (BB\&T checking account) is unavailable to the petitioner due to circumstances beyond his control. However, no evidence was presented to verify petitioner has restricted or no access to the account at issue.
19. After careful review of the evidence and controlling legal authorities, the undersigned concludes the respondent correctly denied the petitioner's October 27, 2015 application for ICP Medicaid benefits.

## 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 14 day of _ March 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

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

## FILED

Mar 15, 2016
Office of Appeal Hearings
Dept. of Children and Farnilies

APPEAL NO. 15F-10463 16F-01066

PETITIONER,
Vs.
FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 17 Broward
UNIT: 88585

## CASE NO.

RESPONDENT. 1

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the abovereferenced matter on February 10, 2016 at 11:02 a.m. All parties appeared telephonically from different locations.

For the petitioner:
For the respondent:


Kevin Carlisle, Economic Self-Sufficiency Specialist II

## STATEMENT OF ISSUE

At issue is whether the respondent's action to deny the petitioner full Medicaid benefits, enroll him in the Medically Needy (MN) program with a $\$ 1,633$ Share of Cost (SOC) and deny the Medicare Savings Plan (MSP) benefits is proper. Petitioner is seeking full Medicaid benefits or a lower SOC.

FINAL ORDER (Cont.)
15F-10463, 16F-01066
PAGE -2
In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof by a preponderance of evidence was assigned to the petitioner.

## PRELIMINARY STATEMENT

Hilary Campbell, ESS II, was present as an observer for the department.
Petitioner submitted no exhibits. Respondent submitted seven exhibits, which were marked and entered into evidence as Respondent's Exhibits "1" through "7".

The record was held open until February 15, 2016 for parties to submit additional evidence including policy related to dual receipt of full Medicaid and Medicare benefits and policy related to recurring medical expenses. The subsequent evidence was received on February 12, 2016. The evidence was marked and entered as Respondent's Exhibits "8" through " 10 ". Upon further review of the additional evidence provided, an interim order was issued requesting additional information including the Notice of Case Action. The Notice of Case Action was received, entered and marked into evidence as Respondent's Exhibit "11" on February 17, 2016, and the record was closed the same day.

## FINDINGS OF FACT

1. On December 1, 2015, the petitioner submitted an application for Medicaid for himself.
2. The petitioner reported on the application that he receives $\$ 1,834$ monthly in Social Security Disability Income (SSDI). Medical expenses were also reported.
3. As part of the eligibility process, the respondent verified the petitioner receives monthly $\$ 1,938$ in SSDI. He also pays monthly $\$ 104.90$ for the Medicare Part B premium.
4. MSP is a Medicaid Buy-in Program in which the State of Florida pays the Medicare premiums.

FINAL ORDER (Cont.)
15F-10463, 16F-01066
PAGE -3
5. To be eligible for the MSP, an individual's income (minus any applicable income disregards) cannot exceed the following income standard for an individual: Ql-1 \$1,325.
6. The petitioner's income of $\$ 1,933$ exceeds the $\$ 1,325$ QI 1 individual income standard.
7. For the petitioner to be eligible for full Medicaid, his income cannot exceed the income limit of $\$ 864$. The petitioner's income $\$ 1,933$ SSDI exceeds the $\$ 864$ income limit. The next available program is MN with a SOC.
8. The department calculated petitioner's SOC as follows:

| $\$$ | $1,938.00$ | SSDI |
| :--- | ---: | :--- |
| - | 20.00 | unearned income disregard |
| - | 180.00 | MN Income Level (MNIL) for a household size of one |
| $\$$ | $1,738.00$ | SOC |
| - | 104.90 | Medical Insurance Premium |
| $\$$ | $1,633.00$ | SOC |

9. The respondent asserts that recurring medical expenses were not addressed with the petitioner.
10. On December 16, 2015 the respondent mailed the petitioner a Notice of Case Action notifying he was denied QI 1, "Reason: Your household's income is too high to qualify for this program" and enrolled the petitioner in MN with a $\$ 1,633$ SOC.

## 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.

FINAL ORDER (Cont.)
15F-10463, 16F-01066
PAGE -4

## Full Medicaid benefits will be addressed first:

13. The department determines Medicaid eligibility based on the household circumstances.

When the household consists of parents and children, Medicaid eligibility is determined under
Family-Related Medicaid policy. When the household consists of an elderly or disabled
individual or couple, Medicaid eligibility is determined under Adult-Related Medicaid policy
(also referred to as SSI-Related Medicaid or Medically Needy). Medicaid eligibility is based on
federal regulations. The petitioner was evaluated under the SSI-Related Medicaid coverage
group.
14. Fla. Admin. Code R. 65A-1.713 defines the income limits for SSI - Related Medicaid
programs. It states:
(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
(a) For MEDS-AD Demonstration Waiver, income cannot exceed 88 percent of the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.
...(h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses.
15. The Department's Policy Manual, CFOP 165-22 at Appendix A-9, sets forth $88 \%$ of the federal poverty level (FPL) for a household size of one at $\$ 864$.
16. Fla. Admin. Code R. 65A-1.701 states in the pertinent part:
(20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services. (emphasis added)

FINAL ORDER (Cont.)
15F-10463, 16F-01066
PAGE -5
17. In accordance with the above authority, the petitioner's income cannot exceed $88 \%$ of the FPL and he cannot be receiving Medicare unless he is receiving institutional care services, hospice services, or home and community based services.
18. The petitioner's $\$ 1,933$ SSDI exceeds the $\$ 864$ FPL for a household size of one and the petitioner is also currently receiving Medicare Part A and B without institutional care services, hospices services, or home and community based services. Therefore, the petitioner is not eligible for full Medicaid.

## Enrollment in Medically Needy and Share of Cost amount will now be addressed:

19. Fla. Admin. Code R. 65A-1.710, SSI-Related Medicaid Coverage Groups, states in part:
(5) Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. §§ 1396a and 1396d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance due to their level of income or resources.
20. The above authority explains MN provides coverage for individuals who do not qualify for full Medicaid due to income 21. 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.
21. 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."

## 23. The Fla. Admin. Code R. 65A-1.713, SSI-Related Medicaid Income

Eligibility Criteria, states in part:
(h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses...
(4)(c) Medically Needy. The amount by which the individual's countable income exceeds the Medically Needy income level, called the "share of cost shall be considered available for payment of medical care and services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical costs.
23. 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."
24. The 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..."
25. The Fla. Admin. Code R. 65A-1.716 sets forth the MNIL at $\$ 180$ for a family size of one.
26. In accordance with the authorities, the respondent deducted $\$ 20$ unearned income and $\$ 180$ MNIL from the petitioner's $\$ 1,933$ SSDI to arrive at $\$ 1,733$ SOC.

FINAL ORDER (Cont.)
15F-10463, 16F-01066
PAGE -7
27. The Code of Federal Regulations 42 C.F.R. § 436.831 outlines Medically Needy
income eligibility and how to determine countable income as follows:
The agency must determine income eligibility of medically needy individuals in
accordance with this section. It states:
...(b) Determining countable income. The agency must, to determine countable income, deduct amounts that would be deducted in determining eligibility under the State's approved 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 § 436.814, the individual is eligible for Medicaid.
(d) Deduction of incurred medical expenses: If countable income exceeds the income standard, the agency must deduct from income medical expenses incurred by the individual...that are not subject to payment by a third party.
(e) Determination of deductible incurred expenses: Subject to the provisions of paragraph ( g ) of this section, in determining incurred medical expenses to be deducted from income, the agency must include the following...
(1) Expenses for Medicare and other health insurance premiums...
(2) Expenses incurred by the individual...for necessary medical and remedial services that are recognized under State law but not included in the plan;
(g) Determination of deductible incurred medical expenses: Optional deductions. In determining incurred medical expenses to be deducted from income, the agency-
(1) May include medical institutional expenses (other than expenses in acute care facilities) projected to the end of the budget period at the Medicaid reimbursement rate;
(2) May, to the extent determined by the agency and specified in its approved plan, include expenses incurred earlier than the third month before the month of application; and
(3) May set reasonable limits on the amount to be deducted for expenses specified in paragraphs $(\mathrm{e})(1),(\mathrm{e})(2)$, and $(\mathrm{g})(2)$ of this section.
28. In accordance with the authorities, the respondent deducted the Medical Insurance

Premium of $\$ 104.90$ to arrive at the $\$ 1,633$ SOC.

FINAL ORDER (Cont.)
15F-10463, 16F-01066
PAGE -8
29. 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.

## The denial of the Medicare Savings Plan will now be addressed:

30. Fla. Admin. Code R. 65-1.702 Medicaid Special Provisions, states in relevant part:
(12) Limits of Coverage.
(a) Qualified Medicare Beneficiary (QMB). Under QMB coverage, individuals are entitled only to Medicare cost-sharing benefits, including payment of Medicare premiums.
(b) Special Low-Income Medicare Beneficiary (SLMB). Under SLMB coverage, individuals are entitled only to payment of the Part B Medicare premium. If eligible, AHCA shall pay the premium for up to three months retroactive to the month of application...
(d) Part B Medicare Only Beneficiary (Ql1). Under Ql1 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.)...
31. Fla. Admin. Code R. 65A-1.713, SSI-Related 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...
(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. Q11 is eligible only for payment of the Part B Medicare premium through Medicaid...

FINAL ORDER (Cont.)
15F-10463, 16F-01066
PAGE -9
32. The Department's Program Policy Manual at Appendix A-9, identifies MSP income standards for an individual as follows:

$$
\text { July } 2015
$$

QMB
\$981

SLMB
\$1,177

Q11
\$1,325
33. In careful review of the cited authorities and evidence, the undersigned concludes the respondent followed rule in denying the petitioner Q11 benefits due to exceeding the standard income limit for an individual.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal relating to the denial of full Medicaid and enrollment in the Medically Needy Program is denied. The appeal related to the respondent's action to deny the petitioner's request for the Medicare Savings Plan benefits is also denied.

## NOTICE OF RIGHT TO APPEAL

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

FINAL ORDER (Cont.)
15F-10463, 16F-01066
PAGE -10
DONE and ORDERED this $\qquad$ 15 day of $\qquad$ , 2016, in Tallahassee, Florida.


Pamela Vance
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myffamilies.com

Mar 25, 2016
STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES

PETITIONER,
Vs.
AGENCY FOR HEALTH CARE
ADMINISTRATION
CIRCUIT: 13 Hillsborough
UNIT: AHCA

## RESPONDENT.

CASE NO.

## FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 3, 2016, at approximately 3:05 p.m.

## APPEARANCES

For Petitioner: Petitioner

For Respondent: Stephanie Lang, RN Specialist
Agency for Healthcare Administration

## STATEMENT OF ISSUE

Whether the Agency, through its agents Humana and DentaQuest ("plan") was correct in denying Petitioner's request for a crown on tooth number 20. The burden of proof is assigned to the Petitioner.

## PRELIMINARY STATEMENT

Appearing as witnesses for Respondent were Mindy Aikman (Grievance and Appeals Specialist with Humana), Stacy Larsen (Clinical Guidance Analyst with Humana); Jacklyn Salcedo (DentaQuest Grievance and Appeals); and Dr. Frank Manteiga (Florida Dental Director with DentaQuest).

Respondent admitted eight exhibits into evidence, which were marked and entered as Respondent's Exhibits 1 through 8. The record was held open until February 5, 2016 for the plan's crown utilization criteria, which was marked and entered as Respondent's Exhibit 9 upon receipt. Petitioner was given until February 15, 2016 to submit a written response to the guidelines if he chose to do so. The record closed on February 15, 2016 without any response from Petitioner.

Administrative notice was taken of Florida Statutes 409.910, 409.962 through 409.965, and 409.973. Administrative notice was also taken of Florida Administrative Code Rules 59G-1.001, 1.010, and 4.060, as well as 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 over 21 years of age. His cousin, a dentist overseas, previously performed a root canal on tooth number 20.
2. On or about November 18, 2015, Petitioner's current dentist submitted a prior authorization request to Petitioner's managed care plan, Humana. DentaQuest handles the prior authorization reviews for Humana members. On the prior authorization

FINAL ORDER (Cont.)
15F-10491
PAGE - 3
request, Petitioner's dentist noted that tooth number 20 has "deep decay" and provided an x-ray dated July 29, 2015 to support the request.
3. DentaQuest, by notice dated November 19, 2015, denied Petitioner's request for code D2740, which is a crown for the tooth. A dental director reviewed and denied the request because "the tooth does not appear to have significant breakdown due to decay or trauma." Tooth 21 was "denied due to a clinically unacceptable root canal fill." Humana's November 19, 2015 Notice of Case Action restated DentaQuest's findings.
4. Petitioner requested a fair hearing due to the denials. DentaQuest re-reviewed the service requests as part of its hearing preparation on January 8, 2016. A second dental director upheld the denial because tooth 21 had a clinically unacceptable root canal fill and tooth 20 did not show breakdown of tooth structure including 3 surfaces and one cusp.
5. A third dental director reviewed the case and appeared at the hearing. He agreed with the findings of the prior two reviewers. He reviewed panoramic and individual tooth x-rays and determined that the root canal is a substandard fill with poor lateral condensation. It was not instrumented enough and would need to be redone and properly filled. While he agreed that Petitioner's tooth needs repair, he indicated the tooth needs to be better prepared for the crown.
6. Petitioner testified that the dentist who did the root canal believes the root canal was adequate. He trusts the dentist's opinion and he trusts his current dentist who wants to do the crown.

## CONCLUSIONS OF LAW

7. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80, Florida Statutes.
8. This is a final order pursuant to Sections 120.569 and 120.57 , Florida Statutes.
9. This hearing was held as a de novo proceeding pursuant to Florida Administrative Code Rule 65-2.056.
10. 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 652.060(1).
11. Section 409.912, Florida Statutes, notes that AHCA shall purchase goods and services for Medicaid recipients in the most cost-effective manner possible, consistent with the delivery of quality medical care. 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.
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. According to page 2-3 of the Medicaid Dental Services Coverage and Limitations Handbook (Dental Handbook), Medicaid covers some dental services for adults over 21. The Dental Handbook is promulgated into law by Rule 59G-4.060(2), Florida Administrative Code. According to the Dental Handbook, Medicaid will cover dentures and denture related procedures, as well as:
...medically-necessary emergency dental procedures to alleviate pain and/or infection for eligible adults... Emergency dental care shall be limited to emergency problem-focused evaluations, necessary radiographs to make a diagnosis, extraction, and incision and drainage of abscess.
15. 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.

FINAL ORDER (Cont.)
15F-10491
PAGE-6
(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. Root canal and crown services are not covered benefits for adults over 21 , such as Petitioner, under fee-for-service Medicaid. The HMO may provide services beyond what fee-for-service Medicaid provides. Part of the medical necessity rule above is that the service requested must be consistent with the generally accepted professional medical standards as determined by the Medicaid program. The HMO uses such standards and guidelines to make medical necessity determinations. In this case, Petitioner's HMO will provide the requested services if they meet the plan's utilization criteria.
17. DentaQuest provided the utilization criteria it reviews when determining whether a crown can be approved. The general criteria for crowns include a requirement for damaged teeth. It states "permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp." For a request for a crown following root canal therapy, the criteria states in relevant part:

- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a cunature or calcification of the canal that limits the ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

18. Petitioner had the burden of proof in this case to show he meets the criteria for the crown. Petitioner's only evidence in support of his entitlement to the procedure was hearsay statements made by dentists who were not present at the hearing. Petitioner's

FINAL ORDER (Cont.)
15F-10491
PAGE-7
dentists were not present at the hearing to explain why they felt the root canal was adequate or to show the decay in his teeth meets the requirements. Respondent presented a dental director, who is a dentist, who explained the criteria and his opinion of the submitted materials. The dental director's testimony is given great weight in the absence of contrary information.
19. After careful review of the relevant authorities, the testimony and the evidence in this matter, the hearing officer concludes that Petitioner did not meet his burden of proof to show entitlement to the requested service.

## 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.

FINAL ORDER (Cont.)
15F-10491
PAGE-8
DONE and ORDERED this 25 day of __March , 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

Mar 01, 2016

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

APPEAL NO. 15F-10516

PETITIONER,
Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 17 Broward
UNIT: 88071

## RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on February 2, 2016, at 11:00 a.m. All parties appeared telephonically from different locations.

APPEARANCES
For the Petitioner:
For the Respondent:
Ashley Brunelle, economic self-sufficiency supervisor.

## STATEMENT OF ISSUE

At issue is whether the respondent's actions denying full Medicaid benefits for petitioner and her unborn child and her enrollment in the Medically Needy Program (MN) with an estimated share of cost (SOC) are correct. Additionally, whether the petitioner is entitled to any Medicaid coverage effective October 2015. The petitioner carries the burden of proof by the preponderance of evidence.

FINAL ORDER (Cont.)

## 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 17 exhibits, which were marked as Respondent's Exhibits 1 through 17.

## FINDINGS OF FACT

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

1. On November 23, 2015, the petitioner submitted an application requesting Temporary Cash Assistance (TCA), Food Assistance (FA) and Medicaid benefits. On her application, she reported that she was pregnant with one unborn expected on June 11, 2016. The petitioner also reported that she was employed at and that her salary included tips. The petitioner only included herself on the application and indicated that she is filling taxes and that she has past medical expenses for the previous three months.
2. On November 24, 2015, the Department send the petitioner a notice requesting that she contact the office for an interview. The Department sent a pending notice requesting verification of income and proof of pregnancy be provided. During the interview, petitioner reported that she was receiving assistance from her child's father.
3. On November 17, 2015, the petitioner submitted a proof of pregnancy from Planned Parenthood and on November 25, 2015, she submitted her October paystubs and a statement from M. O. stating he helps her out. On December 23, 2015, a notice

FINAL ORDER (Cont.)
15F-10516
PAGE -3
was sent to the petitioner informing her that her case was denied, see Respondent Exhibits 1 through 9. On December 28, 2015, the petitioner requested a hearing challenging her Medicaid denial and her enrollment in the Medically Needy Program. 4. On January 6, 2016, the case was reopened for processing. The Department denied full Medicaid for the petitioner and her unborn and FA benefits for her due to excess income. Petitioner was approved for MN with a $\$ 3,605$ SOC. Petitioner is only appealing the Medicaid issue.
5. Petitioner received the following checks for October 2015: \$1,276.09 (10/9), \$621.48 (10/16), \$882.55 (10/23) and \$1,212.83 (10/30). The Department considered all four of the petitioner's checks as representative of her salary. To determine petitioner's eligibility for Medicaid, her income was converted to a monthly amount by averaging the four of her checks and multiplying her weekly average (\$998.24) by a conversion factor of 4 to equal $\$ 3,992.96$. The respondent considered this to be the modified adjusted gross income (MAGI). The Department counted two members (the petitioner and her unborn) in the petitioner's standard filing unit (SFU). The Department determined petitioner's SFU ineligibility for full Medicaid benefits because the household income of $\$ 3,992.96$ exceeded the $\$ 2,456$ income limit for a pregnant woman with one unborn child. As the income exceeded the maximum limit, petitioner and her unborn were found ineligible for full Medicaid benefits. Petitioner was evaluated and approved for the MN Program.
6. The respondent enrolled petitioner in the Medically Needy Program with a SOC. To determine the estimated SOC the Medically Needy Income Level (MNIL) of \$387 for a standard filing unit size of two was subtracted from the $\$ 3,992.96$ gross monthly

FINAL ORDER (Cont.)
15F-10516
PAGE -4
household income, resulting to the petitioner estimated SOC of \$3,605 effective January 2016. A Notice of Case Action was sent to the petitioner on January 7. 2016, informing her of the outcome, see Respondent's Exhibits 10 through 12. No eligibility determination was done for November and December 2015.
7. On January 14, 2016, the Department received additional income verification from the petitioner. The verification indicates that she receives she receives $\$ 250$ biweekly from M.O. Additionally, petitioner provided the following paystubs: 12/24/15 (\$981.59), $12 / 31 / 15(\$ 1,160.16), 1 / 8 / 16(\$ 931.46)$ and $1 / 15 / 16(\$ 1,277.32)$. The respondent used the same methodology in (4) and the most recent paystubs to arrive at $\$ 4,350.52$ as petitioner's MAGI. This amount exceeds the $\$ 2,456$ Medicaid Income limit for the petitioner and her unborn (SFU of two).
8. As the petitioner was determined ineligible for full Medicaid, the respondent enrolled her in the Medically Needy (MN) Program using the same methodology in (5), with an estimated SOC of $\$ 3,963$ effective March 2016. A Notice of Case Action was sent to the petitioner on January 26, 2016, informing her of the outcome, see Respondent's Exhibits 13 through 17.
9. The respondent explained that the petitioner is not eligible for any Medicaid benefits for herself and her unborn because her household income exceeds the Family Related Medicaid income limit. Additionally, she explained that her estimated SOC amount is directly related to the income and her household size at time of action.
10. The petitioner disputed the checks amounts presented by the respondent.

Petitioner explained that she does not make that much money on a regular basis and that the tips are not issued to her. The undersigned finds that the amounts used by the

FINAL ORDER (Cont.)
15F-10516
PAGE -5
respondent are correct. The respondent advised the petitioner to report any decrease in income for consideration. During the hearing, the petitioner reported that she has a seven year-old child she did not include on her application because she did not wish to receive any assistance for that child. She testified that she had submitted a Medicaid application in October 2015 and was denied for no apparent reason. The respondent acknowledged the October 21, 2015 application, but was not sure why it was denied. The undersigned will evaluate petitioner's eligibility for Medicaid/Medically Needy benefits effective October 2015 based her income and the household composition at the time of application.

## 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 $\S 409.285$, 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. 652.056.
13. The Family-Related Medicaid income criteria is set forth in 42 C.F.R $\S 435.603$.

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.
14. 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 $\S 435.956(f)$ 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.
15. The Department's Program Policy Manual, CFOP 165-22 (The Policy Manual) at
2230.0400 Standard Filing Unit (MFAM) states:

For tax filers, the Standard Filing Unit (SFU) is the tax filing group for the tax year in which eligibility is being determined. Eligibility is determined by each individual using the tax filing group's income. Individuals cannot receive Medicaid benefits under more than one coverage group, but can have their income included in more than one SFU.
For individuals who neither file a federal tax return nor are claimed as a tax dependent (non-filers), the Standard Filing Unit consists of the individual and, if living with the individual, their spouse, their natural,

FINAL ORDER (Cont.)
15F-10516
PAGE -7
adopted, and step children under age 19 , or 19 and 20 if in school fulltime.
16. Additionally, the Policy Manual at 2230.0404 explains that when a pregnant
woman is included in the SFU, the number of expected unborn must also be included.
17. In accordance with the above controlling authorities, the Medicaid household
group is the petitioner and her (1) unborn child (two members). The findings show the
Department determined the petitioner's eligibility with a household size of two to determine her eligibility for Medicaid.
18. 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-

FINAL ORDER (Cont.)
15F-10516
PAGE -8
based methodologies in the applicable Title of the Act, but not to determine eligibility for a particular eligibility group.
19. 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 selfemployment 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).
20. The Policy Manual at Appendix A-7 shows the Family-Related Medicaid Income Limit as $\$ 2,456$ and a Standard Disregard of $\$ 80$ for a pregnant woman and her unborn child to be eligible for full Family-Related Medicaid Program. It also indicates the MNIL to be $\$ 387$.
21. 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 $\$ 3,992.96$. Step 2: There are no deductions provided as there was no tax return.

Step 3: The total income of $\$ 3,992.96$ less the standard disregard of $\$ 80$ is $\$ 3,912.96$.

FINAL ORDER (Cont.)
15F-10516
PAGE -9
Step 4: The balance of $\$ 3,912.56$ is greater than the income limit of $\$ 2,456$ for a pregnant woman and her unborn child to receive full Medicaid. Step 5: With no MAGI disregard applied, the countable balance remains $\$ 3,912.56$. This amount was greater than the income limit of $\$ 2,456$. The undersigned concludes that the petitioner is ineligible for full Medicaid. The undersigned further concludes Medically Needy eligibility must be explored.
22. 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.
23. 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.
24. Effective January 2015, Appendix A-7 indicates that for a pregnant woman and her unborn child, the MNIL is $\$ 387$.
25. To determine petitioner's SOC the respondent determined the petitioner's
household monthly to be $\$ 3,992.96$. The Medically Needy Income Level of $\$ 387$ for a

FINAL ORDER (Cont.)
15F-10516
PAGE-10
standard filing unit size of two was subtracted resulting to the petitioner estimated SOC of $\$ 3,605$ effective January 2016. It was later increased to $\$ 3,963$ effective March 2016, based on petitioner's most recent paystubs.
26. The hearing officer found that no exception to these calculations. It is concluded that a more favorable share of cost could not be determined. Eligibility for full Medicaid was not found. The petitioner has failed to meet her burden that she is eligible for full Medicaid.
27. Addressing petitioner's October 21, 2015 application, the undersigned used the reported income and the household composition and found no eligibility for full Medicaid for the petitioner for that month. However, the undersigned concludes that the petitioner is eligible for Medically Needy coverage for that month. The petitioner has met her burden that she is eligible for some type of coverage effective October 2015. The respondent is ordered to explore eligibility for MN for the petitioner from October 2015 through December 2015. Petitioner is encouraged to include her 7 year-old child in the case, as an increase in her Medicaid standard filing unit may potentially decrease her share of cost.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied in part, as petitioner is not eligible for full Medicaid and approved in part, as no Medically Needy eligibility determination was done from October 2015 through

December 2015. The respondent is ordered to explore Medically Needy eligibility for petitioner for the months at issue.

## 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 _ March 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
Email: Appeal.Hearings@myflfamilies.com

STATE OF FLORIDA
Mar 16, 2016
DEPARTMENT OF CHILDREN AND FAMILIES Office of Appeal Hearings OFFICE OF APPEAL HEARINGS Dept. of Children and Farnilies

## APPEAL NO. 15F-10544

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 February 2, 2016 at 1:30 p.m.

## APPEARANCES

For the Petitioner:

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

## STATEMENT OF ISSUE

At issue is whether the Respondent's denial of the Petitioner's request for dental services 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.
Respondent submitted several documents as evidence for the hearing, which were marked as follows: Exhibit 1 - Summary/Sequence of Events; Exhibit 2 Authorization Request; Exhibit 3 - Covered Services; and Exhibit 4 - Denial Notices.

Appearing as witnesses for the Respondent were Dr. Susan Hudson, Dental Consultant, and Jackeline Salcedo, Grievance Specialist, from DentaQuest, which is the Petitioner's dental services organization. Also present as a witness for the Respondent was Carlene Brock, Quality Operations Nurse, from Amerigroup, which is Petitioner's managed health care plan.

## FINDINGS OF FACT

1. The Petitioner is a forty-one (41) year-old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) - Managed Medical Assistance (MMA) plan. She receives services under the plan from Amerigroup, which utilizes DentaQuest for review and approval of dental services.
2. On or about December 16, 2015, the Petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from DentaQuest (and Amerigroup) to perform deep gum and root cleaning, also known as periodontal scaling and root planing. Amerigroup and DentaQuest denied this request on December 17, 2015, stating that the requested services were not covered services under the Plan.

FINAL ORDER (Cont.)
15F-10544
PAGE - 3
3. Petitioner testified she needs the requested services because the deep cleaning will improve the condition of her teeth and her teeth are in pain and she cannot eat.

She also stated her dental x-rays show bone loss and she may lose her teeth in the future.
4. The Respondent's witness, Ms. Salcedo from DentaQuest, testified that the services requested by the Petitioner - deep gum and root cleaning - are non-covered services under the Amerigroup dental plan provisions.
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. $\S 120.569$ and $\S 120.57$.
8. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
9. The standard of proof in an administrative hearing is a preponderance of the evidence, in accordance with Rule 65-2.060 (1), Fla. Admin. Code. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, $7^{\text {th }}$ Ed.).

FINAL ORDER (Cont.)
15F-10544
PAGE - 4
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.
6. 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 provisions.
7. 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 Amerigroup, 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 the deep cleaning will improve the condition of her teeth and alleviate pain and bone loss.
16. Respondent's witness did not address whether the services requested by Petitioner are medically necessary, but stated that the requested services are noncovered services.
17. After considering the evidence and testimony presented, the undersigned concludes that the Petitioner has not demonstrated that the requested services should have been approved by DentaQuest or Amerigroup. The services requested are noncovered services for adults under the Medicaid guidelines referenced above and under

FINAL ORDER (Cont.)
15F-10544
PAGE - 6
the Amerigroup 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 16 day of March 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

Mar 28, 2016

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

APPEAL NO. 15F-10548
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 February 3, 2016 at 8:50 a.m.

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

## STATEMENT OF ISSUE

The issue is whether respondent's denial of petitioner's request for Prescribed Pediatric Extended Care (PPEC) services for up to 12 hours a day, Monday through Friday, for the certification period spanning from September 21, 2015 through March 18, 2016 is appropriate. Because the matter under appeal involves an initial request for PPEC services Petitioner carries the burden of proof.

FINAL ORDER (Cont.)

## PRELIMINARY STATEMENT

Dr. Rakesh Mittal, board-certified pediatrician and physician consultant for eQHealth Solutions, presented testimony on AHCA's behalf as a representative from the Agency's Quality Improvement Organization (QIO).

Respondent submitted two documents which were entered into evidence and marked Respondent Exhibit 1 and 2. The first exhibit provided documentation of the respondent's decision and copies of notices to petitioner and provider. The second exhibit provided medical information for the petitioner and the request for PPEC services.

## 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 four year-old male Medicaid recipient. He is diagnosed with


Petitioner is not taking any medication for
2. Petitioner lives with his mother and five siblings. He attends public school full time. From September until December, petitioner went to PPEC after school where he received his therapies. The PPEC provider enrolled the petitioner in the program pending approval by Medicaid. When petitioner's PPEC request was denied, the PPEC provider stopped providing therapy services to the petitioner.
3. Petitioner's mother explained that she switched her son's therapy provider to PPEC because PPEC picks her son up from school and delivers him home when his

FINAL ORDER (Cont.)
15F-10548
PAGE - 3
therapy sessions are over. She stated her son needs his physical therapy, speech therapy, and occupational therapy. This is the main reason for wanting PPEC.
4. The physician consultant explained that PPEC services are for children who need skilled nursing intervention and her son only needs/receives therapy services. He advised that the therapy services can be provided in a different setting other than PPEC.

## CONCLUSIONS OF LAW

5. 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. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.
6. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
7. 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).
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 for Health Care Administration.
9. In the Prescribed Pediatric Extended Care (PPEC) Services Coverage and Limitations Handbook, page 2-2 provides the following:

Rule 59G-1. 010 (166), Florida Administrative Code (F.A.C.) defines "medically necessary" or "medical necessity" as follows:
(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."
6. Because the petitioner is under twenty-one-years-old, the requirements of Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT) must be considered. Section 409.905 of the Florida Statutes, 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.
11. In reviewing the appeal for compliance with EPSDT requirements, PPEC services are part of Florida's Medicaid state plan of services. The agency has not previously approved PPEC services for this petitioner; a lack of medical necessity must be shown as the basis of the denial for compliance with EPSDT requirements.

FINAL ORDER (Cont.)
15F-10548
PAGE - 5
12. The Prescribed Pediatrics Extended Care Services (PPEC) Coverage and

Limitations Handbook provides the following purpose for PPEC services on page 1-1:
The purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) services is to enable recipients under the age of 21 years with medically-complex conditions to receive medical and therapeutic care at a non-residential pediatric center.
13. On page 2-1 of the PPEC Handbook, the requirements for those who may receive PPEC services are provided as follows:

To receive reimbursement for PPEC services, a recipient must meet all [emphasis added] 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.

14. The PPEC Handbook also provides, on page 2-5, a list of excluded services:

The Medicaid PPEC rate does not reimburse for the following services:

- Baby food or formulas.
- Total parenteral and enteral nutrition.
- Mental health and psychiatric services.
- Supportive or contracted services which include speech therapy, occupational therapy, physical therapy [emphasis added], social work, developmental evaluations, and child life.

15. The mother explained that her son needs his therapy services and going to the PPEC was a convenience for her.
16. The respondent's witness explained that PPEC services cannot be approved solely for therapy services and the child must need some skilled nursing interventions. The therapy services can be provided in a different setting.

FINAL ORDER (Cont.)
15F-10548
PAGE -6
17. The petitioner does not need skilled nursing intervention but needs therapy services that can be provided in a different setting other than PPEC. The PPEC request appears to be primarily for the mother's convenience. In light of this, Petitioner has not met his burden of proof that PPEC services are medically necessary.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, petitioner's appeal is hereby DENIED and the respondent's action denying PPEC services 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 28 _day of March _, 2016,
in Tallahassee, Florida.


Warren Hunter
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com
Copies Furnished To: $\square$ Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

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

Apr 11, 2016


PETITIONER,

APPEAL NO. 15F-10580

CASE NO.

## FLORIDA DEPARTMENT

 OF CHILDREN AND FAMILIESCIRCUIT: 07 St. Johns

## RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned reconvened a telephonic administrative hearing in the above-referenced matter on March 24, 2016 at 11:32 a.m.

## APPEARANCES

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

## ISSUE

At issue is the Department's action on September 11, 2015 to deny the petitioner's application for SSI-Related Medicaid on the contention that his assets exceeded the asset limit.

The petitioner is also seeking Medicaid coverage for the month of August 2014.

FINAL ORDER (Cont.)
15F-10580
PAGE -2

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

## PRELIMINARY STATEMENT

The hearing originally convened on February 10, 2016 at 1:30 p.m. The petitioner presented evidence that required a review by the respondent. The hearing was rescheduled to February 25, 2016 at 9:00 a.m.

The hearing reconvened as scheduled. The petitioner presented a new issue that required additional evidence from the petitioner and the respondent. The hearing was rescheduled to March 10, 2016 at 2:45 p.m.

The hearing reconvened as scheduled. The respondent was waiting for information from the Automated Verification System (AVS) to verify the petitioner's assets and to possibly resolve his primary issue. The petitioner did not object to rescheduling the hearing. The hearing was rescheduled to March 24, 2016 at 11:30 a.m.

The hearing reconvened as scheduled. The respondent approved the petitioner's application dated August 10, 2015 and enrolled him in the Medically Needy (MN) program with an estimated share of cost in the amount of $\$ 2423$. The Department issued an updated Notice of Case Action dated March 21, 2016 to inform the petitioner of the approval of his application for the MN program. The petitioner stated that he is satisfied with the updated decision and withdrew on the record.

FINAL ORDER (Cont.)
15F-10580
PAGE -3

The petitioner has a remaining issue regarding obtaining Medicaid coverage for August 2014.

Evidence was received and entered as the Petitioner Exhibit 1 and the Respondent Exhibits 1 through 4.

## FINDINGS OF FACT

1. On September 24, 2014, the petitioner applied for Social Security Disability Income (SSDI). On November 29, 2014, the petitioner was awarded SSDI retroactive to September 2013. The petitioner received a lump sum in the amount of $\$ 14016$. The petitioner was determined to be disabled beginning November 2012 (Petitioner Exhibit 1).
2. The petitioner explained that he has unpaid medical bills for the month of August 2014. The petitioner believes that the Department should use his application for SSDI submitted to the Social Security Administration (SSA) on September 24, 2014 to approve retroactive Medicaid benefits for the month of August 2014. The petitioner explained that he was informed that he was potentially eligible for the MN program and that he completed an application to apply for Medicaid on April 10, 2015.
3. It is the Department's contention that the petitioner did not complete an application for Medicaid until April 10, 2015, according to its records. The Department contends that the application the petitioner submitted to the SSA for disability benefits cannot be used since it was not an application for Medicaid through DCF. The respondent contends that the application filed in April 2015 was denied due to not receiving all of the information requested.

FINAL ORDER (Cont.)
15F-10580
PAGE -4
4. The Respondent Exhibit 3 includes the Notice of Case Action dated May 12, 2015 mailed to the petitioner to inform him of the denial of his application for Medically Needy (MN) as the Department did not receive all the information requested to determine his eligibility for the program. There was no evidence or testimony provided to show that the petitioner requested a hearing at that time.
5. Because there is a disputed relevant fact (the date of the application for Medicaid) the undersigned must make the finding. The petitioner believes he applied for Medicaid when he completed the application for SSDI with the SSA in September 2014. The petitioner submitted a printout of his SSDI application submitted to the SSA on September 24, 2014. The Department's business record includes an application for Medicaid dated April 10, 2015. The Department considered the date of the application for Medicaid to be April 10, 2015. Based on the above evidence and testimony, the undersigned finds that the application made to the SSA was to apply for disability income and not Medicaid. Therefore, the undersigned finds that the date of the Medicaid application was April 10, 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 Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.
7. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
8. Fla. Admin. Code R. 65A-1.702 Special Provisions states in part:
(9) Retroactive Medicaid. Retroactive Medicaid is based on an approved, denied, or pending application for ongoing Medicaid benefits.
(a) Retroactive Medicaid eligibility is effective no later than the third month prior to the month of application for ongoing Medicaid if the individual would have been eligible for Medicaid at the time of application for Medicaid covered services...The individual or his or her representative has up to 12 months after the date of application for ongoing Medicaid to request retroactive Medicaid eligibility...
9. The above authority explains that the Department may approve retroactive Medicaid coverage no later than the third month prior to the month of application for ongoing Medicaid if the individual would have been eligible for Medicaid at the time of the application. The individual has up to 12 months after the date of the application to request retroactive Medicaid. The findings show that the petitioner applied for Medicaid on April 10, 2015. The earliest possible months for retroactive coverage would be the three months prior to April 2015, which are January 2015, February 2015, and March 2015; these months are not the months for which the petitioner is seeking Medicaid coverage.
10. Based on the above findings of facts and conclusions of law, the undersigned concludes that the respondent was correct to not approve retroactive Medicaid coverage for the month of August 2014 as the three months prior to the petitioner's application were January 2015, February 2015, and March 2015.

## 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 $\qquad$ day of $\qquad$ , 2016,
in Tallahassee, Florida.


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

## FILED

Mar 04, 2016

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES

APPEAL NO. 15N-00110
PETITIONER,
vs.


RESPONDENT.
1

## FINAL ORDER

Pursuant to notice and agreement, an administrative hearing in the abovereferenced matter convened on January 7, 2016, at approximately $2: 14$ p.m. and reconvened on January 29, 2016 at approximately 3:05 p.m. All parties appeared inperson, in Gainesville, Florida. On January 7, 2016, representatives from the Agency for Health Care Administration (AHCA) joined the hearing via teleconference.

## APPEARANCES



## STATEMENT OF THE ISSUE

Respondent seeks to discharge Petitioner from its nursing home facility (NHF), alleging that her needs cannot be met in same, and that "the safety of other individuals

FINAL ORDER (Cont.)
15N-00110
Page 2 of 14
in this facility is endangered" by Petitioner's actions. Respondent bears the burden of proving, by clear and convincing evidence, that discharge would be appropriate under federal regulations (42 C.F.R. § 483.12).

## PRELIMINARY STATEMENT

Via Nursing Home Transfer and Discharge Notice dated November 5, 2015, Respondent notified Petitioner that she was to be discharged from its NHF effective December 6, 2015, due to an asserted safety risk. On or about November 13, 2015, the Petitioner requested a hearing to challenge the Respondent's action.

When hearing convened on January 7, 2016, Petitioner requested a continuance to seek assistance/representative from the local ombudsman's office. Respondent agreed to a brief continuance, and hearing was rescheduled for January 29, 2016.

AHCA representatives Chuck Bory, Supervisor, and Kriste Mennella, Field Officer Manager, joined the proceeding via teleconference on January 7th, but did not appear when hearing reconvened on January 29th.
 Petitioner was present and received assistance in her representation from Ombudsmen.

Additional NHF staff were present in the conference room when hearing on January 29, 2016 commenced; however, upon confirmation that they would not

FINAL ORDER (Cont.)
15N-00110
Page 3 of 14
participate as witnesses, and based on Petitioner's request that they not observe the proceedings, the non-witness staff members were excused from the room.

As the Ombudsmen invoked the Rule of Witness Sequestration, Respondent's witnesses were called one at a time to provide their testimony. Respondent's Exhibits 1 through 7, inclusive, and Petitioner's Exhibit 1, were entered into evidence. As noted on the record, all names of residents other than Petitioner and the affiant witness contained within Respondent's Exhibit 4 have been redacted by the hearing officer.

## FINDINGS OF FACT

1. The Petitioner has been a resident of Respondent's facility since July 25, 2013. She was admitted as a Medicaid-pending patient, following approximately 15 spinal surgeries and the continued presence of : She mobilizes using a wheelchair.
2. Petitioner smokes cigarettes. At the time of her admission to Respondent's facility, the NHF permitted smoking to all residents whom staff evaluated and approved as "safe smokers." As of the date of hearing, Petitioner states that she smokes less than one pack of cigarettes per month.
3. Respondent's smoking policy at or about the time of Petitioner's admission was to assess residents who wished to smoke within 24 hours of their admission. It is not clear when Petitioner was initially assessed, but in 2014, following an external survey of risk factors within the NHF, the facility decided to become non-smoking for all future patients/residents. While Petitioner was "grandfathered in" as a smoker, based on her

FINAL ORDER (Cont.)
15N-00110
Page 4 of 14
admission date, the facility held a meeting to reaffirm its smoking policy and rules (initiated in July of 2012), and to review same with all smoking residents.
4. By signature dated August 21, 2014, Petitioner acknowledged receipt of the smoking policy. Said policy outlines the requirement that smoking occur only at specific times of the day, in pre-designated spaces, near fire extinguishers, a smoking blanket, smoking aprons, and ashtrays that meet "Life Safety Code Regulations." The policy also requires all residents to be supervised by staff while smoking, mandates that staff retain all smoking materials, and specifies that patients will be observed and/or reassessed based on occurrence or history of smoking-related incidents. The policy further prohibits smoking in any areas containing oxygen-related devices.
5. A "Safe Smoking Evaluation," also dated August 21, 2014, reflects that Petitioner does smoke safely and confines her smoking to designated areas, but specifies that her smoking materials must be kept at the nurse's station and that she must have constant supervision while smoking on facility grounds.
6. An "Assessment Tool for Smoking Safety and Care Plan Guideline," completed on or about October 30, 2014, reflects that Petitioner possessed cognitive, functional, communicative, and dexterity skills necessary to safely smoke, but noted that she engaged in "unauthorized smoking - non-compliant [with] smoking P\&P." The Tool recommended interventions including facility storage of smoking and fire materials, and staff supervision while smoking.
7. By notice received by Petitioner (per her signature) on November 5, 2014, the facility informed Petitioner, in pertinent parts:

We would like to take this opportunity to remind everyone of our Center Smoking Policy. While many other Centers have chosen to maintain a "smoke free" campus, we at Signature HealthCARE of Gainesville have decided to permit smoking on our campus under the following safety conditions:

- Smoking is permitted on the 200 wing patio only. This patio is accessible off of the 200 wing between rooms 207 and 209.
- All patients, regardless of level of function, must be supervised by staff while smoking. No one, other than staff, may assist a patient with smoking. This is for everyone's safety.
- To accommodate staff and other patient needs, patient smoking will only be permitted at the designated times of 9:00 am - 9:45 am, 2:00 pm 2:45 pm, and 6:00 pm - 6:45 pm....
- All cigarettes smoked by patients will be distributed and lit by staff. Patients will be allowed one cigarette at a time only. Again, no one, other than staff, may assist a patient with smoking. This is for everyone's safety.... patients may not have, been given [sic] or use any matches or lighters at any time or under any circumstances....
- The Center, in its sole discretion, has the right to prohibit anyone from smoking who:
- creates a safety risk to him/herself or others while smoking, or
- demonstrates non-compliance with this smoking policy

In this event, the person will not be permitted to smoke and may have their smoking materials removed and/or immediately be removed from the smoking area. As well, a resident will be subject to a search of his/her room for any smoking materials.

- Any patient or visitor who demonstrates repeated non-compliance with the smoking policy may be asked to leave the Center. Patients will be offered smoking cessation options and assisted in finding alternative placement at [sic] or living arrangements.

8. Per Clinical Report notes and/or testimony, on September 8, 2015, Petitioner was observed smoking in a non-smoking area. On or about October 22, 2015, Petitioner's room was searched by administration, and Petitioner turned in one half of a cigarette. On November 5, 2015, Petitioner was observed outside of the facility, near the back parking lot, smoking behind the central supply building, where oxygen is stored. Petitioner was asked to extinguish her cigarette and complied. Following a room search that same date, the facility confiscated from Petitioner a cigarette lighter.

FINAL ORDER (Cont.)
15N-00110
Page 6 of 14
Respondent does not contend, however, that Petitioner has ever been observed smoking inside the facility buildings.
9. Petitioner does not deny either possession of half of a cigarette or the lighter, and admits to smoking in a non-designated area on September 8, 2015 as well as in the parking lot on November 5, 2015; however, she did not realize at the time that the building close to where she was smoking on November 5th housed oxygen supplies, and testified that she has observed staff smoking in this same location. Petitioner questions why staff never mentioned the presence of oxygen to her at the time she was asked to extinguish her cigarette or at any time prior to the date of hearing.
10. On November 5, 2015, Respondent issued to Petitioner a Nursing Home Transfer and Discharge Notice, checking a box to indicate that the reason for discharge was "Your needs cannot by met in this facility" and "The safety of other individuals in this facility is endangered," and writing in an explanation, which states:

On Sept. 8, 2015 @ 5:25pm resident observed smoking unsupervised in a nonsmoking area: On Oct. 22, 2015 resident observed/found to be in possession of cigarettes; On Nov. 5, 2015 resident observed smoking in a non-smoking area.
11. Respondent proposes to transfer Petitioner to its sister facility in Jacksonville, which has more smoking patients in residence, and continues to operate as a smokingpermitted facility. Respondent contends that it can no longer meet Petitioner's needs to smoke in her residential environment.
12. Respondent's Notice was signed by the NHF Administrator, and by the NHF


FINAL ORDER (Cont.)
15N-00110
Page 7 of 14
13. By hearing request taken by the Office of Appeal Hearings on November 13, 2015, Petitioner filed an appeal of Respondent's proposed transfer/discharge, stating that she disagrees with same because she "Spoke to the Ombudsman
 told her that she's grandfathered in for smoking."
14. At hearing, it was noted that at some point prior to the instant proceeding, Respondent pursued a separate discharge/transfer based upon alleged smoking violations. By agreement between the parties, said discharge was rescinded. As such, the hearing officer has not considered any incidents related to the previous discharge attempt.
15. Per the NHF Administrator, on or about January 8, 2016, Petitioner was attempting to exit the NHF (or had already exited the NHF, but was still on facility grounds) when he stopped her to ask if she had any smoking materials on her person. Petitioner indicated that she did, as she was planning to go off facility grounds to smoke. She surrendered the materials (a cigarette and a lighter) to the administrator upon his request for same.
16. A resident witness who was present at hearing testified that he had seen Petitioner in possession of smoking materials at some point in 2015, but had never himself provided Petitioner with materials or cigarettes.
17. At hearing, the parties walked to the site at which Petitioner was observed smoking on November 5, 2015. As described for the record, signs posted along the corridor near this parking lot area warn of the presence of oxygen and designate the area as a no-smoking location. A print-out "No Smoking" sign, affixed to the central supply building door, faces the area of the parking lot in which Petitioner was smoking.

FINAL ORDER (Cont.)
15N-00110
Page 8 of 14
Just outside said door (on January 29, 2016) was a bucket containing many cigarette butts and empty cigarette packs, and many butts and filters were strewn across the ground.
18. It is Petitioner's position that violation of a smoking policy, alone, does not constitute a danger to others within the NHF, as Petitioner's decision to smoke as a recreation is her choice, and should remain her choice as long as she does so safely without endangering others. Petitioner notes that smoking is not illegal, and that staff are permitted to possess smoking materials and to smoke in certain outside areas of the facility campus. It is Petitioner's contention that she is willing to observe the same restrictions as staff, and that mere possession of smoking materials, while it may violate facility policy, does not constitute a safety threat. Petitioner was assessed as a safe smoker, such that the act of her smoking, in and of itself, was found to pose no danger to those around her; as such, Petitioner does not feel that her smoking poses a significant threat to safety, particularly when she attempts to smoke off the facility grounds.
19. Respondent contends that its smoking policy is specifically designed to promote safety, and that the rules which apply to staff are separate than those that apply to residents; however, the facility administrator testified that if employees/staff are caught smoking near any oxygen supply, they are subject to termination. It is Respondent's position that Petitioner had many instances of non-compliance with the smoking policy, but that the incident of November 5, 2015 was the most serious, leading to the decision to discharge.

FINAL ORDER (Cont.)
15N-00110
Page 9 of 14
20. At some point following the noted incidents, Petitioner's smoking privileges were revoked. There is no evidence as to when this occurred, or documentation that Petitioner was advised that she was no longer permitted to smoke. The facility administrator testified that once Petitioner lost her smoking privileges, the facility had no more residents approved to smoke, and thus removed all protective gear from the previously designated smoking area. As a result, the facility currently has no designated location for residents to smoke.
21. As of December, 2015, Petitioner has been attempting to obtain residence outside of the facility. She has been working with a transitional support agency, but has so far been unable to secure an alternate residence. She wishes to remain in Respondent's NHF until she is ready to transition back into the community.

## CONCLUSIONS OF LAW

22. 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. § $400.0255(15)$. In accordance with that section, this Order is the final administrative decision of the Department of Children and Families.
23. The burden of proof (clear and convincing evidence) is assigned to the Respondent.
24. Federal Regulations appearing at 42 C.F.R. § 483.12 , set forth the reasons a facility may involuntary discharge a resident as follows:

Admission, transfer and discharge rights.
(a)(2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--
(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
(ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(iii) The safety of individuals in the facility is endangered;
(iv) The health of individuals in the facility would otherwise be endangered;
(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(vi) The facility ceases to operate.
(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.
(emphasis added)
25. Per documentation and testimony, Petitioner was admitted to

Respondent's facility for post-operative care. There is no indication within any documentation proffered into evidence that the resident's physician has determined her needs can no longer be met in the facility, regardless of whether this includes (as Respondent asserts) her "need" to smoke.

FINAL ORDER (Cont.)
15N-00110
Page 11 of 14
26. With regard to Respondent's smoking policy, provision of such written policy is a requirement of federal law. Per 42 C.F.R. § 483.10:
(b) Notice of rights and services.
(1) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under section 1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. (emphasis added)
27. Petitioner did acknowledge, via signature, her receipt of the facility smoking policy, as well as later clarifications to same. The undersigned notes that the policy does not specifically indicate why smoking is considered a safety risk (e.g., because of accidental combustion of flammable gas, burns to other residents, etc.); however, it does specify that smoking is not permitted near oxygen storage, and asserts that all provisions of the smoking policy are "for everyone's safety."
28. The undersigned finds validity in Petitioner's argument that possession of smoking materials, itself, while a violation of policy, does not constitute a threat to the safety of other residents, particularly when the patient has been determined by the facility to be a safe smoker, because she possesses functional and adaptive/cognitive skills necessary to hold and smoke cigarettes. Indeed, retention of personal possessions is in keeping with provisions of the C.F.R., as well as Florida Statutes:

42 C.F.R. § 483.15 Quality of life
(e) (e) Accommodation of needs. A resident has the right to-
(1) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and
(2) Receive notice before the resident's room or roommate in the facility is changed.
and
Fla. Stat. § 400.022 Residents' rights
(1)(m) The right to have privacy in treatment and in caring for personal needs; to close room doors and to have facility personnel knock before entering the room, except in the case of an emergency or unless medically contraindicated; and to security in storing and using personal possessions. Privacy of the resident's body shall be maintained during, but not limited to, toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. Residents' personal and medical records shall be confidential and exempt from the provisions of $s .119 .07(1)$.
(r) The right to retain and use personal clothing and possessions as space permits, unless to do so would infringe upon the rights of other residents or unless medically contraindicated as documented in the resident's medical record by a physician. If clothing is provided to the resident by the licensee, it shall be of reasonable fit.
(s) The right to have copies of the rules and regulations of the facility and an explanation of the responsibility of the resident to obey all reasonable rules and regulations of the facility and to respect the personal rights and private property of the other residents.
(emphasis added)
29. Petitioner argues, essentially, that the only time a policy violation infringes on the safety of others is when there is a direct relationship between the infraction and a risk of harm. In this sense, the incident involving Petitioner's decision to smoke in the parking lot area, near oxygen storage, can be considered a risk to the safety of others; however, it is noted that Petitioner did not see the posted "no-smoking" signs, and that there is no indication within the records or via testimony that she was counseled on the presence of

FINAL ORDER (Cont.)
15N-00110
Page 13 of 14
oxygen within the nearby building at any point before, during, or after the November 5, 2015 incident, or at any time until the date of hearing.
30. The record reflects that Petitioner has never been observed smoking within the facility, nor is there evidence that she engaged in smoking or lighting of cigarettes near oxygen storage, near other residents, or in any inherently "unsafe" area, other than on November 5, 2015. While Petitioner has since continued to retain smoking materials, she testified that she utilizes these materials off of the facility grounds. Nothing within the record contradicts this testimony, and there is no federal regulation which permits transfer or discharge of a resident, solely because the resident fails to comply with facility policy.
31. After considering the entire record, the undersigned concludes that Respondent has not met its burden to prove, by clear and convincing evidence, that the Petitioner presents a continued risk to the safety of her fellow residents. Should Petitioner be observed in violation of the smoking policy in a manner which directly correlates to a safety risk (i.e., smoking near combustible substances, smoking near other residents, dropping or improperly disposing of lit cigarettes, lighting cigarettes indoors), the facility may record these incidents and pursue discharge or transfer, as needed.

## DECISION

Based upon the foregoing Findings of Fact and Conclusion of Law, the Petitioner's appeal is GRANTED. The facility has not established, at this time, that discharge is permissible under federal regulations.

## NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility. DONE and ORDERED this ___ 04 day of _ March 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@myfffamilies.com


Ms. Kriste Mennella, Agency for Health Care Administration

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

APPEAL NO. 15N-00115
PETITIONER,
vs.

RESPONDENT.

## FINAL ORDER

Pursuant to notice, an administrative hearing in the above-referenced matter convened on January 12, 2016, at approximately 3:00 p.m. in

APPEARANCES


## STATEMENT OF THE ISSUE

Respondent seeks to discharge Petitioner from its nursing home facility (NHF),
alleging that Petitioner's needs cannot be met by the facility because his "behaviors are inappropriate towards other residents." Respondent bears the burden of proof to show, by clear and convincing evidence, that this discharge is appropriate per federal regulations (42 C.F.R. § 483.12).

FINAL ORDER (Cont.)
15N-00115
Page 2 of 16

## PRELIMINARY STATEMENT

Via Nursing Home Transfer and Discharge Notice dated November 24, 2015, the Respondent notified the Petitioner that he was to be discharged from its NHF effective December 24, 2015, due to the facility's asserted inability to meet his needs. On November 25, 2015, the Petitioner's son and daughter-in-law requested a hearing to challenge the Respondent's action. represented the Respondent. Ms.

McGinley presented five additional witnesses


At hearing, Respondent's Exhibit 1 and Petitioner's Exhibits 1 and 2, as well as one Hearing Officer's Exhibit, were entered into evidence. Respondent did not prepare Petitioner's records for admission prior to hearing, but attempted to gather same as the hearing progressed. Although Respondent initially entered portions of Petitioner's record (then marked as Respondent's Exhibit 2 and Respondent's Composite Exhibit 3), it later requested that said paperwork be omitted until other residents' names could be redacted from same. These exhibits were thus stricken from the record. As Petitioner's daughter-in-law had written notes on her copies of the stricken exhibits, which she did not wish to return to Respondent, the parties agreed that Petitioner's copies would be turned over to the hearing officer for disposal.

FINAL ORDER (Cont.)
15N-00115
Page 3 of 16
A 15-page, redacted copy of several Five Day Reports filed with the Agency for Health Care Administration (AHCA) was submitted into evidence and copied to Petitioner just prior to the close of testimony. These 15 pages are hereby marked and moved as Respondent's Composite Exhibit 2.

Since Respondent required additional time to collect and redact its records, Respondent was given until January 14, 2016 to file the remainder of its redacted documentary evidence. Petitioner was given until January 22, 2016 to respond to all documentation received.

Respondent's supplemental documentation was timely received and has been entered, as follows:

- Respondent's Composite Exhibit 3: Exceptions Reports ranging from November of 2014 through November of 2015 (hand-numbered pages 1-136);
- Respondent's Composite Exhibit 4: Prescriptions/Orders and Medication Review Reports (hand-numbered pages 137-230); and
- Respondent's Composite Exhibit 5: Goal/Intervention Sheets re: Petitioner's Behavior (hand-numbered pages 230-235).

It is noted that Respondent has redacted all names - i.e., not only those of other residents, but also the names of witnesses, reporting staff, and treating physicians from all incident reports filed post-hearing. ${ }^{1}$

Petitioner's response (a 4-page narrative) was also timely received. Said response has been entered as Petitioner's Exhibit 3.

[^5]FINAL ORDER (Cont.)
15N-00115
Page 4 of 16

## FINDINGS OF FACT

1. The Petitioner has been a resident of Respondent's facility since October 17, 2014. He was admitted as a Medicaid and Medicare patient, with diagnoses including

2. Petitioner is an 85-year old male, born in 1931. His medical records reflect that shorty after admission to the NHF, Petitioner was prescribed psychotropic medications, including daily and as-need $\square$ Throughout his stay at the facility, Petitioner has had multiple medication changes, designed to address each of his diagnoses. He has had dietary changes, lost weight, and received physical and speech therapy. He has also received restorative nursing to assist with dressing, grooming, ambulation, transfers, and range of motion exercises. Petitioner currently mobilizes by using a wheelchair. He is noted to be confused and forgetful, sometimes mistaking other females for his own wife (who does not reside at the NHF), and their male partners as his competitors.
3. Per Respondent's Social Services Director, Brad Letu, Petitioner has had behavioral issues that peak and then subside in approximate two-month cycles.

Petitioner's behaviors generally include aggression towards other male residents, and sexual behaviors towards both female residents and facility staff.
4. While the facility has attempted to deter these behaviors through a multidisciplinary approach including redirection and diversion, and responded to specific incidents with medication changes and increased supervision, it is Respondent's

FINAL ORDER (Cont.)
15N-00115
Page 5 of 16
position that the facility can no longer meet Petitioner's needs. Although the facility's physician referred Petitioner to a psychologist (Dr. Roberts), the Social Services Director testified he believed the psychologist declined to work with Petitioner, finding Petitioner's cognition insufficient to retain behavior modification techniques.
5. Petitioner's family is concerned with the care Petitioner has received since entering the facility. They note his decreased weight and declining mobility, and wonder how he can be considered any sort of threat when he ambulates via wheelchair and has difficulty performing self-care tasks. Petitioner's son and daughter-in-law, who frequently visit Petitioner in the facility, testified that the CNAs assigned to him are often using their cell phones or otherwise distracted, and do not seem to properly supervise Petitioner, at times, not even knowing his whereabouts. Petitioner's daughter-in-law is concerned that the facility does not properly handle Petitioner's $\square$, noting as an example that Petitioner has been instructed to call for help if he needs to use the bathroom, though he may not remember to do so. Petitioner's family further testified that they have witnessed other residents strike out at one another, but accepted this as part of life in a facility that houses $\square$ patients.
6. At hearing, Respondent reviewed approximately 19 behavioral incident reports in which Petitioner was cited, spanning from January through November of 2015. Respondent's Risk Manager explained that when incidents are reported to the floor nurse, the names of any witness(es), a description of the event, and, if the witnesses include residents, a "BIM" score assessment of witness reliability is included within each report. Each event is written up by the nurse who receives the report, and an investigation follows. Respondent noted that the witness information and BIM scores

FINAL ORDER (Cont.)
15N-00115
Page 6 of 16
(degree of clarity ranging from 0 to 15 , with $12-15$ considered "good") would be visible on the reports which Respondent planned to redact and file, post-hearing, such that the hearing officer and Petitioner's family would see who witnessed/reported each event. However, only one of Respondent's employees who was present at hearing (Vanessa Gillam) directly observed Petitioner's behaviors towards other staff members, and no one present had observed his alleged behaviors towards other residents.
7. Prior to the conclusion of testimony, Respondent submitted into evidence several redacted "Five Day Reports," which the NHF filed with the Agency for Health Care Administration. Said reports document any reported or observed behaviors between residents, but do not specify who witnessed the event(s), other than the alleged victims. Notably, some of the incidents documented within the Five Day Reports duplicate those filed as internal incident reports (which, as discussed below, were not necessarily witnessed by the NHF staff who compile these reports), and none of the alleged victims were present to testify at hearing. The only Five Day Report that clearly references staff observation of Petitioner's behavior is one dated October 27, 2015. This report states that Petitioner was observed touching a female resident near the chest while they were sitting side-by-side in their wheelchairs. There is no indication as to how the female responded or whether the touch was consensual, but the parties were separated and redirected, and the facility noted, "[Petitioner's] behaviors have shown a distinct decline until a recent medication reduction which was restarted by the psychiatrist after this incident with good results."
8. Review of the documentation submitted by Respondent after hearing reflects multiple, internal incident reports, consistent with Ms. Harris' overview during the

FINAL ORDER (Cont.)
15N-00115
Page 7 of 16
proceeding. However, as noted above, Respondent has redacted from these records all names of witnesses, reporting staff, reviewing staff, and physicians. Additionally, some of the reported incidents seem to involve Petitioner as the recipient/victim of behaviors, some are unclear as to who initiated the incident (or whether there was any direct witness), and most the incidents involving sexual touching of residents do not indicate whether or not such touching was consensual and/or accidental. As such, many of these reports are uncorroborated hearsay, or have been rendered insufficient and unreliable as grounds upon which to base a finding of fact.
9. Incidents dated April 24 and 27 (x3), and July 7, 14, and 16 of 2015 appear to have been directly witnessed by (or inflicted upon) NHF staff. On April 24, 2015, a staff member reported that Petitioner grabbed her crotch while she was attempting to shave him. The facility's response was to redirect Petitioner. On April 27, 2015 at 8:00, 12:50, and 1:30, respectively, a CNA was assisting Petitioner with eating or dressing, when Petitioner grabbed the staff member's crotch and/or breasts. It is not clear if this was the same staff member each time; however, Petitioner was redirected, his medications were increased, and he was placed on $1: 1$ supervision, with instructions that CNAs perform 2-person assists at all times. On July 7, 2015, staff observed Petitioner "attempting to throw punches" at another resident, and redirected him. However, as Petitioner was noted to be agitated, he was administered Ativan (as prescribed) to calm him. On July 14, 2015, Petitioner was observed mobilizing in his wheelchair in pursuit of a female resident. He was redirected and then began swinging at staff, after which he was placed on $1: 1$ supervision. On July 16, 2015, Petitioner grabbed a CNAs crotch as she was attempting to help him toilet. When the CNA reprimanded him, Petitioner

FINAL ORDER (Cont.)
15N-00115
Page 8 of 16
reportedly said, "You get to touch me so why can't I touch you." Petitioner was counseled about keeping his hands to himself, the CNA was reminded that Petitioner required a 2-person assist, and Petitioner was continued on 15 minute checks.
10. Review of Petitioner's medication chart and physician orders provide background as to Petitioner's medical status at the time of the incidents in April, July, and October, 2015. In late April of 2015, Petitioner underwent dietary changes and speech therapy to assist in eating/swallowing. He was on 15 minute checks beginning April 22nd, and on April 27, 2015, he was moved to a different room and his was changed to (though the incident reports from April 27 note a change tc . The facility physician also ordered a consult with the facility's psychiatrist. Petitioner was again on 15 minute checks beginning June 28, 2015, and was prescribed per day for agitation on July 2, 2015. His physician ordered urinalysis and labs on July 7th, and prescribed beginning July 14, 2015. Various medications were changed or discontinued (some due to "non-use" and other as a result of "0 behaviors"), especially around October of 2015. A psychology evaluation was ordered on November 7, 2015, but no results are indicated.
11. Based upon the medication review and physician orders, it appears that Petitioner should have been receiving daily psychotropic medications of some form throughout his stay at the facility; however, many of the incident reports do not record any medication administration under the section which calls for entering the date and time of the "last dose" of anti-anxiety, anti-psychotic, or "other" prescriptions.

Additionally, it does not appear that Petitioner's blood glucose was monitored (or at

FINAL ORDER (Cont.)
15N-00115
Page 9 of 16
least, was not recorded) at the time of many incident reports, and he was often noted to be oriented to less than all four spheres (person, place, time, situation). In general, the incident reports lack consistent information regarding Petitioner's behavior and medical management at or near the time each incident occurred.
12. Review of the behavioral portion of Petitioner's Plan of Care reflects the facility's approach to his behavioral issues as relatively unchanged between January of 2015 and January of 2016. This approach, developed by Social Services staff, includes being careful not to invade Petitioner's personal space, giving Petitioner medications prescribed by his physician, giving him items or tasks to distract him, placing Petitioner on 1:1 supervision/15 minute/30 minute checks as needed, praising good behavior, removing Petitioner from public areas when behavior is disruptive, documenting summaries of each incident along with changes in mood and/or mental status, and psychiatric intervention or referrals, as needed.
13. Respondent contends that on or about November 23, 2015, Petitioner engaged in inappropriate touching of a female resident. There is no incident report or Five Day Report in evidence that corresponds with this occurrence. Nonetheless, per the Social Services Director, following this incident, the facility's interdisciplinary team met to discuss Petitioner's case and decided that the NHF could no longer meet Petitioner's needs. Also per the Social Services Director, the facility physician agreed with the determination to discharge Petitioner; however, there is no indication of the physician's decision to discharge within Petitioner's clinical record.
14. Via 30-day discharge notice dated November 24, 2015, Respondent informed Petitioner and his family of its intent to pursue discharge, checking a box to indicate

FINAL ORDER (Cont.)
15N-00115
Page 10 of 16
"Your needs cannot be met in this facility," and noting, by way of explanation:
"Behaviors are inappropriate towards other residents." The discharge notice was signed by the facility's attending physician.
15. On November 25, 2015, Petitioner's family requested a hearing to challenge the discharge.
16. At hearing, Petitioner's family clarified that they are open to relocating Petitioner to a different facility, if Respondent can locate one close enough for the family to continue their frequent visits. However, they questioned why Petitioner did not seem to be on consistent medication to address his behaviors at Respondent's facility, instead receiving medication only after incidents occurred.
17. Respondent clarified that Petitioner was assessed quarterly by the facility's contracted psychiatrist, had his medications reviewed monthly by the pharmacist, and saw weekly during the doctor's rounds. Respondent noted that residents' medication schedule is developed by the physician, and that it is generally best practice not to over-medicate. Respondent further indicated that while it had attempted to find alternate placement for Petitioner, no other nearby NHFs would accept him, due to the sexual nature of his behaviors.

## CONCLUSIONS OF LAW

18. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat. § $400.0255(15)$. In accordance with that section, this Order is the final administrative decision of the Department of Children and Families.

FINAL ORDER (Cont.)
15N-00115
Page 11 of 16
19. The burden of proof (clear and convincing evidence) is assigned to the

Respondent.
20. Federal Regulations appearing at 42 C.F.R. § 483.12(a), set forth the reasons a
facility may involuntary discharge a resident as follows:
Admission, transfer and discharge rights.
(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.
(emphasis added)
21. Petitioner's medical record was not documented by his physician to reflect the doctor's agreement with the discharge and/or the facility's inability to meet

FINAL ORDER (Cont.)
15N-00115
Page 12 of 16
Petitioner's needs. Per documentation and testimony offered, Petitioner was admitted to Respondent's facility as a $\square$ patient with issues, and $\quad$ Respondent's records reflect that Petitioner experiences confusion and believes various females within the facility to be his wife.
22. The majority of Petitioner's behaviors towards staff occur when staff is performing personal grooming or activity of daily living-based care. While it is understandable that staff should not have to deal with inappropriate sexual touching, it does not appear that Petitioner has been instructed or trained on appropriate interaction, as only one incident report (in July, 2015) notates followup counseling for Petitioner to keep his hands to himself. Further, it appears that the facility's approach of using 2:1 CNA care has reduced or eliminated incidents with staff, as might utilizing male staff to avoid Petitioner's potential confusion of other females as his wife.
23. With regard to Petitioner's alleged behaviors towards other residents, the majority of such incidents are uncorroborated hearsay. Hearsay is defined by Fla. Stat. § $90.801(1)(\mathrm{c})$ as "... a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted." Indeed, hearsay evidence is inadmissible in a court proceeding unless authorized by statute or exception (See Fla. Stat. § 90.802). 24. Fla. Stat. § 120.57 (1)(c) allows for the admission of hearsay evidence in administrative hearings, provided that it is "used for the purpose of supplementing or

FINAL ORDER (Cont.)
15N-00115
Page 13 of 16
explaining other evidence, but it shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions."
25. Although the Respondent filed several incident reports, it did not proffer any witnesses who could substantiate such reports, or give testimony regarding direct observation of the events described within same. Incident reports would be independently admissible only if a proper foundation was laid for their submission as either a statement for medical treatment or a business report, as defined in Fla. Stat. §
90.803(4) and (6):
(4) STATEMENTS FOR PURPOSES OF MEDICAL DIAGNOSIS OR TREATMENT.-Statements made for purposes of medical diagnosis or treatment by a person seeking the diagnosis or treatment, or made by an individual who has knowledge of the facts and is legally responsible for the person who is unable to communicate the facts, which statements describe medical history, past or present symptoms, pain, or sensations, or the inceptions or general character of the cause or external source thereof, insofar as reasonably pertinent to diagnosis or treatment.
(6) RECORDS OF REGULARLY CONDUCTED BUSINESS ACTIVITY.-
(a) A memorandum, report, record, or data compilation, in any form, of acts, events, conditions, opinion, or diagnosis, made at or near the time by, or from information transmitted by, a person with knowledge, if kept in the course of a regularly conducted business activity and if it was the regular practice of that business activity to make such memorandum, report, record, or data compilation, all as shown by the testimony of the custodian or other qualified witness, or as shown by a certification or declaration that complies with paragraph (c) and s. 90.902(11), unless the sources of information or other circumstances show lack of trustworthiness. The term "business" as used in this paragraph includes a business, institution, association, profession, occupation, and calling of every kind, whether or not conducted for profit. (emphasis added)
26. The incident reports were not made by Petitioner for the purposes of treatment, nor were they compiled by direct witnesses (or reported by NHF employees). As such,

FINAL ORDER (Cont.)
15N-00115
Page 14 of 16
without further corroboration in the form of testimony or bolstering documentation, many of the incidents reports are unreliable.
27. More importantly, however, even given that Petitioner has engaged in some inappropriate behavior, Respondent bears the burden to prove that as a result of said behavior, the facility is no longer able to meet Petitioner's needs. The facility contends that Petitioner's is too severe to enable participation in a plan geared toward targeted behaviors (i.e., decreasing sexual touching). However, there is no evidence that such measures were attempted, failed, and ruled out, nor is there any documentation or testimony from the facility's physicians or psychologist related to Petitioner's potential to benefit from behavioral therapy. Indeed, Petitioner was referred to the psychologist, but no follow up from this referral is indicated in his medical record. Further, while Petitioner was prescribed some form of psychotropic medication at all times since his admission, neither incident reports nor testimony from his caregiving staff reflect consistent administration of medication. In fact, one of the Five Day Reports entered into evidence confirms that Petitioner showed improvement in behaviors through October of 2015, until one of his medications was reduced.
28. It is understandable that the facility may not be able to provide 24 -hour,

1:1 supervision for Petitioner. However, Respondent's facility does house

attempt provision of appropriate services, and to exhaust all reasonable attempts at addressing Petitioner's behavioral issues, as well as to thoroughly document

FINAL ORDER (Cont.)
15N-00115
Page 15 of 16
all incidents and physician recommendations that might substantiate
Respondent's inability to meet Petitioner's needs.
29. Should Petitioner continue to engage in behaviors, despite ongoing and exhaustive attempts to deter same, Respondent may wish to consult with their physicians and determine whether discharge is proper, at some future date.

However, after considering the entire record, the undersigned concludes that Respondent has not met its burden to prove, by clear and convincing evidence, that the facility can no longer meet Petitioner's needs.

## DECISION

Based upon the foregoing Findings of Fact and Conclusion of Law, the Petitioner's appeal is GRANTED. The facility has not established, at this time, that discharge is permissible under federal regulations.

## NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

FINAL ORDER (Cont.)
15N-00115
Page 16 of 16
DONE and ORDERED this $\qquad$ 04 day of $\qquad$ , 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:
Ms. Kriste Mennella,
Agency for Health Care Administration

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

Office of Appeal Hearings
Dept. of Children and Farrilies

APPEAL NO. 15N-00120

## PETITIONER,

Vs.


RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on January 19, 2016 at 2:06 p.m.

## APPEARANCES

For the Petitioner:


For the Respondent:


ISSUE
At issue is whether the facility's intent to discharge the petitioner based on
Federal Regulations found at 42 C.F.R § 483.12 is correct. A Nursing Home Transfer and Discharge Notices was issued to the petitioner on December 8, 2015. The facility indicated the reasons for discharge as: Your needs cannot be met in this facility. The

FINAL ORDER (Cont.)
15N-00120
PAGE - 2
safety of other individuals in this facility is endangered. The facility hold the burden of proof to establish be clear and convincing evidence that the discharge is appropriate.

## PRELIMINARY STATEMENT

Agency for HealthCare Administration (AHCA) submitted a letter on January 21, 2016 informing the undersigned an unannounced visit was made to the facility by AHCA staff on January 13, 2016. AHCA staff indicated no deficiencies were identified during the visit to the facility.

The facility provided evidence prior to the hearing, which was entered as Respondent Exhibit 1. The facility presented additional evidence during the hearing, which was entered as Respondent Exhibit 2.

The record was held open through February 19, 2016 for Proposed Final Orders. Neither party submitted a Proposed Final Order.

## FINDINGS OF FACT

1. The petitioner was admitted to this facility from Crosswinds, a sister facility, on May 7, 2015.
2. The petitioner is a who requires physical assistance transferring from bed to chair and chair to bed and toileting.
3. The respondent issued a Nursing Home Transfer and Discharge Notice to the petitioner. The Notice is dated November 30, 2015. The facility acknowledges the loss of the original notice. This delayed the facility in giving the notice to the petitioner until December 8, 2015. The notice cites "Your needs cannot be met in this facility" and "The safety of other individuals in the facility is endangered."

FINAL ORDER (Cont.)
15N-00120
PAGE-3
4. The respondent contends the facility is unable to meet the petitioner's needs as he refuses psychiatric treatment/medication and other medical appointments when they conflict with the smoking schedule.
5. The respondent provided documentation showing the petitioner's refusal psychotropic medications, monitoring and wound care.
6. The petitioner maintains he has the right to decide which treatments and medications he wants to take.
7. The respondent contends the safety of others in the facility is endangered due to the petitioner's physical aggression.
8. The respondent has implemented a "rule of two" in regards to care and treatment of the petitioner due to false accusations he has made regarding staff. The "rule of two" means that two staff members must be present at all times when providing care for the petitioner.
9. The respondent contends the petitioner is verbally threatening and frequently curses at staff, calling them obscene names.
10. The petitioner stated he resorts to cursing when he feels he is being ignored. He admitted use of profanity and name-calling.
11. The respondent cited a specific example of the petitioner "throwing" a leg rest from his wheelchair toward staff on November 5, 2015 to show the problem with the safety of others being endangered.
12. The petitioner maintains he did not intend to "throw" the leg rest on the date cited above, but rather move it out of his wheelchair seat so that he could get into

FINAL ORDER (Cont.)
15N-00120
PAGE-4
the wheelchair. He believes staff took the action as "throwing" rather than him losing control of the leg rest as he moved it.
13. The respondent attempted to have the petitioner moved under the Baker Act following the issue on November 5, 2015. However, he returned to the facility on November 6, 2015.
14. The respondent is concerned with placing another resident in the room with the petitioner due to the escalating behaviors/aggression.
15. The respondent explained the petitioner performs "self-gratification activities" without ensuring other residents/visitors are unable to view his actions.
16. The petitioner believes he has a right to perform "self-gratifying activities" and if staff come into the room during such, they should leave and return later.
17. The petitioner has threatened to, attempted and succeeded in "throwing himself" from the bed according to the respondent. The respondent maintains the petitioner cannot lower his bed low enough to the ground to safely lower himself to the floor.
18. The petitioner maintains he was not trying to "throw" himself from the bed. He lowered his bed as low as possible and lowered himself to the floor as best he could and pulled himself to the hallway after his call light was ignored. The petitioner further argued why would he "throw" himself to the floor when he knows that would cause him more harm and possibly leave him in a worse state physically. He wants to do for himself as best he can, but being unable to move himself about is frustrating.
19. The petitioner maintains he likes living in this facility. He admits he gets frustrated with having to wait extended periods for staff to come assist him with

FINAL ORDER (Cont.)
15N-00120
PAGE - 5
transferring. He also admitted he turns up his radio or television when trying to get staff attention.
20. The petitioner believes he no longer has confidentiality available when he talks with the social worker now because of the "rule of two." The petitioner stated he does not have family or friends locally that can sit in when he wants speak confidentially with the social worker.
21. The petitioner is trying to better control his language and think before he speaks, but that it is difficult to break the habit when he still gets frustrated.
22. The respondent stated the petitioner has tried to "reign it in" as far as his language goes since the discharge notice was issued. He has not been completely successful, but efforts have been noted by the respondent.
23. The respondent stated there is no anger management or behavior modification activities ongoing with the petitioner.
24. The petitioner has made several calls to the Florida Abuse Hotline and at least one call to local law enforcement regarding this facility. The petitioner acknowledged his call to local law enforcement was done in error and rescinded the claim with them.
25. The respondent stated the claims have been all proven unfounded. The respondent further stated she deals with an investigator from one agency or another regarding the petitioner's reports.

## CONCLUSIONS OF LAW

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

FINAL ORDER (Cont.)
15N-00120
PAGE-6
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.
27. Florida Statutes section 400.255 (3) Resident transfer or discharge; requirements and procedures; hearings" states:
(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 circumstances, 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 health or safety of 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.
(10)(a) A resident is entitled to a fair hearing to challenge a facility's proposed transfer or discharge. The resident, or the resident's legal representative or designee, may request a hearing at any time within 90 days after the resident's receipt of the facility's notice of the proposed discharge or transfer.
(b) If a resident requests a hearing within 10 days after receiving the notice from the facility, the request shall stay the proposed transfer or discharge pending a hearing decision. The facility may not take action, and the resident may remain in the facility, until the outcome of the initial fair hearing, which must be completed within 90 days after receipt of a request for a fair hearing.
(emphasis added)
28. Federal Regulations found at 42 C.F.R. § 483.12 "Admission, transfer and discharge rights" states in relevant part:
(5) Timing of the notice. (i) Except as specified in paragraphs (a)(5)(ii) and (a)(8) 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.
29. The findings show the facility clearly did not issue the Notice of Intent to Discharge or Transfer until December 8, 2015 with an effective date of December 30, 2015. The undersigned concludes the petitioner was not given 30 day notice as prescribed in the above controlling authorities. However, the petitioner was able to file an appeal within 10 days of receiving the Notice. The discharge or transfer was stayed pending the outcome of the appeal. The undersigned concludes no harm was caused in this instance by the delayed receipt of the notice.
30. 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

FINAL ORDER (Cont.)
15N-00120
PAGE - 8
facility, the facility may charge a resident only allowable charges under Medicaid; or
(vi) The facility ceases to operate.
31. Based on the evidence presented, the nursing facility has established that (list reason for discharge). 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.
32. 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.
33. 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) 4193456.
34. 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 the petitioner's refusal of medication or treatment does not show that his needs cannot be met at its facility. The federal regulation is clear the intent of a discharge under this stated reason is when the transfer or discharge is necessary for

FINAL ORDER (Cont.)
15N-00120
PAGE - 9
the resident's welfare and the resident's needs cannot be met in the facility. The undersigned concludes the petitioner's choice to refuse medication and or treatment, while not necessarily a good choice in the eyes of the facility, is not an indication that the facility cannot meet the petitioner's needs.
35. The respondent bears the burden of proof, by clear and convincing evidence, to show that the safety of other individuals in the facility in endangered. The findings show the facility presented one instance of physical aggression in "throwing" an object. The findings also show the petitioner's version of "losing control of the object". The findings also show the respondent's version of the petitioner "throwing himself" versus the petitioner's version of "moving as safely as possible" to the floor as a reported safety incident. The undersigned does not concludes the evidence presented by the respondent does not meet the clear and convincing standard of evidence required for meeting the burden of proof required by the above controlling authorities for discharge.

## 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

FINAL ORDER (Cont.)
15N-00120
PAGE - 10
be filed within thirty (30) days of the date stamped on the first page of the 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 $\qquad$ 25 day of March , 2016,
in Tallahassee, Florida.


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:

Respondent
Ms_Donna_Heiberg, Agency for Health Care Administration

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

Mar 04, 2016


PETITIONER,
Vs.


RESPONDENT.
APPEAL NO. 15N-00121

1

## FINAL ORDER

Pursuant to notice an administrative hearing convened before the undersigned at 1:30 p.m. on January 26, 2016, at Island Health and Rehabilitation Center in Merritt Island, Florida.

## APPEARANCES

For the Petitioner:
For the Respondent:


At issue is whether the respondent's intent to discharge the petitioner from due to nonpayment is proper. The respondent carries the burden of proof by clear and convincing evidence.

## PRELIMINARY STATEMENT

By Nursing Home Transfer and Discharge Notice, dated December 1, 2015, the respondent (or the Facility) notified the petitioner they were seeking to discharge her

FINAL ORDER (Cont.)
15N-00121
PAGE - 2
from the Facility due to nonpayment; after reasonable and appropriate notice to pay.
Petitioner timely requested a hearing to challenge the transfer and discharge.
Appearing as witnesses from the Facility were Petitioner did not submit exhibits. Respondent submitted one exhibit, entered as Respondent Exhibit "1". The record was closed on January 26, 2016.

## FINDINGS OF FACT

1. Petitioner was admitted to the respondent's Facility on May 20, 2015, from for rehabilitation after taking a fall at her home.
2. Petitioner is receiving Medicaid Institutional Care Program benefits. Petitioner's patient responsibility to the Facility after Medicaid pays is $\$ 1,656$ monthly. Petitioner's current balance owed to the Facility is $\$ 14,804$ with a past due balance of $\$ 13,148$. The petitioner has made one payment of $\$ 100$ in October 2015, since she entered the Facility.
3. The Facility provided the petitioner monthly billing statements starting in June 2015.
4. On November 18, 2015 and December 15, 2015, the Facility gave petitioner "Past Due" letters. The letters in part state:

We have not yet received payment for As explained at the time of admission, each month's charges are due and payable on the $1^{\text {st }}$ of the month and are considered past due if not paid by the $10^{\text {th }}$ of the month...
5. Petitioner agreed that she has only paid the Facility $\$ 100$ since she was admitted and is aware that her patient responsibility is $\$ 1,656$ monthly.

FINAL ORDER (Cont.)
15N-00121
PAGE - 3
6. Petitioner stated that she "understands what the Facility is saying". Petitioner asserts that when she entered the Facility, she explained that she was only able to pay what Medicaid was paying. Because her husband was in jail and she has to the pay bills on the "outside"; which only leaves her $\$ 350$ monthly. And while her husband was in jail he fell and broke his hip and is unable to work.

## 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 § $400.0255(15)$,

Fla. Stat. In accordance with that section this order is the final administrative decision of the Department of Children and Families.
8. Federal Regulations 42 C.F.R. § 483.12, Admission, transfer and discharge rights, sets forth the reasons a facility may involuntary discharge a resident and in part states:
(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.
9. The evidence establishes that the petitioner "has failed, after reasonable and
appropriate notice, to pay for a stay at the facility". This is one of the six reasons

FINAL ORDER (Cont.)
15N-00121
PAGE-4
provided in the above federal regulation for which a facility may involuntarily discharge a resident.
10. Federal Regulations 42 C.F.R. § 483.12 Admission, transfer and discharge rights, in part states:
(a)(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.
11. Establishing that the reason for a discharge is lawful is one step in the discharge process. In accordance with the above authority, the Facility must also provide discharge planning, which includes identifying an appropriate transfer or discharge location and sufficiently preparing the resident for a safe and orderly transfer or discharge from the facility. The Hearing Officer cannot and has not considered either of these issues. The Hearing Officer only considered whether the discharge is for a lawful reason and requirements of the controlling authorities have been met.
12. Discharge by the Facility must comply with all applicable Federal Regulations, Florida Statutes, and AHCA requirements. Should the petitioner have concerns about the appropriateness of the discharge location or the discharge planning process, she may contact AHCA's complaint line at (888) 419-3456.
13. In careful review of the cited authority and evidence, the undersigned concludes that the respondent met its burden of proof in its position that the petitioner "has failed, after reasonable and appropriate notice, to pay for a stay at the facility".

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal is denied. The Facility's action to discharge the petitioner is in

FINAL ORDER (Cont.)
15N-00121
PAGE - 5
accordance with Federal Regulations. The respondent may proceed with the discharge as described in the Conclusions of Law and in accordance with the applicable AHCA 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 $\qquad$ day of $\qquad$ , 2016,
in Tallahassee, Florida.

# Miscilla Peterson 

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


Agency for Health Care Administration

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


PETITIONER,
Vs.


RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened a nursing home discharge hearing in the above-referenced matter on February 17, 2016, at 9:02 a.m.,


At issue is whether the facility's intent to discharge the petitioner due to nonpayment 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 December 23,2015 . The facility has the burden of proof to establish by clear and convincing evidence that the discharge is appropriate.

# FINAL ORDER (Cont.) 

15N-00128
PAGE -2


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 (Hearing Officer Exhibit 1).

The petitioner did not present any exhibits. The respondent presented two exhibits, which were accepted into evidence and marked as Respondent's Exhibit 1 and Respondent's Composite Exhibit 2.

## FINDINGS OF FACT

1. The petitioner resided at the respondent's nursing facility since 2008. He incurred a past due balance in 2013. His owes the facility $\$ 3,140.20$, according to his January 2016 monthly statement. The petitioner was receiving Medicaid and Medicare.
2. The petitioner made an arrangement with the administrator in 2013 to have his Social Security transferred to $\square$ as the payee with the understanding that in doing so, the nursing facility would not discharge him. He did not have any documentation of the arrangement made with the prior administrator.
3. The petitioner made The payee and discharge actions were not pursued. He continued to live at the facility with the outstanding balance.

FINAL ORDER (Cont.)
15N-00128
PAGE -3
4. The nursing facility underwent administrative changes and a new administrator was assigned to $\square$ n August 2015. The new administrator (current) ordered a review of residents' files. It was found the petitioner had an outstanding balance.
5. On August 20, 2015, the outstanding balance was discussed with the petitioner and he indicated that he would work to get his account current. The facility continued sending monthly statements to the petitioner informing him of his outstanding balance. He was sent statements for August 2015, September 2015, October 2015, November 2015 and December 2015.
6. In addition to the monthly statements the petitioner was verbally informed of his outstanding balance again on December 9, 2015.
7. On December 23, 2015, the respondent issued the petitioner a Nursing Home Transfer and Discharge Notice that indicated the petitioner would be discharged from the facility effective January 23, 2016, due to non-payment of his bill for services. The discharge location listed was Regal Park, 1708 NE, $4^{\text {th }}$ Street, Boynton Beach, FL 33435.
8. The petitioner acknowledged receiving periodic notices of his outstanding balance and he does not dispute the amount.
9. The petitioner did not dispute the amount owed to the facility and he acknowledged being aware he owed the facility a past due amount. He argued that the facility wants to discharge him as retaliation and not on his past due balance. He argued that he had a confrontation with the administrative staff and as a result, actions to discharge him were taken.

FINAL ORDER (Cont.)
15N-00128
PAGE -4
10. The current administrator was not aware of any arrangement binding the facility not to take action to discharge the petitioner. The facility is not willing, as of the date of the hearing, to negotiate any arrangement for non-payment.

## 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 section 400.0255(15),

Fla. Stat. In accordance with that section, this order is the final administrative decision of the Department of Children and Families.
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...

FINAL ORDER (Cont.)
15N-00128
PAGE -5
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. The nursing facility provided the petitioner with monthly statements with the balance he owed. The petitioner admitted to receiving the monthly statements. He also acknowledged that he owed a past due balance however, he argued that he made a verbal agreement with the previous administrator that the facility would not discharge him on the contingency that he made $\quad$ his Social Security payee which he did. He did not provide evidence of such arrangement. 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 is $\$ 3,140.20$.
15. 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 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.
16. 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

FINAL ORDER (Cont.)
15N-00128
PAGE -6
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 only considered whether the discharge is for a lawful reason.
17. 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.

FINAL ORDER (Cont.)
15N-00128
PAGE -7

DONE and ORDERED this $\qquad$ 17 day of $\qquad$ March 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


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

Vs.
PETITIONER,

RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened a nursing home discharge hearing in the above-referenced matter on March 2, 2016 1:32 p.m. at in

## APPEARANCES

For the petitioner:
For the respondent:
Mia McKown, attorney, Holland \& Knight LLP

## STATEMENT OF ISSUE

At issue is whether the facility's intent to discharge the petitioner due to nonpayment 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 January 8, 2016. The facility has the burden of proof to establish by clear and convincing evidence that the discharge is appropriate.

## PRELIMINARY STATEMENT

Witness for the respondent was Craig Koff, Administrator for care center.
At the request of the undersigned, the Agency for Health Care Administration (AHCA) conducted an on-site inspection of the facility and found no violations.

The petitioner presented one exhibit which was accepted, entered into evidence and marked as Petitioner's Composite Exhibit 1. The respondent presented one exhibit, which was accepted into evidence and marked as Respondent's Composite Exhibit 1. The record was closed.

On March 9, 2016, the petitioner submitted a PETITIONER'S MOTION FOR 5 DAYS' LEAVE TO FILE MEMORANDUM OF LAW ADDRESSING ISSUE RAISED BY RESPONDENT DURING HEARING. On March 11, 2016, the respondent filed a RESPONDENT'S OPPOSITION TO PETITIONER'S MOTION FOR 5 DAYS' LEAVE TO FILE MEMORANDUM OF LAW ADDRESSING ISSUE RAISED BY

## RESPONDENT DURING HEARING AND RESPONDENT'S MOTION TO REOPEN

 THE HEARING FOR ADDITIONAL DISCOVERY.The undersigned makes the following ruling on the outstanding motions. The petitioner's motion is denied. The RESPONDENT'S MOTION OPPOSITION TO

PETITIONER'S MOTION FOR 5 DAYS' LEAVE is granted. The RESPONDENT'S MOTION TO REOPEN THE HEARING FOR ADDITIONAL DISCOVERY is denied.

The record remains closed.

FINAL ORDER (Cont.)

## FINDINGS OF FACT

1. The petitioner entered the facility on October 26, 2016. Her daughter signed the admissions contract on November 3, 2015. The petitioner was admitted to VI at Lakeside Village for six days. She was at another facility for 94 days and then transferred to VI. She came with the understanding that she would be converted to private pay status after six days as a Medicare pay resident.
2. On October 22, 2015, the petitioner made a payment of $\$ 9,180.08$ to VI .
3. On November 30, 2015, the petitioner applied for Medicaid and was initially denied. She reapplied on February 2, 2016, and was approved retroactively from December 2015. Her patient responsibility was zero for December 2015 and $\$ 1,955.86$ per month for January 2016 ongoing.
4. On December 16, 2015, the petitioner's daughter was sent correspondence informing her that at was terminating the Admission Agreement as the petitioner failed to pay all fees and charges. No official Discharge and Transfer Notice was issued.
5. On December 28, 2015, the petitioner requested a hearing to challenge the facility's action.
6. On January 6, 2016, the respondent received two checks from the petitioner dated January 2, 2016 check number 4950 for $\$ 2,580.72$ and check number 4951 for \$2,580.72 reducing her past due balance from $\$ 21,217.84$ to $\$ 16,056.40$.
7. The nursing facility asserts it provided the petitioner with monthly statements with the balance owed. Prior to January 6, 2016, the petitioner's past due balance was

FINAL ORDER (Cont.)
15N-00129
PAGE -4
$\$ 21,217.84$. The petitioner did not dispute receiving the monthly statements or the balance owed to the facility
8. On January 8, 2016, the facility issued a proper Discharge Notice to the petitioner informing her that she was to be discharged from the nursing facility effective February 7, 2016, due to non-payment of bill for services.
9. On February 3, 2016, the Department sent the petitioner a Notice of Case Action informing her that her application for Medicaid dated February 2, 2016 was approved. She was eligible for Medicaid for December 2015, January 2016, February 2016, and March 2016 ongoing. She was expected to pay zero for December 2015, and $\$ 1,955.86$ for January 2016 ongoing to the nursing facility provider. As of February 29, 2016 the petitioner's past due balance was $\$ 26,343.73$.
10. The respondent argued that it cannot bill the petitioner as a Medicaid resident as she was not occupying a Medicaid bed but a private pay bed and it would be fraudulent to claim she was in a Medicaid bed. As of the date of this hearing the amount owed has not been paid. The respondent explained the facility has only four Medicaid beds and they were all filled when the petitioner was admitted to the facility. Additionally, those beds have remained filled by the same residents.
11. The facility is willing to rescind the discharge notice if the petitioner pays the past due balance in full and remains as a private pay resident.
12. The petitioner's representative argued that the facility violated the federal regulations as it seeks to discharge the petitioner because she has applied for Medicaid as her payment source and that the facility may not transfer or discharge a resident solely because the source of payment for care changes.

FINAL ORDER (Cont.)
15N-00129
PAGE -5

## CONCLUSIONS OF LAW

13. The jurisdiction to conduct this hearing is conveyed to the Department of

Children and Families by Federal Regulations appearing at 42 C.F.R. § 431.200. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to section $400.0255(15)$, Fla. Stat. In accordance with that section, this order is the final administrative decision of the Department of Children and Families.
14. Federal Regulations appearing at 42 C.F.R. § 483.12, Admission, transfer and discharge rights, sets forth the limited reasons a Medicaid or Medicare certified nursing facility may involuntary discharge a resident and states in part:
(a)(2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--
(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
(ii) The transfer or discharge is appropriate because the president's health has improved sufficiently so the resident no longer needs the services provided by the facility
(iii) The safety of individuals in the facility is endangered;
(iv) The health of individuals in the facility would otherwise be endangered;
(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid or
(vi) The facility ceases to operate.
15. The undersigned's jurisdiction is limited to the above six reasons and will only consider if the discharge is for a legal reason based on any of the six allowable reasons listed above.

FINAL ORDER (Cont.)
15N-00129
PAGE -6
16. The petitioner's representative argued the facility may not discharge a resident based on changes in payment. The petitioner's representative acknowledged that her daughter received monthly statements for the petitioner's stay at the facility and has not disputed the amount owed. Although the petitioner was approved for Medicaid benefits on February 2, 2016, the facility is unable to bill Medicaid for her stay. The petitioner is not in a Medicaid certified bed and if the facility billed Medicaid for such services, it would be fraudulent. The amount owed remains unpaid.
17. 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.
18. 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 $\$ 26,343.70$. This fact is not disputed.
19. The nursing facility provided the petitioner with monthly statements with the balance owed. The petitioner did not dispute receiving the monthly statements or the balance owed to the facility.
20. The hearing officer concludes that the facility has given the petitioner reasonable and appropriate notice to pay for her stay at the facility. Based on the evidence presented, the nursing facility established the petitioner failed, after reasonable and

FINAL ORDER (Cont.)
15N-00129
PAGE -7
appropriate notice, to pay for 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.
21. The petitioner's representative argues that the petitioner should not be discharged because her payer source has changed from private pay to Medicaid. The petitioner representative also argues the petitioner is eligible for Medicaid ongoing and retroactive to December 2015.
22. 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.
23. 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

FINAL ORDER (Cont.)
15N-00129
PAGE -8
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 $\qquad$ 01 day of $\qquad$ , 2016, in Tallahassee, Florida.


Christian 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@myfIfamilies.com


Ms. Arlene Mayo-Davis
Agency for Health Care Administration

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

PETITIONER,
VS

RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened a nursing home discharge hearing in the above-referenced matter on March 14, 2015, at 1:27p.m., at


APPEARANCES
For the petitioner:
For the respondent:
Dianne O' Sullivan, administrator

## STATEMENT OF ISSUE

At issue is whether the facility's intent to discharge the petitioner due to nonpayment 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 December 22,2015 . The facility has the burden of proof to establish by clear and convincing evidence that the discharge is appropriate.


## FINDINGS OF FACT

1. The petitioner was admitted to the facility on October 20, 2015.
2. On December 8, 2015, the business office manager met with the petitioner's daughter and discussed the Medicaid application process and what was needed for the application.
3. On December 10, 2015, the facility applied for Medicaid benefits for the petitioner.
4. On December 15, 2015, the Department of Children and Families (DCF) sent the petitioner a Notice of Case Action, informing her that she needed to sign the financial release form, and to provide income, assets and out of pocket medical expenses. The information was due by December 28, 2015.
5. On December 18, 2015, the administrator called the petitioner's daughter and requested the petitioner's bank statements.
6. On December 22, 2015, the Transfer and Discharge Notice was sent to the petitioner's daughter by certified mail. The mail was returned to the facility.
7. On December 29, 2015, a facility representative called the petitioner's daughter and informed her that she will have to pay the bills owed by the petitioner.

FINAL ORDER (Cont.)
15N-00130
PAGE 3
8. On January 13, 2016, DCF denied the petitioner's Medicaid application. The reason given for the denial was that the requested information was not received.
9. On January 13,2016 , the facility sent the petitioner's daughter a notice informing her that the petitioner had an outstanding balance. The notice informed her that $\$ 1,527.08$ was due. It also informed that payment is due by the $5^{\text {th }}$ of each month for the current month's charges.
10. On January 25, 2016, the facility sent the petitioner's daughter a second notice. The notice informs that her account was 20 days past due and the amount due was \$1,527.08.
11. On February 16,2016 , the facility sent the petitioner's daughter a notice informing her that it has not received a payment. The notice informed her that the amount owed was $\$ 2,132.08$. The notice allowed her five days to pay the amount due or legal actions could be taken.
12. On March 3, 2016, the petitioner was sent to the hospital to be evaluated. The petitioner's daughter alleged the petitioner was seen by a physician at the hospital and released after 45 minutes. The nursing facility was contacted to coordinate the petitioner's release from the hospital but the facility did not accept her back. She remained at the hospital until she found another nursing facility that accepted her. The petitioner wishes to return to the respondent's facility.
13. The facility claimed it sent the petitioner's first monthly statement on December

22, 2015. The facility did not provide evidence of such statement. As of the date of this hearing, the petitioner owes the facility $\$ 22,665.82$.

FINAL ORDER (Cont.)
15N-00130
PAGE 4
14. The respondent has not provided evidence that it issued a discharge notice for another reason other than the one for non-payment.

## CONCLUSIONS OF LAW

15. The jurisdiction to conduct this hearing is conveyed to the Department of

Children and Families by Federal Regulations appearing at 42 C.F.R. § 431.200. The
Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to section $400.0255(15)$, Fla. Stat. In accordance with that section, this order is the final administrative decision of the Department of Children and Families.
16. 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...
17. 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:

FINAL ORDER (Cont.)
15N-00130
PAGE 5

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.
18. The nursing facility has not provided the petitioner with monthly statements showing the balance she owed prior to issuing the Transfer and Discharge Notice. The facility has not provided evidence that it billed, or informed the petitioner of a past due balance prior to issuing the Discharge Notice. 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 $\$ 22,665.82$.

Since the Transfer and Discharge Notice was issued, the facility has since provided monthly statements with past due balances.
19. The hearing officer concludes the facility has not given the petitioner reasonable and appropriate notice to pay for stay at the facility prior to issuing the Transfer and Discharge 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. The nursing facility has not met its burden of proof.
20. 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 only considered whether the discharge is for a lawful

FINAL ORDER (Cont.)
15N-00130
PAGE 6
reason. Based upon the evidence presented, the nursing facility has failed to establish by clear and convincing evidence that the petitioner has, after reasonable and appropriate notice, failed to pay for her stay at the facility. The facility has not provided evidence of a discharge notice other than for non-payment. The petitioner is allowed to return to the facility. The undersigned concludes the discharge was not in accordance with the controlling authority cited above; therefore, the petitioner is allowed to return to the nursing facility.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted as the facility's action to discharge the petitioner is not permissible under federal regulations. The petitioner must be readmitted to the facility's first available bed in accordance with section $400.0255(15)(c)$, Fla. Stat. and the Agency for Health Care Administration's 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.

FINAL ORDER (Cont.)
15N-00130
PAGE 7
DONE and ORDERED this $\qquad$ 25 day of $\qquad$ March 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@myffamilies.com

Copies Furnished To Petitioner
Ms. Arlene Mayo-Davis
Agency for Health Care Administration
CASSANDRA HICKS

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

Mar 16, 2016


PETITIONER,
Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 20 Charlotte
UNIT: 88287

APPEAL NO. 16F-00041

CASE NO.

RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 9, 2016 at 2:04 p.m. CST.

## APPEARANCES



For the Respondent: Signe Jacobson, Economic Self-Sufficiency Specialist II, Department of Children and Families

## STATEMENT OF ISSUE

The Petitioner is appealing the Respondent's action to terminate her Medicaid eligibility. The Respondent bears the burden of proof by a preponderance of evidence.

## PRELIMINARY STATEMENT

The Respondent presented a packet which was submitted into evidence as Respondent Exhibits 1 through 6. The record was left open until February 19, 2016 for the Respondent to submit Notices of Case Action (NOCA), and the Division of Disability

FINAL ORDER (Cont.)
16F-00041
PAGE -2
Determination's (DDD) packet. The Respondent submitted the additional evidence February 10, 2016. This second packet was admitted into evidence as Respondent Exhibits 7-9. The Petitioner had until close of business February 19, 2016 to provide any written response desired to the Respondent's submission. Petitioner did not respond. The record was closed on February 19, 2016.

## FINDINGS OF FACT

1. Petitioner is 39 years old.
2. Petitioner filed for a redetermination of Medicaid eligibility on December 7, 2015. A NOCA was mailed December 28, 2015 informing Petitioner that her Medicaid would be denied effective January 2016 with reason for denial cited, "You or a member(s) of your household do not meet the disability requirement (R65A-1.711)."
3. Petitioner filed an application for additional assistance (Medicaid) on January 8, 2016. A NOCA mailed February 1, 2016 denied the Petitioner's Medicaid for the following reasons: "You are not age 65 or older. You or a member(s) of your household do not meet the disability requirement. No household members are eligible for this program (S409.9065 R65A-1.711 R65A-1.205)."
4. Petitioner applied for Supplemental Security Income (SSI) disability benefits with Social Security Administration (SSA) on May 26, 2015.
5. Petitioner reported speaking with a SSA representative by phone in July, 2015 and expressing that her situation had worsened.
6. Petitioner's SSI application is currently in appeal. Petitioner states she is at the stage of requesting a hearing and is working on the paperwork to do so.

FINAL ORDER (Cont.)
16F-00041
PAGE -3
7. The SSA determined Petitioner did not meet the disability criteria and issued an unfavorable decision on September 14, 2015. The denial was coded N35, "Non-pay Impairment is severe at time of adjudication but not expected to last twelve months, no visual impairment (Appendix F, SVES/SOLQ - April 2013).
8. The Department denied both of the Petitioner's Medicaid requests due to not meeting the disability criteria. The Department did not make an independent disability determination.
9. The DDD decision considered diagnoses of and affected mood disorder. The denial is coded N32, "Non-pay - Capacity for substantial gainful activity other work, no visual impairment (Appendix F, SVES/SOLQ - April 2013)."
10. Because Petitioner is under the age of 65 , she must be determined disabled prior to the Department determining Medicaid eligibility on other factors.
11. The Petitioner was diagnosed with
in April 2015. She has
undergone seven surgeries, each related to the diagnosis and subsequent surgeries.
12. The Petitioner has foregone surgery on her left ankle because of the complication of treatment. The ankle issues were not considered by the petitioner or SSA in the disability determination.
13. On July 28, 2015, Tatiana Medins, Admin. Assist to Dr. C. Wayne Cruse \& Dr.

Dunya Atisha, writes:


FINAL ORDER (Cont.)
16F-00041
PAGE -4
14. On December 31, 2015 MD writes:

Due to her she is unable to lift her arms and she has chronic chest and back pains. She has also has a known fracture of her left foot. She has required surgery to that area since July of 2013. Due to this has yet to be completed. She is not able to stand for more than 60 min intervals due to the degree of pain.

I feel that this natient will have long term consequences from her malignant

She needs additional breast and foot surgeries and is unable to work for an indefinite time period.
15. On January 16, 2016, Ario Yaege D. P. M. writes:

This is to verify that it's (apostrophe added) my professional opinion, based on the current clinical and physical findings it was recommended to the patient to follow up with her oncologist for potential clearance for left ankle surgery. At this time the patient has failed all non-surgical treatments, and due to the continued pain and instability, I am recommending Left ankle arthroscopic debridement with lateral ankle ligament repair. The goals of treatment are reduction of symptoms, improvement of activity.
16. Petitioner previously worked as a hair dresser. She states that she currently cannot lift her arms enough to do her job and cannot bathe herself properly. Her goal is to return to work. She would like to get medical coverage so she can receive the proper treatment to regain her health.

## 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. 652.056 .

## 19. Federal Medicaid Regulations at 42 C.F.R. $\S 435.541$ "Determinations of

disability" states in part:
(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.
(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 $\S 435.912$ 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.
20. Findings show that Petitioner applied for disability benefits with the SSA and was denied as she was found not disabled. The denial date was September 19, 2015.

Petitioner's eligibility for Medicaid was reviewed in December 2015. Petitioner applied for Medicaid January 2016. The SSA denial date was within 12 months of the Medicaid application dates. Petitioner indicated that SSA was aware of all impairments. Outside of the ankle injury, all impairments are related to the $\square$ The undersigned does not consider the ankle injury a disabling impairment since the doctor states

Petitioner can stand on it for an hour at a time and as recoupment from ankle surgery should be less than 12 months. Therefore, the undersigned agrees with the Petitioner that SSA was aware of all impairments and that there are no new disabling conditions not known by the SSA.

FINAL ORDER (Cont.)
16F-00041
PAGE-7
21. In accordance with the above controlling authority, the undersigned concludes
that the Department correctly adopted the federal SSA disability decision rather than make a duplicate independent decision on Petitioner's disability request.
22. Fla. Admin Code 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 ... (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).
23. According to the above controlling Medicaid authority, an individual must be age 65 or older, or disabled (by either the Department of SSA), to meet the technical criteria for Medicaid in the SSI-Related Medicaid Programs. Because Petitioner has not yet been determined disabled by SSA, she does not meet the technical criteria to be eligible for SSI-Related Medicaid. Therefore, the Department correctly denied the two requests for Medicaid at issue.

## DECISION

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

## NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The

FINAL ORDER (Cont.)
16F-00041
PAGE -8
petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 16 day of $\quad$ March , 2016,
in Tallahassee, Florida.


Gregory Watson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myffamilies.com

Copies Furnished To: Petitioner
Office of Economic Self Sufficiency

Apr 05, 2016
Office of Appeal Hearings
STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES OFFICE OF APPEAL HEARINGS

PETITIONER,
Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 05 Hernando
UNIT: 88002

## RESPONDENT.

CASE NO.


FINAL ORDER (Cont.)
16F-00043
PAGE-2
MN with an $\$ 874$ SOC. Petitioner timely requested a hearing to challenge enrollment in the MN Program.
 petitioner's sister, appeared as a witness for the petitioner. Petitioner did not submit exhibits. Respondent submitted three exhibits, entered as Respondent Exhibits "1" through " 3 ". The record was held open through end of business day on February 10, 2016, for the respondent to submit an additional exhibit.

The exhibit was received timely and entered as Respondent Exhibit "4". The record was closed on February 10, 2016.

## FINDINGS OF FACT

1. Petitioner submitted a Food Assistance and SSI-Related Medicaid application for herself on November 23, 2015. Medicaid is the only issue.
2. In December 2015, the petitioner's Social Security income changed from $\$ 884$ retirement to $\$ 1,074$ disability (SSDI).
3. For petitioner to be eligible for SSI-Related Medicaid, her income cannot exceed the \$864 Medicaid income standard. Petitioner's $\$ 1,074$ SSDI exceeds the $\$ 864$ Medicaid income standard. The next available program is the MN with a SOC.
4. The Department determined petitioner's SOC as follows:

| $\$ 1,074$ | SSDI |  |
| ---: | ---: | :--- |
| $-\$$ | 20 | unearned income disregard |
| $-\$$ | 180 | MN income level (MNIL) |
| $\$$ | 874 | SOC |

5. On December 16, 2015, the Department mailed petitioner a Notice of Case Action, notifying she was approved MN with an $\$ 874$ SOC.

FINAL ORDER (Cont.)
16F-00043
PAGE - 3
6. Petitioner said she cannot afford to pay $\$ 874$ monthly and she needs many medical procedures.
7. Respondent's representative responded that petitioner does not pay $\$ 874$ monthly and explained that petitioner must incur $\$ 874$ in medical bills/prescriptions and submit to the Department for bill tracking.
8. Petitioner's sister testified she understands that as long as petitioner has at least
$\$ 874$ monthly in medical bills/prescriptions she is eligible for 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 § 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. 652.056.
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

FINAL ORDER (Cont.)
16F-00043
PAGE-4
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 (FPL). And 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, appendix A-9, identifies $\$ 864$ as 88 percent of the FPL for a household size of one.
14. Petitioner's $\$ 1,074$ SSDI exceeds the $\$ 864$ income limit to be eligible for full Medicaid. Therefore, petitioner is not eligible for full Medicaid.
15. 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..."
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 $\$ 1,074$ SSDI to arrive at $\$ 874$ SOC.
18. In carefully review of the cited authorities and evidence, the undersigned agrees with the respondent's action to approve petitioner in the MN Program with an $\$ 874$ monthly SOC.

FINAL ORDER (Cont.)
16F-00043
PAGE - 5

## 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 $\qquad$ 05 day of $\qquad$ , 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:



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

Office of Appeal Hearings
Dept. of Children and Families

PETITIONER,
Vs.

## AGENCY FOR HEALTH CARE ADMINISTRATION

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on March 4, 2016 at 10:00 a.m. in Doral, Florida.

## APPEARANCES

For the Petitioner:
For the Respondent:

Petitioner's mother
Linda Latson, Registered Nurse Specialist Agency for Health Care Administration

## STATEMENT OF ISSUE

At issue is whether the Respondent's action to partially deny the Petitioner's request for personal care service (PCS) hours for the certification period December 8, 2015 through February 5, 2016, was correct. The Petitioner bears the burden of proof in this matter by a preponderance of the evidence.

## PRELIMINARY STATEMENT

The Petitioner did not submit any documents as evidence for the hearing.
Appearing as a witness for the Respondent was Dr. Rakesh Mittal, PhysicianConsultant 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 Notes, Exhibit 3 - Denial Notices, and Exhibit 4 - Supporting Documentation.

Also present for the hearing as an observer was Fatima Leyva, Senior Program Specialist for AHCA.

## FINDINGS OF FACT

1. The Petitioner's home health agency, Regions Healthcare Services (hereafter referred to as "Provider"), requested the following PCS hours for the certification period at issue: 8 hours daily, 7 days per week.
2. eQHealth Solutions, Inc. is the Quality Improvement Organization (QIO) contracted by the Respondent to perform prior authorization reviews for home health services. The Petitioner's provider submitted the service request through an internet based system. The submission included, in part, information about the Petitioner's medical conditions; her functional limitations; and other pertinent information related to the household.
3. eQHealth Solutions personnel had no direct contact with the Petitioner, her family, or her physicians, other than a phone call to the parent. All exchange of information was through eQHealth Solutions' internet based system. The decision

FINAL ORDER (Cont.)
16F-00085
PAGE - 3
made by each physician at eQHealth was solely based on the information submitted by the provider and the caregiver.
4. The medical information submitted by the provider contained, in part, the following information in regard to the Petitioner:

- 15 years of age and resides with her mother
- Ambulatory
- Incontinent at times
- Consumes a regular diet

5. The Petitioner's mother works from 3:00 p.m. to 11:00 p.m., 7 days per week. The Petitioner father lives in Ft. Myers and does not reside with the family. The Petitioner had a cousin who sometimes assisted with her care, but that individual has recently moved away.
6. The Petitioner attends school from 8:00 a.m. to 3:00 p.m., Monday to Friday.
7. The Petitioner is currently approved for 2 hours of PCS daily, which is utilized from 3:00 p.m. to 5:00 p.m. each day.
8. 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 home health aide/personal care aide. The duties include, in part:

- Provide assistance with personal care and ADLs (activities of daily living) such as bathing and grooming, oral hygiene, feedings, and toileting

9. A physician at eQHealth Solutions, who is board certified in pediatrics, reviewed the submitted information and partially denied the requested PCS hours. This physician-reviewer wrote, in part: "The clinical information provided does not support

FINAL ORDER (Cont.)
16F-00085
PAGE - 4
the medical necessity of the additional requested hours. The already approved hours should be sufficient to assist the patient with ADLs. The additional hours appear to be for supervision which is not a covered service." A notice of this determination was sent to all parties on December 16, 2015.
10. The above notice stated should the parent, provider, or Petitioner's physician disagree with the decision, a reconsideration review could be requested. Additional information could be provided with the request. A reconsideration review was requested on December 16, 2015.
11. A second physician at eQ Health Solutions reviewed the submitted information and upheld the initial decision to approve only 2 PCS hours daily. A notice of this reconsideration determination was sent to all parties on January 4, 2016. The Petitioner thereafter requested a fair hearing and this proceeding followed.
12. The Respondent's witness, Dr. Mittal, testified that 2 hours of assistance in the afternoon is sufficient to provide the medically necessary care to the Petitioner. He stated the additional requested hours appear to be for monitoring and supervision which can be provided by non-medical personnel.
13. The Petitioner's mother testified that she is requesting the additional PCS hours because there is no other person currently in the home that can take care of her daughter after the personal care aide leaves at 5:00 p.m. each day. She also stated her daughter has
14. Personal Care Service (PCS) for children is a covered service under the Medicaid State Plan in Florida. These services are provided in accordance with the

FINAL ORDER (Cont.)
16F-00085
PAGE - 5
Respondent's Home Health Services Coverage and Limitations Handbook (October 2014).

## 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 $\S 120.57$.
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 Petitioner since the Petitioner is requesting 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 $1201,7^{\text {th }}$ 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 personal care aide 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.

FINAL ORDER (Cont.)
16F-00085
PAGE - 6
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 $\S \S 1902(a)(43)$ 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 (personal care services) is one of the services provided by the state to treat or ameliorate an individual's conditions under the State plan. Chapter 409, Fla. Stat., states, in part:

[^6]Any service under this section shall be provided only when medically necessary ...
(4) (a) In providing home health care services, the agency may require prior authorization of care based on diagnosis
(b) The agency shall implement a comprehensive utilization management program that requires prior authorization of all private duty nursing services ... 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 any other family dependents.
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.
5111. 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

FINAL ORDER (Cont.)
16F-00085
PAGE - 8
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.
6. Based upon the information submitted by the Petitioner's provider, eQHealth

Solutions completed a prior authorization review to determine medical necessity for the requested personal care services.
27. In the Petitioner's case, the Respondent has determined that some personal care services are medically necessary, but has approved 2 hours daily rather than the 8 hours daily requested by the Petitioner's provider.
28. 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.
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. The Petitioner's request for service is governed by the Respondent's Home Health Services Coverage and Limitations Handbook (October 2014). The Handbook, on page 1-2, addresses Personal Care Services as follows:

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. Medicaid reimburses for these services provided to eligible recipients under the age of 21 years.

ADLs include:

FINAL ORDER (Cont.)
16F-00085
PAGE-10

- 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).

IADLs (when necessary for the recipient to function independently) include:

- Personal hygiene;
- Light housework;
- Laundry;
- Meal preparation;
- Transportation;
- Grocery shopping;
- Using the telephone to take care of essential tasks (examples include paying bills and setting up medical appointments);
- Medication management; and
- Money management.

31. Page 2-24 of the Handbook addresses who can receive personal care services, as follows:

Medicaid reimburses personal care services for recipients under the age of 21 who meet all of the following criteria:

- Have a medical condition or disability that substantially limits their ability to perform their ADLs or IADLs.
- Have a physician's order for personal care services.
- Require more individual and continuous care than can be provided through a home health aide visit.
- Do not have a parent or legal guardian capable of safely providing these services.

32. Page 2-25 of the Handbook imposes a parental responsibility requirement with
respect to personal care services, which is described as follows:
Personal care services can be authorized to supplement care provided by parents and legal guardians. Parents and legal guardians must participate in providing care to the fullest extent possible. Where needed, the home health service provider must offer training to enable parents and legal

FINAL ORDER (Cont.)
16F-00085
PAGE-11
guardians to provide care they can safely render without jeopardizing the health or safety of the recipient. The home health services provider must document the methods used to train a parent or legal guardian in the medical record.

Medicaid can reimburse personal care services rendered to a recipient whose parent or legal guardian is not able to provide such care. Supporting documentation must accompany the prior authorization request in order to substantiate a parent or legal guardian's inability to participate in the care of the recipient.
33. Page 2-11 of the Handbook also addresses which services Medicaid does not
provide reimbursement for under the home health services program. This list includes:

- Housekeeping (except light housekeeping), homemaker, and chore services, including any shopping except grocery shopping when provided as an IADL
- Meals-on-wheels
- Mental health and psychiatric services
- Normal newborn and postpartum services, except in the event of complications
- Respite care
- Services which can be effectively and efficiently obtained outside the recipient's place of residence without any medical contraindications
- Baby-sitting
- Services to a recipient residing in a community residential facility when those services duplicate services the facility or institution is required to provide
- Social services
- Transportation services (except when necessary to protect the health and safety of the recipient and no other transportation service is available or when provided as an IADL)
- Escort services
- Care, grooming, or feeding of pets and animals
- Yard work, gardening, or home maintenance work
- Day care or after school care
- Assistance with homework
- Companion sitting or leisure activities

34. The Petitioner's physician ordered a service frequency greater than that approved by eQHealth Solutions. Rule 59G-1.010(166) (c), however, specifically states

FINAL ORDER (Cont.)
16F-00085
PAGE - 12
a prescription does not automatically mean the requirements of medical necessity have been satisfied.
35. The Respondent's witness, Dr. Mittal, stated the currently approved hours (2 hours daily) are sufficient to provide the medically necessary assistance to the Petitioner with her ADL needs in the afternoon and the additional requested hours appear to be for supervision.
36. The Petitioner's mother stated the Petitioner needs the additional requested service hours due to the mother's work schedule and her medical conditions.
37. Although the undersigned acknowledges the Petitioner may benefit from additional supervision and cannot be left alone at home, the scope of services to be performed by a personal care aide is limited as set forth in the Handbook provisions cited above. Services such as monitoring and supervision do not require the services of a para-professional such as a personal care aide. The evidence presented establishes that 2 hours daily in the afternoon is medically necessary to provide assistance to the Petitioner with ADL needs. The Petitioner's mother is available in the mornings to address ADL needs.
38. The undersigned concludes that the Petitioner has not demonstrated that the Respondent was incorrect in partially denying the requested personal care services.

## 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 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 April 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@myffamilies.com

Copies Furnished To:

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

Mar 16, 2016
Office of Appeal Hearings
Dept. of Children and Families

APPEAL NO. 16F-00098
16F-00099
PETITIONER,
Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 11 Dade
UNIT: 88076

## CASE NO

## RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on February 8, 2016 at 2:30 pm. All parties appeared telephonically from different locations.

## APPEARANCES

For the petitioner:
For the respondent:
Oneida Gamboa, Operations Management Consultant I

## STATEMENT OF ISSUE

At issue is the petitioner's eligibility for Temporary Cash Assistance (TCA) based on the termination of Supplemental Security Income (SSI) for her son and Medicaid eligibility for her son due to the above mentioned termination. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner.

FINAL ORDER (Cont.)
16F-00098, 16F-00099
PAGE -2

## PRELIMINARY STATEMENT

On January 8, 2016, a hearing was requested by the petitioner. The petitioner submitted no exhibits. The respondent submitted three exhibits, which were marked and entered into evidence as Respondent's Exhibits "1" through " 3 ". The record was held open until February 15, 2016 for parties to submit additional evidence including the Notice of Case Action related to Medicaid for the minor child, SSI termination letter or alert, policy related to request of additional benefits, and application submitted by the petitioner by close of business. On February 15, 2015 the above mentioned information was provided, excluding policy related to request of additional benefits. The additional evidence was marked and entered as Respondent's Exhibits " 4 " through " 9 ". The record was closed the same day.

## FINDINGS OF FACT

1. The petitioner's household consists of herself and her 9 year old son. The petitioner is receiving $\$ 261$ in Food Assistance Program (FAP) benefits for her household. She is also receiving Medically Needy (MN) with a $\$ 271$ Share of Cost (SOC) and Medicare Savings Plan (MSP) benefits for herself.
2. On September 21, 2015, the department was notified through an electronic Data Exchange Alert of the termination of SSI for the petitioner's son due to the end of his disability.
3. Medicaid was terminated on December 31, 2015 for the petitioner's son due to no longer being deemed disabled by the Social Security Administration (SSA).

FINAL ORDER (Cont.)
16F-00098, 16F-00099
PAGE -3
4. The petitioner asserts no new application was submitted once SSI benefits were terminated. No new application was submitted upon notification of termination of Medicaid.
5. On February 9, 2015 the respondent mailed a Notice of Case Action notifying the petitioner full Medicaid for the minor child was open with a beginning eligibility date of January 1, 2016 and ongoing.

## 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 $\S 409.285$, 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.

## Temporary Cash Assistance will be addressed first:

8. The Code of Federal Regulations 45 C.F.R. §206.10: Application, determination of
eligibility and furnishing of assistance states in part:
(a) State plan requirements. A State plan under title I, IV-A, X, XIV, or XVI(AABD), of that Social Security Act shall provide that:
(1) Each individual wishing to do so shall have the opportunity to apply for assistance under the plan without delay. Under this requirement:
(i) Each individual may apply under whichever of the State plan plans he chooses;
(ii) The agency shall require a written application, signed under a penalty of perjury, on a form prescribed by the State agency, from the applicant himself, or his authorized representative, or, where the applicant is incompetent or incapacitated, someone acting responsibly for him. When an individual is required to be included in an existing assistance unit pursuant to paragraph (a)(1)(vii), such individual will be considered to be included in the application, as of the date he is required to be included in the assistance unit;...

FINAL ORDER (Cont.)
16F-00098, 16F-00099
PAGE -4
9. Fla. Admin. Code. R. 65A-1.205 Eligibility Determination Process states:
(1) The individual completes a Department application for assistance to the best of the individual's ability using either the ACCESS Florida Application, CF-ES 2337, 11/2011, or an ACCESS Florida Web Application (only accepted electronically), CF-ES 2353, 09/2011, and submits it. An application must include at least the individual's name, address and signature to initiate the application process...
(a) The Department must determine an applicant's eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter. (emphasis added)
10. Based on the above cited authorities, an application is required to apply for assistance. No application was submitted by the petitioner requesting TCA; therefore, the department was unable to determine eligibility.
11. After careful review of the oral testimony and evidence provided, the undersigned concludes there was no request to determine eligibility submitted for the petitioner.

## The Medicaid Program will now be addressed:

12. The respondent has completed the Ex-Parte process and authorized full Medicaid benefits for the minor child beginning January 1, 2016 and ongoing. There is no loss of benefit, therefore, this issue is now moot.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal related to TCA eligibility is denied. The appeal related to the Medicaid coverage for the minor child is dismissed as moot.

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 16 day of March , 2015,
in Tallahassee, Florida.


Pamela Vance
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

Mar 30, 2016

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

APPEAL NO. 16F-00109
PETITIONER,
Vs.
FLORIDA DEPARTMENT
CASE NO. 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 February 19, 2016 at 3:11p.m.

## APPEARANCES

For the Petitioner: pro se

For the Respondent: Mary Triplett, supervisor

## STATEMENT OF ISSUE

Petitioner is appealing the Department's action denying his application for
SSI-Related Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

## PRELIMINARY STATEMENT

The Department of Children and Families (Department or DCF or respondent) determines eligibility for participation in the Florida Medicaid Program.

By notice dated January 11, 2016, the Department informed the petitioner that his application for SSI-Related Medicaid was denied. The notice reads in pertinent part: "You...do not meet the disability requirement."

There were no additional witnesses for the petitioner. The petitioner submitted documentary evidence which was admitted into the record as Petitioner's Composite Exhibit 1.

Lauren Coe, program operations administrator with the Division of Disability Determination (DDD), was present as a witness for the Department. The Department submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1. Alyce Tyner, disability examiner with DDD, was present as an observer.

Hearing officer Christiana Gopaul-Narine was present as an observer.
The record was held open until close of business on February 26, 2016 for the submission of additional evidence. Evidence was received from the petitioner admitted into the record as Petitioner's Composite Exhibit 2. No additional evidence was received from the Department.

## FINDINGS OF FACT

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

1. The petitioner (age 58) filed on online application for SSI-Related Medicaid with the Department on November 24, 2015.
2. The petitioner is single, he does not have minor children who live in the home. Single adults without minor children are not eligible to participate in the Florida Medicaid Program unless they are elderly (age 65 or older) or have been determined disabled by the Social Security Administration (SSA) or the Department.
3. The petitioner is not elderly. He filed a disability application with SSA; the application was still pending as of the date of the hearing.
4. The petitioner asserts that he is disabled due to a shattered (broken) ankle, neuropathy in both feet, and diabetes.
5. Via inter-agency agreement, DDD performs disability determinations for the Department. The Department referred the petitioner's case to DDD for a disability determination on December 3, 2015.
6. DDD determined that the petitioner did not meet the disability criterion because his impairments were not expected to last 12 continuous months. DDD explains its decision in the Case Analysis section of the petitioner's Disability Report:

58 year old English speaking man with $12^{\text {th }}$ grade education alleging shattered ankle, and neuropathy in feet. X-ray of ankle on 11/15/15 found the fracture of the fibula has been reduced and stabilized with the lateral plate and screws. There is a single long screw extending across the midportion of the plate into the distal tibia. Anatomic alignment has been achieved at the fracture site. No complicating feature is appreciated.

FINAL ORDER (Cont.)
16F-00109
PAGE - 4

Most recent physical exam found Neuro to be WNI and extremities showed normal pulses. There is tenderness, decreased ROM and edema, no deformity. On discharge claimant was instructed NWB for 3 months. The claimant's impairment is not expected to last for 12 consecutive months. Decision - N35 Denial.
7. The Department issued a denial notice to the petitioner on January 11, 2016.
8. The petitioner argued that his Medicaid application should have been approved because he is unable to work, drive a car, or walk more than a few steps.

The petitioner explains his medical condition in a Statement of Matters:
The foot neuropathy started nearly two years ago while still employed at ... [P]ain that I have with my teet...attects my ability to pertorm my job....[The doctor] prescribed creams and lotions [and] informed me there is not cure and that the symptoms were likely to get worse....After a few months, I went back to a neurologist...he prescribed medication to give some relief from the pain. After two months, I returned to the [doctor] and informed him that the medication...was not working. He prescribed a different medication....This medication deadens the nerves and the nerve signals to the brain, which takes away control of your feet and they no longer perform as normal. You can't feel cold, hot or wet. And although your feet are numb the pain is still there. This detachment between your brain and your feet was the primary cause of the accident [broken ankle]. And the neuropathy pain has increased to the point where I can no longer walk more than a couple steps. Neuropathy pain is greater than the shattered ankle.... am confined to a wheel chair...12-15 months for the ankle alone.
9. The petitioner argued that DDD's conclusion that his impairments are not expected to last 12 continuous months is wrong. He was diagnosed with over two years ago; there is no cure, and his condition is getting progressively worse.
10. DDD conceded that the petitioner may meet the durational criterion for disability, but stands by the denial decision in this case due to another criterion, the petitioner's ability to perform other work in the national economy. DDD argued that the

FINAL ORDER (Cont.)
16F-00109
PAGE - 5
petitioner's education and 30 year career in boat construction qualify him for other work in the national economy. Individuals who can perform other work in the national economy are not considered disabled.
11. The petitioner argued that he has worked for two marine construction companies in the last 30 years, as a crew member, crew supervisor, and a general manager. He has never done any other type of work. The division of the company he worked in for the last 22 years closed in April or May 2015 due to lack of work. Even the managerial positions require a lot of physical exertion, climbing in and out of boats, etc. He can no longer perform this kind of work. The petitioner did not complete high school. He obtained an equivalency diploma and immediately began working in boat construction. He is able to read and write. He is well spoken and communicates effectively. He has full use of his upper extremities and has no vision or hearing impairments which prevent him for being able to work.

## CONCLUSIONS OF LAW

12. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under the same Florida Statutes.
13. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 652.056.
14. In accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof was assigned to the petitioner.
15. The Fla. Admin. Code, Section 65A-1.710 et seq., sets 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. $\S 416.905$.
16. The petitioner is not 65 years old and has not been determined disabled by

SSA. The cited authority explains that 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. On behalf of the Department, DDD makes the disability determination when an individual has not been determined disabled by the SSA.
17. Federal Regulations at 20 C.F.R. $\S 404.1520$ addresses the disability evaluation:
(4) The five-step sequential evaluation process. The sequential evaluation process is a series of five "steps" that we follow in a set order. See paragraph ( h ) of this section for an exception to this rule. 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 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 § 404.1509, 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.)

FINAL ORDER (Cont.)
16F-00109
PAGE-7
(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 of this subpart 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 paragraphs (f) and (h) of this section and $\S 404.1560$ (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 paragraphs (g) and (h) of this section and § 404.1560(c).
18. Step one of the sequential analysis for disability is to determine if the individual is engaging in substantial gainful activity (20 C.F.R. § 404.1520(b) and 416.920(b)). The petitioner is not working. He last worked in April or May 2015. The petitioner meets step one criterion.
19. Step two of the sequential analysis for disability is to determine if the individual has an impairment that is "severe" or a combination of impairments that is "severe" (20 C.F.R § 404.1520(c) and 416.920(c)). The evidence proves that the petitioner's neuropathy pain is severe. The petitioner meets step two criterion.
20. Step three of the sequential analysis for disability is to determine whether nor not the individual's impairments meets or equals a listed impairment in Appendix 1 of the Social Security Act, which includes section

For an applicant to be considered disabled under this section, he or she must have a diabetes mellitus diagnosis with neuropathy characterized by

FINAL ORDER (Cont.)
16F-00109
PAGE - 8
paralysis, ataxia, tremors, of involuntary movement in at least two or more extremities, causing inability to walk, perform fine and gross motor movements.
21. The clinical record does not prove that the petitioner's $\square$ meets the cited disability criterion. Based on the record, the undersigned could not conclude that the petitioner's impairments meet or equal a listing in the federal regulation.
22. Step four of the sequential analysis for disability is to determine if the individual's impairments prevent him performing past relevant work. The petitioner is 58 years old and worked exclusively in boat construction for the last 30 years. This type of work, even at the managerial level, requires considerable physical exertion. The evidence proves that the petitioner was no longer capable of returning to past work. He is no longer capable of more than light physical exertion. The petitioner meets step four criterion.
23. Step five of the sequential analysis for disability is to determine if the individual has the capacity to do any work in the national economy. The cumulative evidence proves that the petitioner is literate and articulate; he has no visual or hearing impairment which prevent him from being able to work. The petitioner has full use of his upper extremities. The medical evidence shows the petitioner is capable of sedentary work such as customer service representative. The undersigned concludes that the petitioner fails the disability criterion at step five.
24. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the petitioner does not meet the SSI-Related Medicaid disability requirement. The Department's decision in this matter 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 $\qquad$ 30 day of $\qquad$ , 2016,
in Tallahassee, Florida.


Leslie Green
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myffamilies.com

Copies Furnished To:
Petitioner
Office of Economic Self Sufficiency

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

PETITIONER, Vs.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES CIRCUIT: 19 ST. LUCIE UNIT: 88322

RESPONDENT.

CASE NO

## FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter March 15, 2016, at 1:33 a.m.

APPEARANCES
For the Petitioner:
For the Respondent:
Mary Triplett, supervisor

## STATEMENT OF ISSUE

At issue is the denial of Medicaid benefits for the petitioner. The petitioner carries the burden of proof by a preponderance of evidence in this appeal.

## PRELIMINARY STATEMENT

The petitioner did not present any exhibits into evidence. The respondent presented four exhibits which were accepted into evidence and marked as Respondent Exhibits 1 through 4.

## FINDINGS OF FACT

1. On October 5, 2015, an application for SSI-Related Medicaid was submitted on behalf of the petitioner.
2. On October 7, 2015, the respondent sent the petitioner's representative a Notice of Case Action requesting proof of INS status, identification, citizenship, income and assets. It was due no later than October 19, 2015. The requested information was not provided to the Department by the due date.
3. On October 12, 2015, the application/package was sent to the Division of Disability Determinations (DDD).
4. On October 14, 2015, the petitioner died.
5. On October 16, 2015, DDD determined the petitioner was disabled and informed the Department of its decision.
6. On November 4, 2015 the Department denied the petitioner's Medicaid application. On November 5, the Department sent the petitioner's representative a Notice of Case Action informing the petitioner's Medicaid application was denied. The reason given for the denial was that all the requested information was not received. 7. On December 24, 2015, the petitioner's representative requested a hearing to challenge the Department's action to deny the petitioner SSI-Related Medicaid benefits. 8. At the hearing, the petitioner's representative explained he was brought to the hospital by his roommate. The representative explained that the petitioner came from Mexico and has no INS status or identification. His representative is asking that an exception be made as his situation is unusual.

FINAL ORDER (Cont.)
16F-00132
PAGE -3
9. The respondent argued that there was no documentation provided to verify the identity of the petitioner. The Department claims that it is unable to verify that the petitioner is whom the representative says he is. The Department will accept two collateral contacts from two persons who can provide their own identification and use that to verify the identity of the petitioner with another application.

## 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. 652.056.
12. Fla. Admin. Code R 65A-1.205, Eligibility Determination Process, states in relevant part:
(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...
(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. If the applicant does not provide required verifications or information by the deadline date the application will be denied, unless the applicant requests

FINAL ORDER (Cont.)
16F-00132
PAGE -4
an extension or there are extenuating circumstances justifying an additional extension.
13. The cited rule explains that when the Department determines verification is necessary to determine an applicant's eligibility, it is the applicant's (or designated representative's) responsibility to provide the verification. The Department is to provide as much assistance as possible, but the ultimate responsibility for providing the verification rests with the applicant (or designated representative).
14. The Department's Program Policy Manual (Policy Manual), CFOP 165-22 at section 0640.0109, addresses Designated Representatives (MSSI). It states:

A designated representative may be appointed or self-designated to act on behalf of the household. If the individual does not select a specific person as designated representative, determine if the self-designated representative is the most appropriate person to fulfill this responsibility. An applicant must authorize a designated representative in writing prior to eligibility determination or anytime during the review period. The applicant does not have to be functionally or legally incompetent to have a designated representative...
15. The petitioner had a designated representative to act on his behalf. This included providing the representative with a written request for verification of his identification. A pending letter requesting identification for the petitioner was mailed on

October 7, 2015 and a due date of October 19, 2015 was given.
16. The Fla. Admin. Code R. 65A-1.715, Emergency Medical Services for Aliens, sets forth:
(1) Aliens who would be eligible for Medicaid but for their immigration status are eligible only for emergency medical services. Section 409.901(10), F.S., defines emergency medical conditions.
(2) The Utilization Review Committee (URC) or medical provider will determine if the medical condition warrants emergency medical services and, if so, the projected duration of the emergency medical condition. The
projected duration of the emergency medical condition will be the eligibility period provided that all other criteria are continuously satisfied.
(3) Emergency services are limited to 30 consecutive days without prior approval. For continued coverage beginning with the 31st day prior authorization must be obtained from the Agency for Health Care Administration (Medicaid Program Office).
17. The above authority states that for Emergency Medicaid for Noncitizens all
technical factors must be met except citizenship.
18. The Code of Federal Regulations at 42 C.F.R. $\S 435.407$ sets forth the level of evidence required.
(e) Evidence of identity. The following documents may be accepted as proof of identity and must accompany a document establishing citizenship from the groups of documentary evidence of citizenship in the groups in paragraphs (b) through (d) of this section.
(1) Identity documents described in 8 CFR 274a.2(b)(1)(v)(B)(1).
(i) Driver's license issued by State or Territory either with a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight or eye color.
(ii) School identification card with a photograph of the individual.
(iii) U.S. military card or draft record.
(iv) Identification card issued by the Federal, State, or local government with the same information included on drivers' licenses.
(v) Military dependent's identification card.
(vi) Certificate of Degree of Indian Blood, or other American Indian/Alaska Native Tribal document with a photograph or other personal identifying information relating to the individual. Acceptable if the document carries a photograph of the applicant or beneficiary, or has other personal identifying information relating to the individual such as age, weight, height, race, sex, and eye color.
(vii) U.S. Coast Guard Merchant Mariner card.

Note to paragraph (e)(1): Exception: Do not accept a voter's registration card or Canadian driver's license as listed in 8 CFR
274a.2(b)(1)(v)(B)(1). CMS does not view these as reliable for identity. (2) At State option, a State may use a cross match with a Federal or State governmental, public assistance, law enforcement or corrections agency's data system to establish identity if the agency establishes and certifies true identity of individuals. Such agencies may include food stamps, child support, corrections, including juvenile detention, motor vehicle, or child protective services. The State Medicaid Agency is still responsible for assuring the accuracy of the identity determination.
(3) At State option, a State may accept three or more documents that together reasonably corroborate the identity of an individual provided such documents have not been used to establish the individual's citizenship and the individual submitted second or third tier evidence of citizenship. The State must first ensure that no other evidence of identity is available to the individual prior to accepting such documents. Such documents must at a minimum contain the individual's name, plus any additional information establishing the individual's identity. All documents used must contain consistent identifying information. These documents include employer identification cards, high school and college diplomas from accredited institutions (including general education and high school equivalency diplomas), marriage certificates, divorce decrees and property deeds/titles.
(f) Special identity rules for children. For children under 16, a clinic, doctor, hospital or school record may be accepted for purposes of establishing identity. School records may include nursery or daycare records and report cards. If the State accepts such records, it must verify them with the issuing school. If none of the above documents in the preceding groups are available, an affidavit may be used. An affidavit is only acceptable if it is signed under penalty of perjury by a parent, guardian or caretaker relative (as defined in the regulations at 45 CFR 233.90(c)(v)) stating the date and place of the birth of the child and cannot be used if an affidavit for citizenship was provided. The affidavit is not required to be notarized. A State may accept an identity affidavit on behalf of a child under the age of 18 in instances when school ID cards and drivers' licenses are not available to the individual in that area until that age.
(g) Special identity rules for disabled individuals in institutional care facilities. A State may accept an identity affidavit signed under penalty of perjury by a residential care facility director or administrator on behalf of an institutionalized individual in the facility. States should first pursue all other means of verifying identity prior to accepting an affidavit. The affidavit is not required to be notarized.
(h) Special populations needing assistance. States must assist individuals to secure satisfactory documentary evidence of citizenship when because of incapacity of mind or body the individual would be unable to comply with the requirement to present satisfactory documentary evidence of citizenship in a timely manner and the individual lacks a representative to assist him or her.
(i) Documentary evidence. (1) All documents must be either originals or copies certified by the issuing agency. Uncertified copies, including notarized copies, shall not be accepted.
(2) States must maintain copies of citizenship and identification documents in the case record or electronic data base and make these copies available for compliance audits.

## 19. The Policy Manual at section $\mathbf{1 4 3 0 . 0 4 0 0}$ addresses IDENTITY (MFAM)

The identity of each U.S. citizen applying for, or receiving Medicaid must be documented.
The following documents are acceptable as proof of identity:

1. State driver's license with photo or other identifying information;
2. State ID card with photo or other identifying information;
3. School ID card with photo (for children under 16, includes nursery, daycare records, or school records, including school conference records and no photo is required);
4. Clinic, doctor, or hospital record for children under 16 (except for voided Puerto Rican birth certificates after September 30, 2010);
5. U.S. military card or draft record;
6. A military dependent's ID card;
7. Federal, state, or local government ID card with photo;
8. A certificate of Indian blood;
9. Native American tribal document;
10. Three or more of the following documents unless a fourth tier verification of citizenship was used:
a. Marriage license,
b. Divorce decree,
c. High school diploma,
d. Employer ID card, or
e. Any other document from a similar source.
11. Food Stamp, CSE, Department of Corrections, child protection and DJJ data records,
12. U.S. Coast Guard merchant mariner card; or
13. Attestation (a written, signed statement under penalty of perjury) for children under age 16, or a disabled adult living in a residential facility, stating the date and place of birth. (cannot be used if statement was used for citizenship verification.)
14. The above authorities informs of the various documents needed to prove identity.

As of the date of this hearing, none of the above documentation was provided to the
Department.
21. The evidence demonstrates that the Department issued a written request for additional information on October 7, 2015. The requested information included verification of the petitioner's identity as a factor of eligibility in the Medicaid Program.

The information was due by October 19, 2015. The petitioner's representative did not

FINAL ORDER (Cont.)
16F-00132
PAGE -8
provide the requested information. The Department denied the application on November 5, 2015.
22. The designated representative argued that an exception should be made to the verification requirement because the petitioner has died and was unable to participate in the application process. The representative had no knowledge of the petitioner's circumstances beyond his name, address, and date of birth.
23. The evidence proves that the designated representative did not provide identity verification required to determine the petitioner's eligibility for SSI- Related Medicaid. The undersigned reviewed Medicaid rules and regulations, but found no exception to the identity verification requirement for the reason asserted by the designated representative, the petitioner's death is not an exception to verifying identity. The undersigned concludes that there was no assistance the Department could have provided to the representative in obtaining the needed verification.
24. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the petitioner's designated representative did not meet her burden of proof in this matter. The Department's action to deny the application is upheld.

## DECISION

Based upon the foregoing Findings of Fact and Conclusion 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 21 day of March 2016,
in Tallahassee, Florida.


Christian 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@myfffamilies.com

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

PETITIONER,
Vs.
AGENCY FOR HEALTH CARE ADMINISTRATION CIRCUIT: 17 Broward
UNIT: AHCA

## RESPONDENT.

## FINAL ORDER

Pursuant to notice, a telephonic administrative hearing was convened in this matter before the undersigned hearing officer on February 17, 2015 at 2:59 p.m.

|  | APPEARANCES |
| :--- | :--- |
| For the Petitioner: |  |
| For the Respondent: | Fatima Leyva, <br> Senior Human Services Program Specialist, <br> Agency for Health Care Administration |

## STATEMENT OF ISSUE

The Petitioner is appealing the Agency for Health Care Administration's (AHCA) decision, through DentaQuest, to deny the Petitioner's requests for dental procedures D5213-maxillary partial denture-cast metal framework with resin denture bases for upper arch and D5214-mandibular partial denture-cast metal framework with resin

FINAL ORDER (Cont.)
16F-00143
PAGE - 2
denture bases for lower arch. Because the issue under appeal involves requests for services, Petitioner bears the burden of proof.

PRELIMINARY STATEMENT
Mindy Aikman, Grievance and Appeals Specialist, and Stacey Larson, Clinical Guidance Analyst appeared as Respondent's witnesses from Petitioner's managed care plan Humana Healthcare (Humana). Dr. Frank Manteiga, Dental Consultant, and Jackelyn Salcedo, Complaints and Grievance Specialist appeared as Respondent's witnesses from DentaQuest.

Respondent submitted a 25-page document which was entered into evidence and marked Respondent Exhibit 1. Petitioner submitted a two-page document which was entered into evidence and marked as Petitioner Exhibit 1.

## FINDINGS OF FACTS

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

1. The Petitioner is a 53 year-old Medicaid recipient enrolled with Humana, a Florida Health Managed Care provider.
2. Humana requires prior authorization for services related to dental care and has subcontracted with DentaQuest to perform prior authorization requests.
3. The Petitioner's dentist requested prior authorization for dental procedures D5213-upper denture and D5214-lower denture, which was received on November 6, 2015.
4. DentaQuest made its determination on November 10, 2015 denying both procedures. Notice was sent to the provider providing the denial reasons:

FINAL ORDER (Cont.)
16F-00143
PAGE - 3
Procedure D5213-upper denture denied because masticatory function does not appear to be severely impaired.

Procedure D5214-lower denture denied because service exceeds benefit allowance. Service is limited to one per lifetime per patient.
5. The Petitioner's dentist submitted a second request for prior authorization for dental procedure code D5214-partial lower denture, which was received by DentaQuest on December 11, 2015.
6. DentaQuest made a determination of December 12, 2015 denying procedure D5214-lower denture because service exceeds benefit allowance. Service is limited to one per lifetime per patient.
7. DentaQuest's Dental Director conducted a second review of the requests for procedure D5213 and D5214 on February 1, 2016 and upheld both denials.
8. Petitioner explained that he has three upper teeth which need to be removed and all three are on the left side. He has a total of six lower teeth with four on one side and two on the other side. Because of the few teeth he has, he finds it difficult to eat.
9. Petitioner stated that he misplaced his lower partial denture due to mental illness and was requesting an exception to the one partial denture per patient.
10. Respondent explained that not only is the partial denture limitation one per patient in their lifetime but Medicaid does not replace misplaced or lost dentures.
11. The dental consultant explained the upper denture was denied because Petitioner currently has sufficient upper and lower teeth to chew. He noted that DentaQuest is aware that tooth number 2 and 4 are to be removed, but that still leaves sufficient teeth for chewing. Along with removal of tooth 2 and 4 , removal of one of the following could support need for a partial upper denture: tooth $3,12,13,14,19,20,21$,

FINAL ORDER (Cont.)
16F-00143
PAGE - 4
or 31. He indicated Petitioner should have his dentist submit a new request for partial upper denture if teeth removal as noted occurs. The Dental Consultant explained the Petitioner has received one partial lower denture and cannot receive a replacement.

## CONCLUSIONS OF LAW

12. By agreement between the Agency for Health Care Administration and the Department of Children and Families, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80 Florida Statutes.
13. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
14. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Florida Administrative Code Rule 652.060(1).
15. Florida Statutes 409.971 - 409.973 establishes the requirement for Medicaid recipients to be enrolled in the statewide managed medical assistance program and the minimum benefits the managed care plans shall cover. Dental services are one of the mandatory services that must be provided.
16. Section 409.912, Fla. Stat. also provides that the Agency may mandate prior authorization for Medicaid services.
17.Fla. Admin. Code R. 59G-1.010 defines "prior authorization" as:
(226) "Prior authorization" means the approval by the Medicaid office for a Medicaid provider, or by a prepaid health plan for its affiliated providers, to deliver Medicaid covered medical or allied care, goods, or services in advance of the delivery of the care, goods, or services.
17. 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:
18. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
19. 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;
20. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
21. 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
22. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.
23. The Florida Medicaid Dental Services Coverage and Limitations Handbook-

November 2011 (Handbook), which is incorporated by reference into Chapter 59G-4,
Fla. Admin. Code, sets standards for dental services. Page 2-3 "Covered Adult
Services (Ages 21 and Over)" indicates:
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

FINAL ORDER (Cont.)
16F-00143
PAGE - 6
make a diagnosis, extraction, and incision and drainage of abscess.
20. In addition, page 2-32 of the Handbook provides the following limitations for partial dentures:

Full and removable partial dentures may be reimbursed once for an upper, a lower or a complete set per the lifetime of the recipient.

Medicaid does not reimburse the replacement of lost partial or full dentures.
21. While the Petitioner asserted he needs upper and lower partial dentures in order to eat, Respondent explained that Petitioner has already received his one-time only lower partial denture. No replacement can be covered by Medicaid. Respondent also provided testimony that the upper denture is not currently medically necessary because Petitioner has sufficient upper and lower teeth to chew. Petitioner was advised to have his dentist re-submit a request for an upper partial denture, once Petitioner has the three upper teeth removed.
22. Petitioner has failed to meet his burden of proof. Respondent has provided medical expert testimony and cited Medicaid limitations that support the agency's denial of upper and lower partial dentures for the Petitioner.

## DECISION

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

## NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the Petitioner disagrees with this decision, the Petitioner may seek a judicial review. To begin the judicial review, the Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The Petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The 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 $\qquad$ March 2016,
in Tallahassee, Florida.


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

Copies Furnished To: Petitioner<br>Rhea Gray, Area 11, AHCA Field Office Manager

Mar 30, 2016

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

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 February 24, 2016 at approximately $1: 30$ p.m.

## APPEARANCES

For Petitioner:
Petitioner's daughter
For Respondent: Lisa Sanchez
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 10 additional hours of companion care per week was correct. The burden of proof is assigned to Petitioner.

FINAL ORDER (Cont.)
16F-00145
PAGE-2

## PRELIMINARY STATEMENT

Petitioner's daughter represented her at the hearing. She may sometimes be referred to hereinafter as "Petitioner's representative." Lisa Sanchez, Medical/Health Care Program Analyst represented and appeared as a witness for Respondent, the Agency for Health Care Administration ("AHCA" or "Agency").

Respondent presented the following witnesses:

- Dr. John Carter - Long Term Care Medical Director - Sunshine Health
- Paula Daley - Grievance and Appeals Coordinator II - Sunshine Health
- Heidi Oehler - Case Manager - Sunshine Health
- Jane Weigl - Long Term Care Supervisor - Sunshine Health
- Carolyn Smith - Director of Case Management - Sunshine Health

Petitioner's Exhibit 1 was entered into evidence. Respondent's Exhibits 1 through 6 were entered into evidence at the hearing. The record was held open for Respondent to submit additional evidence. Respondent submitted additional evidence, entered as Exhibits 7 and 8. The undersigned took administrative notice of Fla. Stat. § 409.978.

## FINDINGS OF FACT

1. Petitioner is an 85 -year-old female. Petitioner is a dual-enrolled Medicare/Medicaid recipient with Sunshine Health ("Sunshine") as her Long Term Care ("LTC") plan and her Managed Medical Assistance ("MMA") plan.
2. Petitioner's medical conditions include:

- Chronic pain in her legs, knees, feet, and neck
- Burning and tearing of the eyes
- Blindness in her left eye
- Urinary incontinence
- Hypertension
- High Cholesterol
- Osteoarthritis
- Dizziness

FINAL ORDER (Cont.)
16F-00145
PAGE - 3
3. Petitioner lives in her home with her husband. Petitioner's representative said she is starting to get more forgetful. Petitioner's current services are 10 hours per week of personal care, two (2) hours per week of companion care, eight (8) hours per week of homemaker services, two (2) home-delivered meals per day, five (5) days per week, one (1) case per month of disposable liners, and case management. At the time of the hearing, Petitioner was also going to physical therapy three (3) times per week for one (1) hour each visit, and she had 10 authorized visits remaining.
4. Petitioner's husband is 94-years-old. He broke his hip and had surgery on it. As a result, he is unable to assist with Petitioner's care. He also receives home health services, and the combined total between the two is 52 hours. Her husband has a Personal Emergency Response System, and she has been approved to receive one as well.
5. On November 17, 2015, Sunshine received a request for an increase of 10 hours of companion care, for a total of 12 hours per week. On December 2, 2015, Sunshine issued a Notice of Action denying the request as not being medically necessary (Respondent's Exhibit 3). The Notice of Action stated:

The Case Management Assessment done by the member's case manager shows that the member's presently provided home services are adequate to meet the member's care needs. The member's present care plan includes 8 hours/week Homemaker Services + 10 hours/week Personal Care Services +2 hours/week Companion Care Services, and 10 meals/week Home Delivered Meals.

The facts that we used to make our decision are: Sunshine Health Policy LT.UM. 09 Long Term Care Ancillary Service Criteria.
6. Sunshine's Policy and Procedure (Respondent's Exhibit 6), defines Adult Companion

## Care as:

FINAL ORDER (Cont.)
16F-00145
PAGE-4

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 for activities of daily living ("ADLs").

Companions provide socialization and supervision, and incidental assistance with some instrumental activities of daily living ("IADLs").
8. Petitioner receives personal care and homemaker services, which provide discreet services, including shopping, meal preparation, laundry, light housekeeping, bathing and personal hygiene, transferring, and medication administration.
9. Sunshine's Policy and Procedure takes into account the recipient's level of support needed, living situation, and need for supervision. The criteria for Adult Companion

Care are as follows:
Members who may benefit from Adult Companion Care, include those who:

- Live alone and have inadequate caregiver support
- Have someone in the home but has inadequate caregiver support
- Require assistance and/or supervision with meal preparation, shopping, light housekeeping as an incidence to care provided and/or laundry
- Require assistance or supervision to maintain safe living conditions in the home
- Require assistance to maintain independence due to functional status (i.e. member has difficulty with bending, twisting and ambulation or has a medical condition that affects endurance, such as a heart or breathing problem) and/or cognitive status (i.e. dementia)

FINAL ORDER (Cont.)
16F-00145
PAGE - 5
10. Per Petitioner's most recent 701B Comprehensive Assessment ("701B"), updated on February 23, 2016 (Respondent's Exhibit 8), Regarding her IADLs, Petitioner needs total assistance with heavy chores, light housekeeping, managing money, preparing meals, and shopping. She needs assistance (but not total help) with using the telephone, managing medication, and using transportation. The 701B says she always has assistance for all of these tasks, with the exception of using the telephone, where she has assistance most of the time. Petitioner's daughter provided the answers to the questions on the 701B.
11. Petitioner's daughter is 57-years-old and has some health problems and said she is unable to help as much as she would like. She said she helps care for Petitioner approximately four (4) hours per week and that there is no other family in the area to assist. She said she needs someone to help transport her mother to and from her doctor appointments. Ms. Daley said companions are allowed to escort her to the doctor, but they cannot provide the transportation themselves. Ms. Sanchez said they cannot use their own vehicle or the recipient's vehicle.
12. Ms. Daley said Sunshine is very sympathetic to Petitioner's needs, but they are following the policy. Dr. Carter said Sunshine's Policy and Procedure looks at the overall picture of Petitioner's services and takes into account the case manager's 701B assessment. He said he thinks Petitioner's overall services are adequate. Petitioner's daughter does not want her mother left alone. Sunshine suggested both the Participant Directed Option ("PDO") program or an assisted living facility as alternatives, but she is not interested in them at this time.

FINAL ORDER (Cont.)
16F-00145
PAGE-6
13 said she does not think the 10 additional hours of companion care will fix the problems Petitioner's daughter claims exist. She said her daughter should contact her or her supervisor if she wants to request a change in services, because they are able to process it.
14. Petitioner's daughter submitted Exhibit 1 at the hearing, which is a letter stating she is requesting 15 hours of personal care and 15 hours of companion care, and a prescription from her mother's physician. She said she made a phone request for these services in early January of 2016, but did not fax the request to Sunshine until February 23, 2016, the day before the hearing. Sunshine has not taken any action on that request and it is not under appeal at this time, therefore it will not be considered.

## 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, $7^{\text {th }}$ 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.

FINAL ORDER (Cont.)
16F-00145
PAGE-7
20. 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...."
21. Fla. Stat. 409.98 requires that LTC plans include, among other services, personal care, home-delivered meals, case management, medication management, respite care, and transportation.
22. 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.
23. 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.
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.
6. Sunshine concluded the two (2) hours of companion care are sufficient to meet Petitioner's needs. Petitioner's daughter says she needs more assistance for tasks, for example, transportation.
7. Petitioner's daughter does not want her mother left alone. While an additional 10 hours of companion care would help reduce her mother's alone time, anything beyond supervision would duplicate services her mother is already receiving. Companion care is designed to provide companionship and socialization, not specific services. 27. Petitioner's daughter provided the answers to the 701B, and indicated her mother either always has assistance or usually has assistance for all of the IADLs where a companion could incidentally assist her. If Petitioner's daughter feels like her other services are insufficient to meet her needs, such as with transportation, she is encouraged to work with her mother's case manager to request the appropriate services. The totality of the evidence indicates that the additional 10 hours of companion care requested will not provide Petitioner with the benefits she is seeking.

## DECISION

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

FINAL ORDER (Cont.)
16F-00145
PAGE - 9

## 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 $\qquad$ 30 day of $\qquad$ , 2016,
in Tallahassee, Florida.


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

Mar 18, 2016

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


APPEAL NO. 16F-00158
PETITIONER,
Vs.
FLORIDA DEPARTMENT
CASE NO.
OF CHILDREN AND FAMILIES
CIRCUIT: 17 Broward
UNIT: 88071

## RESPONDENT.

$\qquad$ 1

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on February 19, 2016 at 1:12p.m.


For the Respondent: Verma Jordan, assistant supervisor

## STATEMENT OF ISSUE

Petitioner is appealing the Department's action denying her request for Hospice Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

```
FINAL ORDER (Cont.)
```

16F-00158
PAGE - 2

## PRELIMINARY STATEMENT

The Department of Children and Families (DCF or respondent) determines eligibility for participation in the Florida Medicaid Program.

By notice dated December 4, 2015, the Department informed the petitioner that her application for Hospice Medicaid was denied. The notice reads in pertinent part: "[w]e did not receive proof the value of assets. We did not receive all information needed to determine eligibility. No appropriate placement."

The petitioner timely requested a hearing to challenge the Department's decision on January 8, 2016.
case manager supervisor with
as witness for the petitioner. The petitioner did not submit documentary evidence during the hearing.

There were no additional witnesses for the Department. The Department submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

Hearing officer Christiana Gopaul-Narine was present as an observer.
The record was held open until close of business on February 22, 2016 for the submission of additional evidence. Evidence was received from both parties and admitted into the record as Petitioner's Composite Exhibit 1 and 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 was admitted to on October 29, 2015 in a comatose state. The petitioner died in the November 19, 2015 without ever regaining consciousness.
2. staff obtained written authorization from the petitioner's only known next-of-kin, her ex-husband, to act as her designated representative and apply for Medicaid to cover the facility's cost of care. The ex-husband refused any further involvement in the application process.
3. staff, acting as designated representative, filed a paper application for Hospice Medicaid with the Department on November 3, 2015. The application contained only the petitioner's name, address, and date of birth. $\quad$ did not complete the other sections of the application which address household general information, assets, income, and expenses.
4. Medicaid applicants must meet technical, asset, and income eligibility criteria. The applicant must provide verification, when necessary, to prove eligibility.
5. The Department issued a Notice of Case Action to the designated representative on November 5, 2015 requesting verification of the following information: proof of loans, contributions or gifts used to pay household expenses for the month of November 2015 or a statement from anyone paying household bills; proof of November 2015 shelter payments; bank statements for September and October 2015; and proof of

FINAL ORDER (Cont.)
16F-00158
PAGE - 4
application for Social Security disability benefits. The information was due by November 16, 2015.
6. The designated representative did not return any of the requested verification.
7. The Department denied the petitioner's application on December 4, 2015 for failure to return verification needed to determine eligibility.
8. The designated representative confirmed receipt of the Department's request for additional information. She explained that she did not provide any of the verification because she knew nothing about petitioner's circumstances. She did not know the petitioner's income, expenses, or assets and did not know how to obtain that information after the petitioner died.
9. The designated representative argued that a good cause exception to the verification requirements should be allowed because the petitioner was in a coma and unable to assist in the application process.

## 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, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under the same Florida Statutes.
11. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 652.056.
12. In accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof was assigned to the petitioner.

## FINAL ORDER (Cont.)

16F-00158
PAGE - 5
13. The Fla. Admin. Code R. 65A-1.203(9) defines representative:
"Authorized/Designated Representative: An individual who has knowledge of the assistance group's circumstances and is authorized to act responsibly on their behalf."
14. The cited authority explains that a designated representative must be knowledgeable about the applicant's circumstances.
15. Fia. Admin. Code R. 65A-1.710 defines SSI-Related Medicaid Coverage

Groups and states in part:
The Department covers all mandatory coverage groups and the following optional coverage groups:
(3) Hospice Program. A coverage group for terminally ill individuals (or couples) who elect hospice services and who meet all categorical or Medically Needy eligibility criteria, and who also meet special Medicaid hospice requirements as provided in 42 U.S.C. § $1396 \mathrm{~d}(\mathrm{a})$, subsection 65A-1.711(3) and Rule 65A-1.713, F.A.C.
16. Applicants for Hospice Medicaid must meet the eligibility criteria explained in the above citation.
17. Fla. Admin. Code R. 65A-1.205 addresses the eligibility determination process and states in relevant part:
(a) The Department must determine an applicant's eligibility initially at application...It is the applicant's responsibility to...furnish information, documentation and verification needed to establish eligibility.... 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,

FINAL ORDER (Cont.)
16F-00158
PAGE-6
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 interview, or 60 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...
18. The cited rule explains that when the Department determines that verification is necessary to determine an applicant's eligibility it is the applicant's (or designated representative's) responsibility to provide the verification. The Department is to provide as much assistance as possible, but the ultimate responsibility of providing the verification rests with the applicant (or designated representative).
19. The evidence proves that the Department issued a written request for additional information to the petitioner's designated representative on November 5, 2015. The requested information included verification of the petitioner's income and assets; both are factors of eligibility in the Medicaid Program. The information was due by November 16, 2015. The petitioner's representative did not provide any of the requested information. The Department denied the application on December 4, 2015.
20. The designated representative argued that an exception should be made to the verification requirement because the petitioner was in a coma and unable to participate in the application process. The representative had no knowledge of the petitioner's circumstances beyond her name, address, date of birth, and social security number.
21. Fla. Admin. Code R. 65A-1.712 SSI-Related Medicaid Resource Eligibility Criteria states:
(2) Exclusions. The Department follows SSI policy prescribed in 20 C.F.R. § 416.1210 and 20 C.F.R. § 416.1218 in determining resource exclusions, with the exceptions in paragraphs (a) through ( g ) below, in accordance with 42 U.S.C. § 1396a(r)(2).
(a) Resources of a comatose applicant (or recipient) are excluded when there is no known legal guardian or other individual who can access and expend the resource(s).
22. SSI-Related Medicaid rule includes a provision to exclude the resources of a comatose applicant when there is no legal guardian. The undersigned concludes that the asset exclusion is applicable in this case.
23. Fla. Admin. Code R. 65A-1.713 SSI-Related Medicaid Income Eligibility Criteria states:
(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
(f) For hospice services, income cannot exceed 300 percent of the SSI federal benefit rate or income must meet Medically Needy eligibility criteria, including the share of cost requirement. Effective October 1, 1998, institutionalized individuals with income over this limit may qualify for institutional hospice services by establishing an income trust which meets criteria set forth in subsection 65A-1.702(15), F.A.C.
24. An applicant for Hospice Medicaid cannot have countable income that exceeds 300 percent of the federal benefit rate. Medicaid rules do not include a provision which excludes the income of a comatose applicant. Income verification is required to determine if the applicant meets the eligibility criteria.
25. The evidence proves that the designated representative did not provide income verification required to determine the petitioner's eligibility for Hospice Medicaid.

The undersigned reviewed Medicaid rules and regulations, but found no exception to

FINAL ORDER (Cont.)
16F-00158
PAGE - 8
the income verification requirement for the reasons asserted by the designated representative, petitioner incapacitation and representative's lack of knowledge of the petitioner's financial circumstances. In fact, the representative's lack of knowledge regarding the petitioner's financial circumstances precluded her from being an effective representative. The undersigned concludes that there was no assistance the Department could have provided the representative in obtaining the needed verification due to the representative's lack of familiarity with the petitioner.
26. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the petitioner's designated representative did not meet her burden of proof in this matter. The Department's 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.

FINAL ORDER (Cont.)
16F-00158
PAGE-9

DONE and ORDERED this 18 day of March 2016,
in Tallahassee, Florida.
Leslic Sheen

Leslie Green
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myffamilies.com

Copies Furnished TO Petitioner
Office of Economic Self Sufficiency
VITAS HOSPICE

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

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

## RESPONDENT.

## FINAL ORDER OF DISMISSAL

Pursuant to notice, the undersigned convened a telephonic administrative hearing in this matter on February 24, 2016 at 10:03 a.m. and reconvened on March 22, 2016 at 10:05 a.m.

## APPEARANCES

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

## STATEMENT OF ISSUE

The Petitioner is appealing the Agency for Health Care Administration's (AHCA) decision, through eQHealth Solutions, to reduce the Petitioner's Occupational Therapy services from three (3) hours a day, seven (7) days a week, to one (1) hour a day,

FINAL ORDER (Cont.)
16F-00181
PAGE-2
seven (7) days a week. Because the issue under appeal involves a reduction in services, the Respondent bears the burden of proof.

Dr. Rakesh Mittal, Physician Consultant for eQHealth Solutions, appeared as a witness for the Respondent.

Upon reconvening the hearing on March 22, 2016, the Petitioner's father explained that his son was adopted three years ago and did not receive any services until that time. Based on this new information, Dr. Mittal approved the three hours of Occupational Therapy for the current certification period from October 5, 2015 to March 27, 2015. The father was advised to provide a written description of his son's social and medical history with the renewal request for the next certification period to ensure this information is considered at that time.

Petitioner has continued to receive three hours of Occupational Therapy services pending outcome of this appeal based on administrative approval by Medicaid.

Petitioner had no other issues. Because the matter under appeal is now resolved, this 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 _ 06 day of April _ 2016, in Tallahassee, Florida.


Warren Hunter
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myffamilies.com

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

Mar 16, 2016
Office of Appeal Hearings Dept. of Children and Families

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 February 19, 2016 at 11:30 a.m.

## APPEARANCES

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

## STATEMENT OF ISSUE

At issue is whether the Respondent's action to deny the Petitioner's request for a cranial helmet was correct. The Petitioner bears the burden of proving her case by a preponderance of the evidence.

FINAL ORDER (Cont.)
16F-00208
PAGE - 2

## PRELIMINARY STATEMENT

The Petitioner did not submit any documents as evidence for the hearing.
The Respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Exhibit 1: denial notice, authorization request, and medical review form.

Appearing as witnesses for the Respondent were Dr. Jorge Cabrera, Chief Medical Officer, Summer Brooks, Contract Manager, Jennifer Demaris, Health Services Manager, and Maureen McNamara, Grievance/Appeals Manager, from Coventry Healthcare, which is the Petitioner's managed health care plan.

## FINDINGS OF FACT

1. The Petitioner is a one (1) 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 Coventry Healthcare.
2. On or about November 17, 2015, the Petitioner's treating physician (hereafter referred to as "the provider"), submitted a prior authorization request for a custom cranial remolding orthosis ( $\mathrm{a} / \mathrm{k} / \mathrm{a}$ cranial helmet). Coventry Healthcare denied this request on November 30, 2015 based on medical necessity criteria. The denial notice stated the following:

The State of Florida Medicaid DME Handbook, page 2-48, says that the cranial device must be medically needed to correct a deformity in the shape of the head bones. The information received from your doctor was reviewed by a Medical Director. It was decided that your condition did not

FINAL ORDER (Cont.)
16F-00208
PAGE - 3
meet the guidelines. For a helmet to be approved, you need to have the following:
Your head measurements, called the cranial index of symmetry (CIS), have to be less than $83 \%$.
You have something in writing from a specialist surgeon saying that your head shape did not get better after 6 months of active head turning and changing positions.
Photographs showing the head from different views, top, front, back, and sides.
A prescription from a specialist surgeon (orthopedic or craniofacial).
You have not completed 6 months of therapy and repositioning and we have no pictures as needed for approval. Therefore, your request is denied.
3. The Petitioner's father testified he believes the cranial helmet should be approved because his daughter's condition will not resolve on its own and she needs the helmet. He also stated his daughter's head tilts to the side and he is concerned about the long-term effects on her motor skills. In addition, he stated his daughter has been receiving physical therapy for the past five (5) months.
4. The Respondent's witness, Dr. Cabrera, testified that the cranial helmet was denied because there were no pictures submitted with the request and there have not been at least six (6) months of attempted repositioning therapy to correct the condition. He also stated approval of a cranial helmet requires the patient's cranial index to be less than 83 , and the Petitioner's cranial index was 89.2.
5. Durable medical equipment, including a cranial helmet, is a covered service under the Medicaid State Plan in Florida. These services are provided in accordance with the Respondent's Durable Medical Equipment/Medical Supply Services Coverage and Limitations Handbook ("DME Handbook"), effective July, 2010.

FINAL ORDER (Cont.)
16F-00208
PAGE - 4

## 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 $\S 120.57$.
8. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
9. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the Petitioner. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at $1201,7^{\text {th }}$ Ed.).
10. The Florida Medicaid Program is authorized by Chapter 409, Fla. Stat. and Chapter 59G, Fla. Admin. Code. The Medicaid Program is administered by the Respondent.
11. The petitioner has requested DME services (a cranial helmet). 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 this service.
12. 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.

FINAL ORDER (Cont.)
16F-00208
PAGE-5
13. 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.
14. The service the petitioner has requested (DME services) is one of the services provided by the state to treat or ameliorate an individual's conditions under the State plan. Section 409.905, Fla. Stat., states, in part:

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.

[^7]FINAL ORDER (Cont.)
16F-00208
PAGE - 6
15. 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.
2. Once a service has been identified as requested under EPSDT, Medicaid 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:
3. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
4. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
5. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
6. 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
7. 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.
8. Based upon the information submitted by the Petitioner's provider, Coventry

Healthcare completed a prior authorization review to determine medical necessity for the requested durable medical equipment (i.e., the cranial helmet).
18. In the Petitioner's case, the Respondent has determined that the cranial helmet is a covered service under the Medicaid state plan but is disputing the medical necessity for the cranial helmet.
19. Section 409.913, Fla. Stat. governs the oversight of the integrity of the Florida Medicaid Program. Section (1)(d) sets forth the "medical necessity or medically necessary" standards, and states in pertinent part as follows:
"Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or prec/ude 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

FINAL ORDER (Cont.)
16F-00208
PAGE - 8
must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.
20. Section (1)(d) highlights 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.
21. The DME Handbook, on page 2-48, describes a cranial helmet as follows:

A custom cranial remolding orthosis is a non-invasive device used to correct the symmetry of an infant's skull.
22. The DME Handbook also sets forth the following requirements for approval of a cranial helmet:

Custom cranial remolding orthotic devices are covered by Medicaid when it is determined medically necessary to correct a moderate to severe craniofacial deformity. 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 cranial index of symmetry (CIS) is $<83$; and

Current color photographs of the infant's head, taken from the following views:
$\square$ Superior;
$\square$ Frontal;
$\square$ Posterior;
$\square$ Right and left lateral; and
A statement from a treating orthopedic or craniofacial surgeon, stating that treatment using a cranial remolding orthosis is recommended due to poor improvement in the infant's CIS, after a documented six (6) months trial period of active counter positioning has been completed; and

Six (6) month's worth of documentation regarding daily counter positioning

FINAL ORDER (Cont.)
16F-00208
PAGE - 9
therapy.
23. The Petitioner's physician prescribed a cranial helmet, but it was not approved by Coventry Healthcare. Rule 59G-1.010(166) (c), however, specifically states a prescription does not automatically mean the requirements of medical necessity have been satisfied.
24. The Respondent's witness stated that photographs were not submitted with the authorization request and the submitted cranial measurements indicated a cranial index of 89.2. In addition, he stated there must be at least six months of attempted repositioning therapy.
25. The Petitioner's father stated his daughter has been receiving physical therapy for the past five months and he believes her condition will not resolve on its own without the use of the cranial helmet.
26. Petitioner has not established by a preponderance of the evidence that her requested cranial helmet is medically necessary as defined by Fla. Admin. Code R. 59G-1.010(166). The submitted medical evaluation shows a cranial index of 89.2, and the applicable criteria require this index to be less than 83. In addition, photographs were not submitted with the authorization request and there has not been at least six months of attempted repositioning therapy to correct the condition. After considering the evidence and relevant authorities set forth above, the undersigned concludes that the Petitioner has not met her burden of proof in establishing that the Respondent's action was incorrect.

## DECISION

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

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this _ 16 day of __ March , 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

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

APPEAL NO. 16F-00223
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 March 1, 2016 at 1:39 p.m.

## APPEARANCES

For the Petitioner:

For the Respondent: Monica Otalora
Senior Human Services Program Specialist

## ISSUE

Whether the denial of petitioner's request for escort services through respondent's Statewide Long Term Managed Care Program (LTMC Program) was proper. The burden of proof was assigned to the petitioner.

## PRELIMINARY STATEMENT

An interpreter from
translation.

FINAL ORDER (Cont.)
16F-00223
PAGE - 2
Petitioner was present and represented by her brother-in-law. Petitioner entered no exhibits into evidence.

Ms. Otalora appeared as both a representative and witness for the respondent. Present from United Health Care (UHC) were: Dr. Sloan Karver, M.D., Long Term Care Medical Director and Christian Laos, Senior Compliance Analyst. Respondent's exhibits " 1 " and " 2 " were entered into evidence.

## 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 95 years of age and resides with her sister and brother-in-law. She requires assistance with most activities of daily living.
2. Respondent administers Florida's Medicaid Program and contracts with Health Maintenance Organizations to provide comprehensive, cost-effective medical services to Medicaid recipients in the LTMC Program.
3. LTMC services must, at a minimum, include those enumerated in $\S 409.98$, Fla. Stat. Those services are: nursing facility care; assisted living; hospice; adult day care; medical equipment and supplies; personal care; home accessibility adaptation; behavior management; home-delivered meals; case management; certain therapies; skilled nursing; medication administration; medication management; nutritional assessments; caregiver training; respite care; transportation; and personal emergency response systems-
4. All services in the LTMC Program are defined by contract.

FINAL ORDER (Cont.)
16F-00223
PAGE - 3
5. Petitioner's LTMC services are provided by UHC. Petitioner is approved, in part, to receive personal care and homemaker services.
6. An escort is not an expanded service provided by UHC to LTMC Program enrollees.
7. On or about December 1, 2015 petitioner requested escort services. The escort would accompany petitioner to medical appointments.
8. On December 3, 2015 UHC issued a Notice of Action which denied escort services. The notice stated, in part: "The facts that we used to make our decision are: You asked for an escort. The long term care health plan does not cover this. It is not a covered benefit. The request is not approved."
9. The above notice informed petitioner of fair hearing rights.
10. On January 7, 2016 petitioner contacted the Office of Appeal Hearings and timely requested a fair hearing.
11. The representative argues difficulties with walking and transferring require someone, such as a companion, to accompany petitioner to medical appointments. Petitioner's sister is 83 years of age and is no longer able to provide this type of assistance.
12. Respondent asserts an escort is not a service covered by the LTMC Program. A case manager can provide assistance locating physicians who make house calls.

## CONCLUSIONS OF LAW

13. 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.

FINAL ORDER (Cont.)
16F-00223
PAGE-4
14. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R.

65-2.056.
15. The standard of proof in an administrative hearing is by a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at $1201,7^{\text {th }}$ Ed.).
16. LTMC Program service definitions are included in respondent's contract with

UHC. The definitions are found on respondent's website at:

## http://www.fdhc.state.fl.us/medicaid/statewide mc/plans.shtml

17. The above list contains 26 LTMC service definitions.
18. Escort services is not an identified service.
19. Service definitions reviewed by the undersigned include:
(1) Adult Companion Care - Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discreet services. The provision of companion services does not entail hands-on nursing care. This service includes light housekeeping tasks incidental to the care and supervision of the enrollee.
(11) Homemaker Services - General household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control may be included in this service.
(19) Personal Care - A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

FINAL ORDER (Cont.)
16F-00223
PAGE - 5
(26) Transportation - Non-emergent transportation services shall be offered in accordance with the enrollee's plan of care and coordinated with other service delivery systems. This non-emergency transportation service includes trips to and from services offered by the LTC Managed Care Plan and includes trips to and from the Managed Care Plan's expanded benefits.
20. Homemaker and personal care are services currently received by the petitioner.

The definitions for neither include escorting the recipient to medical appointments.
21. The definition for an adult companion addresses supervision. The description, however, does not include accompaniment to medical appointments.
22. Transportation is a service through the LTMC Program. The definition, however, does not include an individual to accompany the person being transported. The purpose is for transport, only.
23. When a LTMC enrollee requests an allowable service, a medical necessity review is completed. In this instant appeal, the service requested by the petitioner is neither required by Florida Statute nor identified by contract. As such, a medical necessity review was not warranted.
24. The Findings of Fact establish an escort is not an expanded service provided by UHC.
25. Petitioner has presented no authority which justifies approval of the requested service. The undersigned lacks jurisdiction to mandate services not required by an appropriate authority.
26. After considering all evidence and testimony, petitioner has not met the required evidentiary burden in this matter.

## 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 16 day of March 2016, in Tallahassee, Florida.


Frank Houston
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myffamilies.com

# STATE OF FLORIDA <br> DEPARTMENT OF CHILDREN AND FAMILIES <br> OFFICE OF APPEAL HEARINGS 



APPEAL NO. 16F-00302
PETITIONER,
Vs.
AGENCY FOR HEALTH CARE ADMINISTRATION CIRCUIT: 17 Broward
UNIT: AHCA

## RESPONDENT.

## 1

## FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in this matter on March 7, 2016 at 11:36 a.m.

## APPEARANCES

For the Petitioner:

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

## STATEMENT OF ISSUE

The Petitioner is appealing the Agency for Health Care Administration's (AHCA) decision, through South Florida Community Care Network (SFCCN), to deny the Petitioner's requests for genetic testing procedure 81479 (ORC1 sequencing). Because the issue under appeal involves a request for a service, the Petitioner bears the burden of proof.

FINAL ORDER (Cont.)
16F-00302
PAGE - 2

## PRELIMINARY STATEMENT

Catherine Ruiz, Grievance and Appeals Coordinator; Alex Fabano, CMS
Contract Manager; and Dr. Ikpeazu, Medical Director of Pediatrics; appeared as
Respondent's witnesses from Petitioner's managed care plan, South Florida Community
Care Network (SFCCN).
Respondent submitted a 47-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 an 8 year-old Medicaid recipient enrolled with SFCCN, a Florida Health Managed Care provider. He has been diagnosed with due to physical anomalies which include
2. SFCCN received a prior authorization request for genetic testing (procedure 81479) on December 28, 2015. On December 29, 2015, SFCCN sent the Petitioner a Notice of Action denying the request and provided the following explanation for the denial:

Medical necessity could not be established, per Medicaid guidelines, requested test will most likely not impact the management of the patient.
3. Petitioner filed a timely request for a fair hearing on January 8, 2016.
4. Petitioner's mother explained that her son no longer has Meier-Gorlin syndrome and new genetic testing is needed to confirm the correctness of his diagnosis. She

FINAL ORDER (Cont.)
16F-00302
PAGE-3
wants to ensure her son receives the appropriate treatment according to his syndrome.
She feels genetic testing is the only means for properly diagnosing her son. She stated she wants to prevent future medical problems or limitations for her son.
5. SFCCN's Medical Director for Pediatrics explained the Petitioner has always received treatment for features resulting from his syndrome. She stated he appears to have features from overlapping effects of both the He has received a cochlear implant for his hearing and surgery for his
He also has received speech therapy. She noted that genetic testing would not change his medical case management and, therefore, was not medically necessary to meet his medical needs.

## CONCLUSIONS OF LAW

6. By agreement between the Agency for Health Care Administration and the Department of Children and Families, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80 Florida Statutes.
7. This proceeding is a de novo proceeding pursuant to Florida Administrative Code R.65-2.056.
8. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Florida Administrative Code Rule 65-2.060(1).
9. Florida Statutes 409.971 - 409.973 establishes the requirement for Medicaid recipients to be enrolled in the statewide managed medical assistance program and the

FINAL ORDER (Cont.)
16F-00302
PAGE - 4
minimum benefits the managed care plans shall cover. Laboratory services are one of the mandatory services that must be provided.
10. Section 409.912, Fla. Stat. also provides that the Agency may mandate prior authorization for Medicaid services.
11. Fla. Admin. Code R. 59G-1.010 defines "prior authorization" as:
(226) "Prior authorization" means the approval by the Medicaid office for a Medicaid provider, or by a prepaid health plan for its affiliated providers, to deliver Medicaid covered medical or allied care, goods, or services in advance of the delivery of the care, goods, or services.
12. Fla. Admin. Code R. 59G-1.010 (166) provides:
"Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.
6. Florida Medicaid's Independent Laboratory Coverage and Limitations HandbookJanuary 2007 (Handbook), incorporated by reference into Chapter 59G, Fla. Admin.

FINAL ORDER (Cont.)
16F-00302
PAGE - 5
Code, sets policies and standards for laboratory services and describes the purpose of the program on page 1-1:

The Medicaid independent laboratory program provides for payment of medically necessary clinical laboratory procedures provided in freestanding laboratory facilities [emphasis added].
14. On page 2-6 of the Handbook, it provides the following:

All procedures must be ordered by the treating health care practitioner, be medically necessary and be listed on the Independent Laboratory Procedure Codes and Fee Schedule (Appendix E) in this handbook to be covered by Medicaid [emphasis added].
15. 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 Statutes $\S 409.905$, 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.
16. The Petitioner's mother is seeking genetic testing to ensure her son is receiving the appropriate medical services for his diagnosed syndromes and to avoid future medical complications. Respondent explained that the Petitioner's medical case management is addressing all his needs, including the anomalies resulting from the genetic syndrome(s) he has. Respondent explained petitioner's medical care would not change with any genetic testing results and, therefore, the genetic testing is not

FINAL ORDER (Cont.)
16F-00302
PAGE-6
medically necessary. Petitioner failed to meet her burden of proof. Respondent's decision meets the ESPDT requirements as cited above because the Petitioner's medical needs are being met with appropriate treatment and would not be affected by the results of genetic testing.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the
Petitioner's appeal is hereby DENIED and the Agency's action is AFFIRMED.

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this $\qquad$ day of $\qquad$ , 2016,
in Tallahassee, Florida.

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

Copies Furnished T
etitioner
Rhea Gray, Area 11, AHCA Field Office Manager

Apr 08, 2016

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

## 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 this matter on February 29, 2016 at 10:04 a.m.

## APPEARANCES

For the Petitioner:

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

## STATEMENT OF ISSUE

The Petitioner is appealing the Agency for Health Care Administration's (AHCA) decision, through DentaQuest, to deny the Petitioner's requests for dental procedure D7240 (removal of impacted tooth) for tooth 1 and 16 and with sedation, dental procedure D9220 (general anesthetic-first 30 minutes) and procedure D9221 (general

FINAL ORDER (Cont.)
16F-00308
PAGE - 2
anesthetic-each additional 15 minutes). Because the issue under appeal involves requests for services, the Petitioner bears the burden of proof.

## PRELIMINARY STATEMENT

Appearing as Respondent's witnesses from Better Health were Lourdes Gayo, Director of Member Services, and Dr. Jeanette Rios, Medical Director. Appearing as Respondent's witnesses from DentaQuest were Heidi Penderanda, Grievance and Appeals Specialist, and Dr. Frank Manteiga, Dental Consultant.

Respondent submitted a 30-page document which was entered into evidence and marked Respondent Exhibit 1.

The initial prior authorization requests were received by Better Health on December 21, 2015 and included requests for dental procedure code D7220 for removal of tooth 1 and 16 and dental procedure code D7240 for removal of tooth 17 and 32. On December 22, 2015, DentaQuest sent a notice to the petitioner that only removal of tooth 17 was approved. Subsequently, petitioner's dentist submitted a new request and for dental procedure code D7230 for removal of tooth 32 which was approved by DentaQuest on January 12, 2016.

Removal of tooth 1 and 16 remain at issue for this appeal.

## 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 35 year-old Medicaid recipient enrolled with Better Health, a Florida Health Managed Care provider.

FINAL ORDER (Cont.)
16F-00308
PAGE - 3
2. Better Health requires prior authorization for services related to dental care and has subcontracted with DentaQuest to perform prior authorization reviews.
3. DentaQuest received a prior authorization request from Petitioner's dentist on December 21, 2015 for the following procedure codes: D7220-removal of impacted tooth-soft tissue for Tooth 1 and 16 along with dental procedure D9220 (general anesthetic-first 30 minutes) and procedure D9221 (general anesthetic-each additional 15 minutes).
4. DentaQuest sent a Notice of Action to the Petitioner on December 22, 2015 advising the requests for removal of tooth 1 and tooth 16 were denied because they found no sign of infection or other medical reason for removal of either tooth.
5. Petitioner filed a timely request for a fair hearing on January 11, 2016.
6. Petitioner acknowledged that tooth 1 and 16 are still giving her pain and causing her to lose sleep. She feels the wisdom teeth don't belong and should be removed.
7. DentaQuest's dental consultant explained the teeth have already erupted and are coming in straight. There is no pathology or medical reason for removing tooth 1 or 16. He stated the source of petitioner's pain could be related to some bone loss the x-rays show.

## CONCLUSIONS OF LAW

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

FINAL ORDER (Cont.)
16F-00308
PAGE - 4
9. This proceeding is a de novo proceeding pursuant to Florida Administrative

Code R.65-2.056.
10. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Florida Administrative Code Rule 652.060(1).
11. Florida Statutes 409.971 - 409.973 establishes the requirement for Medicaid recipients to be enrolled in the statewide managed medical assistance program and the minimum benefits the managed care plans shall cover. Dental services are one of the mandatory services that must be provided.
12. Section 409.912, Fla. Stat. also provides that the Agency may mandate prior authorization for Medicaid services.
13. Fla. Admin. Code R. 59G-1.010 defines "prior authorization" as:
(226) "Prior authorization" means the approval by the Medicaid office for a Medicaid provider, or by a prepaid health plan for its affiliated providers, to deliver Medicaid covered medical or allied care, goods, or services in advance of the delivery of the care, goods, or services.
14. Fla. Admin. Code R. 59G-1.010 (166) 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.
6. 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.
16. While the petitioner stated she was experiencing pain from tooth 16 and that she felt wisdom teeth 1 and 16 needed to be removed, respondent's dental consultant determined there was no medical necessity for removing either. There is no pathology or infection indicated and they are coming in straight. The petitioner failed to meet her burden.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Petitioner's appeal is hereby DENIED and the Agency's action is AFFIRMED.

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this $\qquad$ day of $\qquad$ , 2016,
in Tallahassee, Florida.


Warren Hunter
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myffamilies.com

Copies Furnished Td
etitioner
Rhea Gray, Area 11, AHCA Field Office Manager

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

Office of Appeal Hearings
Dept. of Children and Families

APPEAL NO. 16F-00309

PETITIONER,
VS.
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 06 PINELLAS
UNIT: AHCA
RESPONDENT.
RESPONDENT.

CASE NO.

## FINAL ORDER

Pursuant to notice, a telephonic hearing in the above-styled matter convened on February 10, 2016 at 1:02 p.m.

## APPEARANCES

For the Petitioner:

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

## STATEMENT OF ISSUE

At issue is whether Respondent improperly denied Petitioner's request for one can of Boost per day (B4150). Petitioner held the burden of proof in this case by a preponderance of the evidence.

## PRELIMINARY STATEMENT

The Agency for Healthcare Administration (AHCA or Agency) is responsible for administering Florida's Medicaid Program.

FINAL ORDER (Cont.)
16F-00309
Page 2 of 8
Petitioner appeared with as a witness. Dr. Jeanette Rios (Medical Director with Clear Health Alliance) and Diana Anda (Grievance and Appeals Manager with Clear Health), appeared as witnesses for the Respondent.

The hearing officer took administrative notice of Florida Statutes 409.910, 409.962 through 409.965, 409.973, Florida Administrative Code Rules 59G-1.001, 59G1.010, and 59G-4.070.

Respondent entered three exhibits into the record at the time of hearing, marked as Respondent's Exhibits 1 through 3. The record was held open until February 19, 2016 for the plan to submit its nutritional supplement guidelines and Petitioner to submit a response. Upon receipt, the plan's submission of the Agency's enteral category listing and its letter regarding the case were marked and entered as Respondent's Exhibit 4 and 5. Petitioner's response to the plan's submission was submitted after the deadline, but as this was due to Respondent' s failure to timely mail a copy to Petitioner, the response was accepted and marked and entered as Petitioner's Exhibit 1.

## FINDINGS OF FACT

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

1. Petitioner is an adult male diagnosed with He is enrolled with Clear Choice Alliance, a managed care plan.
2. Petitioner's doctor ordered one can of Boost per day for Petitioner to drink orally. Boost is also referred to as ensure or enteral. It is a nutritional drink used to supplement a person's diet. Petitioner's doctor ordered the drink because Petitioner

FINAL ORDER (Cont.)
16F-00309
Page 3 of 8
has been on the drink for approximately nine years to manage his weight. He submitted the request with HCPCS code B4150 for preauthorization. The plan has not covered the drink to date; his waiver has covered it, but the waiver is not going to continue covering it as the waiver is required to be a payor of last resort.
3. Petitioner's weight is currently managed and appropriate, but he has difficulty eating. His body mass index and weight are within appropriate ranges for his size. Petitioner's medication list states he drinks one can of Boost four times per day. It also indicates he receives home delivered meals. However, records note that food tends to taste spoiled and he has a loss of appetite, a result of complications from $\square$ He has no physical limitations that keep him from taking or swallowing regular food orally.
4. Petitioner's witness testified that Petitioner suffers from cachexia and AIDS wasting syndrome. His weight is currently maintained because he has taken Boost on a consistent basis for an extended period of time prior to the instant appeal, paid for by his waiver.
5. Petitioner's doctor requested preauthorization for Boost (B4150) on or about December 30, 2015. The prescription stated "Drink one can four times daily."
6. Clear Health Alliance denied this request as not medically necessary via notice dated December 31, 2015. Specifically the notice stated:

Your request for Ensure is denied because according to the information we got you don't have any trouble swallowing, you are not being fed with a tube, and you don't have trouble absorbing your food.
7. Respondent explained that its criteria for supplements require that the member be tube fed, unable to chew and swallow and/or show malabsorption or anorexia in the

FINAL ORDER (Cont.)
16F-00309
Page 4 of 8
medical documentation. The guidelines Respondent submitted after the hearing were not clinical guidelines. It was a letter and argument from Respondent's witness.

## CONCLUSIONS OF LAW

8. 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.
9. 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.
10. This is a Final Order, pursuant to Sections 120.569 and 120.57, Florida Statutes.
11. This hearing was held as a de novo proceeding, in accordance with Florida Administrative Code Rule 65-2.056.
12. Section 409.912, Florida Statutes (2014), 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. In addition, the statute provides AHCA may contract with HMOs to provide these services, which AHCA has done with Clear Health Alliance.
13. "The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures." 42 C.F.R 440.230(d).
14.Section 409.905, Florida Statutes (2015), 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....
15. Florida Administrative Code Rule 59G-1.010(166) defines medical necessity, as
follows:
'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. ...
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.
6. In order to determine medical necessity of a requested service, guidelines may
be used. The governing law states as follows:
42 C.F.R. 438.236 - Practice guidelines.
(b) Adoption of practice guidelines. Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements:
(1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.
(2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees.
(3) Are adopted in consultation with contracting health care professionals.
(4) Are reviewed and updated periodically as appropriate.
(c) Dissemination of guidelines. Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.
(d) Application of guidelines. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.
7. Petitioner's physician inadvertently requested enteral that was intended for tube fed patients (code B4150). Petitioner is not tube fed so he does not need tube fed enteral. Therefore, the medical necessity definition at parts $1,2,3$, and 4 above cannot be met because HCPCS code B4150 is inappropriate for someone without a tube.
8. The prescription states to "drink" the supplement. The word "drink" makes the intent clear that this was an oral supplement, not a tube supplement. The "drink" request is also consistent with Petitioner's medication records which indicate he has one can of Boost four times a day.
9. The Category Lists for the HCPCS Codes for Enteral Formula (July 1, 2014) states on its front page:

Managed Care plans may elect to cover specific products not found in this listing or may exceed the limits established by Medicaid, if the plan's physician has deemed them medically necessary in the treatment of their enrollee. The provision of services to recipients enrolled in a Medicaid managed care plan shall not be subject to more stringent criteria or limits than specified by this listing.
20. The code Petitioner requested (B4150) is listed in the Category List booklet as a supplement administered through an enteral feeding tube. For an oral supplement, the correct code is B4150SC. "Boost" is listed and indicated as a "general dietary supplement" under the oral supplement coding. The request was properly denied

FINAL ORDER (Cont.)
16F-00309
Page 7 of 8
because Petitioner is not tube fed and thus, the tube fed enteral he requested is not medically necessary.
21. However, the plan's testimony did indicate that an oral nutritional supplement was not medically necessary. It explained the oral supplement was not necessary because Petitioner's medical records did not reflect a need for the supplement. Respondent did not provide clinical guidelines to explain what would be necessary to show in the records for an oral supplement request.
22. The hearing officer is only permitted to review the Respondent's action and whether it was proper. Based on the coding, Respondent did not deny a request for oral nutrition. It denied a request for tube fed enteral. The hearing officer cannot review whether or not Petitioner would be entitled to an oral supplement which has not yet been properly requested. Petitioner may submit a new request to his plan for an oral nutritional supplement. He is advised to make sure his medical records accurately reflect his condition and need for the supplement. If the plan denies his request for oral nutritional supplements, he would be entitled to another fair hearing on the matter.
23. Based on the evidence presented, the Agency properly denied the request for nutritional supplement.

## DECISION

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

DONE and ORDERED this 14 day of April_, 2016,
in Tallahassee, Florida.
Dandle Allay
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@myfffamilies.com
Copies Furnished To
Petitioner
Don Fuller, Area 5, AHCA Field Office Manager

Apr 25, 2016

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

# PETITIONER, 

## Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION CIRCUIT: 18 Brevard UNIT: AHCA

## RESPONDENT.

## FINAL ORDER OF DISMISSAL

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on March 7, 2016 at approximately 3:30 p.m. Petitioner represented herself. Respondent, the Agency for Health Care Administration ("AHCA" or Agency") was represented by Lisa Sanchez, Medical/Health Care Program Analyst. The Agency presented the following witnesses:

- Carlene Brock, Quality Operations Nurse, Amerigroup
- Dr. Amy Zitello, Medical Director, Amerigroup
- Dr. John Davis, Clinical Vision Director, EyeQuest

Dr. Marisa Bravo and Ruth Wilsing, both with EyeQuest, observed the hearing. The parties and witnesses gave oral testimony, but did not move any exhibits into evidence. Petitioner is enrolled with Amerigroup as her Managed Medical Assistance (MMA) plan. Petitioner's issues (1) dissatisfaction with her difficulty obtaining prescriptions, (2) a denial of her request to change MMA plans, and (3) Amerigroup's

FINAL ORDER (Cont.)
16F-00305 \&
16F-00555
PAGE - 2
denial of cataract surgery and after care. Petitioner withdrew her request to change
MMA plans on the record, therefore this issue will not be addressed.
Dr. Davis said the surgery has been approved, as well as 90 days of after care, which is included in the fee. Dr. Davis said he thought the surgery was already scheduled. Dr. Davis testified he looked into the computer system and that the surgery was formally approved on February 19, 2016. Petitioner said the surgery has not been scheduled because she needs to get clearance from a cardiologist. She said she would have already had the clearance done the prior week, but the transportation did not pick her up. After the hearing, Respondent submitted a letter from EyeQuest dated February 19, 2016, which shows the surgery was approved.

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....

In the instant matter, Respondent did not terminate, suspend, or reduce
Petitioner's Medicaid eligibility or services. Regarding the prescriptions, the problem is a customer service issue regarding difficulty filling prescriptions.

Amerigroup approves and pays for the prescriptions, but there is a hassle with

FINAL ORDER (Cont.)
16F-00305 \&
16F-00555
PAGE -3
getting authorization. The Office of Appeal Hearings does not have the authority
to hear customer service disputes. Dr. Zitiello said there is a case manager
assigned to Petitioner who she can work with to resolve any customer service disputes.

Based upon the foregoing, this 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 $\qquad$ 25 day of $\qquad$ , 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@myfffamilies.com

Copies Furnished To: Petitioner
Judy Jacobs, Area 7, AHCA Field Office

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

Vs.
PETITIONER,

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

## RESPONDENT.

CASE NO.

## FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 18, 2016 at 11:08 a.m.

APPEARANCES

For the Petitioner:
For the Respondent:

Stephanie Lang, Agency for Health Care Administration

## STATEMENT OF ISSUE

At issue is whether the Agency properly denied Petitioner's request to continue medication therapy using holds the burden of proof on 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. It has contracted with Staywell, a managed

FINAL ORDER (Cont.)
16F-00415
PAGE - 2
care plan, to provide services to Medicaid recipients. Petitioner is enrolled with Staywell.

Petitioner represented herself at the hearing. She did not present any other witnesses or documentary evidence. Respondent's witnesses were Alexandria Hicks (Regulatory Research Coordinator), Lauren Barnes (Manager of Pharmacy Operations), and Lisa Hogan (Senior Manager of Pharmacy Appeals), all with Staywell.

Respondent submitted eleven exhibits during the hearing, marked and entered as Respondent's Exhibits 1 through 11, into evidence.

## FINDINGS OF FACT

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

1. Petitioner is an adult female diagnosed with and other ailments. She has children and responsibilities to attend to, and the pain disrupts her life. Her pain has been a life-long problem, and she has tried numerous medications in an attempt to resolve the issue. After a long struggle, she had success with $\quad$ tablets. She has been taking this drug for over three years without issue.
2. Petitioner's doctor submitted drug evaluation reviews to the plan requesting continued approval of the that Petitioner has been on. He submitted the requests on December 30 and December 31, 2015.
3. The plan denied both requests on the same day they were received. The plan sent Notice of Action letters dated December 30 and December 31, 2015 advising the

FINAL ORDER (Cont.)
16F-00415
PAGE - 3
Petitioner of the denials and the reason for the denials. The plan denied the requests because there was no information showing that Petitioner has tried
4. The Medicaid Preferred Drug List (PDL) lists the drugs available for coverage under Medicaid. Drugs that are not on the PDL require prior authorization. The Agency created guidelines showing the criteria necessary to obtain those non-PDL drugs. The Agency may add or remove drugs from the PDL and the plans are required to enforce the criteria the Agency sets forth. authorization. In the past, Petitioner met the prior authorization criteria and received the drug. However since that time a new drug,
 except it contains an additional ingredient to prevent drug abuse $\square$ The plan reviews prescription requests for continued therapy and determines whether there is a clinical reason that a recipient cannot try the new PDL drug. In this case, the plan found no reason that Petitioner would be unable to try the new drug.
6. Respondent's position is that Petitioner no longer meets the prior authorization criteria for because there is now a drug on the PDL that is clinically similar to $\square$ she must try before receiving the $\square$ Respondent agreed to approve Petitioner's'
 $\square$ while the hearing decision was pending. Petitioner was encouraged to try in the meantime to help avoid any breaks in therapy. If the works for Petitioner, then she is on a PDL drug that can be approved and there is no further issue. If it does not work for her, her doctor could submit an approval request for the

does not work. If the hearing decision is in Petitioner's favor, the plan would continue to approve the , and if it is not in Petitioner's favor, she would need to try the $\square$ before being approved for the . Regardless, the plan agreed it would work with Petitioner to ensure she does not suffer a detrimental stop in her morphine therapy as it is not clinically advised to simply stop taking it. As a result, this issue may have been resolved before the hearing decision was rendered.

## 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. The Office of Appeal Hearings provided the parties with adequate notice of the administrative hearing.
8. Florida Medicaid State Plan 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. 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. For prescription drugs, Sections 409.912(8)(a)(14) through 409.912(8)(a)16), Florida Statutes (2015) explain the process.
11. Specifically, Section $409.912(8)(a)(16)$ explains that recipients must try drugs on the PDL before trying a non-PDL drug, unless certain criteria are met.

The agency shall implement a step-therapy prior authorization approval process for medications excluded from the preferred drug list. Medications listed on the preferred drug list must be used within the previous 12 months before the alternative medications that are not listed. The steptherapy prior authorization may require the prescriber to use the medications of a similar drug class or for a similar medical indication unless contraindicated in the Food and Drug Administration labeling. The trial period between the specified steps may vary according to the medical indication. The step-therapy approval process shall be developed in accordance with the committee as stated in s. 409.91195(7) and (8). A drug product may be approved without meeting the step-therapy prior authorization criteria if the prescribing physician provides the agency with additional written medical or clinical documentation that the product is medically necessary because:
a. There is not a drug on the preferred drug list to treat the disease or medical condition which is an acceptable clinical alternative;
b. The alternatives have been ineffective in the treatment of the beneficiary's disease; or
c. Based on historic evidence and known characteristics of the patient and the drug, the drug is likely to be ineffective, or the number of doses have been ineffective.

## 12. The Prescribed Drug Services Coverage, Limitations and Reimbursement

Handbook (July 2014) ("The Medicaid Handbook") is promulgated into law by Florida
Administrative Code Rule 59G-4.250. The Handbook echoes the information from the
Florida Statutes.
13. The Medicaid Handbook states on page 2-2 that:

To be reimbursed by Medicaid, a drug must be medically necessary and either (a) prescribed for medically accepted indications and dosages found in the drug labeling or drug compendia in accordance with Section 1927(k)(6) of the Social Security Act, or (b) prior authorized by a qualified clinical specialist approved by the Agency. Notwithstanding this rule, the Agency may exclude or otherwise restrict coverage of a drug in accordance with Section 1927 of the Social Security Act.
14. At page 2-11, the Medicaid Handbook explains that:

FINAL ORDER (Cont.)
16F-00415
PAGE-6
In order to be reimbursed by Medicaid, providers must obtain prior authorization before dispensing certain drugs.

Prior authorization from Medicaid is required prior to reimbursement in the following situations:

1. The drug is not on the Preferred Drug List.
2. Clinical Prior Authorization is required for specific drugs a) For an indication not approved in labeling; b) To comply with certain clinical guidelines; or $c$ ) If the product has the potential for overuse, misuse, or abuse. The Agency may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug. A current list of drugs for which clinical prior authorization is required, and clinical prior authorization forms, may be found on the webpage at www.ahca.myflorida.com/Medicaid/Prescribed Drug . ${ }^{1}$
3. If a prescriber hand writes "brand medically necessary" on the face of a prescription when a generic is available with a state or federal pricing limit.
4. Petitioner's request is for a drug that requires prior authorization. There is specific criteria that must be met for the drug to be approved or continued. This criteria was provided as Respondent's Exhibit 1. It was developed on December 21, 2015 and updated on January 15, 2016. To continue drug therapy, the patient must continue "to meet all of the initial review criteria." The criteria for a six month authorization for morphine sulfate, extended release (generic) requires that the "patient has tried and failed or has an intolerance or contraindication to the preferred long-acting oral morphine product formulation." The "preferred long-acting $\quad$ product formulation" is called It is on the PDL.
5. Certain information may be considered under the statutes to skip step-therapy. That information is not present or alleged here. There is no evidence that there is no alternative on the PDL because embeda is on the PDL. There is no evidence that the
[^8]FINAL ORDER (Cont.)
16F-00415
PAGE - 7
alternative $\square$ has been ineffective in the treatment of the beneficiary's disease, or that based on historic evidence and known characteristics of the patient and the drug, the drug is likely to be ineffective, or the number of doses have been ineffective.
17. Petitioner does not want to try $\square$ because she has tried many drugs and they have failed. Since works for her, it is an inconvenience to try something else when she has finally found something that works. Petitioner's frustration is noted but this is not a reason that she cannot try
18. After careful review of the evidence submitted and the relevant laws set forth above, the undersigned finds the Agency met its burden of proof. 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 $\qquad$ 13 day of April , 2016,
in Tallahassee, Florida.
Danilletllumay

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@myfffamilies.com

Copies Furnished To: Petitioner
Don Fuller, Area 5, AHCA Field Office Manager

## FILED

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

Apr 15, 2016 Office of Appeal Hearings Dept. of Children and Families

APPEAL NO. 16F-00431
PETITIONER,
Vs.

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 24, 2016 at 11:38 a.m.

## APPEARANCES

For the Petitioner:


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

## STATEMENT OF ISSUE

At issue is the Agency's action in denying Petitioner's prescription requests for Because the matter at issue is a request for service, the burden of proof is assigned to the Petitioner.

## PRELIMINARY STATEMENT

Alexandria Hicks, Regulatory Research Coordinator, and Dr. Lauren Barnes, Manager for Pharmacy Operations, appeared as witnesses for the Respondent from Staywell Managed Medical Assistance (MMA).

The Respondent submitted one composite document which was entered into evidence and marked Respondent Exhibit 1.

## FINDINGS OF FACT

1. The Petitioner is a 62 year-old Medicaid recipient who enrolled with the managed care provider Staywell effective May 1, 2014 and is a current active member.
2. On November 19, 2015, Staywell (Plan) received a Drug Evaluation Review
3. On November 20, 2015, the Plan sent a Notice of Action to the Petitioner advising his request for was denied as of November 19, 2015. The basis for the denial was:


4. Petitioner submitted an expedited appeal on December 23, 2015. Because the appeal exceeded the 30 day deadline, the request was treated as a second Drug Evaluation Review. On December 24, 2015, the second request was denied and a Notice of Action was sent to the Petitioner providing the same explanation as provided in Staywell's original denial notice.
5. Petitioner filed a timely request for a fair hearing on January 18, 2016.
6. Petitioner's representative asserted that guidelines published by the American
 America recommend treating all except those with short life expectancy. She stated that if the Petitioner were treated with his would be cured.
7. Respondent's witness from Staywell explained that Petitioner's request for was denied because he did not meet criteria established by Florida Medicaid.

The criteria not met, included:


## CONCLUSIONS OF LAW

8. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80, Fla. Stat.
9. This is a final order pursuant to $\S 120.569$ and $\S 120.57$, Fla. Stat. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
10. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence.
11. The Florida Medicaid Program is authorized by Chapter 409, Fla. Stat. and Chapter 59G, Fla. Admin. Code. The Medicaid Program is administered by the respondent.
12. Fla. Admin. Code 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:
13. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
14. 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;
15. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
16. 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;
17. 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...
18. AHCA's Prescribed Drug Coverage, Limitations, and Reimbursement Handbook-

July 2014 (Handbook) is incorporated in Florida Administrative Code Rule 59G-4.250
and states the following on page 1-4:
HMO prescribed drug services are defined the same as for the Medicaid fee-for-service program and include all legend drug products covered by fee-for-service Medicaid as defined in Chapter 2 of this handbook, Legend Drugs. Medicaid's contract with HMOs states that Medicaid HMOs may use prior authorization and/or step therapy to encourage compliance with the preferred drug list.
A Medicaid HMO is required to cover any product that is required to be covered under the fee-for-service Medicaid program as specified in section 1927 of Title XIX of the Social Security Act. If a product meets the definition of a covered service under that section there must be a provision to make it available through the HMO and through fee-for-service.
14. On page 2-4 of the Handbook, the Preferred Drug List is explained under covered services, 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 in selected therapeutic classes will be presented to the P \& T Committee with their relevant clinical efficacy and relative net cost positions. The P \& T Committee will recommend the most cost effective drugs in each therapeutic category to AHCA for consideration for inclusion on the PDL. A minimum of two products per therapeutic class, if available, will be recommended. 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. Please see the following section of this handbook for explanation of the prior authorization process for non-PDL products.
Non-PDL drugs may be approved for reimbursement upon prior authorization. A step-therapy process that requires initial use of PDL
products before authorization of non-PDL products will then permit prior authorization (PA) for non-listed drugs. Oral contraceptives and HIV/AIDSrelated anti-retroviral products are covered, and are exempt from PDL requirements. Mental health drugs are not exempt from PDL requirements. Nursing home residents and waiver program participants are not exempt from PDL requirements.
[emphasis added]
15. On page 2-12 of the Handbook, How Non-PDL Requests are Processed states:

Medications on the Preferred Drug List must have been tried within the twelve months prior to the request for a non-PDL alternative product. Certain step-therapy prior authorization protocols require the prescriber to use medications in a similar drug class or for a similar medical indication unless contraindicated in the federal Food and Drug Administration labeling. Reimbursement for a drug product may be approved without meeting the step-therapy prior authorization criteria if the prescribing physician provides written medical or clinical documentation that the product is medically necessary because:

- There is not an acceptable clinical alternative on the PDL to treat the disease or medical condition; or
- The PDL alternatives have been ineffective in the treatment of the recipient; or
- The number of doses has been ineffective, or based on historic evidence and known characteristics of the patient the PDL drug is likely to be ineffective.

16. Florida Medicaid's Harvoni criteria can be found at the website:
http://www.fdhc.state.fl.us/Medicaid/Prescribed Drug/drug_criteria_pdf/Harvoni Criteria .pdf
17. The criteria was recently updated on February 24, 2016. is not on the

by Florida Medicaid which the Petitioner failed to meet.
18. Petitioner argued that the criteria is not consistent with guidelines promulgated by the American Association for the Study of Liver Diseases and the Infectious Diseases Society of America. Respondent explained the criteria are developed by a group at Florida Medicaid's headquarters in Tallahassee. Annotated at the top of Florida Medicaid's Harvoni criteria, the undersigned notes that the criteria were originally established October 24, 2014 and were subsequently revised on: November 25, 2014, April 21, 2015, November 18, 2015, February 22, 2016, and February 24, 2016. The Petitioner does not meet the most recent revised criteria for Harvoni.
19. After review of the totality of the evidence presented, the undersigned concludes 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 is AFFIRMED.

## NOTICE OF RIGHT TO APPEAL

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

FINAL ORDER
16F-00431
Page 8 of 8
DONE and ORDERED this $\qquad$ day of April , 2016, in Tallahassee, Florida.


Warren Hunter
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myfffamilies.com

## Copies Furnished To:

Don Fuller, Area 6, AHCA Field Office Manager

Apr 12, 2016

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

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 February 23, 2016 at 1:30 p.m.


## 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.

FINAL ORDER (Cont.)
16F-00437
PAGE - 2

## PRELIMINARY STATEMENT

The Petitioner did not submit any documents as evidence for the hearing.
Appearing as witnesses for the Respondent were Dr. Brittney Vo, Dental Consultant, Laurie Eubanks, Account Manager, and Susan Frischman, Senior Compliance Analyst, for United Healthcare, which is Petitioner's managed health care plan.

Respondent submitted several documents as evidence for the hearing, which were marked as follows: Exhibit 1 - Statement of Matters; Exhibit 2 - Notice of Action; Exhibit 3 - Prior Authorization Request; and Exhibit 4 - Customer Service Notes.

## FINDINGS OF FACT

1. The Petitioner is a thirty-eight (38) year-old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) - Managed Medical Assistance (MMA) plan. She receives services under the plan from United Healthcare.
2. On or about November 30, 2015, the Petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from United Healthcare to perform various dental procedures, including fillings, oral surgery, extraction, and deep gum cleaning. United partially denied this request on December 3, 2015. The request for the fillings was approved, but the request for deep gum cleaning was denied as not being a covered service and the request for oral surgery and extraction was denied due to insufficient information.

FINAL ORDER (Cont.)
16F-00437
PAGE - 3
3. Petitioner testified that she had a tooth extraction performed during an emergency visit and is trying to get approval for another tooth extraction. She also stated she needs oral surgery on the bone under her tooth and deep gum cleaning.
4. The Respondent's witness, Dr. Vo from United Healthcare, testified that deep gum cleaning is not a covered service under United Healthcare's dental plan provisions for individuals over age 21. She also stated that tooth extraction and oral surgery are covered services, but additional information is needed from the Petitioner's provider (such as a diagnostic x-ray) to demonstrate the need for those services.
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 $\S 120.57$.
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

FINAL ORDER (Cont.)
16F-00437
PAGE - 4
preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, $7^{\text {th }}$ 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.
6. Some of the Petitioner's requested dental services (extraction and oral surgery) were denied due to insufficient information submitted by the provider to establish

FINAL ORDER (Cont.)
16F-00437
PAGE - 5
medical necessity for those services. The request for deep gum cleaning was denied
as being a non-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 United Healthcare, may provide more generous benefits but cannot be more restrictive than the Medicaid guidelines contained in the Dental Handbook.
15. 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 United Healthcare. Deep gum cleaning is a non-covered service for adults under the Medicaid guidelines referenced above and under the United Healthcare dental plan provisions. Therefore, the hearing officer cannot make a determination that this service must be covered by the Petitioner's plan. With respect to the request for tooth extraction and oral surgery, the Petitioner's provider did not submit sufficient information to United Healthcare to establish the need for those services.

FINAL ORDER (Cont.)
16F-00437
PAGE-6
Petitioner should contact her provider to discuss submitting additional information to
United Healthcare for another review of those requested services.

## DECISION

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

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this $\qquad$ 12 day of April , 2016,
in Tallahassee, Florida.

[^9]Fax: 850-487-0662
Email: Appeal.Hearings@myfffamilies.com

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

Mar 16, 2016
Office of Appeal Hearings Dept. of Children and Families


APPEAL NO. 16F-00460
16F-00461
PETITIONER,
Vs.
FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 Seminole
UNIT: 55207
RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 10:45 a.m. on February 19, 2016. The hearing was reconvened at 10:30 a.m. on February 26, 2016.

## APPEARANCES

For the Petitioner:
For the Respondent:

Sylma Dekony, ACCESS Economic Self-Sufficiency Specialist II

## STATEMENT OF ISSUE

At issue is whether the respondent's action to reduce petitioner's Food
Assistance (FA) benefits and enroll her in the Medically Needy (MN) Program is proper. The petitioner carries the burden of proof by the preponderance of evidence on the FA issue. The respondent carries the burden of proof by the preponderance of evidence on the MN issue.

FINAL ORDER (Cont.)
16F-00460 \& 16F-00461
PAGE - 2

## PRELIMINARY STATEMENT

By notice dated January 13, 2016, the respondent (or the Department) notified the petitioner FA benefits would decrease from \$527 to \$264, effective February 2016. And petitioner was enrolled in MN with an $\$ 849$ Share of Cost (SOC). Petitioner timely requested a hearing to challenge the FA decrease and enrollment in the MN Program.

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 end of business day on February 26, 2016, for the petitioner to submit an additional exhibit. Petitioner's exhibit was received timely and entered as Petitioner Exhibit " 2 ". The record was also held open until March 4, 2016, for the respondent to review and respond to petitioner's additional exhibit. Respondent's response to petitioner's exhibit was received timely and entered as Respondent Exhibit " 6 ". The record was closed on March 4, 2016.

## FINDINGS OF FACT

1. On January 12, 2016, petitioner submitted a FA and Medicaid redetermination application for her household. Household includes petitioner and five children; ages of the children at the time of application were, sixteen, eleven, eight, seven and five. Household income listed includes child support (CS) for each child and petitioner's
2. Also on January 12, 2016, the Department processed petitioner's application. And on January 13, 2016, the Department mailed petitioner a Notice of Case Action (NOCA), notifying FA benefits would decrease from \$527 to $\$ 264$ effective February 2016. And petitioner was enrolled in MN with an $\$ 849$ SOC.

FINAL ORDER (Cont.)
16F-00460 \& 16F-00461
PAGE-3
3. Petitioner is employed as $\square$ she submitted the following two paystubs. Both paystubs state, "Pay Rate: $\$ 17,979$ Annual Rate, $\$ 12.08$ hourly rate of pay and $\$ 6.04$ Premium Pay".

| DATE | GROSS AMOUNT | YTD GROSS AMOUNT |
| :--- | :---: | :---: |
| $12 / 18 / 2015$ | $\$ 782.69$ | $\$ 20,098.69$ |
| $12 / 31 / 2015$ | $\$ 741.91$ | $\$ 20,840.60$ |
| Total | $\$ 1,524.60$ |  |

4. At the hearing, petitioner submitted a letter from SCPS, dated February 1, 2016, that states:

5. The Department converted petitioner's biweekly income to monthly income by dividing $\$ 1,524.60$ by two weeks and multiplying by a conversion factor of 2.15 , to arrive at $\$ 1,638.95$.
6. Petitioner is paid weekly at she submitted the following four paystubs.

| DATE | GROSS AMOUNT |
| :--- | :---: |
| $12 / 17 / 2015$ | $\$ 18.25$ |
| $12 / 24 / 2015$ | $\$ 7.69$ |
| $12 / 31 / 2015$ | $\$ 53.61$ |
| $01 / 07 / 2016$ | $\$ 28.50$ |
| Total | $\$ 108.05$ |

7. The Department converted petitioner's weekly income to monthly income by dividing $\$ 108.05$ by 4 weeks and multiplying by a conversion factor of 4.3 , to arrive at $\$ 116.14$.
8. In February 2016, the Department reviewed petitioner's FA budget due to petitioner's hearing request. The Department determined the CS income they included in the FA budget was incorrect.

FINAL ORDER (Cont.)
16F-00460 \& 16F-00461
PAGE - 4
9. The Department verified that the sixteen year old child receives $\$ 227.08$ CS twice a month, totaling $\$ 454.16$ monthly. And the remaining four children receive $\$ 145.85$ weekly, totaling \$583.40 monthly.
10. The FA budget calculation is as follows:

| \$1,638.95 |  |
| :---: | :---: |
| +\$ 116.14 |  |
| \$1,755.09 | total earned income |
| +\$ 454.16 | CS |
| +\$ 583.40 | CS |
| \$1,037.56 | total unearned income |
| \$1,755.09 | earned income |
| +\$1,037.56 | unearned income |
| \$2,792.65 | total household income |
| -\$ 351.01 | 20\% earned income deduction (\$1,755.09X.20) |
| -\$ 226.00 | standard deduction |
| -\$ 365.52 | dependent care |
| \$1,850.12 | adjusted income |
| \$ 850.00 | shelter costs |
| +\$ 345.00 | standard utility allowance (SUA) |
| \$1,195.00 | shelter/utility costs |
| -\$ 925.06 | 50\% adjusted income (\$1,850.12/2) |
| \$ 269.94 | excess shelter/deduction |
| \$1,850.12 | adjusted income |
| -\$ 269.94 | excess shelter deduction |
| \$1,580.18 | adjusted income after deductions |
| \$1,580.18 X | 75 (round up) FA reduction |

11. The maximum FA benefit amount a household size of six can receive is $\$ 925$.

Subtracting \$475 from $\$ 925$ leaves $\$ 450$ monthly in FA.
12. On February 9, 2016, the Department mailed petitioner a NOCA, notifying she would receive an additional $\$ 186$ in FA for February 2016. Petitioner had already

FINAL ORDER (Cont.)
16F-00460 \& 16F-00461
PAGE - 5
received $\$ 264$ FA for February 2016; the additional $\$ 186$ FA totals $\$ 450$ FA for February 2016.
13. In August 2013 petitioner reported her employment at SCPS. As a result, petitioner's Medicaid was extended for 12 months; which should have ended in August 2014. The Department erred by continuing petitioner's Medicaid through January 2016. The next available Medicaid Program for the petitioner is MN with a SOC.
14. The following is the Department calculation of petitioner's SOC amount:

| $\$ 1,524.60$ |  |
| ---: | :--- |
| $+\$ 108.05$ |  |
| $\$ 1,632.65$ | total income |
| $\$ 783.00$ | MN income limit (MNIL) for a household size of six |
| $\$ 849.00$ | SOC (cents dropped) |

15. On February 9, 2016, the Department mailed the petitioner a NOCA, notifying she was enrolled in MN with an $\$ 849 \mathrm{SOC}$.
16. Petitioner claims that she is a contracter and earns \$17,979 yearly over a 10 month period; which total 26 paychecks. Petitioner asserts that SCPS "withholds some of her income through-out the year" and the withheld monies is given to her in her final check/checks. And she has to "maintain" that money to cover her expenses during the two months she is not paid. Petitioner alleges that in accordance with the Department's policy "held income" is not counted.
17. Petitioner believes $\$ 17,979$ should be divided by 12 months for her monthly income. Petitioner alleges the Department is incorrect in using her December paystubs to determine her monthly income; because she is not guaranteed additional income above $\$ 17,979$ yearly. Petitioner requested until the end of business day on February 26,2016 , to submit additional evidence to support her allegation.

FINAL ORDER (Cont.)
16F-00460 \& 16F-00461
PAGE-6
18. Respondent's representative responded that petitioner's December 31, 2015, paystub lists her YTD gross at $\$ 20,840.60$. Therefore, $\$ 17,979$ is petitioner's "base amount" and petitioner received an additional $\$ 2,861.60$.
19. The Hearing Officer agreed to leave the record until end of business day on February 26, 2016, for the petitioner to submit the additional evidence. And until March 4, 2016, for the respondent to respond to petitioner's additional evidence.
20. After the hearing, petitioner submitted "2015-16 Payroll Schedule" listing the 2015 and 2016 pay schedule.
21. After the hearing, respondent's representative submitted a letter from dated August 10, 2015, stating that petitioner receives "annual base rate...with an hourly rate of pay of $\$ 12.08$ ".
22. Respondent's representative also submitted a copy of $\square$ web site titled "Extra Overtime Worked For Contracted Hourly Employees". That in part states:

Employees who are asked to work additional hours beyond their originally contracted duty day shall be paid their pay grade hourly wage if they work forty (40) hours or less during a work week. When employees are directed or allowed to work overtime in addition to their regular hours, aggregating more than a maximum of forty (40) hours per week, they shall be compensated as follows:
The rate of time and one half ( $1-1 / 2$ ) of the normal rate shall be paid for all hours in pay status per week over the regular weekly task assignment aggregating more than a maximum of forty (40) hours per week...

## CONCLUSIONS OF LAW

## 23. The Department of Children and Families, Office of Appeal Hearings has

jurisdiction over the subject matter of this proceeding and the parties, pursuant to $\S 409.285$, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

FINAL ORDER (Cont.)
16F-00460 \& 16F-00461
PAGE - 7
24. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 652.056.

## FOOD ASSISTANCE ISSUE

25. Petitioner argued that she is a contracted employee and earns $\$ 17,979$
yearly, over a 10 month period; which total 26 paychecks. Petitioner argued that SCPS "withholds some of her income through-out the year" and the withheld monies is given to her in her final check/checks; which she has to "maintain" that money to cover her expenses during the two months she is not paid. And in accordance with the

Department's following policy "held income" is not counted.
26. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage
1810.0201 Wages Held by Employer (FS) states:

## Wages (even if illegally) held by the employer are not considered as income until the wages are received. (emphasis added)

 Exceptions:1. The assistance group (AG) anticipates an advance, or
2. The AG is expected to receive wages previously withheld that were not previously counted.
Advances on wages may count as income in the month received or may be averaged over the certification period in which received, if reasonably anticipated.
Example: A school employee has a base salary of $\$ 10.80$ hourly. The union policy states that the individual must receive paid vacation and holidays. The employer withholds part of the base salary (regular pay) to be paid at a future date when the individual is on vacation or holiday.
3. The above Policy Manual passage explains held wages are not considered as income until they are received.
4. Federal Regulation at 7 C.F.R § 273.9, defines income in the FA determination and in part states:
(b) Definition of income. Household income shall mean all income from whatever source...
(1) Earned income shall include: (i) All wages and salaries of an employee...
(2) Unearned income shall include, but not be limited to...
(iii) Support or alimony payments made directly to the household from nonhousehold members...
5. In accordance with the above Federal Regulation, "All wages and salaries of an employee" shall be included as earned income. And support payments (CS) shall be included as unearned income.
6. Federal Regulation at 7 C.F.R $\S 273.10$ further explains income and in part states:
(c) Determining income...
(ii) Wages held at the request of the employee shall be considered income to the household in the month the wages would otherwise have been paid by the employer. However, wages held by the employer as a general practice, even if in violation of law, shall not be counted as income to the household, unless the household anticipates that it will ask for and receive an advance, or that it will receive income from wages that were previously held by the employer as a general practice and that were, therefore, not previously counted as income by the State agency... (ii) Households which, by contract or self-employment, derive their annual income in a period of time shorter than 1 year shall have that income averaged over a 12-month period, provided the income from the contract is not received on an hourly (emphasis added) or piecework basis...
7. The above Federal Regulation explains wages held by an employer are considered income if not previously counted by the Department. And contracted employees shall have their income averaged over a 12-month period provided the income is not received on an hourly basis.
8. The two paystubs (dated December 18, 2015 and December 31, 2015) submitted by the petitioner show her "Pay Rate: \$17,979 Annual Rate, $\$ 12.08$ hourly rate of pay

FINAL ORDER (Cont.)
16F-00460 \& 16F-00461
PAGE-9
and $\$ 6.04$ Premium Pay". Petitioner's paystub dated December 31, 2015, indicates her YTD gross was $\$ 20,840.60$.
33. website, "Extra Overtime Worked For Contracted Hourly Employees" states employees that work "beyond their originally contracted duty day shall be paid their pay grade hourly wage if they work forty (40) hours or less during a work week" and "The rate of time and one half (1-1/2) of the normal rate shall be paid for all hours in pay status per week over the regular weekly task assignment aggregating more than a maximum of forty (40) hours per week..."
34. Petitioner's paystubs (\#3) confirm website; petitioner was paid $\$ 12.08$ hourly rate of pay and $\$ 6.04$ Premium Pay.
35. Federal Regulation at 7 C.F.R § 273.10 explains income conversion in the FA calculation and in part states:
(c) Determining income-(1) Anticipating income...
(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...
36. In accordance with the above Federal Regulation, the Department converted petitioner's biweekly income fron to monthly income using a 2.15 conversion factor and petitioner's weekly income from monthly income using a 4.3 conversion factor.
37. Federal Regulation at 7 C.F.R § 273.9, defines allowable deductions in the FA determination and in part states:

FINAL ORDER (Cont.)
16F-00460 \& 16F-00461
PAGE - 10
(d) Income deductions. Deductions shall be allowed only for the following household expenses:
(1) Standard deduction...
(2) Earned income deduction. Twenty percent of gross earned income as defined in paragraph (b) (1) of this section...
(4) Dependent care. Payments for the actual costs for the care of children or other dependents when necessary for a household member to accept or continue employment, comply with the employment and training requirements...
(6) Shelter costs...
(ii) Excess shelter deduction. Monthly shelter expenses in excess of 50 percent of the household's income after all other deductions...
(C) The cost of fuel for heating; cooling (i.e., the operation of air conditioning systems or room air conditioners); electricity or fuel used for purposes other than heating or cooling; water; sewerage; well installation and maintenance; septic tank system installation and maintenance; garbage and trash collection; all service fees required to provide service for one telephone
(iii) Standard utility allowances...Only utility costs identified in paragraph (d)(6)(ii)(C) of this section must be used in developing standards...
38. The Department's Policy Manual at Appendix A-1, set forth for a household size of six the following:
\$925 maximum FA benefit
\$226 standard deduction
\$345 standard utility allowance
39. Federal Regulations at 7 C.F.R. § 273.10, explains income and deduction calculations:
(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...
(B) Multiply the total gross monthly earned income by 20 percent and subtract that amount from the total gross income...
(C) Subtract the standard deduction...
(E) Subtract allowable monthly dependent care expenses...
(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...
40. The cited authorities sets forth income and allowable deductions in the FA benefit
determination. In accordance with the authority, respondent subtracted allowable deductions (20\% earned income deduction, standard deduction, dependent care, shelter and utilities) in the FA calculations.

## MEDICALLY NEEDY ISSUE

41. 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...
(f) Household...
(2) Basic rule for individuals claimed as a tax dependent. In the case of an individual who expects to be claimed as a tax dependent by another taxpayer for the taxable year in which an initial determination or renewal of eligibility is being made, the household is the household of the taxpayer claiming such individual as a tax dependent...
42. The above Federal Regulation explains that the petitioner and her five children are included in petitioner's Medicaid eligibility.
43. 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:

FINAL ORDER (Cont.)
16F-00460 \& 16F-00461
PAGE - 12
(a) Income. Income is earned or non-earned...
44. Fla. Admin. Code R. 65A-1.716 Income and Resource Criteria explains:
(2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows:

Family Size 6

Income Level \$487
45. The above authority explains for petitioner to be eligible for Family-Related Medicaid, the income for a household size of six cannot exceed $\$ 487$ monthly. Petitioner's $\$ 1,632.65$ income from $\quad$ exceeds $\$ 487$; therefore, petitioner is not eligible for full Medicaid. The next available Program is MN with a SOC.
46. 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...
47. The above authority explains the SOC is determined by subtracting the income level (MNIL) from the gross income.
48. Policy Manual at Appendix A-7 sets forth the MNIL at $\$ 783$ for a household size of six.
49. In accordance with the above authorities, the Department calculated petitioner's SOC by including her income from (\$108.05) and $(\$ 1,524.60)$ and then subtracted $\$ 783$ (MNIL) to arrive at $\$ 849$.

## HEARING OFFICER'S CONCLUSION

50. In careful review of the cited authorities and evidence presented, the undersigned agrees with the respondent's action to include petitioner's December 2015 paychecks in

FINAL ORDER (Cont.)
16F-00460 \& 16F-00461
PAGE -13
the FA calculations. The undersigned agrees with the respondent's FA income and deduction calculation to arrive at $\$ 450$ in FA monthly benefits.
51. The undersigned also agrees with the respondent's action to enroll petitioner in the

MN Program. And the respondent's income and deduction calculation to arrive at \$849
SOC for the petitioner.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are denied and the respondent's actions are affirmed.

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this $\qquad$ 16 day of March , 2016,
in Tallahassee, Florida.

Ruiscilla Peterson
Priscilla Peterson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myfffamilies.com

Copies Furnished To: Petitioner
Office of Economic Self Sufficiency

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

PETITIONER,
Vs.

## FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES

CIRCUIT: 20 Lee
UNIT: 88287

## RESPONDENT.

FINAL ORDER (Cont.)
16F-00481
PAGE - 2
more than 90 days after the notice. This motion was denied as it was discovered that the Notice of Case Action (NOCA) was not sent to the authorized representative. Fla Admin Code 65-2.046 "Time Limits in Which to Request a Hearing" states in part "the time limitation does not apply when the Department fails to send a required notification..."

The Department submitted evidence prior to the hearing. The undersigned neglected to enter such into the record. An Order to Reconvene Hearing was issued for March 10, 2016 at 8:30 a.m. CST. At that time the record was reopened with the same parties present. The packet of information submitted by the Department was entered into evidence as Respondent's Exhibits " 1 " through " 9 ".

The undersigned took administrative notice of three pages of the Department's Policy Manual CFOP $165-22$ at section 0440.0500 through 0440.0610 and it is now labeled it as Respondent's Exhibit "10".

## FINDINGS OF FACT

1. Petitioner is 24 -years-old and has no minor children living with her.
2. Petitioner was hospitalized April 23 through May 5, 2015 and diagnosed with code 11-3450.
3. Petitioner applied for SSI-Related Medicaid on April 30, 2015 with the Department of Children and Families (DCF). A packet was forwarded to the Division of Disability Determination (DDD) on May 7, 2015.
4. DDD's response was received by the Department May 26, 2015. The petitioner was determined disabled effective May 1, 2015. Retro months were denied as "Retro not possible. Traumatic onset."

FINAL ORDER (Cont.)
16F-00481
PAGE - 3
5. Petitioner also applied for Medicaid with the Department as a disabled adult on June 16, 2015.
6. On June 24, 2015 a NOCA was mailed to petitioner, but not also to the authorized representative, stating that Medicaid eligibility was approved effective May 1, 2015 ongoing, while retro months of March and April 2015 were denied.
7. Petitioner applied for Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) benefits on May 1, 2015.
8. The Social Security Administration (SSA) determined petitioner did not meet the disability criteria and denied the SSI and SSDI applications on July 10, 2015.

Subsequent to this decision, the petitioner has returned to substantial gainful activity. 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. 652.056.
11. Federal Medicaid Regulations at 42 C.F.R. § 435.541 "Determinations of disability" states in part:

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 $\S 435.912$ 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.
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:
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.
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.
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.
The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, andAlleges 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.

FINAL ORDER (Cont.)
16F-00481
PAGE -5
(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-
Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.
12. The findings show that petitioner applied for Medicaid with DCF on April 30, 2015 and again on June 16, 2015. Petitioner was determined by DDD to be disabled effective May 1, 2015; however, in the same decision eligibility for the month of April 2015 denied.
13. The SSA application of May 1, 2015 was denied July 10, 2015 as SSA concluded petitioner did not meet the standards set to be determined disabled.
14. The petitioner has returned to work and is participating in substantial gainful activity.
15. Petitioner's question of the DDD determination as to why/how the month of May was determined a month of disability and April not (as the petitioner was hospitalized in both months for the same reason) is made moot by the determination of non-disability made by SSA. As stated in the above controlling authority, "An SSA disability determination is binding on an agency until the determination is changed by SSA." The Department is bound to accept the decision of SSA, to review the Department's decision denying eligibility is without efficacy. Therefore, the undersigned concludes the Departments determination of ineligibility for Medicaid for April 2015 correct.
16. Fla. Admin Code 65A-1.711 "SSI-Related Medicaid Non-Financial Eligibility Criteria" states in part:

FINAL ORDER (Cont.)
16F-00481
PAGE -6
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 reference ... (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).
17. According to the above controlling Medicaid authority, an individual must be age 65 or older, or disabled (by either the Department of SSA), to meet the technical criteria for Medicaid in the SSI-Related Medicaid Programs. Because petitioner has been determined non-disabled by SSA and the Department, she does not meet the technical criteria to be eligible for SSI-Related Medicaid. Therefore, the Department correctly denied the request for Medicaid at issue.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied. This decision does not affect the months of Medicaid eligibility granted by the DDD decision prior to the SSA determination of non-disability, or the benefits of Medicaid eligibility received thereof. The Department is reminded not to seek overissuance or over-payment of said benefits.

## NOTICE OF RIGHT TO APPEAL

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

FINAL ORDER (Cont.)
16F-00481
PAGE -7
DONE and ORDERED this 16 day of March 2016, in Tallahassee, Florida.


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

Copies Furnished Tc Petitioner
Santos Melendez, Authorized Representative Office of Economic Self Sufficiency

Apr 12, 2016

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

Office of Appeal Hearings
Dept. of Children and Families

APPEAL NO. 16F-00492
PETITIONER,
Vs.
CASE NO.
AGENCY FOR HEALTH CARE ADMINISTRATION CIRCUIT: 13 Hillsborough
UNIT: AHCA

RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on March 8, 2016, at 2:45 p.m.

## APPEARANCES

For the Petitioner:

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

## STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the Agency for Health Care Administration incorrectly denied her request for

Pharm. D., Clinical Pharmacist at Quality Specialty Pharmacy, appeared as a witness on behalf of the petitioner. $\quad$ 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: Susan Frishman, Senior Compliance Analyst with United Healthcare; Deborah Smith, Pharm. D., Director of Pharmacy at United Healthcare; and Marc Kaprow, D.O., Executive Director of Long-Term Care at United Healthcare.

The respondent introduced Exhibits " 1 " through " 8 ", inclusive, at the hearing. The petitioner did not introduce any exhibits.

The hearing officer took administrative notice of the following: Florida Statutes 409.910; 409.962; 409.963; 409.964; 409.965; 409.973; 409.912; 409.91195; Florida Administrative Code Rules 59G-1.001; 59G-1.010; 59G-4.255; 59G-4.250; the Florida Medicaid Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook; and the Florida Medicaid Preferred Drug List.

## 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:

FINAL ORDER (Cont.)
16F-00492
PAGE - 3

1. Petitioner is an adult female.
2. Petitioner was eligible to receive Medicaid services at all times relevant to this proceeding.
3. Petitioner is an enrolled member of United Healthcare. United Healthcare is a health maintenance organization ("HMO") contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in Florida.
4. Petitioner's effective date of enrollment with United Healthcare Community Plan was February 1, 2015.
5. $\square$ are prescription medications used to treat and potentially cure The two drugs are taken simultaneously.
6. On September 28, 2015, petitioner's doctor submitted a prior authorization request to United Healthcare for $\square$
7. In a Notice of Action to the petitioner dated September 28, 2015, United Healthcare denied the petitioner's request for The Notice [Resp. Exhibit 4] 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 below: (See Rule 59G-1.010)

The request does not meet your health plan's rules for medical necessity.
The facts that we used to make our decision:

FINAL ORDER (Cont.)
16F-00492
PAGE - 4
8. United Healthcare also sent a Notice of Action dated September 28, 2015
to the petitioner's doctor denying the petitioner's request for $\square$ The Notice
[Resp. Exhibit 4] states, in part:
The facts that we used to make our decision:

9. In a Notice of Action to the petitioner dated September 28, 2015, United Healthcare denied the petitioner's request for Viekira Pak. The Notice [Resp. Exhibit 4] 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 below: (See Rule 59G-1.010)

10. United Healthcare also sent a Notice of Action dated September 28, 2015 to the petitioner's doctor denying the petitioner's request for $\quad$ The $\underline{\text { Notice }}$ [Resp. Exhibit 4] states, in part:

The facts that we used to make our decision:

11. The petitioner requested an internal reconsideration of the health plan's decision to deny on October 12, 2015.
12. On October 14, 2015, United Healthcare upheld its decision to deny the two medications on reconsideration and sent an appeal resolution letter to petitioner.
 contracts with the State of Florida to provide managed care to Medicaid recipients must use the Agency for Health Care Administration Preferred Drug List ("PDL").
16. The Preferred Drug List includes specific requirements for the approval of certain drugs, including

17. The State of Florida and United Healthcare criteria for the approval of

Ribavirin and Viekira Pak include a requirement that the patient has

18. The presence of
19.

## CONCLUSIONS OF LAW

20. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80, Fla. Stat.
21. This is a final order pursuant to $\S 120.569$ and $\S 120.57$, Fla. Stat.
22. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
23. In the present case, the petitioner is requesting a new service. Therefore, in accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof is assigned to the petitioner.
24. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, $7^{\text {th }}$ Ed.).
25. The Florida Medicaid program is authorized by Chapter 409, Fla. Stat. and Chapter 59G, Fla. Admin. Code. The Medicaid program is administered by respondent.
26. 42 C.F.R. § 438.210 Coverage and authorization of services addresses the contractual requirements of agreements between states and managed care organizations and explains as follows:
(b) Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must require-
(3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

FINAL ORDER (Cont.)
16F-00492
PAGE-7
27. In accordance with 42 C.F.R. § 438.210, the decision to deny the service authorization request in the instant matter was made by a health care professional.
28. The Florida Medicaid Provider General Handbook - July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Rule 59G-5.020. 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.
29. Page 1-22 of the Florida Medicaid Provider General Handbook provides a list of Medicaid covered services. These services include prescribed drug services.
30. Page 1-28 of the Florida Medicaid Provider General Handbook provides a list of HMO covered services. These services include prescribed drug services.
31. 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-forservice."
32. The criteria used by United Healthcare to assess eligibility Viekira Pak and Ribavirin are identical to those used by the Agency for Health Care Administration.

FINAL ORDER (Cont.)
16F-00492
PAGE - 8
33. Fla. Admin. Code R. 59G-4.250 Prescribed Drug Services incorporates by reference the Florida Medicaid Prescribed Drug Services Coverage, Limitations, and Reimbursement Handbook, updated July 2014.
34. Fla. Admin. Code R. 59G-1.010(166) explains that medical or allied care, goods, or services furnished or ordered must meet the definition of medically necessary or medical necessity, and defines medical necessity as:
(a) "Medical necessary" or "medical necessity" means that medical or allied care, goods or services furnished or ordered must meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patent's needs;
3. Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational;
4. Be reflective of the level of service that can safely be furnished, for which no equally effective and more conservative or less costly treatment is available statewide; and,
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. . .
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods or services medically necessary, or a medical necessity, or a covered service.
6. Section 409.912 (8)(a), Florida Statutes states, in relevant parts:
7. 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.

FINAL ORDER (Cont.)
16F-00492
PAGE - 9
The agency may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug....
36. The Agency for Health Care Administration prior authorization criteria for are the same as
those of United Healthcare. They require, among other things:


Accordingly, she does not meet the Florida Medicaid requirements for the approval of
38. The United Healthcare prior authorization guidelines for the approval of

also not approved.
39. Pursuant to the above, the petitioner has not met her burden of proof to demonstrate the Agency incorrectly denied her request for

## 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 12 day of April 2016,
in Tallahassee, Florida.


Peter J. Tsamis
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myfffamilies.com
Copies Furnished To: Petitioner
vomruner, area 6, AHCA Field Office Manager

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

APPEAL NO. 16F-00493
PETITIONER,
Vs.
CASE NO.
AGENCY FOR HEALTH CARE ADMINISTRATION CIRCUIT: 13 Hillsborough
UNIT: AHCA

RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on March 8, 2016, at 4: 30 p.m.

APPEARANCES
For the Petitioner:

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

## STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the Agency for Health Care Administration incorrectly denied her request for $\square$

## PRELIMINARY STATEMENT



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: Susan Frishman, Senior Compliance Analyst with United Healthcare; Deborah Smith, Pharm. D., Director of Pharmacy at United Healthcare; and Marc Kaprow, D.O., Executive Director of Long-Term Care at United Healthcare.

The respondent introduced Exhibits "1" through " 14 ", inclusive, at the hearing. The petitioner did not introduce any exhibits.

The hearing officer took administrative notice of the following: Florida Statutes 409.910; 409.962; 409.963; 409.964; 409.965; 409.973; 409.912; 409.91195; Florida Administrative Code Rules 59G-1.001; 59G-1.010; 59G-4.255; 59G-4.250; the Florida Medicaid Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook; and the Florida Medicaid Preferred Drug List.

## 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:

FINAL ORDER (Cont.)
16F-00493
PAGE - 3

1. Petitioner is an adult female.
2. Petitioner was eligible to receive Medicaid services at all times relevant to this proceeding.
3. Petitioner is an enrolled member of United Healthcare. United Healthcare is a health maintenance organization ("HMO") contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in Florida.
4. Petitioner's effective date of enrollment with United Healthcare Community Plan was August 1, 2015.

C. The two drugs are taken simultaneously.
5. On November 11, 2015, petitioner's doctor submitted a prior authorization request to United Healthcare for
6. In a Notice of Action to the petitioner dated November 12, 2015, United Healthcare denied the petitioner's request for The Notice 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 below: (See Rule 59G-1.010)

The request does not meet your health plan's rules for medical necessity.
The facts that we used to make our decision:

FINAL ORDER (Cont.)
16F-00493
PAGE - 4
8. United Healthcare also sent a Notice of Action dated November 12, 2015 to the petitioner's doctor denying the petitioner's request for $\square$ The Notice states, in part:

9. In a Notice of Action to the petitioner dated November 12, 2015, United Healthcare denied the petitioner's request for The Notice 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 below: (See Rule 59G-1.010)

The request does not meet your health plan's rules for medical necessity.
The facts that we used to make our decision:

10. United Healthcare also sent a Notice of Action dated November 12, 2015 to the petitioner's doctor denying the petitioner's request for $\square$ The Notice states, in part:

The facts that we used to make our decision:

11. The petitioner requested an internal reconsideration of the health plan's decision to deny and Sovaldi on December 7, 2015.
12. On December 10, 2015, United Healthcare upheld its decision to deny the two medications on reconsideration and sent an appeal resolution letter to petitioner.
13. Petitioner has
14.


15. All of the health plans who have Managed Medical Assistance ("MMA") contracts with the State of Florida to provide managed care to Medicaid recipients must provide all prescription drugs listed in the Agency for Health Care Administration Preferred Drug List ("PDL"). Coverage and limitations for PDL drugs may be no more restrictive than those posted on the Agency website.
16. The Medicaid Preferred Drug List (PDL) lists the drugs available for coverage under Medicaid. Drugs that are not on the PDL require prior authorization. The Agency created guidelines showing the criteria necessary to obtain those non-PDL drugs. The Agency may add or remove drugs from the PDL and the plans are required to enforce the criteria the Agency sets forth.
17. The State of Florida and United Healthcare criteria for the approval of


## CONCLUSIONS OF LAW

20. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80, Fla. Stat.
21. This is a final order pursuant to $\S 120.569$ and $\S 120.57$, Fla. Stat.
22. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
23. In the present case, the petitioner is requesting a new service. Therefore, in accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof is assigned to the petitioner.
24. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, $7^{\text {th }}$ Ed.).
25. The Florida Medicaid program is authorized by Chapter 409, Fla. Stat. and Chapter 59G, Fla. Admin. Code. The Medicaid program is administered by respondent.

FINAL ORDER (Cont.)
16F-00493
PAGE-7
26. 42 C.F.R. § 438.210 Coverage and authorization of services addresses the contractual requirements of agreements between states and managed care organizations and explains as follows:
(b) Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must require-
(3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.
27. In accordance with 42 C.F.R. § 438.210, the decision to deny the service authorization request in the instant matter was made by a health care professional.
28. The Florida Medicaid Provider General Handbook - July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Rule 59G-5.020. 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.
29. Page 1-22 of the Florida Medicaid Provider General Handbook provides a list of Medicaid covered services. These services include prescribed drug services.
30. Page 1-28 of the Florida Medicaid Provider General Handbook provides a list of HMO covered services. These services include prescribed drug services.

FINAL ORDER (Cont.)
16F-00493
PAGE - 8
31. 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-forservice."
32. The criteria used by United Healthcare to assess eligibility for and are identical to those used by the Agency for Health Care Administration.
33. Fla. Admin. Code R. 59G-4.250 Prescribed Drug Services incorporates by reference the Florida Medicaid Prescribed Drug Services Coverage, Limitations, and Reimbursement Handbook, updated July 2014.
34. Fla. Admin. Code R. 59G-1.010(166) explains that medical or allied care, goods, or services furnished or ordered must meet the definition of medically necessary or medical necessity, and defines medical necessity as:
(a) "Medical necessary" or "medical necessity" means that medical or allied care, goods or services furnished or ordered must meet the following conditions:

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

FINAL ORDER (Cont.)
16F-00493
PAGE - 9
35. Section 409.912 (8)(a), Florida Statutes states, in relevant parts:
14. The agency may require prior authorization for Medicaid-covered prescribed drugs. The agency may prior-authorize the use of a product:
a. For an indication not approved in labeling;
b. To comply with certain clinical guidelines; or
c. If the product has the potential for overuse, misuse, or abuse.

The agency may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug....
36. The Prescribed Drug Services Coverage, Limitations, and Reimbursement

Handbook, on Page 2-2, states:
To be reimbursed by Medicaid, a drug must be medically necessary and either (a) prescribed for medically accepted indications and dosages found in the drug labeling or drug compendia in accordance with Section 1927(k)(6) of the Social Security Act, or (b) prior authorized by a qualified clinical specialist approved by the Agency. Notwithstanding this rule, the Agency may exclude or otherwise restrict coverage of a drug in accordance with Section 1927 of the Social Security Act.
37. The Prescribed Drug Services Coverage, Limitations, and Reimbursement

Handbook, on Page 2-11, explains:
In order to be reimbursed by Medicaid, providers must obtain prior authorization before dispensing certain drugs.

Prior authorization from Medicaid is required prior to reimbursement in the following situations:

1. The drug is not on the Preferred Drug List.
2. Clinical Prior Authorization is required for specific drugs a) For an indication not approved in labeling; b) To comply with certain clinical guidelines; or c) If the product has the potential for overuse, misuse, or abuse. The Agency may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug. A current list of drugs for which clinical prior authorization is required, and clinical prior authorization forms, may be found on the webpage at www.ahca.myflorida.com/Medicaid/Prescribed Drug . ${ }^{1}$
[^10]FINAL ORDER (Cont.)
16F-00493
PAGE - 10
3. If a prescriber hand writes "brand medically necessary" on the face of a prescription when a generic is available with a state or federal pricing limit.
38. The Agency for Health Care Administration prior authorization criteria for $\square$ and for the treatment of $\square$ are the same as those of

United Healthcare. They require, among other things:

40. Pursuant to the above, the petitioner has not met her burden of proof to demonstrate the Agency incorrectly denied her request for $\square$

## 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

FINAL ORDER (Cont.)
16F-00493
PAGE-11
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 April 2016, in Tallahassee, Florida.


Peter J. Tsamis
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To:

STATE OF FLORIDA


APPEAL NO. 16F-00495
PETITIONER,
Vs.

```
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 22, 2016 at 10:17 a.m.


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

## STATEMENT OF ISSUE

At issue is the Agency's action in denying the Petitioner's prescription requests for $\square$ and $\square$ Because the matter at issue is a request for service, the burden of proof is assigned to the Petitioner.

## PRELIMINARY STATEMENT

From Staywell Managed Medical Assistance (MMA), Stephanie Shupe, Regulatory Research Coordinator; Lauren Barnes, Manager for Pharmacy Operations; and Lisa Hogan, Clinical Pharmacist and Senior Manager for Medication Appeals Department, appeared as witnesses for the Respondent.

The Respondent submitted eight documents which were entered into evidence and marked Respondent Exhibits 1 to 8.

While Respondent denied a request for Viekira Pak, Petitioner is not appealing this decision because he is unable to use this medication because his disease has progressed to decompensated (showing symptoms) liver disease.

## FINDINGS OF FACT

1. The Petitioner is a 57 year-old Medicaid recipient who enrolled with the managed care provider Staywell effective October 1, 2015 and is a current active member.
2. On November 6, 2015, Staywell (Plan) received a Drug Evaluation Review for On November 6, 2015, the Plan denied coverage for is not on Medicaid's preferred drug list and no documentation of a previous trial and failure of $\square$ Pak was provided.
3. On November 13, 2015, the Plan received a Coverage Determination Request
for
4. On November 13, 2015, the Plan denied Petitioner's request for

FINAL ORDER
16F-00495
Page 3 of 9
5. On November 13, 2015, the Plan also received a Coverage Determination


The Plan denied this request
because it is a concomitant therapy with which had been previously denied.
6. On December 1, 2015, the Plan received a request to authorize

On December 3, 2015, the Plan denied coverage for the medication is concomitant therapy with which was previously denied.
7. Petitioner filed a timely request for a fair hearing on January 14, 2016.
8. Because is not a viable option for the Petitioner due to his decompensated condition, his representative noted that $\square$ along with $\square$ is indicated for decompensated patients. She stated that use of would not only be therapeutic but also mitigate other complications the Petitioner is experiencing.
9. While is not on Medicaid's preferred drug list, Medicaid's prior authorization criteria (see Respondent Exhibit 6) also indicates one of the denial criteria as (defined as a Child-Pugh score greater than 6 [class B or C]. The reason provided is safety and efficacy of Harvoni have not been established in patients with decompensated cirrhosis.
10. Petitioner did not submit a Child-Pugh score with his request fol
11. A letter faxed from Petitioner's doctor to the Plan on December 1, 2015 in


Clinical studies suggest effective and safe...

After providing the results of studies, the letter further notes:

FINAL ORDER
16F-00495
Page 4 of 9

12. Respondent explained, as stated in the Notices of Action, Petitioner's requests for were denied based on Florida Medicaid's criteria for these medications. Petitioner was denied for $\square$ because the criteria specifies patient be without decompensated liver disease. Request for $\square$ was denied because the medication is concomitant therapy with which was previously denied. Denial of the was not disputed by the Petitioner because it is contraindicated for him based on his decompensated condition.

## CONCLUSIONS OF LAW

13. 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.
14. This is a final order pursuant to $\S 120.569$ and $\S 120.57$, Fla. Stat. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
15. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence.
16. 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.
17. 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:
18. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
19. 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;
20. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
21. 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;
22. 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...
23. AHCA's Prescribed Drug Coverage, Limitations, and Reimbursement Handbook-

July 2014 (Handbook) is incorporated in Florida Administrative Code Rule 59G-4.250
and states the following on page 1-4:
HMO prescribed drug services are defined the same as for the Medicaid fee-for-service program and include all legend drug products covered by fee-for-service Medicaid as defined in Chapter 2 of this handbook, Legend Drugs. Medicaid's contract with HMOs states that Medicaid HMOs may use prior authorization and/or step therapy to encourage compliance with the preferred drug list.
A Medicaid HMO is required to cover any product that is required to be covered under the fee-for-service Medicaid program as specified in section 1927 of Title XIX of the Social Security Act. If a product meets the definition of a covered service under that section there must be a provision to make it available through the HMO and through fee-for-service.
19. On page 2-4 of the Handbook, the Preferred Drug List is explained under
covered services, 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 in selected therapeutic classes will be presented to the P \& T Committee with their relevant clinical efficacy and relative net cost positions. The P \& T Committee will recommend the most cost effective drugs in each therapeutic category to AHCA for consideration for inclusion on the PDL. A minimum of two products per therapeutic class, if available, will be recommended. 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. Please see the following section of this handbook for explanation of the prior authorization process for non-PDL products.
Non-PDL drugs may be approved for reimbursement upon prior authorization. A step-therapy process that requires initial use of PDL products before authorization of non-PDL products will then permit prior authorization (PA) for non-listed drugs. Oral contraceptives and HIVIAIDSrelated anti-retroviral products are covered, and are exempt from PDL requirements. Mental health drugs are not exempt from PDL requirements. Nursing home residents and waiver program participants are not exempt from PDL requirements.
[emphasis added]
20. On page 2-12 of the Handbook, How Non-PDL Requests are Processed states:

Medications on the Preferred Drug List must have been tried within the twelve months prior to the request for a non-PDL alternative product. Certain step-therapy prior authorization protocols require the prescriber to use medications in a similar drug class or for a similar medical indication unless contraindicated in the federal Food and Drug Administration labeling. Reimbursement for a drug product may be approved without meeting the step-therapy prior authorization criteria if the prescribing physician provides written medical or clinical documentation that the product is medically necessary because:

- There is not an acceptable clinical alternative on the PDL to treat the disease or medical condition; or
- The PDL alternatives have been ineffective in the treatment of the recipient; or
- The number of doses has been ineffective, or based on historic evidence and known characteristics of the patient the PDL drug is likely to be ineffective.

21. Florida Medicaid's criteria can be found at the website: http://www.fdhc.state.fl.us/Medicaid/Prescribed_Drug/drug_criteria_pdf/Harvoni_Criteria .pdf
22. The criteria was recently updated on February 24, 2016. is not on the
 is. Florida Medicaid's criteria continues to require the member to be without Respondent's denial of the was not disputed by the Petitioner because it is contraindicated for him based on his decompensated condition.
23. The Petitioner's doctor explained in his December 1, 2015 letter that

24. While Florida Medicaid's $\square$ criteria continues to require the member to be
 to the Petitioner and $\quad$ in conjunction with
will enhance the Petitioner's outcomes. Florida Medicaid's $\quad$ guidelines do not address the use of $\square$ in conjunction with $\square$ for those with decompensated liver disease.

FINAL ORDER
16F-00495
Page 8 of 9
25. After considering the Petitioner's testimony, the letter from the Petitioner's doctor, and all of the appropriate authorities set forth in the findings above, the undersigned finds the Petitioner's evidence and documentation from his doctor sufficient to support the approval and medical necessity of $\square$ Petitioner's use of $\square$ in conjunction with low doses ol for members with $\square$ is not addressed in the Harvoni criteria established by Florida Medicaid. It should be noted the PDL alternative suggested by Respondent, $\square$ was also denied by Respondent because it is contraindicated for petitioner based on his decompensated condition, specifically his $\square$ Based on the evidence presented, there appears to be no acceptable clinical alternative on the PDL to treat the disease or medical condition. Therefore, the petitioner's burden is considered met.

## DECISION

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

FINAL ORDER
16F-00495
Page 9 of 9
DONE and ORDERED this $\qquad$ day of April , 2016, in Tallahassee, Florida.


Warren Hunter
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myfffamilies.com

Copies Furnished To: $\begin{aligned} & \text { Petitioner } \\ & \text { Don Fuller, Area 6, AHCA Field Office Manager }\end{aligned}$

Mar 15, 2016
STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES OFFICE OF APPEAL HEARINGS

## APPEAL NO. 16F-00539

16F-00540
16F-00541
PETITIONER,
Vs.
FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 Brevard
UNIT: 88222

## CASE NO.

## RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 10:45 a.m. on February 15, 2016. The hearing was reconvened at 9:10 a.m. on February 25, 2016.

## APPEARANCES

For the Petitioner:

For the Respondent:


Stan Jones, ACCESS
Economic Self-Sufficiency Specialist II Susan Martin, ACCESS
Operations Management Consultant

## STATEMENT OF ISSUE

Petitioner's issues are: 1) denial of Medicaid Qualifying Individual 1 (Q11)
2) termination of Food Assistance (FA) and 3) Medically Needy (MN) ineligibility for his wife. The respondent carries the burden of proof by the preponderance of evidence.

FINAL ORDER (Cont.)
16F-00539, 15F-00540 \& 16F-00541
PAGE - 2

## PRELIMINARY STATEMENT

By notice dated January 13, 2016, the respondent (or the Department) notified the petitioner Medicaid Q11 was denied. Also by notice, dated January 14, 2016, the respondent notified petitioner his FA benefits would end on January 31, 2016; his wife was ineligible for MN and petitioner was enrolled in MN with a $\$ 1,286$ Share of Cost (SOC), effective December 2015. Petitioner timely requested a hearing to challenge denial of Medicaid Q11, termination of FA and ineligibility of MN for his wife.

Stan Jones represented the Department at the February 15, 2016 hearing. Gregory Watson, Hearing Officer, appeared as an observer at the February 15, 2016 hearing. Susan Martin represented the Department at the February 25, 2016 hearing.

Petitioner did not submit exhibits. Respondent submitted five exhibits, entered as Respondent Exhibits " 1 " through " 5 ". The record was closed on February 25, 2016.

## FINDINGS OF FACT

1. Prior to the action under appeal, petitioner submitted a Buy-In Application on September 28, 2015, for himself. The application lists $\$ 1,547$ income from Social Security for the petitioner and lists petitioner's wife with no income.
2. On October 1, 2015, the Department denied petitioner's September 28, 2015 application. And on December 16, 2015, the Department agreed to reprocess petitioner's September 28, 2015 Buy-In Application.
3. On January 13, 2016, the respondent mailed petitioner a Notice of Application Disposition, denying Medicaid Q11; reason "Customer income of $\$ 1,547$ is greater than the income limit of $\$ 1,325$ for the Q11 program."

FINAL ORDER (Cont.)
16F-00539, 15F-00540 \& 16F-00541
PAGE - 3
4. Petitioner argued that he is eligible for Q11 because the income limit for a couple is $\$ 1,793$ and his $\$ 1,547$ income is less than $\$ 1,793$.
5. Respondent's representative agreed that petitioner is eligible for QI1 and agreed to approve petitioner QI1, back to the September 28, 2015 application.
6. The Department's computer is having technical difficulties approving QI1. The respondent's representative will refer the problem to its Technical Department. Once the issue is resolved, the Department will mail petitioner a Notice of Case Action (NOCA) approving Ql1, effective with petitioner's September 28, 2015 application. 7. Petitioner was satisfied with the Department's action to approve QI1, back to his September 28, 2015 application.
8. Petitioner's last FA application (for himself) was in July 2015, his FA certification period was from August 2015 through January 2016.
9. On January 14, 2016, the Department mailed the petitioner a NOCA, notifying his FA would end on January 2016; his wife was ineligible for MN and he was enrolled in MN with a $\$ 1,286$ SOC.
10. Prior to petitioner's September 28, 2015 Buy-In Application, petitioner received FA in his own case and his wife received FA in a different case. Petitioner and his wife were married on July 4, 2015.
11. The Department included petitioner's wife in petitioner's FA case, effective in October 2015; due to the petitioner listing his wife on the September 28, 2015 Buy-In Application. Petitioner and his wife are eligible for $\$ 60$ monthly in FA benefits.
12. On February 23, 2016, the Department issued FA auxiliaries in the amounts of $\$ 44$ for October 2015 through January 2016 and \$31 for February 2016 and March 2016.

FINAL ORDER (Cont.)
16F-00539, 15F-00540 \& 16F-00541
PAGE-4
13. Petitioner had already received $\$ 16$ FA for October 2015 through January 2016, the additional \$44 monthly totals \$60. Petitioner also received \$29 FA for February 2016 and March 2016; the additional $\$ 31$ totals $\$ 60$.
14. Petitioner was satisfied with the Department's additional FA approval.
15. Respondent's representative stated that because petitioner's wife previously received SSI the Department is including and approving her in the MN Program.
16. During the hearing, the respondent's representative included petitioner's wife in the MN Program with the petitioner; SOC for both petitioner and his wife is $\$ 1,181$.
17. Petitioner was satisfied with the Department's action to include his wife in the MN Program with $\$ 1,181$ SOC for both.
18. Petitioner did not dispute the Department's deductions or calculations used in the QI1, FA or MN benefit determination.

## 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 $\S 409.285$, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under $\S 409.285$, Fla. Stat.
20. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 652.056.
21. The evidence submitted established that petitioner is eligible for Medicaid Q11. The respondent's representative agreed to authorize petitioner Q11 back to his September 28, 2015, date of application. The Department is to mail petitioner a NOCA notifying of Q11 approval.

FINAL ORDER (Cont.)
16F-00539, 15F-00540 \& 16F-00541
PAGE - 5
22. The evidence submitted also established that the Department approved petitioner and his wife additional FA; \$44 for October 2015 through January 2016 and $\$ 31$ for February 2016 and March 2016.
23. During the hearing, the respondent's representative approved petitioner's wife in the MN Program, with a $\$ 1,181$ SOC for both the petitioner and his wife. The Department is to mail petitioner a NOCA notifying of MN with a $\$ 1,181$ SOC approval for petitioner and his wife.
24. Petitioner was satisfied with the Department's approval of: 1) Medicaid QI1, back to the September 28, 2015, date of application, 2) the additional FA benefits and 3) MN for his wife, with a $\$ 1,181$ SOC for himself and his wife.
25. This Final Order provides written confirmation of the agreement reached between the respondent and the petitioner.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are granted in accordance with 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 indigence 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 $\qquad$ 15 day of March , 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

Apr 20, 2016
STATE OF FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES OFFICE OF APPEAL HEARINGS


PETITIONER,
Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 12 Manatee
UNIT: 88326

APPEAL NO. 16F-00552

CASE NO.

## RESPONDENT.



## FINAL ORDER

Pursuant to notice, an administrative hearing in the above-referenced matter convened before the undersigned on March 1, 2016 at 8:32 a.m. CST. Both parties appeared via teleconference.

## APPEARANCES

For the petitioner: pro se

For the respondent: Christine McKee, Economic Self-Sufficiency Specialist II, Department of Children and Families

## STATEMENT OF ISSUE

At issue is whether respondent, the Department of Children and Families (DCF or 'the Department') properly calculated petitioner's monthly Share of Cost in the Medicaid Program for the retro month of October 2015.

FINAL ORDER (Cont.)

## PRELIMINARY STATEMENT

Respondent submitted a packet of information that was entered into evidence and marked as Respondent's Exhibits " 1 " through " 16 ".

The undersigned took administrative notice of 20 pages of the Department's Policy Manual CFOP 165-22; it is now labeled as Respondent's Exhibit "17".

## FINDINGS OF FACT

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

1. On November 18, 2015, petitioner applied for Medicaid for herself and her son, born October 16, 2015. Also in the household is her husband for whom no benefits were requested. Retro Medicaid coverage was requested for October 2015. The petitioner and her husband file federal income taxes jointly. The son, JLH, is identified as a tax dependent of the petitioner on the application (Respondent's Exhibit 2).
2. Petitioner started a year of maternity leave after the birth of her son. The final pay from her job at was November 5, 2015. Her husband is employed at Respondent determined October 2015 countable income as $\$ 5,248.22$ (Respondent's Exhibit 13).
3. Petitioner's and her husband's income verification both have entries for health insurance premiums (Respondent's Exhibit 14).
4. The respondent determined the petitioner's household income exceeded the income limit for full Medicaid benefits and enrolled them in the Medically Needy Program with a share of cost (SOC).

FINAL ORDER (Cont.)
16F-00552
PAGE - 3
5. By notice December 23, 2015, respondent notified petitioner the application was approved for Medically Needy for October 2015 with an estimated SOC of (\$5,248.22 486) $\$ 4,762$ (Respondents Exhibit 13).
5. Petitioner supplied medical bills and remaining balances after third-party payment from Blue Cross. Respondent has reached out to medical providers in search of any other outstanding medical bills. The medical bills incurred for the month of October 2015 do not meet the SOC (Respondent's Exhibit 16).
6. The petitioner stated that she understands the rules and regulations upon which the determination for October 2015 is based. She also states she has no disagreement with that determination.
7. Petitioner requests that her special circumstances be considered and an exception be granted so Medicaid can help pay the outstanding October medical bills.

## 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. 652.056.
10. 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.
11. 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 $\S 435.956(\mathrm{f})$ 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.

12 The Department's Program Policy Manual, CFOP 165-22 (The Policy Manual) at
2230.0400 Standard Filing Unit (MFAM) states:

For tax filers, the Standard Filing Unit (SFU) is the tax filing group for the tax year in which eligibility is being determined. Eligibility is determined by
each individual using the tax filing group's income. Individuals cannot receive Medicaid benefits under more than one coverage group, but can have their income included in more than one SFU.
For individuals who neither file a federal tax return nor are claimed as a tax dependent (non-filers), the Standard Filing Unit consists of the individual and, if living with the individual, their spouse, their natural, adopted, and step children under age 19, or 19 and 20 if in school fulltime.
13. In accordance with the above controlling authorities, the Medicaid household
group is the petitioner, her husband and child (three members). The findings show the
Department determined the petitioner's eligibility with a household size of three to determine her eligibility for Medicaid.
14. 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-

FINAL ORDER (Cont.)
16F-00552
PAGE -6
based methodologies in the applicable Title of the Act, but not to determine eligibility for a particular eligibility group.
15. 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).
16. The Policy Manual at Appendix A-7 indicates the Family-Related Medicaid Income Limit as $\$ 303$ and a Standard Disregard of $\$ 185$ for an adult with a child between 1-5 years old to be eligible for full Family-Related Medicaid Program. It also indicates the MNIL to be $\$ 486$.
17. 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 $\$ 5,248.22$. Step 2: There are no deductions included in the calculation. Step 3: The total income of $\$ 5,248.22$ less the standard disregard of $\$ 185$ is $\$ 5,063.22$. Step 4: The

FINAL ORDER (Cont.)
16F-00552
PAGE -7
balance of $\$ 5,063.22$ is greater than the income limit of $\$ 303$ for the mother with her
husband and newborn child to receive full Medicaid for herself. Step 5: With no MAGI
disregard applied, the countable balance remains $\$ 5,063.22$. This amount was greater
than the income limit of $\$ 303$. The undersigned concludes that the petitioner is ineligible
for full Medicaid. The undersigned further concludes Medically Needy eligibility must be explored.
18. 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.
19. 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.
20. Effective April 2015, Appendix A-7 indicates that for an adult in a three-person household the MNIL is $\$ 486$.
21. To determine petitioner's SOC the respondent determined the petitioner's household monthly to be $\$ 5,248.22$. The Medically Needy Income Level of $\$ 486$ for a

FINAL ORDER (Cont.)
16F-00552
PAGE -8
standard filing unit size of three was subtracted resulting to the petitioner SOC of \$4,762 effective October 2015.
22. The hearing officer found an exception to these calculations. The deduction for recurring medical expenses, specifically the health insurance premiums documented on the earned income verification, was not included in the budget computations. Eligibility for full Medicaid was not found, nor will it be as the result of this change; however, it is concluded that a more favorable share of cost could be determined.

## DECISION

Based upon the Findings of Facts and Conclusions of Law, the appeal is granted and remanded to the Department for further development. The Department is ordered to re-compute the Share of Cost for the retro month of October 2015 considering all appropriate expenses and compare the new resulting SOC with medical bills to determine if this change results in the household meeting the October SOC.

## NOTICE OF RIGHT TO APPEAL

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

FINAL ORDER (Cont.)
16F-00552
PAGE -9
DONE and ORDERED this _ 20 day of _ April_, 2016, in Tallahassee, Florida.


Gregory Watson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myffamilies.com

Copies Furnished To: $\begin{aligned} & \text { Office of Economic Self Sufficiency }\end{aligned}$

Apr 25, 2016

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

Office of Appeal Hearings
Dept. of Children and Families

APPEAL NO.

PETITIONER,
Vs.
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 12 Sarasota
UNIT: AHCA

CASE NO.

## RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative
hearing in the above-referenced matter on February 24, 2016, at approximately 1:12 p.m.

APPEARANCES
For Petitioner:
For Respondent: Stephanie Urban, Registered Nurse Specialist Agency for Healthcare Administration

## STATEMENT OF ISSUE

Whether the Agency was correct in denying Petitioner's requests for dental
extractions of teeth 1, 16, and 32, and nitrous (D9230). Petitioner holds the burden of proof by a preponderance of the evidence.

FINAL ORDER (Cont.)
16F-00553
PAGE - 2

## PRELIMINARY STATEMENT

Appearing as witnesses for Respondent were Esther Pierre-Louis (Supervisor of Grievance and Appeals), and Janice Shurst (Grievance and Appeals Coordinator) both with Prestige Health Care.

Petitioner submitted two exhibits into evidence, marked and entered as Petitioner's Composite Exhibit 1 and Petitioner's Exhibit 2. Respondent submitted two exhibits into evidence, which were marked and entered as Respondent's Composite Exhibit 1 and Respondent's Exhibit 2. The record was left open until March 2, 2016 to receive the guidelines Prestige and Argus relied upon to make the decision. Petitioner was given until March 9, 2016 to file a written response to the guidelines.

On March 4, 2016, Petitioner submitted a letter reiterating her testimony at the hearing and explaining she did not receive any guidelines. The record closed on March 9, 2016. On March 11, 2016, Prestige contacted the Office of Appeal Hearings directly and explained that it submitted the guidelines to the Agency on March 1, 2016. The Agency, in turn, failed to forward these to Petitioner and the Office of Appeal Hearings.

The record was re-opened to admit the guidelines which were submitted timely, and Petitioner was given the opportunity to respond to the guidelines. Petitioner's response was received on March 26, 2016, and the record closed at that time. The guidelines were submitted with accompanying articles, which were marked and entered together as Respondent's Composite Exhibit 3. Petitioner's responses after the hearing were marked and entered as Petitioner's Exhibits 3 and 4.

FINAL ORDER (Cont.)
16F-00553
PAGE - 3

## 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 enrolled with managed care organization Prestige Health ("Prestige"). Petitioner's mother is a former dental assistant with knowledge of dental conditions and x-rays. Petitioner has three fully formed, impacted or partially impacted wisdom teeth which have caused her ongoing pain for almost a year. She has recurrent pericoronitis (swelling and infection around the tooth) and grinds her teeth at night. Food and other bacteria become caught in the gum tissue under partially erupted tooth number 32 causing pain, swelling, and infection. She is unable to eat on her left side due to pain associated with teeth numbers 1 and 32. Petitioner has had multiple visits to her dentist associated with her pain, and has treated unsuccessfully with ibuprofen.
2. Based on the x-ray, Petitioner's teeth have numerous problems. Tooth number 1 is twisted and sharp as it erupts, pinching Petitioner's cheek when she bites down and causing inflammation. The medial portion of tooth 32 is growing into the distal portion of tooth 31. Her gum tissue is inflamed and bacterial growth is present on tooth 32, due to a tissue flap behind the tooth. Tooth 16 has no room to erupt and is covered by thick gum tissue, which is creating pressure, pain, and swelling. The pain impacts Petitioner's TMJ and causes her high anxiety. Argus approved the removal of one of Petitioner's four wisdom teeth, and that was done on December 30, 2015. Petitioner still has ongoing pain with the three remaining teeth.

FINAL ORDER (Cont.)
16F-00553
PAGE-4
3. Petitioner had difficulty working with Prestige's third-party dental vendor, Argus Dental ("Argus") to get her care covered. Argus handles the prior authorization reviews for Prestige. Argus reviews the prior authorization request and supporting documentation to determine whether a service meets the plan's criteria for coverage. Argus then sends its results to Prestige, and to the recipient.
4. The prior authorization request included a narrative that indicated it was an emergency and Petitioner had pain and high anxiety. The requesting dentist recommended surgical removal of the teeth because they are unable to erupt because there is not enough room and Petitioner is having problems with TMJ.
5. Argus reviewed Petitioner's request on December 17, 2015. It denied the request because it didn't meet clinical criteria, but agreed to "approve the tooth that hurts" which is not at issue in this appeal because that service was already rendered. Based on Argus's decision, Prestige issued a denial notice to Petitioner on December 17, 2015. It stated that the service was not a covered benefit, not medically necessary, and it did not meet Argus's clinical guidelines. The clinical guidelines were excerpted in the letter, and indicated that Petitioner would need to show active pathology to remove impacted teeth. It further noted that pericoronitis would be impossible on a fully impacted third molar tooth.
6. On December 29, 2015, the request was re-reviewed by a different Argus dental director who agreed with the initial decision. Prestige sent another notice to Petitioner denying the service, dated January 15, 2016. This notice excerpted different Argus criteria from the prior notice, indicating among other criteria, that Petitioner must have inflammation and/or infection involving the gums around the tooth, pain and swelling

FINAL ORDER (Cont.)
16F-00553
PAGE - 5
because the tissue is preventing the tooth from coming in through the gum, or the service is needed on a fully formed wisdom tooth.
7. Petitioner requested a fair hearing following this denial. Another Argus dental director reviewed the decision once more on February 9, 2016, in anticipation of the hearing. The final Argus review upheld the prior denials because it did not find active infection visible on the $x$-ray with teeth 1,16 , and 32 "because of periapical radiolucency." This means the dental director who reviewed the case did not see any infection near the tips of the teeth down by the alveolar nerve on the x-ray.

## CONCLUSIONS OF LAW

8. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80, Florida Statutes.
9. This is a final order pursuant to Sections 120.569 and 120.57 , Florida Statutes.
10. This hearing was held as a de novo proceeding pursuant to Florida Administrative Code Rule 65-2.056.
11. Section 409.912, Florida Statutes, notes that AHCA shall purchase goods and services for Medicaid recipients in the most cost-effective manner possible, consistent with the delivery of quality medical care.
12. The Florida Medicaid Provider General Handbook (Provider Handbook) - July 2012 is incorporated by reference in Florida Administrative Code Rule 59G-5. In accordance with the Florida law, the Provider Handbook discusses managed care coverage, stating on page 1-27:

Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.

Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee. Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.
13. Page 1-30 of the Provider Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."
14. All Medicaid services must be medically necessary. 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.
6. The Medicaid Dental Services Coverage and Limitations Handbook (Dental Handbook)- November 2011 is promulgated into law by Rule 59G-4.060(2), Florida Administrative Code.
7. 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...
8. 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."
9. The Dental Handbook states on page 2-2: "Medicaid reimburses for services that are determined medically necessary..."
10. 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.
20. The Dental Handbook explains when oral surgery services are appropriate on page 2-13. The relevant portions are as follows:

Covered Services: ...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. On page 2-37 of the Dental Handbook, there is more information about oral and maxillofacial surgery criteria. It states that:

Recipients under age 21 are eligible for the following services:

- All the oral and maxillofacial surgery services available to recipients 21 years and older; and
- Surgery for relief of pain or infection and the maintenance of dental health.

22. Based on Medicaid's criteria, treatment is covered under the above authorities for a child under 21 if it is a medically necessary service. Petitioner showed that she has active infection, swelling, inflammation, and pain due to the impacted wisdom teeth. She showed that the teeth will not grow in properly and will only continue to cause pain.
23. Respondent submitted its guidelines for third molar extractions after the hearing. The guidelines state that for removal, a tooth must have active pathology, such as infection, advanced periodontal disease, or evidence of damage to adjacent teeth. It also states that "by definition, completely covered and un-erupted third molars cannot exhibit Pericoronitis." Petitioner's evidence shows that she has recurrent periocoronitis in at least one partially erupted tooth (\#32) and that the other teeth are growing into each other causing damage and pain (\#1 and \#32). Petitioner's other tooth, \#16, has no room to erupt and is creating swelling, pain and pressure against Petitioner's thick gum tissue.

FINAL ORDER (Cont.)
16F-00553
PAGE-9
24. Respondent did not contradict Petitioner's assertions during the hearing with competent legal evidence. No one with dental knowledge or who completed a medical necessity determination appeared for Respondent. Respondent's witnesses read a report prepared by a third party reviewer who was not present, which is considered hearsay without exception. After the hearing, Respondent submitted its guidelines along with two articles to support its guidelines. First, the articles are hearsay and cannot be relied upon for a finding of fact in this hearing. Second, there is no information regarding the source or credibility of these articles. One of the articles appears to be a study opining on services from the British National Health Service, which would be inapplicable to this case even if it were accepted. Lastly, the second article actually supports Petitioner, because it states pericoronitis which is recurrent or did not respond to conservative treatment would be a reason to remove a tooth. Petitioner has had pericoronitis for an extended period of time with no relief despite treatment with ibuprofen (an anti-inflammatory) and visits to her dentist.
25. Petitioner provided evidence and testimony to support her claim for services. Respondent was unable to rebut Petitioner's testimony because none of Respondent's witnesses were trained in dentistry or x-ray interpretation. Further, the information Argus submitted regarding its decision is all hearsay and thus cannot form the basis of a finding of fact. The information is being relied upon to show that communication occurred, but not for the truth of any findings therein. Prestige's representatives do not have the requisite personal knowledge or authority to testify as to what a third party company did and why. The representatives also could not testify as to whether Argus considered EPSDT when reviewing this case.

FINAL ORDER (Cont.)
16F-00553
PAGE - 10
26. Without any contrary testimony from Respondent, Petitioner has met her burden of proof. Therefore, these extractions are medically necessary to alleviate severe pain and infection.
27. After careful review of the relevant authorities, the testimony and the evidence in this matter, the hearing officer concludes that the Agency improperly denied Petitioner's request. Petitioner is entitled to the service.

FINAL ORDER (Cont.)
16F-00553
PAGE - 11

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner's appeal is GRANTED. The Agency is ordered to promptly approve the requested extractions of teeth numbers 1, 16, and 32, and the nitrous anesthetic.

## 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 th $\qquad$
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 Petitioner
Dietra Cole, Area 8, AHCA Field Office Manager

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

APPEAL NO. 16F-00620
PETITIONER,
Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 20 Lee
UNIT: 883CF
RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on March 14, 2016 at 1:44 p.m.

## APPEARANCES

For the Petitioner:
For the Respondent: Signe Jacobson, Economic Self-Sufficiency Specialist II

## STATEMENT OF ISSUE

Petitioner is appealing the Department's action of May 19, 2015 denying the petitioner's application for SSI-Related Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

## PRELIMINARY STATEMENT

Gregory Watson, Hearing Officer, appeared as an observer to the hearing with no objection by the petitioner.

FINAL ORDER (Cont.)
16F-00620
PAGE - 2

The Department submitted evidence prior to the hearing, which was entered as Respondent Exhibit 1. The Department included a Motion to Dismiss in the evidence citing the petitioner failed to timely appeal the decision of May 2015. The petitioner representative claimed non-receipt of the Notice of Case Action dated May 19, 2015.

The undersigned denied the Motion to Dismiss, citing failure to issue a Notice of Case Action to the representative who was listed as such on the application.

## FINDINGS OF FACT

1. The petitioner, with the assistance of submitted an application for SSI-Related Medicaid on May 7, 2015. The petitioner's application does not indicate that she was pregnant during that month.
2. The petitioner's household consisted of herself, a 52-year-old female with no dependent children in the household.
3. The Social Security Administration (SSA) denied the petitioner disability in June 2014.
4. The Department submitted a Disability Determination and Transmittal with the Disability Report to the Division of Disability Determinations (DDD) on May 11, 2015.
5. DDD reviewed the packet. DDD determined SSA denied the petitioner disability in June 2014. DDD adopted the SSA decision as binding on May 15, 2015 and returned the information to the Department. DDD noted on the Transmittal the primary diagnosis of $\square$ and secondary diagnosis of $\square$

FINAL ORDER (Cont.)
16F-00620
PAGE-3
6. The Department issued a Notice of Case Action on May 19, 2015 denying the petitioner's application for SSI-Related Medicaid, as she did not meet the disability requirement.
7. The petitioner's representative reapplied for disability for the petitioner on December 8, 2015 following the petitioner's death on November 2, 2015.
8. DDD approved the petitioner's disability with the Ion December 17, 2015 with a begin date of August 1, 2015.
9. The Department approved the petitioner for SSI-Related Medicaid on December 21, 2015 beginning August 1, 2015.
10. The petitioner explained the May 2015 disability report contains many conditions more than noted on the Disability Determination Transmittal from May 2015. In addition, the petitioner believes these conditions are related to the cause of death in November 2015 and therefore, the petitioner's disability should begin May 2015 according to her representative.
11. The petitioner did not provide a list of the conditions that were considered by SSA in the determination of disability denial in June 2014.
12. The petitioner did not know if any new or worsened conditions were reported to SSA. The representative advised the petitioner had an attorney who was assisting with her disability appeal when they began working with the petitioner to obtain Medicaid.
13. The attorney was not present at the hearing or called as a witness to provide clarification of what was provided to SSA during the appeal process.

FINAL ORDER (Cont.)
16F-00620
PAGE - 4

## CONCLUSIONS OF LAW

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

Section 409.285, Florida Statutes. This order is the final administrative decision of the
Department of Children and Families under Section 409.285, Florida Statutes.
15. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R.

65-2.056.
16. 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.
(7) Re-evaluating Medicaid Adverse Actions. The department shall reevaluate 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.
17. The findings show the petitioner was denied in May 2015. The findings also show the petitioner was approved in December 2015 effective August 2015. The

FINAL ORDER (Cont.)
16F-00620
PAGE - 5
undersigned concludes the petitioner, through the appeal request, requested a reevaluation of the adverse action or denial from May 2015.
18. The definition of Med-AD Demonstration Waiver is found in Fla. Admin.

Code R. 65A-1.701 (20) and states:
MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services.

## 19. Fla. Admin. Code R. 65A-1.711 "SSI-Related Medicaid Non-Financial

Eligibility Criteria" states in part:
To qualify for Medicaid an individual must meet the general and categorical requirements in 42 C.F.R. Part 435, subparts E and F (2007) (incorporated by reference), with the exception that individuals who are neither aged nor disabled may qualify for breast and cervical cancer treatment, and the following program specific requirements as appropriate. Individuals who are in Florida temporarily may be considered residents of the state on a case-by-case basis, if they indicate an intent to reside in Florida and can verify that they are residing in Florida.
(1) For MEDS-AD Demonstration Waiver, the individual must be age 65 or older, or disabled as defined in 20 C.F.R. § 416.905 (2007) (incorporated by reference).
20. 20 C.F.R. § 416.905 "Basic definition of disability for adults" states in
relevant part:
(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see §416.960(b)) or any other substantial gainful work that exists in the national economy.
21. 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.
(b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c)(3) of this section-
(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.
(ii) If the SSA determination is changed, the new determination is also binding on the agency.
(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.
(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:
(4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and-
(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or
(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.
(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and-
(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or
(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility. (emphasis added)
22. The petitioner is 52 years old with no minor children in the home. As she is under age 65, a disability determination is required for eligibility determination in the SSI-Related Medicaid program.
23. The findings show the petitioner applied for Medicaid with the Department on May 7, 2015. The findings also show SSA determined the petitioner was not disabled in June 2014. According to the above controlling authorities, a decision made by SSA within 12 months of the Medicaid application is controlling and binding on the state agency unless the applicant reports a disabling condition not previously reviewed by SSA. In this case, the petitioner could not confirm which conditions were reported to SSA and considered in the determination process. The findings show the petitioner's SSA decision was under appeal and awaiting hearing.
24. Based on the evidence and testimony presented, the above-cited rules and regulations, the undersigned concludes the petitioner did not meet the burden of proof in this matter. Specifically, the petitioner failed to prove what conditions SSA considered, if SSA was notified of any new or worsening disabling conditions and if SSA had refused to consider any new allegations. The undersigned concludes the Department's action to deny Medicaid under the SSI-Related (Adult) Medicaid program is correct.
25. The undersigned explored all other Medicaid groups. The only other Medicaid group is Family-Related Medicaid Program benefits. The petitioner did not have a minor child in the home and was not claiming pregnancy on her May 2015 application. The Family-Related Medicaid Program benefit rules are set forth in the

FINAL ORDER (Cont.)
16F-00620
PAGE - 8
Florida Admin. Code R. 65A-1.705, Family-Related Medicaid General Eligibility Criteria.
The rules set forth that to be eligible for that Medicaid program; the petitioner must be pregnant or have a dependent minor child residing in the home. The petitioner does not meet the criteria for Family-Related Medicaid Program benefits.
26. The undersigned concludes the petitioner's application for Medicaid Program benefits was denied in accordance with the Program rules.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied. The Department's action is affirmed.

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this _ 17 day of __ March 2016,
in Tallahassee, Florida.


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@myfffamilies.com

FINAL ORDER (Cont.)
16F-00620
PAGE - 9

Apr 20, 2016

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


PETITIONER,

APPEAL NO. 16F-00673

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

## RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in West Palm Beach, Florida on March 24, 2016 at 10:07 a.m.

## APPEARANCES

For the Petitioner:

For the Respondent:
Linda Latson
Registered Nurse Specialist

## STATEMENT OF ISSUE

Whether respondent's termination of respiratory therapy was proper. The burden of proof was assigned to the respondent. The standard of proof in an administrative hearing is by a preponderance of the evidence.

## PRELIMINARY STATEMENT

Petitioner was present and represented by her mother. Present as an observer
evidence.

Ms. Latson appeared as both a representative and witness for the respondent.
Present by telephone from Coventry Health Care of Florida (Coventry) were Mellody
Gordon, Manager of Clinical Health Services and Dr. Darwin Caraballo, Medical
Director. Respondent's exhibit "1" was accepted into evidence.

## FINDINGS OF FACT

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

1. Respondent administers Florida's Medicaid Program and contracts with Health Maintenance Organizations (HMOs) to provide comprehensive, cost-effective medical services to Medicaid recipients.
2. Petitioner is enrolled in respondent's Long Term Managed Care Program (LTMC Program).
3. Since January 2014, petitioner's LTMC services have been provided by Coventry.
4. Respiratory therapy is a service covered by the LTMC Program.
5. Coventry must be in compliance with respondent's Therapy Services Coverage and Limitations Handbook (Therapy Handbook).
6. Coventry can provide expanded services beyond those identified by the Therapy Handbook.
7. Coventry offers no expanded respiratory therapy benefits beyond those identified by the Therapy Handbook.

FINAL ORDER (Cont.)
16F-00673
PAGE - 3
8. Petitioner's date of birth is
9. As a result of a vehicle accident at two months of age, petitioner is a quadriplegic. Since the accident, she has been ventilator dependent. Extensive tracheostomy care is required.
10. Petitioner's LTMC services include 24 hours of nursing care by a Licensed Practical Nurse. The service is provided seven days a week.
11. Petitioner has been receiving respiratory therapy since enrollment with Coventry. Most recently, the service was provided one hour per day; five days a week. The therapy includes pulmonary percussion to clear mucous from her lungs.
12. On January 8, 2016 Coventry issued a Notice of Action "denying" respiratory therapy. The notice stated, in part: "... 24 hour nursing can provide pulmonary percussion and suction or as an alternative we can provide a percussion machine."
13. Based on the development of information during the hearing, it was established the above notice represented a termination of respiratory therapy.
14. Respiratory therapy ended on or about January 7, 2016.
15. The January 8, 2016 notice also stated: "For a fair hearing: File the request with the Office of Appeal Hearings no later than 10 days after this letter was mailed or before the first day our action will take place, whichever is later."
16. On January 15, 2016 petitioner's representative contacted the Office of Appeal Hearings and requested a fair hearing.
17. Petitioner requested a fair hearing seven days after the notice of January 8, 2016.

FINAL ORDER (Cont.)
16F-00673
PAGE-4
18. At the hearing, respondent stipulated a hearing was timely requested. As such, Coventry agreed to immediately reinstate respiratory therapy at the frequency of one hour per day; five days a week pending the outcome of this proceeding.
19. When receiving respiratory therapy, petitioner's representative states the ventilator could be removed for up to one minute. Since therapy ended, the ventilator can only be removed for approximately five seconds.

20 Respondent argues the LPN can be trained to perform all duties performed by a respiratory therapist.

## CONCLUSIONS OF LAW

21. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to § 120.80, Fla. Stat.
22. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code
23. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at $1201,7^{\text {th }}$ Ed.).
24. Respondent's promulgated Therapy Handbook states:

Page 1-4:
Respiratory Therapy
Respiratory therapy is treatment of conditions that interfere with respiratory functions or other deficiencies of the cardiopulmonary system.

Respiratory therapy services include evaluation and treatment related to pulmonary dysfunction. Examples are ventilator support; therapeutic and diagnostic use of medical gases; respiratory rehabilitation; management of life support systems and bronchopulmonary drainage; breathing exercises and chest physiotherapy.

FINAL ORDER (Cont.)
16F-00673
PAGE - 5
Page 2-1:
Medicaid reimburses for the physical therapy (PT), occupational therapy (OT), respiratory therapy (RT), and speech-language pathology (SLP) services described in this handbook.

Medicaid reimburses for medically necessary therapy services that are provided to Medicaid recipients under the age of 21 [Emphasis Added].
25. 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.
6. The Therapy Handbook also states on page 1-2:"The therapy services program also provides limited services to recipients age 21 and older specifically SLP services pertaining to the provision of augmentative and alternative communication systems and PT and OT services pertaining to wheelchair evaluations and fittings."
7. The Findings of Fact establish petitioner is over 21 years of age.

FINAL ORDER (Cont.)
16F-00673
PAGE-6
28. An exception to respiratory therapy being limited to only those under 21 years of age was neither presented nor known by the undersigned.
29. It is not clear why Coventry provided respiratory therapy beyond 21 years of age.

Regardless, the undersigned lacks authority to change age limitation imposed by the Therapy Handbook.
30. As such, petitioner is not eligible for the respiratory services through the Florida Medicaid Program.
31. If desired, petitioner can pursue a percussion machine as referenced in the January 8, 2016 Notice of Action.

## 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.

FINAL ORDER (Cont.)
16F-00673
PAGE -7
DONE and ORDERED this $\qquad$ day of $\qquad$ , 2016, in Tallahassee, Florida.


Frank Houston
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myffamilies.com

Copies Furnished To:
PETITIONER
JUDY JACOBS, AREA 7, AHCA FIELD OFFICE

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

PETITIONER,
Vs.
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 DADE
UNIT: AHCA
RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on March 2, 2016 at 11:30 a.m. in Doral, Florida.

## APPEARANCES

For the Petitioner:
For the Respondent:


## STATEMENT OF ISSUE

At issue is whether the Respondent's action to deny the Petitioner's request for the nutritional supplement Pediasure was correct. The Petitioner bears the burden of proving his case by a preponderance of the evidence.

FINAL ORDER (Cont.)
16F-00690
PAGE - 2

## PRELIMINARY STATEMENT

The Petitioner submitted a letter from his physician as evidence for the hearing, which was marked as Petitioner Exhibit 1.

The Respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Exhibit 1: authorization request, denial notice, and medical criteria.

Appearing telephonically as witnesses for the Respondent were Dr. Amy Zitiello, Medical Director, Carlene Brock, Quality Operations Nurse, and Brittney Bialas, Nutritional Consultant, from Amerigroup, which is the Petitioner's managed health care plan.

Also present telephonically for the hearing was a

## FINDINGS OF FACT

1. The Petitioner is a five (5) year-old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) - Managed Medical Assistance (MMA) plan. He receives services under the plan from Amerigroup.
2. On or about November 6, 2015, the Petitioner's treating physician (hereafter referred to as "the provider"), submitted a prior authorization request for the nutritional supplement Pediasure. Amerigroup denied this request on November 9, 2015 based on medical necessity criteria. The denial notice stated the following:

We cannot approve your child's special nutrition drinks. We know he has heartburn issues. We have his height and weight. He is small. These drinks would not provide more than $50 \%$ of the nutrition he needs per day ( 1,600 calories/day for a normal sized active 5 year old male). He needs more calories than this to help him grow. This decision was based on health plan clinical guideline ... .
3. The Petitioner's mother testified she believes the request for Pediasure should be approved because her son's weight is low and he eats very little food. He will vomit when he doesn't want to eat something. He had been drinking Pediasure for about 2 years, until September 4, 2015. This was being provided by the WIC Program until his eligibility under that program ended on his fifth birthday. Her son has also been prescribed medication to stimulate his appetite, but this has not been effective. She has recently been providing her son with Pediasure at her own expense.
4. The Respondent's witness, Dr. Zitiello, agreed that the Petitioner is underweight but stated that the Pediasure supplement would be an inappropriate method of meeting his nutritional needs since it would provide less than $50 \%$ of his caloric needs. She also stated that if behavioral issues are causing the Petitioner to refuse food, the provider would need to submit a plan of care showing the patient would eventually be taken off the supplement.
5. Ms. Bialas, the nutritional consultant for Amerigroup, stated the plan could provide recommendations for weight gain using regular food.
6. The Petitioner's mother pointed out that Amerigroup paid a claim for Pediasure in October, 2015. The Amerigroup representatives stated this claim was paid in error, and Amerigroup has never approved the request for the Pediasure.

FINAL ORDER (Cont.)
16F-00690
PAGE - 4
7. Durable medical equipment and supplies, including nutritional supplements, are covered services under the Medicaid State Plan in Florida. These services are provided in accordance with the Respondent's Durable Medical Equipment/Medical Supply Services Coverage and Limitations Handbook ("DME Handbook"), effective July, 2010.

## CONCLUSIONS OF LAW

8. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Fla. Stat. § 120.80.
9. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.
10. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
11. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the Petitioner. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, $7^{\text {th }}$ Ed.).
12. 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.
13. The Petitioner has requested DME/Medical Supply services (nutritional supplements). As the Petitioner is under 21 years of age, the Early Periodic Screening,

FINAL ORDER (Cont.)
16F-00690
PAGE - 5
Diagnosis, and Treatment (EPSDT) requirements apply to the evaluation of the petitioner's eligibility for this service.
14. 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.
15. 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.
16. The service the petitioner has requested (DME services) is one of the services

[^11]FINAL ORDER (Cont.)
16F-00690
PAGE - 6
provided by the state to treat or ameliorate an individual's conditions under the State
plan. Section 409.905, Fla. Stat., states, in part:
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.
17. 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.

FINAL ORDER (Cont.)
16F-00690
PAGE-7
18. Once a service has been identified as requested under EPSDT, Medicaid 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.
6. Based upon the information submitted by the Petitioner's provider, Amerigroup completed a prior authorization review to determine medical necessity for the requested nutritional supplement (Pediasure).
7. In the Petitioner's case, the Respondent has determined that Pediasure is a covered service or item under the Medicaid state plan but is disputing the medical necessity for the Pediasure.

FINAL ORDER (Cont.)
16F-00690
PAGE - 8
21. 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.
22. 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.
23. The Petitioner's physician prescribed the Pediasure, but it was not approved by Amerigroup. Rule 59G-1.010(166) (c), however, specifically states a prescription does not automatically mean the requirements of medical necessity have been satisfied.
24. The Respondent's witness stated that Pediasure is not medically necessary since it would supply the Petitioner with less than $50 \%$ of his nutritional needs.
25. The Petitioner's mother stated her son needs the Pediasure because of his low weight and his reluctance to eat regular food.

FINAL ORDER (Cont.)
16F-00690
PAGE - 9
26. After considering the evidence presented, the undersigned concludes that the

Petitioner has not met his burden of proof in establishing that the Respondent's action was incorrect. The Petitioner has not established that Pediasure is medically necessary at this time. The fact that the Petitioner was consuming Pediasure for a two year period and has also recently been consuming Pediasure again but is still underweight suggests that other possibilities should be explored to promote weight gain.

## 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 18 day of April 2016,
in Tallahassee, Florida.


Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700

FINAL ORDER (Cont.)
16F-00690
PAGE - 10
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myfIfamilies.com

Copies Furnished To:
RHEA GRAY, AREA 11, AHCA FIELD OFFICE MANAGER

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

APPEAL NO. 15F-10573
APPEAL NO. 16F-00710
Vs.
FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pinellas
UNIT: 88268
CASE NO.

RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened two administrative hearings by phone in the above-referenced matter on February 9, 2016 at 9:02 a.m.; and on March 10, 2016 at 2:36 p.m. Two continuances were granted for the petitioner.

## APPEARANCES

For Petitioner:
For Respondent: Ed Poutre, Economic Self Sufficiency Specialist II

## STATEMENT OF ISSUE

At issues are whether the respondent's actions to decrease petitioner's Food Assistance benefits to $\$ 12.00$ for December 2015 and to $\$ 16.00$ per month effective January 2016 and ongoing; and to enroll petitioner in the Medically Needy (MN) program effective December 2015 and ongoing are correct. The petitioner carries the burden of proof by a preponderance of the evidence for both issues.

FINAL ORDER (Cont.)
15F-10573 \& 16F-00710
PAGE - 2

## PRELIMINARY STATEMENT

At both hearings, the petitioner was present and testified. Petitioner submitted no exhibits at the hearings. At both hearings, the respondent was represented by Ed Poutre with the Department of Children and Families (hereafter "DCF", "Respondent" or "Agency"). Respondent submitted thirteen exhibits, which were accepted into evidence and marked as Respondent's Exhibits "1" through "13".

## FINDINGS OF FACT

1. On December 8, 2015, the petitioner completed an application for Food Assistance (FA) and SSI-Related Medicaid benefits. The application listed petitioner and his father as the only household members; no income for the household; a rental expense; an electric expense; and many ongoing medical expenses.
2. On December 11, 2015, the respondent mailed petitioner a Notice of Case Action indicating petitioner's December 8, 2015 FA application was approved for $\$ 12$ in FA benefits for December 2015 and \$16 per month in FA benefits effective January 2016 and ongoing.
3. Petitioner's Social Security Disability Insurance (SSDI) amount is $\$ 1,820$ (gross) per month and he has Medicare Part $A$ and $B$.
4. Initially, the respondent calculated petitioner's monthly medical expenses as his Medicare premium of $\$ 104.90$ per month; prescription co-pays of $\$ 210$ per month; and other medical expenses of $\$ 245$ per month.
5. Initially, the respondent calculated the petitioner's FA budget for January 2016 and ongoing as follows:

FINAL ORDER (Cont.)
15F-10573 \& 16F-00710
PAGE - 3

| Expenses/Income | Dollar Amount |
| :--- | :---: |
| Unearned Income | $\$ 1820.00$ |
| Total household income | $\$ 1820.00$ |
| Standard deduction for a household of 1 | $\underline{-\$ 155.00}$ |
| Excess Medical Expenses | $\underline{\$ 524.90}$ |
| Adjusted income after deductions | $\$ 1140.10$ |
|  | $\$ 559.90$ |
| Total Medical Costs | $\underline{-\$ 35.00}$ |
| Medical Deduction | $\$ 524.90$ |
| Excess Medical Expenses |  |
|  | $\$ 130.00$ |
| Rent/shelter | $\underline{+\$ 345.00}$ |
| Standard utility allowance | $\$ 475.00$ |
| Total rent/utility costs | $\underline{-\$ 570.05}$ |
| Shelter standard (50\% adjusted income) | $\$$ |
| Excess shelter deduction | $\mathbf{0 . 0 0}$ |
|  | $\$ 1140.10$ |
| Adjusted income | $\underline{-\$} 0.00$ |
| Excess Shelter Deduction | $\$ 1140.10$ |
| Adjusted income after shelter deduction |  |

6. Respondent took $30 \%$ of $\$ 1140.10$ to calculate the benefit reduction of $\$ 343$, which exceeds $\$ 194$ or the maximum FA benefit amount for a household of one.

Petitioner was eligible for the minimum monthly FA benefit amount of $\$ 16$ as his gross income $(\$ 1,820)$ is less than the $200 \%$ gross income limit of $\$ 1,962$ for a household of one.
7. Respondent recalculated the petitioner's monthly medical expenses as his Medicare premium of $\$ 104.90$ per month; prescription co-pays of $\$ 210$ per month; and other medical expenses of $\$ 375$ per month.
8. Respondent recalculated the petitioner's FA budget for January 2016 and ongoing as follows:

FINAL ORDER (Cont.)
15F-10573 \& 16F-00710
PAGE-4

| Expenses/Income | Dollar Amount |
| :--- | :---: |
| Unearned Income | $\$ 1820.00$ |
| Total household income | $\$ 1820.00$ |
| Standard deduction for a household of 1 | $\underline{-\$ 155.00}$ |
| Excess Medical Expenses | $\underline{\$ 654.90}$ |
| Adjusted income after deductions | $\$ 1010.10$ |
|  | $\$ 689.90$ |
| Total Medical Costs | $\underline{-\$ 35.00}$ |
| Medical Deduction | $\$ 654.90$ |
| Excess Medical Expenses |  |
|  | $\$ 400.00$ |
| Rent/shelter | $\underline{+\$ 345.00}$ |
| Standard utility allowance | $\$ 745.00$ |
| Total rent/utility costs | $\underline{-\$ 505.05}$ |
| Shelter standard (50\% adjusted income) | $\$ 239.95$ |
| Excess shelter deduction |  |
|  | $\$ 1010.10$ |
| Adjusted income | $\mathbf{- \$ 2 3 9 . 9 5}$ |
| Excess Shelter Deduction | $\$ 770.15$ |
| Adjusted income after shelter deduction |  |

9. Respondent took $30 \%$ of $\$ 770.15$ to calculate the benefit reduction of $\$ 232$, which exceeds $\$ 194$ or the maximum FA benefit amount for a household of one. Petitioner remained eligible for the minimum monthly FA benefit amount of $\$ 16$ as his gross income $(\$ 1,820)$ is less than the $200 \%$ gross income limit of $\$ 1,962$ for a household of one.
10. Respondent determined petitioner eligible for $\$ 12$ for December 2015 by multiplying the ongoing FA benefit amount of $\$ 16$ by a proration factor of .767 ( $\$ 16$ x $.767=\$ 12)$.
11. Petitioner does not agree with respondent's determination of his FA benefit amount as $\$ 16$ per month because $\$ 16$ in FA benefits is only enough to purchase bread, cheese, and sandwich meat.

FINAL ORDER (Cont.)
15F-10573 \& 16F-00710
PAGE - 5
12. Petitioner argued he did not report all of his ongoing medical expenses to the respondent. Respondent encouraged petitioner to submit all ongoing medical expenses to determine if the expenses increase his FA benefit amount.
13. Respondent determined petitioner's MN SOC amount as $\$ 1,515$ effective

December 2015 and ongoing as follows:

| $\$ 1820.00$ | petitioner's SSDI income |
| :---: | :--- |
| $-\$ 20.00$ | unearned income disregard |
| $\$ 1800.00$ | total countable income |
| $-\$ 180.00$ | MNIL for a household of one |
| $-\$ 104.90$ | Medical Insurance Expenses |
| $\$ 1515.00$ | share of cost |

14. Petitioner does not agree with the respondent's determination that he is not eligible for full SSI-Related Medicaid benefits as he has many illnesses requiring multiple medications, regular physician visits, ongoing physical therapy, surgeries, and various durable medical equipment. Petitioner argued he is not able to pay for all of his medical expenses and requires Medicaid to pay for them.
15. Respondent argued petitioner was not eligible for full SSI-Related Medicaid benefits as he is over the SSI-Related Medicaid income limit for one person.

## CONCLUSIONS OF LAW

16. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to § 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.
17. This proceeding is a de novo proceeding pursuant to Florida Administrative Code R. 65-2.056.

## As to the monthly FA benefit amount for December 2015 and ongoing

18. The Code of Federal Regulations 7 C.F.R. § 273.9 define income and deductions and states, in part:
2) Unearned income shall include, but not be limited to:
(ii) Annuities; pensions; retirement, veteran's, or disability benefits; worker's or unemployment compensation including any amounts deducted to repay claims for intentional program violations as provided in §272.12; old-age, survivors, or social security benefits; strike benefits; foster care payments for children or adults who are considered members of the household...
(d) Income deductions. Deductions shall be allowed only for the following household expenses...
(1) Standard deduction-(i) 48 States, District of Columbia, Alaska, Hawaii, and the Virgin Islands. Effective October 1, 2002, in the 48 States and the District of Columbia, Alaska, Hawaii, and the Virgin Islands, the standard deduction for household sizes one through six shall be equal to 8.31 percent of the monthly net income eligibility standard for each household size established under paragraph (a)(2) of this section rounded up to the nearest whole dollar...
(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. Allowable medical costs are:
(i) Medical and dental care including psychotherapy and rehabilitation services provided by a licensed practitioner authorized by State law or other qualified health professional.
(ii) Hospitalization or outpatient treatment, nursing care, and nursing home care including payments by the household for an individual who was a household member immediately prior to entering a hospital or nursing home provided by a facility recognized by the State.
(iii) Prescription drugs, when prescribed by a licensed practitioner authorized under State law, and other over-the-counter medication
(including insulin), when approved by a licensed practitioner or other qualified health professional.
(A) Medical supplies and equipment. Costs of medical supplies, sick-room equipment (including rental) or other prescribed equipment are deductible;
(iv) Health and hospitalization insurance policy premiums. The costs of health and accident policies such as those payable in lump sum settlements for death or dismemberment or income maintenance policies such as those that continue mortgage or loan payments while the beneficiary is disabled are not deductible...
(6) Shelter costs...
(ii) Excess shelter deduction. Monthly shelter expenses in excess of 50 percent of the household's income after all other deductions in paragraphs (d) (1) through (d)(5) of this section have been allowed...If the household does not contain an elderly or disabled member, as defined in § 271.2 of this chapter, the shelter deduction cannot exceed the maximum shelter deduction limit established for the area.
(A) Continuing charges for the shelter occupied by the household, including rent, mortgage, condo and association fees, or other continuing charges leading to the ownership of the shelter such as loan repayments for the purchase of a mobile home, including interest on such payments...
(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)...
19. Pursuant to the above authority, petitioner's monthly SSDI income must be included in the determination of his household's monthly FA benefit amount.

Furthermore, shelter costs, utilities, excess medical expenses, and a standard deduction must also be included in the determination of his household's monthly FA benefit amount.

FINAL ORDER (Cont.)
15F-10573 \& 16F-00710
PAGE - 8
20. The Department's Program Policy Manual (Policy Manual), CFOP 165-22,

Appendix A-1 sets forth the following Eligibility Standards for Food Assistance benefits:
(1) $\$ 194$ maximum FA benefit for a household size of one; (2) $\$ 345.00$ standard utility allowance; (3) $\$ 155.00$ standard deduction for a household size of one; (4) \$1,962 Monthly 200\% gross income limit for a household of one; (5) uncapped shelter deduction for AGs with elderly or disabled members; and (6) $\$ 16$ per month for the minimum allotment for one or two member household.
21. Since petitioner's gross income $(\$ 1,820)$ is less than the $200 \%$ gross income limit of $\$ 1,962$ for a household of one, he is eligible to receive the monthly minimum FA benefit amount if he meets all other eligibility requirements.
22. The Department's Policy transmittal numbered C-13-10-0007, Food Assistance

Minimum Benefit dated October 11, 2013 shows in pertinent part that:
...all one and two member assistance groups (AGs) are eligible for the minimum monthly food assistance benefit allotment, which is $8 \%$ of the maximum allotment for a one person household....The AG is eligible for the minimum monthly food assistance benefit allotment if the assistance group meets all regular eligibility requirements and....the AG has income less than or equal to the $200 \%$ gross income limit or the AG contains an elderly or disabled member and does not pass the $200 \%$ gross income test but does have income less than or equal to the $100 \%$ of the net income limit...
23. The Policy Manual, CFOP 165-22, passage 2610.0106.02, Minimum Benefits
(FS) states in part, "Recurring months: Issue a minimum of eight percent of the maximum benefit for a one-person assistance group to one or two person assistance groups who meet the net income test or are categorically eligible".
24. Pursuant to the above transmittal and policy, a one person household, which passes the gross income test or has an elderly or disabled member with income below the net income limit, is entitled to receive a minimum FA benefit amount that equals to

FINAL ORDER (Cont.)
15F-10573 \& 16F-00710
PAGE-9
eight percent of the maximum amount for a one person household. Petitioner's FA
group is a one-person household, with a disabled member, and passes the gross and net income tests; therefore, he is eligible to receive the $\$ 16$ monthly minimum FA benefit amount.
25. The Code of Federal Regulations 7 C.F.R. § 273.10(a) explains the effective date of

FA benefits during an application process and states, in part:
(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 to the end of the month unless the applicant household consists of residents of a public institution. For households which apply for SSI prior to their release from a public institution in accordance with §273.1(e)(2), the benefit level for the initial month of certification shall be based on the date of the month the household is released from the institution and the household shall receive benefits from the date of the household's release from the institution to the end of the month. . .
(iii) To determine the amount of the prorated allotment, the State agency shall use either the appropriate Food Stamp Allotment Proration Table provided by FNS or whichever of the following formulae is appropriate:
(A) For State agencies which use a standard 30-day calendar or fiscal month the formula is as follows, keeping in mind that the date of application for someone applying on the 31st of a month is the 30th:
full month's benefits $\times$ (31-date of application) $=$ allotment 30
(C) If after using the appropriate formula the result ends in 1 through 99 cents, the State agency shall round the product down to the nearest lower whole dollar. If the computation results in an allotment of less than \$10, then no issuance shall be made for the initial month...
26. Pursuant to the above authorities, petitioner's FA benefits for December 2015
should begin on December 8, 2015. Since he applied on the 8th of the month, his FA
benefits for December 2015 must be prorated to the date of application. Furthermore, if

FINAL ORDER (Cont.)
15F-10573 \& 16F-00710
PAGE-10
the formula ends in any cent amount, the cents are dropped to the lower whole dollar amount.
27. The formula above describes how to determine a prorated FA benefit amount.
$\left(\$ 16 \times \frac{31-8}{30}=\$ 16 \times \frac{23}{30}\right.$ or $\left.(.767) \$ 16 \times .767=\$ 12.27\right)$. The cents are dropped, so petitioner's FA benefit amount for December 2015 is $\$ 12.00$.
28. Pursuant to the various aforementioned authorities, the respondent correctly calculated petitioner's monthly FA benefit amount for December 2015 and ongoing by including all the required income, expenses, and deductions allowed in the determination of FA benefits.
29. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner has not met his burden of proof in establishing the respondent incorrectly calculated his monthly Food Assistance benefits for December 2015 and ongoing.

## As to the petitioner's eligibility for full SSI-Related Medicaid benefits

30. 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)

FINAL ORDER (Cont.)
15F-10573 \& 16F-00710
PAGE - 11
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.
31. Pursuant to the above authority, since petitioner is considered disabled, he is eligible for Medicaid benefits under the SSI-Related Medicaid program.
32. The Fla. Admin. Code R. 65A-1.713, SSI-Related Medicaid Income Eligibility Criteria defines income limit for the SSI-Related Medicaid Program as income that is at or below 88 percent of the federal poverty level.
33. The Policy Manual, Appendix A-9, lists the SSI-Related Income Standards for a household size of one for MEDS-AD or full SSI-Related Medicaid program as $\$ 864$ for December 2015 through March 2016; and $\$ 872$ for April 2016 and ongoing.
34. Federal Regulations at 20 C.F.R. 416.1124(c)(12) sets forth income that is not counted in this program and states, "The first $\$ 20$ of any unearned income in a month other than...income based on need."
35. The Fla. Admin. Code R. 65A-1.716(2) indicates the Medically Needy Income Level (MNIL) for a family size of one as $\$ 180$.
36. Petitioner's monthly SSDI income exceeds the Medicaid income standard for him to receive full SSI-Related Medicaid benefits; therefore, he is correctly enrolled in the Medically Needy Program with a monthly share of cost.
37. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner has not met the burden of proof to indicate the respondent incorrectly denied his full SSI-Related Medicaid benefits and instead enrolled him in the Medically Needy Program with a monthly share of cost amount effective December 1, 2015.

FINAL ORDER (Cont.)

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, petitioner's
Food Assistance and SSI-Related Medicaid appeals are DENIED.

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this $\qquad$ 11 day of $\qquad$ Abril 2016,
in Tallahassee, Florida.

Mary Gane 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

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

## FILED

Apr 20, 2016

APPEAL NO. 16F-00720
PETITIONER,
Vs.
CASE NO.
FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 PALM BEACH
UNIT: 88322
RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter March 9, 2016, at 1:32 p.m.

## APPEARANCES

For the Petitioner:
For the Respondent:
Mary Triplett, supervisor

## STATEMENT OF ISSUE

At issue is the denial of Medicaid benefits for the petitioner. The petitioner carries the burden of proof by a preponderance of evidence in this appeal.

## PRELIMINARY STATEMENT

The petitioner presented one exhibit which was entered into evidence and marked as Petitioner's Composite 1. The respondent presented one exhibit which was entered into evidence and marked as Respondent Composite Exhibit 1.

## FINDINGS OF FACT

1. On December 22, 2016, an application for SSI-Related Medicaid was submitted to the Department on behalf of the petitioner.
2. On December 26, 2015, the petitioner died.
3. On January 8, 2016, the office of Vital Statistics issued a death certificate.
4. On January 11, 2016, a disability application packet was mailed to the Division of Disability Determination (DDD).
5. On January 12, 2016, DDD determined the petitioner was disabled and informed the Department of its decision. The petitioner had to meet the disability requirement and also technical requirements before Medicaid could be authorized.
6. On January 14, 2016, the respondent sent the petitioner's representative a Notice of Case Action requesting proof of identification and citizenship. It was due on January 25, 2016.
7. On January 21, 2016, the Department reviewed the petitioner's case record and found that proof of identification and proof of citizenship was not received. The Medicaid application was denied as the requested verification was not received.
8. On January 22, 2016, the Department sent the petitioner's representative a Notice of Case Action advising the Medicaid application was denied. The reason given for the denial was that proof of identify was not received.
9. On January 28, 2016, the petitioner's representative requested a hearing to challenge the Department's action to deny the SSI-Related Medicaid benefits.
10. At the hearing, the petitioner's representative explained the petitioner was brought to the hospital unconscious. The representative explained the petitioner was

FINAL ORDER (Cont.)
16F-00720
PAGE -3
born in Virginia and left his parent's home at a very young age. His representative did not provide proof of identity or citizenship for the petitioner as of the date of the hearing. The petitioner's mother appointed the hospital representative as the petitioner's authorized representative. His mother also signed the death certificate. The petitioner's brother was contacted by the petitioner's representative but he did not wish to be contacted again. His representative is asking that an exception be made as the petitioner is deceased and has no family member who is willing to assist in getting proof of the petitioner's identification and citizenship.
11. The respondent argued that there was no documentation provided to verify the identity of the petitioner. The Department asserts that it cannot approve the case without identification. At the hearing, the Department informed the petitioner's representative that it would accept two collateral contacts from two persons who can provide their own identification and use that to verify the identity of the petitioner with another application.

## 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. 652.056 .

FINAL ORDER (Cont.)
16F-00720
PAGE -4
14. Fla. Admin. Code R 65A-1.205, Eligibility Determination Process, states in relevant part:
(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...
(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. 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.
15. The cited rule explains that when the Department determines verification is
necessary to determine an applicant's eligibility, it is the applicant's (or designated representative's) responsibility to provide the verification. The Department is to provide as much assistance as possible, but the ultimate responsibility for providing the verification rests with the applicant (or designated representative).

## 16. The Department's Program Policy Manual (Policy Manual), CFOP 165-22 at

section 0640.0109, addresses Designated Representatives (MSSI). It states:
A designated representative may be appointed or self-designated to act on behalf of the household. If the individual does not select a specific person as designated representative, determine if the self-designated representative is the most appropriate person to fulfill this responsibility. An applicant must authorize a designated representative in writing prior to eligibility determination or anytime during the review period. The applicant does not have to be functionally or legally incompetent to have a designated representative...

FINAL ORDER (Cont.)
16F-00720
PAGE -5
17. The petitioner had a designated representative to act on his behalf. This included providing the representative with a written request for verification of his identification. A pending letter requesting identification and citizenship for the petitioner was mailed on January 14, 2016 and was due on January 25, 2016.
18. The Code of Federal Regulations at 42 C.F.R. $\S 435.406$ addresses Citizenship and alienage
(a) The agency must provide Medicaid to otherwise eligible residents of the United States who are-
(1) Citizens: (i) Under a declaration required by section 1137(d) of the Act that the individual is a citizen or national of the United States; and
(ii) The individual has provided satisfactory documentary evidence of citizenship or national status, as described in §435.407.
(iii) An individual for purposes of the declaration and citizenship documentation requirements discussed in paragraphs (a)(1)(i) and (a)(1)(ii) of this section includes both applicants and beneficiaries under a section 1115 demonstration (including a family planning demonstration project) for which a State receives Federal financial participation in their expenditures, as though the expenditures were for medical assistance. (iv) Individuals must declare their citizenship and the State must document the individual's citizenship in the individual's eligibility file on initial applications and initial redeterminations effective July 1, 2006.
19. The above authority states the petitioner, or designee must provide proof of citizenship. The petitioner's representative stated the petitioner was born in Virginia but has not provided proof of citizenship.
20. The Code of Federal Regulations at 42 C.F.R. $\S 435.407$ sets forth the level of evidence required.
(e) Evidence of identity. The following documents may be accepted as proof of identity and must accompany a document establishing citizenship from the groups of documentary evidence of citizenship in the groups in paragraphs (b) through (d) of this section.
(1) Identity documents described in 8 CFR 274a.2(b)(1)(v)(B)(1).
(i) Driver's license issued by State or Territory either with a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight or eye color.
(ii) School identification card with a photograph of the individual.
(iii) U.S. military card or draft record.
(iv) Identification card issued by the Federal, State, or local government with the same information included on drivers' licenses.
(v) Military dependent's identification card.
(vi) Certificate of Degree of Indian Blood, or other American Indian/Alaska Native Tribal document with a photograph or other personal identifying information relating to the individual. Acceptable if the document carries a photograph of the applicant or beneficiary, or has other personal identifying information relating to the individual such as age, weight, height, race, sex, and eye color.
(vii) U.S. Coast Guard Merchant Mariner card.

Note to paragraph (e)(1): Exception: Do not accept a voter's registration card or Canadian driver's license as listed in 8 CFR 274a.2(b)(1)(v)(B)(1). CMS does not view these as reliable for identity.
(2) At State option, a State may use a cross match with a Federal or State governmental, public assistance, law enforcement or corrections agency's data system to establish identity if the agency establishes and certifies true identity of individuals. Such agencies may include food stamps, child support, corrections, including juvenile detention, motor vehicle, or child protective services. The State Medicaid Agency is still responsible for assuring the accuracy of the identity determination.
(3) At State option, a State may accept three or more documents that together reasonably corroborate the identity of an individual provided such documents have not been used to establish the individual's citizenship and the individual submitted second or third tier evidence of citizenship. The State must first ensure that no other evidence of identity is available to the individual prior to accepting such documents. Such documents must at a minimum contain the individual's name, plus any additional information establishing the individual's identity. All documents used must contain consistent identifying information. These documents include employer identification cards, high school and college diplomas from accredited institutions (including general education and high school equivalency diplomas), marriage certificates, divorce decrees and property deeds/titles.
(h) Special populations needing assistance. States must assist individuals to secure satisfactory documentary evidence of citizenship when because of incapacity of mind or body the individual would be unable to comply with the requirement to present satisfactory documentary evidence of citizenship in a timely manner and the individual lacks a representative to assist him or her.
(i) Documentary evidence. (1) All documents must be either originals or copies certified by the issuing agency. Uncertified copies, including notarized copies, shall not be accepted.
(2) States must maintain copies of citizenship and identification documents in the case record or electronic data base and make these copies available for compliance audits.
21. The above authority informs of the various documents that can be used as proof of identity. The petitioner's designee has not provided any of the above documents as proof of identify.
22. The Policy Manual at section 1430.0400 addresses IDENTITY (MFAM), it states:

The identity of each U.S. citizen applying for, or receiving Medicaid must be documented.
The following documents are acceptable as proof of identity:

1. State driver's license with photo or other identifying information;
2. State ID card with photo or other identifying information;
3. School ID card with photo (for children under 16, includes nursery, daycare records, or school records, including school conference records and no photo is required);
4. Clinic, doctor, or hospital record for children under 16 (except for voided

Puerto Rican birth certificates after September 30, 2010);
5. U.S. military card or draft record;
6. A military dependent's ID card;
7. Federal, state, or local government ID card with photo;
8. A certificate of Indian blood;
9. Native American tribal document;
10. Three or more of the following documents unless a fourth tier verification of citizenship was used:
a. Marriage license,
b. Divorce decree,
c. High school diploma,
d. Employer ID card, or
e. Any other document from a similar source.
11. Food Stamp, CSE, Department of Corrections, child protection and DJJ data records,
12. U.S. Coast Guard merchant mariner card; or
13. Attestation (a written, signed statement under penalty of perjury) for children under age 16, or a disabled adult living in a residential facility, stating the date and place of birth. (cannot be used if statement was used for citizenship verification.)

FINAL ORDER (Cont.)
16F-00720
PAGE -8
23. The above authorities inform of the various documents needed to prove identity. As of the date of this hearing, none of the above documentation was provided to the Department.
24. The evidence demonstrates that the Department issued a written request for additional information on January 14, 2016. The requested information included verification of the petitioner's citizenship and identity as a factor of eligibility in the Medicaid Program. The information was due by January 25, 2016. The petitioner's representative did not provide the requested information as of the date of this hearing. The Department denied the application on January 21, 2016.
25. The designated representative argued that an exception should be made to the verification requirement because the petitioner died and was unable to participate in the application process. The representative had no knowledge of the petitioner's circumstances beyond his name, date of birth and that he was born on Virginia.
26. The petitioner had to meet disability requirement as well as technical requirements. The evidence proves that the designated representative did not provide proof of citizenship and identity which were the verifications required to meet the technical requirements and to determine the petitioner's eligibility for SSI- Related Medicaid. The undersigned reviewed Medicaid rules and regulations, but found no exception to the citizenship and identity verification requirement for the reason asserted by the designated representative. The petitioner's death does meet the requirements for an exception to verifying identity. The undersigned concludes that there was no assistance the Department could have provided to the representative in obtaining the needed verification. The Department explained at the hearing that the petitioner's

FINAL ORDER (Cont.)
16F-00720
PAGE -9
representative could provide two collateral contacts with their identification to verify the petitioner's identity.
27. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the petitioner's designated representative did not meet his burden of proof in this matter. The Department's action to deny the application is upheld.

## DECISION

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

## NOTICE OF RIGHT TO APPEAL

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

FINAL ORDER (Cont.)
16F-00720
PAGE -10
DONE and ORDERED this _ 20 day of April 2016, in Tallahassee, Florida.


Christian 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: Petitioner<br>Office of Economic Self Sufficiency

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

## FILED

Apr 21, 2016
Office of Appeal Hearings Dept. of Children and Farnilies


PETITIONER,

APPEAL NO. 16F-00724
VS.
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 05 MARION
UNIT: AHCA

RESPONDENT.
CASE NO.

## FINAL ORDER

The parties appeared for a telephonic administrative hearing in the abovecaptioned matter on February 24, 2016 at approximately 11:30 a.m. The minor petitioner was not present at the hearing, but was represented by his grandmother/guardian.

## APPEARANCES

For the Petitioner: For the Respondent:

Selwyn Gossett, Medical Health Care Program Specialist Agency for Health Care Administration

## STATEMENT OF ISSUE

At issue is a decision by Respondent, the Agency for Health Care Administration ("AHCA" or "the Agency") through its agent, Staywell Health Plan ("Staywell" or "the plan"), to terminate Petitioner's residential institutional services under the Statewide Inpatient Psychiatric Program ("SIPP") as of January 17, 2016. Respondent held the

FINAL ORDER (Cont.)
16F-00724
Page 2 of 15
burden of proof by a preponderance of the evidence to show the termination was proper.

## PRELIMINARY STATEMENT

Petitioner presented witnesses
witnesses from Petitioner's managed care health plan, Staywell: Alexandria Hicks (Regulatory Research Coordinator) and Dr. Nicholas Abid (Medical Director of Behavioral Health). Petitioner's Composite Exhibit 1 and Respondent's Exhibits 1 through 17 were marked and entered 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 is an approximately 15-year-old male. He has a history of sexual and aggressive behavioral problems. He is hyperactive, impulsive, and frequently lies. His family reported that he watches child pornography online and adult pornography on television, and steals young girl's clothing (as young as toddler age). They restricted his access to electronic devices to keep him from watching it, downloading viruses on the devices, and spending family money on the content. He reacts explosively when caught or when something does not work in his favor. He has not sexually abused anyone at this point. He has threatened to kill his family and classmates, and his family is afraid he will eventually hurt someone. Petitioner is noted to lack empathy and does not care

FINAL ORDER (Cont.)
16F-00724
Page 3 of 15
about others' opinion of him. He did not care enough to manage his own hygiene, and required supervision and prompting to complete activities. He has an inflated sense of his own abilities. He hoards objects such as pieces of concrete, which is characteristic.
2. Petitioner currently lives with his grandmother, grandfather, and sister. His uncle lives nearby on the property. His grandparents are both approximately sixty years old with medical conditions. His grandfather was diagnosed with cancer and is undergoing treatment. Petitioner's grandparents are unable to manage his behaviors or restrain him if he acts violently against them. He has already threatened to kill them and his uncle at least once.
3. Petitioner was receiving therapy on an outpatient basis for approximately one year prior to SIPP placement. There was minimal progress in therapy to stop his behaviors. The therapist provided a letter indicating Petitioner's lack of empathy is beyond what she has seen with other $\square$ spectrum clients, and this combined with his impulsivity could lead to "disastrous outcomes."
4. Petitioner was placed at a residential inpatient behavioral health facility with a starting authorization date of October 21, 2015. The facility requested numerous extensions. The plan approved various length stay extensions. The most recent request for services was dated January 13, 2016. The plan approved six days, with a last covered date of January 17, 2016. There is no indication that this request was for a set period of time, only what the last covered date would be. Petitioner did not acknowledge a specific end date. Petitioner simply wants continuous, ongoing care.

FINAL ORDER (Cont.)
16F-00724
Page 4 of 15
Treatment goals suggest a potential discharge date of April 21, 2016, which may be prior to the date of this order's issuance.
5. The January 13,2016 letter from the plan explained that care was not authorized after January 17, 2016 because:
...the clinical information received shows that you are doing well on medications and are not creating disturbances. You have learned healthy ways to take care of your symptoms. Your daily functioning and self-care have improved. You do not need a $24 / 7$ supervised setting in order to be safe and take care of your needs. Your care could be managed in another setting such as Outpatient....
6. The facility appealed this decision with the plan on January 14, 2016 and the plan upheld its decision. The plan sent notices dated January 15, 2016 to the Petitioner and the provider explaining the decision. At some point, the plan agreed to approve three more days, giving Petitioner until January 20, 2016 in the facility.
7. Petitioner requested a fair hearing on February 1, 2016 because he disagreed with the January 17, 2016 treatment end date. This was 17 days after the last appeal decision notice date (January 15, 2016) explaining the last covered date of January 17, 2016. However, the plan agreed to grant continued benefits pending the outcome of the appeal despite the Petitioner being over deadline to request such benefits.
8. The plan denied additional time at the inpatient facility because the medical records it reviewed did not say he was going to harm himself or anyone else. The plan did not agree that he needed to be in a residential treatment facility any longer, and his care could be managed in an outpatient setting.
9. Petitioner's family and the facility are requesting ongoing residential treatment.

The plan agreed to authorize his inpatient stay while the final order is pending on this

FINAL ORDER (Cont.)
16F-00724
Page 5 of 15
matter. The continuation of care pending appeal thus gives Petitioner at least an additional three months beyond what the plan already approved.
10. Petitioner's treatment team and the plan agree that Petitioner's symptoms will require life-long care. He has made some progress at the facility, but it is minimal. His hygiene and self-care have improved. He is not failing in school. He has become more cooperative at counseling. He doesn't have active psychotic symptoms and it does not appear to be a willful conduct problem. He takes medication. He does not see the connection between his behaviors and how that impacts others, which concerns his treatment team. Medication is helping decrease his lying and delusional beliefs.
11. Petitioner continues to be aggressive with others and he stole a girl's shirt despite sexual restraints at the facility. He attempted to flush the shirt down the toilet to avoid being caught. He is still very emotionally unstable. He has lashed out aggressively to staff at the facility and has been placed in holds while there. He rages at benign issues, for example kicking a wall because he lost a game. He admitted to punching a peer in February in hopes it would help extend his stay as he does not want to go home to his family. The treatment team believes he will still engage in aggression against others and sexually inappropriate behaviors if released from the facility. Discharge planning was noted as a concern because Petitioner's relationship with his grandmother is distant and hostile, and she does not want him back in the home as she cannot maintain him.
12. As of the hearing date, Petitioner had not been tested for nor did he have a psycho-sexual assessment completed despite having been in the facility for three months at that point.

## CONCLUSIONS OF LAW

13. 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.
14. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.
15. This hearing was held as a de novo proceeding pursuant to Florida

Administrative Code Rule 65-2.056.
16. All services covered by Medicaid 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.
6. 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

FINAL ORDER (Cont.)
16F-00724
Page 7 of 15
Treatment Services (EPDST) requirements. Section 409.905, Florida Statutes,
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.
18. 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

FINAL ORDER (Cont.)
16F-00724
Page 8 of 15
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)).
19. 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. The state is authorized to establish the amount, duration, and scope of such services.
20. Consistent with the law, AHCA's contracted plan, Staywell, performs service authorization reviews for its members. Once Staywell receives a service request, its medical personnel conducts file reviews to determine the medical necessity of requested services, pursuant to the authorization requirements and limitations of the Florida Medicaid Program. To this end, the plan relies on utilization guidelines, which were entered into evidence as Respondent's Exhibit 10 and are found on pages 114117 of the evidence packet.
21.42 C.F.R. § 441.152 (Inpatient Psychiatric Services for Individuals Under Age 21
in Psychiatric Facilities or Programs) is the federal criteria that recipients must meet:
Certification of need for services.
(a) A team specified in Sec. 441.154 must certify that--
(1) Ambulatory care resources available in the community do not meet the treatment needs of the recipient;
(2) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
(3) The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.
(b) The certification specified in this section and in Sec. 441.153 satisfies the utilization control requirement for physician certification in Sec. 456.60, 456.160, and 456.360 of this subchapter (emphasis added).
22. Consistent with the federal law, Florida has established criteria to govern the SIPP program. As of January 6, 2016, Florida Administrative Code Rule 59G-4.120 promulgated the Florida Medicaid Statewide Inpatient Psychiatric Coverage Policy, December 2015 ("the SIPP policy") into law. The SIPP policy contains general and specific criteria that must be met to authorize a SIPP service, on top of the standard medical necessity rule applicable to all Medicaid services. The general information in the SIPP policy are the minimum standards for coverage under a managed care plan. While the majority of the SIPP policy applies to all SIPP care, the SIPP policy's specific authorization criteria at section 7.2, applies to the Medicaid fee-for-service program. Petitioner is enrolled in managed care.
23. Section 2.2 of the SIPP policy ("Who Can Receive") explains that only certain Medicaid recipients qualify for SIPP placement.

Florida Medicaid recipients requiring medically necessary SIPP services who meet the following criteria:

- Are under the age of 21 years with emotional disturbance or serious emotional disturbance otherwise defined in Chapter 394, F.S.
- Require treatment in a psychiatric residential setting due to a primary diagnosis of emotional disturbance or serious emotional disturbance

24. The SIPP policy at 4.2.1 further explains what is necessary to authorize admission ("Pre-admission Assessment Requirements"):

Recipients in the care and custody of the state must be assessed in accordance with section 39.407(6)(b), F.S. Recipients not in the care and custody of the state must be assessed by a Florida licensed psychologist
or psychiatrist, with experience or training in childhood disorders. The assessment must result in a report with written findings as required by the Department of Children and Families in Rule 65E-9.008, F.A.C.
25. Florida Administrative Code Rule 9.008(4) explains what must be in the preadmission assessment for a child to qualify for SIPP placement. The relevant portions of the rule applicable to this case are as follows:
...The assessment must result in a report whose written findings are that:
(a) The child has an emotional disturbance as defined in Section 394.492(5), F.S., or a serious emotional disturbance as defined in Section 394.492(6), F.S.;
(b) The emotional disturbance or serious emotional disturbance requires treatment in a residential treatment center;
(c) All available treatment that is less restrictive than residential treatment has been considered or is unavailable;
(d) The treatment provided in the residential treatment center is reasonably likely to resolve the child's presenting problems as identified by the qualified evaluator;
(e) The provider is qualified by staff, program and equipment to give the care and treatment required by the child's condition, age and cognitive ability;
(f) The child is under the age of 18; and
(g) The nature, purpose and expected length of the treatment have been explained to the child and the child's parent or guardian and guardian ad litem.... (emphasis added).
26. In addition, residential placement also requires that a recipient meet certain criteria. These criteria are set forth in Fla. Admin. Code R. 65E-10.018, as follows, and are consistent with the assessment requirements in Fla. Admin. Code R. 9.008(4):
(1) To be eligible to be admitted to a program encompassed by these rules, a child must:
(a) Be under the age of 18;
(b) Be currently assessed within 90 days prior to placement by a psychologist or a psychiatrist licensed to practice in the State of Florida, with experience or training in children's disorders; who attests, in writing, that:

1. The child has an emotional disturbance as defined in Section 394.492(5), F.S., or a serious emotional disturbance as defined in Section 394.492(6), F.A.C.;
2. The emotional disturbance or serious emotional disturbance requires treatment in a residential treatment setting;
3. A less restrictive setting than residential treatment is not available or clinically recommended;
4. The treatment provided in the residential treatment setting is reasonably likely to resolve the child's presenting problems as identified by the psychiatrist or psychologist;
5. The nature, purpose, and expected length of treatment have been explained to the child and the child's parent or guardian.
(c) Have been reviewed at a minimum by the child and family specific team and been presented with all available options for treatment.
(2) General revenue funds designated as children's mental health funding shall not be used to maintain children over the age of 18 in programs encompassed by these rules or to place a child for whom no appropriate services are available in Florida in an out of state residential treatment program which is not an approved Medicaid provider in the state where the child is being placed.
(3) Placement of children and youth in therapeutic out of home settings with general revenue funds is dependent on the availability of funds.
6. The applicable definitions of "emotional disturbance" referenced in the above

Rule are found in Fla. Stat. § 394.492(5 and 6):
(5) "Child or adolescent who has an emotional disturbance" means a person under 18 years of age who is diagnosed with a mental, emotional, or behavioral disorder of sufficient duration to meet one of the diagnostic categories specified in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, but who does not exhibit behaviors that substantially interfere with or limit his or her role or ability to function in the family, school, or community. The emotional disturbance must not be considered to be a temporary response to a stressful situation. The term does not include a child or adolescent who meets the criteria for involuntary placement under s. 394.467(1).
(6) "Child or adolescent who has a serious emotional disturbance or mental illness" means a person under 18 years of age who:
(a) Is diagnosed as having a mental, emotional, or behavioral disorder that meets one of the diagnostic categories specified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association; and
(b) Exhibits behaviors that substantially interfere with or limit his or her role or ability to function in the family, school, or community, which

FINAL ORDER (Cont.)
16F-00724
Page 12 of 15
behaviors are not considered to be a temporary response to a stressful situation.
28. In terms of being specific and individualized, in keeping with Fla. Admin. Code R. 59G-1.010(166)(2), Petitioner's request for SIPP meets portions of the criteria set forth in Fla. Admin. Code R. 65E-10.018. However, both 65E-10.018 and 59G-1.010(166)(2) also require that SIPP (or any service) not be in excess of the patient's needs.
29. The plan's own utilization guidelines for continued psychiatric residential stay require multiple criteria to be met "within the last week" prior to the extension of care. Therefore, he must have engaged in the problem behavior to meet the plan's criteria to extend his stay, during the week of approximately January 3 through January 10. Despite numerous records in the evidence, it is unclear whether the specific behaviors recognized in the criteria were committed during the particular week in question. Regardless, the Florida Administrative Code Rules and the Florida Statutes are dispositive of this case, and are a higher authority than the plan's own guidelines.
30. Both Respondent and members of Petitioner's treatment team acknowledge that Petitioner's behaviors will require life-long care. He has made minimal progress in the three months spent in the facility. That progress is such that Petitioner's self-care and self-awareness have improved to some degree. While his unwanted behaviors of emotional outbursts and stealing girls' clothing continue despite the rigid structure of the SIPP, he is not a danger to himself or others and is relatively stable.
31. His emotional outbursts appear to be triggered by different events (such as others yelling at him, feeling threatened by peers, and not getting his way), and are temporary responses to perceived stressful events. He has only threatened harm to

FINAL ORDER (Cont.)
16F-00724
Page 13 of 15
others, and has not acted on his threats. Respondent notes that SIPP is excessive because Petitioner's behaviors escalate to the point of constituting harm to self or others only on a temporary basis. See Fla. Stat. § 394.492(6)(b). When this happens, he is placed in a temporary hold and released when he is calmer. He is taking medication. There is no evidence that his behavior such as kicking walls when stressed has resulted in significant harm to himself or others requiring physician attention. He did punch a peer in February, but did this in an attempt to stay at the facility rather than out of emotional instability.
32. Petitioner previously received outpatient therapy and made little progress. His behaviors continued, so he was placed in the SIPP. His treating team acknowledges he is difficult to gain rapport with and his progress in therapy at the SIPP is minimal. His improvement in the SIPP has been remarkably slow. He has improved his hygiene, but still requires prompting. He has decreased the amount of aggression towards staff. There is no evidence that "the treatment provided in the residential treatment center is reasonably likely to resolve the child's presenting problems" as all parties acknowledge he has made little progress and will require life-long assistance. His treatment, whether in an outpatient or an inpatient setting, will likely be long, difficult, and very slow. The SIPP is not making much progress with him and it does not appear reasonably likely to solve all of Petitioner's presenting problems.
33. It appears the SIPP is preferred because the family does not feel comfortable with Petitioner in the home and cannot provide as rigid of a structure and supervision as the SIPP program. The medical necessity definition specifically excludes care that is primarily for the family's convenience.

FINAL ORDER (Cont.)
16F-00724
Page 14 of 15
34. SIPP is inherently more restrictive than an outpatient program. It is unreasonable to commit a child to a restrictive setting when he would make similar progress in a less restrictive setting. Medical necessity requires that the service "be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide." SIPP, in this case, is not any more effective than continuous and frequent outpatient care on this particular patient.
35. Petitioner's physician and treatment team at the facility support his inpatient treatment. Outpatient care was attempted in the past with little to no success. However, the SIPP isn't making very much progress with Petitioner either. If the inpatient and outpatient services are providing similar results, then the less restrictive environment is the preferred means of care according to the medical necessity rule. The SIPP was providing Petitioner with prompts for his hygiene, and the family could continue to do that. His other behaviors will require ongoing therapy and medication intervention.
36. When jointly considering the requirements of both EPSDT and medical necessity, along with a review of the totality of the evidence and legal authority, the undersigned concludes that Respondent met its burden to show that SIPP placement was properly terminated.
37. It is evident that Petitioner's team is genuinely concerned for his health and safety. As such, they are strongly encouraged to work with Staywell to develop a comprehensive array of services to meet, but not exceed, Petitioner's needs, including more frequent outpatient therapy if deemed necessary.

FINAL ORDER (Cont.)
16F-00724
Page 15 of 15
38. Petitioner is also encouraged to contact the Agency for Persons with Disabilities to determine whether he has a diagnosis (such as autism or intellectual disability) that would qualify him for waiver services under the Developmental Disabilities program rules.

## DECISION

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


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

PETITIONER,
Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 05 Citrus
UNIT: 88003

## RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 3:00 p.m. on February 22, 2016.

## APPEARANCES

For the Petitioner:
For the Respondent:
Patricia DiSilvestro, ACCESS
Economic Self-Sufficiency Specialist

## 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 (MN) Program with a Share of Cost (SOC) is proper. The respondent carries the burden of proof by the preponderance of evidence.

FINAL ORDER (Cont.)
16F-00730
PAGE - 2

## PRELIMINARY STATEMENT

By notice dated January 15, 2016, the respondent (or the Department) notified the petitioner he was enrolled in the MN Program with a $\$ 745$ SOC, effective in December 2015. Petitioner timely requested a hearing to challenge enrollment in the MN Program and termination of full Medicaid.

Petitioner did not submit exhibits. Respondent submitted six exhibits, entered as Respondent Exhibits " 1 " through " 6 ". The record was closed on February 22, 2016.

## FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner received full Medicaid through the Social Security Administration (SSA), due to receiving Supplemental Security Income (SSI).
2. In November 2015, the SSA changed petitioner's SSI to $\$ 945$ Social Security Disability Income (SSDI). As a result, petitioner's Medicaid through the SSA ended in November 2015.
3. On December 15, 2015, petitioner (age 62) submitted an application for Food Assistance and Medicaid for himself and his girlfriend. Medicaid for petitioner is the only issue.
4. For petitioner to be eligible for full Medicaid, his income cannot exceed the $\$ 864$ SSIRelated Medicaid income limit for a household size of one. Petitioner's \$945 SSDI exceeds the $\$ 864$ income limit. The next available program is MN with a SOC.
5. The Department calculated petitioner's SOC as follows:

FINAL ORDER (Cont.)
16F-00730
PAGE-3

| $\$ 945$ | SSDI |
| :--- | :--- |
| $-\$ 20$ | unearned income disregard |
| $-\$ 180$ | MN income level (MNIL) for a household size of one |
| $\$ 745$ | SOC |

6. On January 15, 2016, the Department notified the petitioner he was enrolled in the

MN Program with a $\$ 745$ SOC, effective in December 2015.
7. Petitioner does not believe the MN Program works and would prefer to have 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 § 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-1.701 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, petitioner's income cannot exceed $88 \%$ of the FPL. Petitioner $\$ 945$ SSDI exceeds the $\$ 864$ FPL for a household size of one.

Therefore, petitioner is not eligible for full Medicaid.

FINAL ORDER (Cont.)
16F-00730
PAGE-4
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 above authorities, respondent deducted $\$ 20$ unearned income and $\$ 180$ MNIL from petitioner's $\$ 945$ SSDI to arrive at a $\$ 745$ SOC.
18. In careful review of the cited authorities and evidence, the undersigned concludes the respondent met its burden of proof. The Department's action to approve petitioner in the MN Program with a $\$ 745$ SOC is proper.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the respondent's action is affirmed.

## NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigence 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 $\qquad$ day of April _, 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

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

Apr 05, 2016

PETITIONER,

Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES CIRCUIT: 13 Hillsborough
UNIT: 88232

CASE NO.

## RESPONDENT.

## ORDER OF DISMISSAL

Pursuant to notice, the undersigned convened a telephonic administrative hearing on February 26, 2016 at 10:32 a.m. Petitioner was present and testified. Respondent was represented by Ed Poutre, Economic Self Sufficiency Specialist II with the Department of Children and Families (hereafter "DCF", "Respondent" or "Agency"). Mr. Poutre testified.

Petitioner requested a hearing for Temporary Cash Assistance (TCA), Food Assistance (FA), and Medicaid benefits. At the February 26, 2016 hearing, the petitioner indicated she did not have any remaining issues concerning her TCA and FA benefits; therefore, she verbally withdrew her TCA and FA appeals while on the record. The undersigned accepts petitioner's verbal withdrawal and DISMISSES her Temporary Cash Assistance and Food Assistance appeals as withdrawn.

The undersigned was unable to complete the February 26, 2016 administrative hearing as petitioner requested a continuance to allow the respondent to resolve her ongoing Medicaid issue. On February 29, 2016, a Notice of Hearing by Telephone was mailed to petitioner, which informed her an administrative hearing by phone was reset for March 23, 2016 at 10:00 a.m. On March 23, 2016, the undersigned and Mr. Poutre appeared for the scheduled hearing. The undersigned and the respondent waited for petitioner for fifteen minutes after the scheduled hearing time. Petitioner never appeared for the hearing. To the date of this Order, petitioner has not contacted the undersigned to request the hearing be rescheduled. Therefore, petitioner's Medicaid appeal is DISMISSED as abandoned.

DONE and ORDERED this _ 05 day of __ April_, 2016, in Tallahassee, Florida.

> Mary Gane 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@myfffamilies.com

Copies Furnished To:
Petitioner
Office of Economic Self Sufficiency

Apr 21, 2016
STATE OF FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES OFFICE OF APPEAL HEARINGS

PETITIONER,
Vs.

## FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES

CIRCUIT: 18 Brevard
UNIT: 88222
RESPONDENT.

## CASE NO.

## FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 1:00 p.m. on February 16, 2016.

## APPEARANCES

For the Petitioner:
For the Respondent:
bro se

Susan Martin, ACCESS
Operations Management Consultant

## STATEMENT OF ISSUE

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

## PRELIMINARY STATEMENT

By notice dated January 26, 2016, the respondent (or the Department) notified the petitioner she was ineligible for Medicaid effective December 2015. Petitioner timely requested a hearing to challenge her Medicaid ineligibility.

FINAL ORDER (Cont.)
16F-00751
PAGE - 2
Petitioner submitted one exhibit, entered as Petitioner Exhibit "1". Respondent submitted four exhibits, entered as Respondent Exhibits "1" through "4". The record was closed on February 16, 2016.

## FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner received Medicaid disability from the Department.
2. The respondent's representative stated that the Department had previously approved petitioner Medicaid in error.
3. On November 23, 2015, the petitioner, age 55, submitted a redetermination application for Food Assistance and SSI-Related Medicaid for herself. Medicaid is the only issue.
4. To be eligible for SSI-Related Medicaid petitioner must be over age 65 or considered disabled by the Social Security Administration (SSA) or the Division of Disability Determination (DDD).
5. Petitioner applied for disability through the SSA in February 2015. SSA denied petitioner disability in May 2015. Petitioner appealed the SSA denial in November 2015; an appeal date has not been set.
6. On January 22, 2016, the Department forwarded petitioner's disability documents to DDD for a disability eligibility determination. DDD reviewed petitioner's disability documents and denied her Medicaid disability on the same day; due to adopting the SSA denial decision.

FINAL ORDER (Cont.)
16F-00751
PAGE - 3
7. On January 26, 2016, the Department mailed petitioner a Notice of Case Action, notifying she was ineligible for Medicaid, effective December 2015, "Reason: You or a member(s) of your household do not meet the disability requirement."
8. Petitioner described her disability as having
 Petitioner stated that she has new medical conditions since she applied with the SSA in February 2015.
9. Petitioner described her new medical conditions as problems with her left leg and her neck. Petitioner has informed the SSA of her new medical conditions and is in the process of submitting her medical records of her new medical conditions to the SSA.

## 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 $\S 409.285$, 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 Code of Federal Regulations at 42 C.F.R. $\S 435.541$, 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 $\S 435.912$ 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...
13. In accordance with the above authority, the respondent denied petitioner's

November 23, 2015, Medicaid application; due to adopting the SSA May 2015 denial decision.
14. The above authority states the Department must make a determination of disability if the individual "alleges a disabling condition different from, or in addition to, that considered by the SSA in making its determination".
15. Petitioner argued that she has new medical conditions since she applied with the SSA in February 2015. She described her new medical conditions as problems with her left leg and neck. Petitioner informed the SSA of her new medical conditions and is in the process of submitting her medical records of her new medical conditions to the SSA. 16. In careful review of the cited authority and evidence, the undersigned concludes the Department met its burden of proof. The Department's action to deny petitioner Medicaid due to adopting the SSA disability denial is proper.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the respondent's action is affirmed.

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this $\qquad$ day of April , 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@myffamilies.com

Copies Furnished To:
Petitioner
Office of Economic Self Sufficiency

Mar 17, 2016

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

APPEAL NO. 16F-00752
16F-00753

PETITIONER,
Vs.

FLORIDA DEPARTMENT
CASE NO. OF CHILDREN AND FAMILIES CIRCUIT: 11 Dade
UNIT: 88076
RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on February 29, 2016 at 9:05 a.m. All parties appeared telephonically from different locations.

## APPEARANCES

For the Petitioner:
For the Respondent:


Joseph Austrie, Operations Management Consultant I

## STATEMENT OF ISSUE

At issue is the respondent's action to approve $\$ 16$ Food Assistance Program (FAP) benefits, the denial of full Medicaid benefits and enrollment in the Medically Needy (MN) Program with a $\$ 1,464$ Share of Cost (SOC).

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

FINAL ORDER (Cont.)
16F-00752, 00753
PAGE -2

## PRELIMINARY STATEMENT

The petitioner did not submit any exhibits. The respondent submitted five exhibits which were entered into evidence and marked as Respondent's Exhibits "1" through " 5 ". The record was held open for additional evidence including, FAP budgets, all Medicaid budgets, policy related to calculations of FAP budget, and termination of Supplemental Security Income and receipt of Social Security Disability Income until March 3,2016. The above mentioned evidence was provided on March 3, 2016, marked and entered as Respondent's Exhibits " 6 " through "10". The record was closed the same day.

## FINDINGS OF FACT

1. On November 23, 2015, the petitioner submitted a recertification application for Food Assistance, SSI-Related Medicaid, and Medicaid Savings Plan (MSP). The application lists the petitioner only. The petitioner listed both $\$ 733$ Supplemental Security Income and \$2,100 Social Security Disability Income (SSDI); and expenses include \$1,100 in rent and utilities.
2. The petitioner received SSI until September 31, 2015. In October 2015, the Social Security Administration (SSA) changed the petitioner's Supplemental Security Income (SSI) to \$1,768 (SSDI), which terminated his full Medicaid through the SSA.
3. The respondent verified the petitioner's income of $\$ 1,873$ in (SSDI. The petitioner also incurred a medical expense of $\$ 104.90$ for his Medicare Part B premium. The medical deduction of $\$ 35$ was subtracted from the medical expense, leaving $\$ 69$ as the excess medical expense.

FINAL ORDER (Cont.)
16F-00752, 00753
PAGE -3
4. The respondent approved the minimum benefit of $\$ 16$ in FAP. The respondent calculated the petitioner's benefits as follows:

| \$ 1,873 | SSDI |
| :---: | :---: |
| 155 | standard deduction |
| 69 | excess medical expense |
| \$ 1,649 | adjusted income |
| \$ 1,000.00 | shelter/rent |
| 345.00 | standard utility allowance |
| \$ 1,345.00 | shelter \& utility costs |
| 824.50 | 50\% adjusted income (\$1544/2) |
| \$ 520.50 | excess shelter/deduction |
| \$1,649.00 | adjusted income |
| - 520.50 | excess shelter/deduction |
| \$ 1,128.50 | food stamp adjusted income |
| $30 \%$ of 1,128.50 = \$339 (round up) |  |

5. The respondent affirms that the petitioner is eligible for the minimum benefit of $\$ 16$.
6. Both the petitioner and the respondent assert that the shelter cost should be $\$ 1,100$.
7. The respondent then evaluated the petitioner for the MN program based on his current SSDI. The respondent calculated the SOC by deducting $\$ 20$ unearned income and $\$ 180 \mathrm{MN}$ income limit (MNIL) from the petitioner's $\$ 1,873$ SSDI to reach the $\$ 1,673$ SOC. The respondent then deducted the $\$ 104$ recurring medical expenses to come to a remaining $\$ 1,569$ SOC.
8. On December 28,2015, the department mailed the petitioner a Notice of Case Action, notifying him that $\$ 16$ in FAP benefits were authorized, he was enrolled in MN with a $\$ 1,569$ SOC, and the denial of Medicare Savings Plan Qualifying Individual 1 "Reason: Your household's income is too high to qualify for this program". The petitioner timely requested a hearing to challenge the action.

FINAL ORDER (Cont.)
16F-00752, 00753
PAGE -4
9. The petitioner is only contesting the \$16 FAP and enrollment in MN. He does not dispute the denial of the MSP.
10. Based on testimony and evidence provided, the case record was updated by the respondent to reflect the SSDI of $\$ 1,768$, not $\$ 1,873$. The case was updated during the hearing to reflect the correct income and the rental expense of $\$ 1,100$, which did not change the benefit amount of the FAP. The SOC was updated to reflect $\$ 1,464$ based on the corrected income.

## 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 $\S 409.285$, Fla. Stat.
12. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 652.056.

## Food Assistance will be addressed first:

13. Federal Regulations at 7 C.F.R. $\S 273.9$ define income and allowable deductions in the Food Assistance Program (FAP) and in part states:
(a) Income eligibility standards...
(1) The gross income eligibility standards for the Food Stamp Program...
(b) Definition of income. Household income shall mean all income from whatever source...
(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 (emphasis added)...
(d) Income deductions. Deductions shall be allowed only for the following household expenses:

FINAL ORDER (Cont.)
16F-00752, 00753
PAGE -5
(1) Standard deduction...
(3) Excess medical deduction...
(6) Shelter costs...
(ii) Excess shelter deduction. Monthly shelter expenses in excess of 50 percent of the household's income after all other deductions...
(C) The cost of fuel for heating; cooling (i.e., the operation of air conditioning systems or room air conditioners); electricity or fuel used for purposes other than heating or cooling; water; sewerage; well installation and maintenance; septic tank system installation and maintenance; garbage and trash collection; all service fees required to provide service for one telephone...
(iii) Standard utility allowances...Only utility costs identified in paragraph (d)(6)(ii)(C) of this section must be used in developing standards...
14. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, at section 1810.0904.01 SSA Income (FS) states:

Benefits that are paid by SSA are considered unearned income. The gross entitlement amount in dollars and cents prior to any deduction is budgeted. Recouped benefits not received by the household as well as Social Security Educational Benefits are excluded as unearned income.
15. In accordance with the above Federal Regulation and the Department's Policy Manual, the petitioner's $\$ 1,768$ SSDI was counted in the FAP determination. Also in accordance with the above federal regulation, the respondent subtracted all allowable deductions (standard, shelter, excess medical, and utilities) in the FAP determination.

The correct budget calculations are as follows:

| \$ 1,768 | SSDI |
| :---: | :---: |
| 155 | standard deduction |
| 69 | excess medical expense |
| \$ 1,544 | adjusted income |
| \$ 1,100 | shelter/rent |
| 345 | standard utility allowance |
| \$ 1,445 | shelter \& utility costs |
| 772 | 50\% adjusted income (\$1544/2) |
| \$ 520 | excess shelter/deduction |
| \$ 1,649 | adjusted income |

FINAL ORDER (Cont.)
16F-00752, 00753
PAGE -6

| $-\quad 673$ | excess shelter/deduction |
| :--- | :--- |
| $\$ 871 \quad$ food stamp adjusted income |  |
| $30 \%$ of $871=\$ 262$ (round up) |  |

16. Federal Regulations at 7 C.F.R $\S 273.10$ states in part:
(2) Eligibility and benefits. (i)(A) Households which contain an elderly or disabled member as defined in §271.2, shall have their net income, as calculated in paragraph (e)(1) of this section (except for households considered destitute in accordance with paragraph (e)(3) of this section), compared to the monthly income eligibility standards defined in §273.9(a)(2) for the appropriate household size to determine eligibility for the month.
(e)(vi) (B) Except as provided in paragraphs (a)(1), (e)(2)(ii)(B), and $(e)(2)(\mathrm{vi})(\mathrm{C})$ of this section, one- and two-person households shall be provided with at least the minimum benefit.
17. The Policy Manual at Appendix A-1, sets forth for a household size of one, the following:

| $\$$ | 194 | maximum FA benefit |
| :--- | ---: | :--- |
| $\$$ | 16 | minimum FA benefit amount |
| $\$$ | 155 | standard deduction |
| $\$$ | 345 | standard utility allowance |
| $\$ 1,962$ | $200 \%$ gross income limit |  |

18. The above cited authorities explains the petitioner is eligible to receive the $\$ 16$ minimum monthly FA allotment due to his income being less than $200 \%$ of the gross income limit.

## Full Medicaid benefits will be now be addressed:

19. Fla. Admin. Code R. 65A-1.713 defines the income limits for SSI - Related Medicaid programs. It states:
(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
(a) For MEDS-AD Demonstration Waiver, income cannot exceed 88 percent of the federal poverty level after application of exclusions specified

FINAL ORDER (Cont.)
16F-00752, 00753
PAGE -7
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.
20. The Department's Policy Manual, CFOP 165-22 at Appendix A-9, sets forth $88 \%$ of the federal poverty level (FPL) for a household size of one at $\$ 864$.
21. Fla. Admin. Code R. 65A-1.701 states in the pertinent part:
(20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services. (emphasis added)
22. In accordance with the above authority, the petitioner's income cannot exceed $88 \%$ of the FPL and he cannot be receiving Medicare unless he is receiving institutional care services, hospice services, or home and community based services.
23. The petitioner's $\$ 1,768$ SSDI exceeds the $\$ 864$ FPL for a household size of one and the petitioner is also currently receiving Medicare Part A and B without institutional care services, hospices services, or home and community based services. Therefore, the petitioner is not eligible for full Medicaid.

## Enrollment in Medically Needy and Share of Cost amount will now be addressed:

24. 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

FINAL ORDER (Cont.)
16F-00752, 00753
PAGE -8
couples) who do not qualify for categorical assistance due to their level of income or resources.
25. The above authority explains MN provides coverage for individuals who do not qualify for full Medicaid due to income.
26. Fla. Admin. Code R. 65A-1.701 (30) states, "Share of Cost (SOC) represents the amount of recognized medical expenses that a Medically Needy enrolled individual or family must incur each month before becoming eligible to receive Medicaid benefits for medical expenses incurred during the remainder of the month."
27. The Fla. Admin. Code R. 65A-1.713, SSI-Related Medicaid Income

Eligibility Criteria, states in part:
(h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses...
(4)(c) Medically Needy. The amount by which the individual's countable income exceeds the Medically Needy income level, called the "share of cost shall be considered available for payment of medical care and services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical costs.
28. The 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..."
29. The Fla. Admin. Code R. 65A-1.716 sets forth the MNIL at $\$ 180$ for a family size of one.
30. In accordance with the authorities, the respondent deducted $\$ 20$ unearned income and $\$ 180$ MNIL from the petitioner's $\$ 1,768$ SSDI to arrive at $\$ 1,568$ SOC.
31. The Code of Federal Regulations 42 C.F.R. § 436.831 outlines Medically Needy income eligibility and how to determine countable income as follows:

FINAL ORDER (Cont.)
16F-00752, 00753
PAGE -9
The agency must determine income eligibility of medically needy individuals in accordance with this section.
...(b) Determining countable income. The agency must, to determine countable income, deduct amounts that would be deducted in determining eligibility under the State's approved 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 $\S 436.814$, the individual is eligible for Medicaid.
(d) Deduction of incurred medical expenses: If countable income exceeds the income standard, the agency must deduct from income medical expenses incurred by the individual...that are not subject to payment by a third party.
(e) Determination of deductible incurred expenses: Subject to the provisions of paragraph ( g ) of this section, in determining incurred medical expenses to be deducted from income, the agency must include the following...
(1) Expenses for Medicare and other health insurance premiums...
32. In accordance with the authorities, the respondent deducted the Medical Insurance Premium of $\$ 104$ to arrive at the $\$ 1,464$ SOC.
33. The undersigned reviewed the respondent's budget calculations and the petitioner's reported income using the rules cited above and did not find a more favorable outcome than the SOC assigned by the respondent.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal relating to the Food Assistance benefits is denied and the respondent's action is affirmed. The appeal relating to the denial of full Medicaid and enrollment in the Medically Needy Program with a Share of Cost is denied and the respondent's action is also 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 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 March , 2016,
in Tallahassee, Florida.


Pamela B. Vance
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: Petitioner
Office of Economic Self Sufficiency

Apr 29, 2016
STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-00768
16F-00769
PETITIONER,
Vs.
FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 Lake
UNIT: 88003
RESPONDENT.

## CASE NO.

## FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 1:00 p.m. on March 28, 2016. The hearing was reconvened at 12:00 p.m. on April 12, 2016.

## APPEARANCES

For the Petitioner:
For the Respondent:


Patricia DiSilvestro, ACCESS Economic Self-Sufficiency Specialist II

## STATEMENT OF ISSUE

At issue is the respondent's action to: 1) reduce the petitioner's Food Assistance (FA) benefits and 2) terminate full Medicaid for petitioner's ex-husband and instead approve Medicaid Medically Needy (MN) with a Share of Cost (SOC). The petitioner carries the burden of proof by the preponderance of evidence on the FA issue. The

FINAL ORDER (Cont.)
16F-00768 \& 16F-00769
PAGE - 2
respondent carries the burden of proof by the preponderance of evidence on the Medicaid issue.

## PRELIMINARY STATEMENT

By notice dated January 8, 2016, the respondent (or the Department) notified the petitioner FA would decrease from $\$ 493$ to $\$ 480$ starting February 2016. Also by notice dated January 26, 2016, the Department notified the petitioner her ex-husband was approved MN with a $\$ 1,720$ SOC. Petitioner timely requested a hearing to challenge the FA decrease and approval of MN for her ex-husband.
 petitioner. Gregory Watson, Hearing Officer, appeared as an observer at the March 28, 2016 hearing.

Petitioner submitted one exhibit, entered as Petitioner Exhibit "1". Respondent submitted eight exhibits, entered as Respondent Exhibits "1" through "8". The record remained open through April 15, 2016, for the respondent to submit an additional exhibit. The exhibit was received timely and entered as Respondent Exhibit " 9 ". The record was closed on April 15, 2016.

## FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner received $\$ 493$ in FA benefits and full Medicaid for the household. Household members include the petitioner, DC and three minor children; petitioner's child and DC and petitioner's two children.
2. On January 6, 2016, the petitioner submitted a recertification application for certification period beginning in February 2016. The application indicates the petitioner was applying for FA, Cash and Medicaid. And indicates household income includes

FINAL ORDER (Cont.)
16F-00768 \& 16F-00769
PAGE-3
child support for petitioner's child and employment for DC; expenses listed include
$\$ 562.50$ rent, child support paid out by DC and utilities. FA for the household and Medicaid for DC are at issue.
3. The Department verified through Florida Clerk of Court that petitioner received $\$ 58.75$ child support income for her child in December 2015. And DC paid weekly child support for three children (not living in the home). The following are the child support amounts paid by DC and conversion from weekly payments to monthly payments:

$$
\begin{array}{ll}
\text { Child one } & \$ 23.08 \text { weekly } \times 4.3=\$ 99.24 \text { monthly } \\
\text { Child two } & \$ 27.14 \text { weekly } \times 4.3=\$ 116.70 \text { monthly } \\
\text { Child three } & \$ 28.85 \text { weekly } 4.3=\$ 124.06 \text { monthly } \\
\hline \text { Total } & \$ 340.00 \text { monthly }
\end{array}
$$

4. DC is paid weekly; petitioner submitted three of the required four paystubs (dated 12/11/15, 12/18/15 and 12/31/15) for DC.
5. The Department incorrectly determined DC's monthly income in the FA calculation.

And on January 8, 2016, the Department mailed the petitioner a Notice of Case Action (NOCA), notifying FA would decrease from $\$ 493$ to $\$ 480$, effective February 2016.
6. At the reconvene hearing (April 12, 2016), the petitioner submitted verification of DC's weekly pay for the month of December 2015.
7. Also at the reconvene hearing, the respondent's representative recalculated petitioner's FA budget using DC's required pay verification. The following is the new calculation:

$$
\begin{array}{rl}
\$ 497.75 & 12 / 11 / 15 \\
+\$ 429.00 & 12 / 18 / 15 \\
+\$ 481.25 & 12 / 24 / 15 \\
+\$ 481.25 & 12 / 31 / 15 \\
\hline \$ 1,889.25 & \text { Total }
\end{array}
$$

FINAL ORDER (Cont.)
16F-00768 \& 16F-00769
PAGE-4
$\$ 1,889.25$ divided by 4 weeks $=\$ 472.31 \times 4.3$ (conversion factor) $=\$ 2,030.93$ weekly income converted to monthly income

| $\$ 2,030.93$ |  |
| ---: | :--- |
| $+\$$ | 58.75 |$\quad$| DC's monthly income |
| :--- |
| child support for petitioners child |

$\$ 812.25 \times 30 \%=\$ 244$ (round up) FA reduction
8. The maximum FA amount for a household size of five is $\$ 771$. Subtracting $\$ 244$ (FA reduction) from $\$ 771$ leaves $\$ 527$ monthly FA.
9. Petitioner received $\$ 480$ FA in February 2016 and March 2016; she also received $\$ 473$ FA in April 2016. The respondent's representative agreed to issue petitioner FA auxiliaries of $\$ 47$ for February 2016 and March 2016; and $\$ 54$ for April 2016, totaling \$527 for each month. Petitioner will receive \$527 starting in May 2016.
10. Petitioner was satisfied with the additional FA benefits. DC asserts that he requested a hearing sometime last year; due to a change he reported on his employment and the Department failed to act on his hearing request.

FINAL ORDER (Cont.)
16F-00768 \& 16F-00769
PAGE-5
11. The Department's Running Record Comments (CLRC) state that DC called the Department on October 12, 2015, to report a change. CLRC dated October 26, 2016, states that DC requested a hearing. The Department did not act on his request.
12. The respondent's representative agreed to request another FA appeal for DC's October 2015 hearing request.
13. DC was satisfied that a new appeal will be issued for his October 2015 change report.
14. Transitional Medicaid is an additional 12 months of Medicaid after recipients are no longer eligible for Cash assistance due to earnings. DC received Transitional Medicaid from February 1, 2015 through January 2016. DC is not eligible for full Medicaid due to income. The next available program is Medicaid MN with a SOC. DC files taxes for only himself; therefore, he is considered in a tax filing unit of only himself.
15. At the reconvene hearing, the respondent's representative also recalculated DC's SOC with his new income verification. The following is the new SOC calculation:

| $\$ 1,889.25$ | unconverted monthly income |
| :--- | :--- |
| $-\$ \quad 289.00$ | MN income limit (MNIL) for household size of one |
| $\$ 1,600$ | SOC (cents dropped) |

16. At the reconvene hearing, petitioner submitted an unsigned Verification of Employment form, indicating that DC quit his job on April 3, 2016. Petitioner agreed to submit a change report since this is a new and different issue.

## 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

FINAL ORDER (Cont.)
16F-00768 \& 16F-00769
PAGE-6
§ 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 ISSUE

19. Federal Regulation at 7 C.F.R § 273.9, defines income in the FA determination and in part states:
(b) Definition of income. Household income shall mean all income from whatever source...
(1) Earned income shall include: (i) All wages and salaries of an employee...
(2) Unearned income shall include, but not be limited to...
(iii) Support or alimony payments made directly to the household from nonhousehold members...
20. In accordance with the above Federal Regulation, the Department included the household monthly income in the FA budget calculation; \$2,030.93 DC's employment earned income and petitioner's $\$ 58.75$ child support unearned income.
21. Federal Regulation at 7 C.F.R § 273.10 explains income and deduction conversion and in part states:
(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...
(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...
(d)(5) Conversion of deductions. The income conversion procedures in paragraph (c)(2) of this section shall also apply to expenses billed on a weekly...
22. In accordance with the above Federal Regulation, the Department converted DC's
$\$ 472.31$ weekly income to monthly income using a 4.3 conversion factor to arrive at \$2,030.93.
23. Federal Regulation at 7 C.F.R § 273.9, defines allowable deductions in the FA determination and in part states:
(d) Income deductions. Deductions shall be allowed only for the following household expenses:
(1) Standard deduction...
(2) Earned income deduction. Twenty percent of gross earned income...
(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...
(C) The cost of fuel for heating; cooling (i.e., the operation of air conditioning systems or room air conditioners); electricity or fuel used for purposes other than heating or cooling; water; sewerage; well installation and maintenance; septic tank system installation and maintenance;
garbage and trash collection; all service fees required to provide service for one telephone
(iii) Standard utility allowances... Only utility costs identified in paragraph (d)(6)(ii)(C) of this section must be used in developing standards...
24. The Department's Policy Manual (Policy Manual), CFOP 165-22, at Appendix A-1, sets forth for a household size of five the following:
\$771 maximum FA benefit
\$197 standard deduction
\$345 SUA
25. Federal Regulations at 7 C.F.R. § 273.10, explains income and deduction calculations:
(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...
(B) Multiply the total gross monthly earned income by 20 percent and subtract that amount from the total gross income...
(C) Subtract the standard deduction...
(F) If the State agency has chosen to treat legally obligated child support payments as a deduction rather than an exclusion in accordance with §273.9(d)(5), subtract allowable monthly child support payments in accordance with §273.9(d)(5)...
(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...
26. The cited authorities set forth income and allowable deductions in the FA benefit determination. In accordance with the authority, the Department subtracted allowable deductions (20\% earned income, standard deduction, child support, shelter and SUA) in petitioner's FA calculation. The child support DC pays weekly to his three children was converted to monthly using the 4.3 conversion factor, in accordance with the above (\#21) Federal Regulation at 7 C.F.R § 273.10 (d)(5).

## MEDICAID MEDICALLY NEEDY ISSUE

27. 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...
28. Fla. Admin. Code R. 65A-1.716 Income and Resource Criteria explains:
(2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows:

FINAL ORDER (Cont.)
16F-00768 \& 16F-00769
PAGE-9

Family Size
5

Income Level
\$426
29. The above authority explains for DC to be eligible for Family-Related Medicaid, the income for a household size of five cannot exceed $\$ 426$ monthly. DC's $\$ 1,889.25$
income exceeds $\$ 426$; therefore, he is not eligible for full Medicaid. The next available Program is MN with a SOC.
30. 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...
31. The above authority explains the SOC is determined by subtracting the income level (MNIL) from the gross income.
32. Federal Regulations at 42 C.F.R. $\S 435.603$ "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...
(f) Household - (1) Basic rule for taxpayers not claimed as a tax dependent. In the case of an individual who expects to file a tax return for the taxable year in which an initial determination or renewal of eligibility is being made, and who does not expect to be claimed as a tax dependent by another taxpayer, the household consists of the taxpayer...
33. In accordance with the above Federal Regulation, the Department only included DC in the MN SOC determination; due to DC only claiming himself on his taxes.
34. Policy Manual at Appendix A-7 sets forth the MNIL at $\$ 289$ for a household size of one.

FINAL ORDER (Cont.)
16F-00768 \& 16F-00769
PAGE - 10
35. In accordance with the above authorities, the Department calculated DC's SOC by subtracting $\$ 289$ (MNIL) from his unconverted $\$ 1,889.25$ income to arrive at $\$ 1,600$.

## HEARING OFFICER'S CONCLUSION

36. In careful review of the cited authorities and evidence, the undersigned agrees with the Department's calculation of petitioner's \$527 monthly FA, effective February 2016.
37. Also in careful review of the cited authorities and evidence, the undersigned agrees with the Department's calculation of $\$ 1,600$ monthly MN SOC for DC.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are denied and the respondent's actions are affirmed.

FINAL ORDER (Cont.)

## 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 petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this $\qquad$ 29 day of $\qquad$ , 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

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

Apr 22, 2016

APPEAL NO. 16F-00775

## CASE NO

## FLORIDA DEPARTMENT

 OF CHILDREN AND FAMILIES CIRCUIT: 19 INDIAN RIVER UNIT: 88510
## RESPONDENT.

 1
## FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on March 1, 2016, at 3:05 p.m.

## APPEARANCES

For the Petitioner:
For the Respondent:


Stacy Ann-Mills, supervisor

## ISSUE

The petitioner is appealing the denial of Qualifying Medicare Beneficiary (QMB) and the approval of Special Low Income Beneficiary (SLMB), instead. The petitioner carries the burden of proof by a preponderance of evidence in this appeal.

## PRELIMINARY STATEMENT

The respondent presented one exhibit which was accepted into evidence and marked as Respondent Composite Exhibit 1. The petitioner did not submit any exhibits into evidence.

## FINDINGS OF FACT

1. On December 14, 2015, the petitioner submitted a recertification application to receive Medicare cost savings benefits for payment of her Medicare Part B premium.
2. The petitioner is disabled and receiving $\$ 1,007$ a month in Social Security Disability benefits. She is receiving Medicare Parts A and B. She was receiving Qualifying Medicare Beneficiary (QMB) in the prior certification.
3. An applicant may be eligible to receive Medicare cost savings benefits for payment of Medicare Part B premium through the Medicaid Program under one of three categories: Qualifying Medicare Beneficiary (QMB), Special Low Income Beneficiary (SLMB), or Qualifying Individual 1 (QI1) benefits, if all criteria are met. To be eligible the applicant must be enrolled in Medicare Part A and meet all technical criteria, including having income within the income limits.
4. The petitioner's income of $\$ 1,007$ minus a $\$ 20$ standard disregard was compared to the income limit of $\$ 981$ for an individual for QMB benefits. The petitioner's countable income of $\$ 987$ exceeded the income limit of $\$ 981$ for the petitioner to be eligible for QMB benefits. Her income was then compared to the next Medicare cost savings benefits SLMB which had an income standard of $\$ 1,177$. The Department determined the petitioner was eligible for SLMB.
5. On December 14, 2015, a Notice of Case Action was sent to the petitioner informing her that her application for SLMB to pay her Part B Medicare premium was approved.

FINAL ORDER (Cont.)
16F-00775
PAGE -3
6. The petitioner stated the she needed the QMB not SLMB. She asserts that her copayments to doctors' visits have increased now that she is getting SLMB instead of

QMB. She is unable to pay for the co-payment.

## 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. Income limits for Medicare savings plan benefits are set forth in the Fla. Admin.

Code R. 65A-1.713:
(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
(b) For QMB, income must be less than or equal to the federal poverty level after application of exclusions specified in subsection 65A1.713(2), F.A.C...
(g) For SLMB, income must be greater than 100 percent of the federal poverty level but less than 120 percent of the federal poverty level....
(j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. Q11 is eligible only for payment of the Part B Medicare premium through Medicaid.
(2) Included and Excluded Income. For all SSI-related coverage groups the department follows the SSI policy specified in 20 C.F.R. 416.1100, et seq...
(4) Income Budgeting Methodologies. To determine eligibility SSI budgeting methodologies are applied except where expressly prohibited by 42 U.S.C. $\S 1396$, or another less restrictive option is elected by the state under 42 U.S.C. §1396a(r)(2)...

FINAL ORDER (Cont.)
16F-00775
PAGE -4
10. The Department's Program Policy Manual (Policy Manual), CFOP 165-22 at section 0240.0115, Special Low Income Medicare Beneficiary (MSSI), sets forth the criteria for SLMB:

This program entitles eligible individuals who have to have Medicaid pay their Part B Medicare premium.
To be eligible for SLMB, an individual must:

1. Be enrolled in Medicare Part A.
2. Meet all technical criteria, except being aged ( 65 or older requirement) or disabled.
3. Income Limit: 120\% of Federal Poverty Level.
4. Asset Limit: Three times the SSI resource limit with annual increases based on the yearly Consumer Price Index. Refer to Appendix A-9.
5. The Policy Manual at Appendix A-9 sets forth that the income limit for QMB was \$981 in January 2016 and $\$ 990$ effective April 2016, SLMB was \$1,177 in January 2016 and is $\$ 1,188$ effective April 2016.
6. The Code of 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..."
7. Effective April 1, 2016, there was a change/increase in the income limit for Medicare cost savings benefits QMB, SLMB, and Q11. As a result of this change/increase, the petitioner's income of $\$ 1,007$ minus $\$ 20$ disregard, equals $\$ 987$ which is below the income standard for QMB effective April 2016. It is concluded that the petitioner was not eligible for QMB for January 2016 through March 2016. The respondent's denial of QMB is correct for January 2016 through March 2016; however, she is eligible for QMB effective April 2016.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal denied in part as petitioner was not eligible for QMB for January 2016 through March 2016 and granted in part as petitioner is eligible for QMB effective April 2016 ongoing. The respondent is to take corrective action to approve QMB benefits effective April 2016.

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 22 day of April_, 2016, in Tallahassee, Florida.


Christian 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@myfIfamilies.com

Mar 24, 2016

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

APPEAL NO. 16F-00778
PETITIONER,
Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 02 Wakulla
UNIT: 88313
CASE NO.

## RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on March 22, 2016 at 9:40 a.m.

APPEARANCES
For the Petitioner:
For the Respondent:
Delecia Greene, ACCESS Supervisor

## STATEMENT OF ISSUE

Petitioner is appealing the Department's action of denying his application for SSIRelated (Adult) Medicaid on November 30, 2015. The petitioner carries the burden of proof by the preponderance of evidence.

## PRELIMINARY STATEMENT

The petitioner submitted evidence on March 14, 2016. The undersigned reviewed the evidence which included the petitioner's medical bills, medical records and and the Notice of Case Action. The petitioner's medical records were entered as

FINAL ORDER (Cont.)
16F-00778
PAGE-2
Petitioner Exhibit 1. The medical bills and Notice of Case Action in the packet was not entered in the record. The petitioner submitted additional medical records on March 15, 2016. These medical records were entered as Petitioner Exhibit 2.

The Department submitted evidence, which included the Notice of Case Action, on March 15, 2016. This evidence was entered as Respondent Exhibit 1.

## FINDINGS OF FACT

1. The petitioner is a 52 -year-old male. He does not have any minor children residing in the home with him.
2. The petitioner applied for SSI-Related Medicaid on November 23, 2015.
3. The petitioner applied for disability with the Social Security Administration (SSA).
4. The petitioner was denied by SSA on June 22, 2015.
5. The petitioner appealed the denial by SSA. He has contacted an advocacy group to assist him with the appeals process with SSA.
6. The petitioner indicated on his application that his health conditions had not changed since he was denied by SSA.
7. The petitioner's is certain his medical diagnosis of were reported to

SSA.
8. The petitioner received diagnosis of $\square$ within the last month.

FINAL ORDER (Cont.)
16F-00778
PAGE - 3
9. The Department issued a Notice of Case Action on November 30, 2015 denying the petitioner's application for SSI-Related Medicaid due to not meeting the disability requirement.
10. The Department explained the policy requires the application denial as the SSA decision is binding on the Department for 12 months.

## CONCLUSIONS OF LAW

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

Section 409.285, Florida Statutes. This order is the final administrative decision of the
Department of Children and Families under Section 409.285, Florida Statutes.
12. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R.

65-2.056.
13. The definition of MEDS-AD Demonstration Waiver is found in Fla. Admin.

Code R. 65A-1.701 "Definitions":
(20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services.
14. Fla. Admin. Code R. 65A-1.711 "SSI-Related Medicaid Non-Financial

Eligibility Criteria" states in relevant part:
To qualify for Medicaid an individual must meet the general and categorical requirements in 42 C.F.R. Part 435, subparts E and F (2007) (incorporated by reference), with the exception that individuals who are neither aged nor disabled may qualify for breast and cervical cancer treatment, and the following program specific requirements as appropriate.

Individuals who are in Florida temporarily may be considered residents of the state on a case-by-case basis, if they indicate an intent to reside in Florida and can verify that they are residing in Florida.
(1) For MEDS-AD Demonstration Waiver, the individual must be age 65 or older, or disabled as defined in 20 C.F.R. § 416.905 (2007) (incorporated by reference).
15. 20 C.F.R. § 416.905 "Basic definition of disability for adults" states in relevant part:
(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see $\S 416.960$ (b)) or any other substantial gainful work that exists in the national economy.
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 $\S 435.912$ on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under §435.909.
(b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c)(3) of this section-
(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.
(ii) If the SSA determination is changed, the new determination is also binding on the agency.
(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.
(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:
(4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and-
(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or
(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and-
(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or
(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.
17. The petitioner is 52 years old. As he is under age 65, a disability determination was required for the SSI-Related Medicaid program.
18. The petitioner applied for Medicaid with the Department on November 23,
2015. The findings show SSA made a determination the petitioner was not disabled on

June 22, 2015. The findings also show the Department adopted the SSA decision on
November 30, 2015. According to the above controlling authorities, a decision made by SSA within 12 months of the SSI-Related Medicaid application is controlling and binding on the state agency unless the applicant reports a disabling condition not previously reviewed by SSA or the determination is changed by SSA. The findings further show the petitioner did not assert any new disabling conditions on his application. The undersigned concludes the Department correctly adopted the SSA decision on

November 30, 2015.

FINAL ORDER (Cont.)
16F-00778
PAGE-6
19. The above controlling authority explains how the Department can review a case if the applicant alleges during the 12 months following the most recent SSA determination denying disability. The authority clearly indicates the applicant must have applied to SSA for reconsideration and SSA had refused to consider the new allegations.
20. The findings show the petitioner now asserts new conditions diagnosed within the last month. The findings also show the petitioner has not notified the advocacy group representing him or SSA of the new conditions. The new diagnosis and onset are after the date the Department adopted the SSA denial on November 30, 2015. The undersigned concludes SSA refuse to reconsider conditions if the petitioner has not made SSA aware of the newly diagnosed conditions. The undersigned concludes the Department's adoption of the SSA decision remains valid.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the Department's action is affirmed.

## NOTICE OF RIGHT TO APPEAL

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

FINAL ORDER (Cont.)
16F-00778
PAGE -7
DONE and ORDERED this 24 day of $\quad$ March 2016, in Tallahassee, Florida.


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

Office of Economic Self Sufficiency

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

Vs.

## AGENCY FOR HEALTH CARE ADMINISTRATION

CIRCUIT: 09 Orange
UNIT: AHCA

RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing on March 17, 2016 at approximately 3:30 p.m.

## APPEARANCES

Petitioner:

For Respondent:
Lisa Sanchez
Medical/Health Care Program Analyst
Agency for Health Care Administration

## STATEMENT OF ISSUE

At issue is Respondent's denial of Petitioner's request for photochromatic (transition) lenses. The burden of proof is assigned to Petitioner

## PRELIMINARY STATEMENT

Respondent presented the following witnesses:

- Carlene Brock, Quality Operations Nurse, Amerigroup
- Ruth Wilsing, Senior Vision Specialist, EyeQuest

FINAL ORDER (Cont.)
16F-00794
PAGE - 2
Petitioner gave oral testimony, but did not move any exhibits into evidence at the hearing. Respondent moved Exhibits 1 through 5 into evidence. Administrative notice was taken of the July 2012 Florida Medicaid Provider General Handbook. The record was held open for the Agency to submit additional information. Respondent submitted additional information, which consists of an excerpt from the Florida Medicaid Visual Aid Services Coverage Policy.

## FINDINGS OF FACT

1. Petitioner is a 59-year-old female. Petitioner is enrolled with Amerigroup as her Managed Medical Assistance (MMA) plan. EyeQuest is Amerigroup's vision services vendor.
2. Petitioner has She has strong headaches when she is in the sun. She said if she's outside for more than 30 minutes it feels like her eyes are bulging out of her head.
3. Petitioner said going out into the sun gives her anxiety. She has been on anxiety medication for a long time, but does not like to take it because it makes her sleep.

She said she wants to be able to have a normal life.
4. On January 13, 2016, Petitioner's optometrist submitted a request for eyeglasses which include transition lenses. On January 19, 2016, Amerigroup issued a letter denying the request, Respondent's Composite Exhibit 5, stating:

Your eye doctor or optical provider requested authorization to provide an optical service, or services, which is not a standard eyeglass lens, contact lens or frames benefit. Since the requested service is not considered medically necessary, this request has been denied. The decision for denial is based on the benefit limitations established by the Plan or by the State Medical Assistance Program you participate with.

FINAL ORDER (Cont.)
16F-00794
PAGE - 3
5. Ms. Wilsing said the transition lenses would not help with Petitioner's condition. Ms. Sanchez said they are not a covered benefit under Medicaid. Ms. Brock said Amerigroup is trying to resolve the issue by having the provider submit a new request with the correct codes for lenses that would be covered.

## CONCLUSIONS OF LAW

6. By agreement between the Agency for Health Care Administration ("AHCA" or "Agency") and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction over this matter pursuant to § 120.80, Fla. Stat.
7. This hearing was held as a de novo proceeding, in accordance with Florida Administrative Code Rule 65-2.056.
8. This is a Final Order, pursuant to $\S \S 120.569$ and 120.57, Fla. Stat.
9. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, $7^{\text {th }}$ Ed.). 10. Legal authority governing the Florida Medicaid Program is found in Chapter 409 of the Florida Statutes, and in Chapter 59G of the Florida Administrative Code. Respondent, AHCA, is the single state agency that administers the Medicaid Program.
10. The November 2015 Florida Medicaid Visual Aid Services Coverage Policy ("Visual Aid Policy") is promulgated into law by Chapter 59G of the Florida Administrative Code.
11. According to Section 5.2 of the Visual Aid Policy, located on page 4, transition lenses are not a covered benefit under Florida Medicaid.
12. Since the plain language of the Visual Aid Policy is that transition lenses are not a covered benefit, the undersigned must conclude that the decision to deny them was correct.
13. Petitioner is encouraged to work with her optometrist and Amerigroup in order to find suitable, covered lenses that will 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.

FINAL ORDER (Cont.)
16F-00794
PAGE - 5
DONE and ORDERED this $\qquad$ 25 day of April 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: Petitioner<br>Juay Jacobs, Area 7, AHCA Field Office

Mar 16, 2016
STATE OF FLORIDA
Office of Appeal Hearings
DEPARTMENT OF CHILDREN AND FAMILIES Dept. of Children and Families OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-00805; 16F-00806
PETITIONER,
Vs.
CASE NO.
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 06 Pasco
UNIT: AHCA

## RESPONDENT.

## FINAL ORDER OF DISMISSAL

The Office of Appeal Hearings received a hearing request in the above matters on January 27, 2016 because Petitioner had an uncovered emergency room visit and fluid drainage procedure. As this matter appeared to be solely related to payment to a provider for services already rendered, a Preliminary Order of Dismissal was issued on February 18, 2016. The order gave Petitioner 14 calendar days to respond in writing to explain whether or not there is an issue for the hearing officer to determine. As of the date of this order, there has been no response. In accordance with the Preliminary Order of Dismissal, this matter is dismissed as non-jurisdictional. No hearing will be scheduled on these issues.

## NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL

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

DONE and ORDERED this 16 day of March 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

# STATE OF FLORIDA <br> DEPARTMENT OF CHILDREN AND FAMILIES OFFICE OF APPEAL HEARINGS 

Apr 26, 2016
Office of Appeal Hearings Dept. of Children and Farrilies

APPEAL NO. 16F-00813

PETITIONER,
Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pinellas
UNIT: 88262

CASE NO.

## RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on March 2, 2016 at 2:04 p.m. All parties appeared telephonically from different locations.

## APPEARANCES

For the petitioner:
For the respondent:
Signe Jacobson,
Economic Self-Sufficiency Specialist II

## STATEMENT OF ISSUE

At issue is the respondent's action to terminate the petitioner's full Medicaid and enroll her in the Medically Needy (MN) program with a $\$ 691$ Share of Cost (SOC).

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

FINAL ORDER (Cont.)
16F-00813
PAGE -2

## PRELIMINARY STATEMENT

By notice dated January 25, 2016, the respondent notified the petitioner that her full Medicaid would end February 29, 2016 and she was enrolled in the Medically Needy Program with a $\$ 691$ SOC, effective March1, 2016. The petitioner timely requested a hearing to challenge the action.

The petitioner did not submit any exhibits. The respondent submitted seven exhibits, which were entered into evidence and marked as Respondent's Exhibits "1" through " 7 ".

## FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner was receiving full Medicaid benefits.
2. The petitioner's household consists of the petitioner and her husband. The petitioner receives $\$ 891$ in Social Security Disability Income (SSDI) per month and her husband received $\$ 229$ in Supplemental Security Income (SSI) per month with a Medicaid entitlement.
3. During August, 2015, Quality Control (QC) evaluated the petitioner's case and it was determined that the petitioner was inadvertently approved for full Medicaid. The respondent asserts the petitioner's husband's income was improperly deemed to the petitioner.
4. On January 25,2016 , action was taken by the respondent to correctly determine the petitioner's SSI-Related Medicaid benefits. The respondent determined the petitioner's gross income to be $\$ 891$, which exceeds the income limit for one person of $\$ 864$ for full Medicaid.
5. The petitioner will not become eligible for Medicare Part A and B until 2017.

FINAL ORDER (Cont.)
16F-00813
PAGE -3
6. On January 25,2016 , during the case correction, the respondent updated the petitioner's household income and determined the petitioner's SOC as follows:

| $\$ 891$ | SSDI |
| :--- | :--- |
| -20 | unearned income disregard |
| -180 | MN income level (MNIL) for a household size of one |
| $\$ 691$ | SOC |

7. The petitioner asserts that this is a "punishment" and the SOC is "impossible" to meet with her additional household expenses each month. She also states she is left with no medical coverage and no way to get her 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 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.
9. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
10. The department determines Medicaid eligibility based on the household circumstances.

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.
11. The Federal Regulations at 20 C.F.R. $\S 416.1801$ Introduction states in part:
(a) What is in this subpart. This subpart contains the basic rules for deciding for SSI purposes whether a person is considered married and, if so, to whom; whether a person is considered a child; and whether a person is considered another person's parent. It tells what information and evidence we need to decide these facts.
(b) Related subparts. Subpart D discusses how to determine the amount of a person's benefits; subpart G discusses what changes in a person's situation he or she must report to us; subpart K discusses how we count
income; and subpart $L$ discusses how we count resources (money and property). The questions of whether a person is married, to whom a person is married, whether a person is a child, and who is a person's parent must be answered in order to know which rules in subparts D, G, K, and $L$ apply.
(c) Definitions. In this subpart-

## Eligible spouse means a person-

(1) Who is eligible for SSI,
(2) Whom we consider the spouse of another person who is eligible for SSI, and
(3) Who was living in the same household with that person on-
(i) The first day of the month following the date the application is filed (for the initial month of eligibility for payment based on that application);
(ii) The date a request for reinstatement of eligibility is filed (for the month of such request); or
(iii) The first day of the month, for all other months. An individual is considered to be living with an eligible spouse during temporary absences as defined in § 416.1149 and while receiving continued benefits under section 1611(e)(1) (E) or (G) of the Act.
Spouse means a person's husband or wife under the rules of §§ 416.1806 through 416.1835 of this part. (emphasis added)
12. The Federal Regulations at 20 C.F.R. $\S 416.1806$. Whether you are married and who is your spouse states in the pertinent part, "(a) We will consider someone to be your spouse (and therefore consider you to be married) for SSI purposes if-(1) You are legally married under the laws of the State where your and his or her permanent home is (or was when you lived together)..."
13. The above authorities define who is an eligible spouse based on the SSI-Related Program policy. The petitioner and her husband are considered married and eligible spouses to one another.
14. The Federal Regulations at 20 C.F.R. § 416.1802 Effects of marriage on eligibility and amount of benefits further states:
(a) If you have an ineligible spouse-
(1) Counting income. If you apply for or receive SSI benefits, and you are married to someone who is not eligible for SSI benefits and are living in
the same household as that person, we may count part of that person's income as yours. Counting part of that person's income as yours may reduce the amount of your benefits or even make you ineligible. Section 416.410 discusses the amount of benefits and $\S 416.1163$ explains how we count income for an individual with an ineligible spouse.
(2) Counting resources. If you are married to someone who is not eligible for SSI benefits and are living in the same household as that person, we will count the value of that person's resources (money and property), minus certain exclusions, as yours when we determine your eligibility. Section 416.1202(a) gives a more detailed statement of how we count resources and § 416.1205(a) gives the limit of resources allowed for eligibility of a person with an ineligible spouse.
(b) If you have an eligible spouse-
(1) Counting income. If you apply for or receive SSI benefits and have an eligible spouse as defined in § 416.1801(c), we will count your combined income and calculated the benefit amount for you as a couple. (emphasis added)
Section 416.412 gives a detailed statement of the amount of benefits and subpart K of this part explains how we count income for an eligible couple.
(2) Counting resources. If you have an eligible spouse as defined in § 416.1801 (c), we will count the value of your combined resources (money and property), minus certain exclusions, and use the couple's resource limit when we determine your eligibility. Section 416.1205(b) gives a detailed statement of the resource limit for an eligible couple.
15. The above authority explains that individuals who are considered as an eligible
spouse will have their income combined and the benefit amount should be calculated as a couple.
16. The petitioner was evaluated under the SSI-Related Medicaid coverage group.
17. Fla. Admin. Code R. 65A-1.701, Definitions, states in part:
(20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services. (emphasis added)

FINAL ORDER (Cont.)
16F-00813
PAGE -6
18. The above authority explains that the MEDS-AD (full Medicaid for an aged or disabled person) has an income limit of $88 \%$ of the Federal Poverty Level (FPL) and in addition to meeting that limit the person must not have Medicare unless he is receiving institutional care services, hospice services, or home and community based services.
19. The Department's Program Policy Manual (Policy Manual), CFOP 165-22 at Appendix A-9, lists the MEDS-AD income limit as $\$ 1,169$ for a couple effective January 2016.
20. The petitioner receives $\$ 891$ in SSDI and her husband receives $\$ 229$ in SSI per month. The petitioner's total household income of $\$ 1,120$ is less than the $\$ 1,169 \mathrm{FPL}$ for a household size of two and the petitioner is not currently receiving Medicare Part $A$ and $B$. Therefore, the petitioner is eligible for full Medicaid.
21. After careful review of the evidence and cited controlling authorities, the undersigned hereby grants the appeal and orders corrective action by the department to reverse the termination of benefits for the petitioner, providing full Medicaid eligibility under the SSI-Related Program effective March 1, 2016.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner appeal is granted. The department is hereby ordered to take corrective action and reverse the termination of benefits 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 indigence 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 April_, 2016, in Tallahassee, Florida.

Pamela Vance
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


APPEAL NO. 16F-00300
16F-00828

PETITIONER,
Vs.
AGENCY FOR HEALTH CARE ADMINISTRATION CIRCUIT: 11 DADE
UNIT: AHCA

RESPONDENT.

## FINAL ORDER OF DISMISSAL

Pursuant to notice, a hearing in the above referenced matters had been scheduled for February 29, 2016 at 1:30 p.m. The issues for the hearing were Petitioner's requests for home-delivered meals and for an increase in personal care hours. Prior to the hearing, the undersigned was informed by the Respondent, AHCA, that the Petitioner had recently passed away. The scheduled hearing was therefore continued by the undersigned hearing officer.

Based on the foregoing, the appeals are dismissed as they are now moot since the Petitioner has passed away and there is no issue which can be decided by the hearing officer.

DONE and ORDERED this $\qquad$ day of April , 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:
PETITIONER
RHEA GRAY, AREA 11, AHCA FIELD OFFICE MANAGER


PETITIONER,
Vs.
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 13 Hillsborough UNIT: AHCA

RESPONDENT.

CASE NO.


FINAL ORDER
Pursuant to notice, the undersigned convened a telephonic administrative
hearing in the above-referenced matter on March 2, 2016 at 1:02 p.m.


## STATEMENT OF ISSUE

At issue is whether the Agency properly denied Petitioner's request for prescription medicatior Petitioner held the burden of proof in this matter by a preponderance of the evidence.

FINAL ORDER (Cont.)
16F-00829
PAGE-2

## 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. was present as Petitioner's representative and witness. Respondent's witnesses were Mindy Aikman (Grievance and Appeals Specialist) and Dr. Ian Nathanson (Florida Medicaid Medical Director) with Humana Health Plan.

Petitioner did not submit any documentary evidence into the record. Respondent submitted two exhibits and one composite exhibit, marked and entered as Respondent's Exhibits 1, 2, and composite exhibit 3, into evidence. The hearing officer took administrative notice of Sections 409.910, 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 male diagnosed with He is treatment naïve (has not been treated before) and has a He is a member of Humana's managed care plan for Medicaid recipients.
2. Petitioner's treating doctor submitted a preauthorization request to the Agency for on or about December 17, 2015. The doctor provided clinical notes and lab results to support the preauthorization request.
3. The Agency, through its agent Humana, reviewed the submitted documentation and denied the request. The denial notice dated December 17, 2014, stated that the member must use the preferred druc unless he has a contraindication with for which he provides documentation. Further, the member must have evidence of $\quad$ In response to the denial, Petitioner's physician requested an expedited appeal through Humana.
4. Petitioner's physician indicated in his letter to Humana that $\square$ contraindicated for Petitioner because of his underlying cardiac risk and other medications he is currently on. Petitioner takes $\square$ for $\square$ and ran cause negative effects. which is taken with can worsen , and Petitioner is already at risk for that due to his medical
history which includes a review its clinical criteria to better align with evidence based guidelines for practice.
5. Humana reviewed the clinical documentation and the physician's letter. Its medical director determined that Petitioner does not have ؛ and denied the appeal. Humana sent a notice explaining this which was dated January 13, 2016.
6. The Agency denied the preauthorization request for $\square$ because Petitioner's condition must meet certain criteria to be approved for that particular drug. Based on

FINAL ORDER (Cont.)
16F-00829
PAGE-4
the Agency's review of Petitioner's medical records, his condition does not meet the specific criteria for $\square$ because he does not have $\square$
7. Petitioner requested a fair hearing to dispute the denial. He contends he should be granted the Harvoni because he cannot take $\square$ He also contends that, in agreement with his doctor's letter, that the American Association for Study of set forth guidelines which recommend his treatment. He argues he should be treated with now at $\square$ ather than waiting for his condition to progress to $\square$ to ensure a positive outcome.

## CONCLUSIONS OF LAW

8. The Department of Children and Families Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 120.80, Florida Statutes.
9. The Florida Medicaid program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The program is administered by the Agency.
10. This hearing was held as a de novo proceeding pursuant to Florida Administrative Code Rule 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 652.060(1).
12. Section 409.912, Florida Statutes (2015) provides that AHCA shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent

FINAL ORDER (Cont.)
16F-00829
PAGE - 5
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.
13. 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.
14. Page 1-30 of the Provider Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."
15. 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;

FINAL ORDER (Cont.)
16F-00829
PAGE-6
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.
16. In order to determine "medical necessity," the Agency has created guidelines.
17. 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.
18. 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.
19. 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.
20. The Agency has the authority to manage its prior authorization process, including establishing criteria for approval. It established specific criteria for The Medicaid drug criteria for for

FINAL ORDER (Cont.)
16F-00829
PAGE-7
approval. Petitioner's scores show his is not that advanced, so he does not meet the established criteria for $\quad$ 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 his circumstances, except when eligibility is limited by law, such as here.
21. Petitioner argues that the medication should be approved because clinical studies show it is useful for people with lower level fibrosis and it is more cost effective. It has been recommended by professional medical associations for treatment of less extreme fibrosis. 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).
22. The Agency has updated its criteria since the original decision was made ${ }^{1}$. The new criteria, effective as of February 24, 2016, do not apply to this case. Based on the rules and regulations in effect at the time the decision was made, the Agency properly denied Petitioner's request. The evidence shows Petitioner failed to meet the requirements of the established clinical guidelines, including the guideline requiring evidence of There is no rule or exception permitting the hearing officer to create or change Agency rules or policy to make such exceptions.

[^12]FINAL ORDER (Cont.)
16F-00829
PAGE - 8
23. Petitioner had the burden of proof in this case. Petitioner did not meet his burden of proof to show that he meets the criteria to receive this medication. He is encouraged to work with his physician and the Agency to find a medication that will meet his needs and can be approved.
24. 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.

FINAL ORDER (Cont.)
16F-00829
PAGE -9

## 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 _26 day of April_, 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: $\square$ Petitioner
Don Fuller, Area 6, AHCA Field Office Manager

# FILED 

Apr 29, 2016

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


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-styled matter on March 11, 2016 at 11:30 a.m.

## APPEARANCES

For Petitioner:
For Respondent: Dianna Chirino, Senior Program Specialist Agency for Health Care Administration

## STATEMENT OF ISSUE

At issue is whether Respondent's denial of Petitioner's request for a customized power wheelchair was proper. The Petitioner bears the burden of proof in this matter by a preponderance of the evidence.

## PRELIMINARY STATEMENT

Appearing as witnesses for the Petitioner were her physical therapist and her teacher, Petitioner submitted as evidence for the hearing a CD containing three short videos, which was marked as Petitioner Exhibit 1. The video CD was distributed to all parties in advance of the hearing date.

Appearing as witnesses for the Respondent were Katherine McGrath, Unit Director, Maria Jam, Director of Medical Management, and Alexander Fabano, Contract Manager, from Children's Medical Services (CMS). Also present as witnesses for the Respondent were Catherine Ruiz, Grievance and Appeals Manager, and Dr. Jocelyn Mateo, Director of Pediatrics, from South Florida Community Care Network, which is the Petitioner's managed care health plan.

The Respondent submitted various documents into evidence including the denial notice, wheelchair evaluation form, and medical records, which were marked as Respondent composite Exhibit 1.

Also present for the hearing was a Spanish language interpreter,

## FINDINGS OF FACT

1. Petitioner is a thirteen (13) year old Medicaid recipient. She receives Medicaid services through Children's Medical Services and South Florida Community Care

FINAL ORDER (Cont.)
16F-00842
Page 3 of 11
Network (CCN). Her medical diagnosis includes
She receives personal care assistance
services through CCN as well as assistance with G-tube feedings.
2. A manual wheelchair would be inappropriate for Petitioner because she does not have sufficient upper extremity function to self-propel a manual wheelchair.
3. On or about November 11, 2015 Petitioner submitted a request for a customized power wheelchair to CCN. The request included a custom wheelchair evaluation form completed by the Petitioner's physical therapist. CCN denied this request on November 12,2015 , stating the custom power wheelchair was not medically necessary. The notice also referred to Medicaid guidelines for wheelchairs as a basis for the decision.
4. Petitioner's mother stated she wants her daughter to have the customized power wheelchair so that she can be more independent and have the ability to move around the home without assistance. It would also allow her to leave the home on her own in case of any emergency. The mother stated her daughter can operate the power wheelchair, as shown in the video, and understands what she's doing while in the wheelchair. She also stated the parents assist her in getting into and out of the wheelchair.
5. Petitioner's physical therapist and teacher also stated the wheelchair would help her be more independent and pointed out she can use the wheelchair both inside and outside the home.
6. Respondent's witness, Dr. Mateo, stated the Petitioner did not meet medical necessity criteria for the customized power wheelchair. Specifically, the criteria require that the patient be able to transfer into and out of the wheelchair.

## 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 $\S 120.57$.
9. 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.
10. The Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook ("DME Handbook") has been incorporated, by reference, into Florida Administrative Code Rule 59G-4.070(2).
11. This hearing was held as a de novo proceeding, in accordance with Florida Administrative Code Rule 65-2.056.
12. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the Petitioner. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at $1201,7^{\text {th }}$ Ed.)..
13. 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.
14. With regard to the need for DME, Section 409.906(10), Florida Statutes, states in relevant part, "The agency may authorize and pay for certain durable medical equipment and supplies provided to a Medicaid recipient as medically necessary."
15. 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).

The DME Handbook further clarifies that customized power wheelchairs require prior authorization (page 2-91).
16. 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.
6. 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.
7. 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.
8. 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.
9. The State Medicaid Manual in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services section states in part:
10. 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...
11. Basic Requirements

OBRA 89 amended $\S \S 1902(\mathrm{a})(43)$ 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, [the State Agency] 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
21. The service the petitioner has requested (durable medical equipment wheelchair) 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 ...

## 22. 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.
2. 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, set forth above.
3. 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.
25. 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.
26. Page 2-94 of the DME Handbook lists the requirements for a recipient to obtain a customized power wheelchair, as follows:

Has documented, severe abnormal upper extremity dysfunction or weakness; and
Has demonstrated that he possesses sufficient eye and hand perceptual capabilities and the cognitive skills necessary to safely operate and guide the chair or POV independently, and is capable of evacuating a residence or building with minimal or no verbal prompting in case of an emergency; and
Currently resides in or will primarily use the equipment in an environment conducive to the use of a motorized wheelchair of the type and size wheelchair requested.

## 27. Page 2-95 of the DME Handbook lists additional criteria for obtaining a powered

 wheelchair, as follows:Recipient's medical necessity requires the use of a POV to independently move around his residence; and
Recipient is physically unable to operate a manual wheelchair; and Recipient is capable of safely and independently operating the controls for the POV requested; and
Recipient can transfer safely in and out of the POV and has adequate trunk stability to be able to safely ride in the POV; and
An independent licensed physical therapist, occupational therapist or physiatrist has determined and documented his recommendation of the most appropriate and medically-necessary POV to meet the recipient's individual mobility needs; and
The recipient does not have a wheelchair that was purchased by Medicaid within the past five years.

FINAL ORDER (Cont.)
16F-00842
Page 10 of 11
28. The testimony of the Petitioner's witnesses and the videos submitted demonstrate that the Petitioner is capable of safely operating the customized power wheelchair.
29. Based on the testimony of Respondent's witness, the main reason for the denial seems to be the Petitioner's ability to transfer in and out of the wheelchair.
30. Although the Petitioner's medical conditions clearly make her unable to transfer on her own, her mother stated that the parents assist her in transferring into the wheelchair. The wheelchair criteria set forth in the DME Handbook do not suggest that the recipient must be able to independently transfer into the wheelchair, and it would be unreasonable to expect that an individual with severe abnormal upper extremity dysfunction could be able to make such transfers on their own.
31. After considering the evidence and testimony presented, the undersigned concludes that the Petitioner has met her burden of proof in demonstrating that the customized power wheelchair should be approved since she meets the criteria outlined in the DME Handbook.

## DECISION

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

## NOTICE OF RIGHT TO APPEAL

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

FINAL ORDER (Cont.)
16F-00842
Page 11 of 11
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 _April_, 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:

# STATE OF FLORIDA <br> DEPARTMENT OF CHILDREN AND FAMILIES OFFICE OF APPEAL HEARINGS 

## FILED

Apr 20, 2016
Office of Appeal Hearings
Dept. of Children and Farnilies


APPEAL NO. 16F-00892
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-referenced matter on March 30, 2016 at $3: 17$ p.m.

## APPEARANCES

For the Petitioner:


For the Respondent: Sheila Broderick, registered nurse specialist with AHCA

## STATEMENT OF ISSUE

Whether the respondent was correct to deny the petitioner's request for the prescription drug

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

FINAL ORDER (Cont.)
16F-00892
PAGE - 2
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 October 2, 2015, Molina informed the petitioner that his request for the prescription drug chart notes do not indicate that you meet the...approval criteria; therefore
 found to be medically necessary at this time. This decision is based upon Florida Medicaid Authorization Criteria and Guideline for the approved indications of

The petitioner requested reconsideration.
By notice dated November 24, 2015, Molina informed the petitioner that the original denial decision was upheld.

The petitioner timely requested a hearing on January 5, 2016.
There were no additional witnesses for the petitioner. The petitioner did not submit documentary evidence.

The respondent presented three witnesses from Molina: Carlos Galvez, government contract specialist; Dr. Alfred Romay, director of pharmacy services; Dr. Luis Ruiz, clinical pharmacist; and Dr. Deopul Budha, clinical pharmacist. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

## FINDINGS OF FACT

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

1. The petitioner (age 57) is a Florida Medicaid recipient. The petitioner is enrolled with Molina HMO. The petitioner's medical history includes
2. The petitioner underwent a fn September 16, 2014. The petitioner was prescribed an immunosuppressant drug to prevent rejection of the


The drug, in combination with the petitioner's pre-existing chronic
3. On September 29, 2015, the petitioner's treating physician requested authorization from Molina to treat his for 24 weeks with the antiviral drug The request reads in pertinent part:

4. All Medicaid goods and services must be medically necessary. Specified goods and services require prior authorization that is performed by the respondent, a contracted HMO or other designee.
5. In October 2015, AHCA's prior service authorization criteria for the drug read:

6. AHCA's prior service authorization fo $\square$ also stated that the safety and effectiveness of $\square$ had not been established ir $\square$
7. Dr. Ruiz, clinical pharmacist with Molina, explained that the petitioner's treating physician did not provide sufficient clinical data to determine if criteria \#3-\#7, as cited in the above finding, were met. Dr. Ruiz explained further that the petitioner was not a candidate for $\square$ due to his $\square$
8. Molina denied the petitioner's request as not medically necessary in October 2015 because the requested treatment is not consistent with generally accepted professional medical standards as determined by AHCA.
9. The petitioner's treating physician submitted a written request for reconsideration in October 2015. The request reads in pertinent part:

10. Molina upheld the original denial decision on November 24, 2015. There were no clinical trials which proved that the drug was effective for individuals with the petitioner's medical conditions. Molina concluded that the drug had not been proven to be safe as prescribed and therefore was prohibited by Medicaid as experimental.
11. Dr. Ruiz noted that AHCA updated the prior service authorization criteria for in February 2016, to include the use of the drug for patients. However, guidelines state that the drug can only be used in conjunction with another antiviral drug and then only for 12 weeks, not 24 weeks as requested by the petitioner's treating physician. Molina stands by its denial decision and suggested that the petitioner's treating physician explore other antiviral medications to treat the

12. The petitioner argued that his treating physician has concluded that is contraindicated for

14. The petitioner argued that his transplant surgery was costly and time consuming; he spent months in the hospital recovering. He has made significant progress and feels better than he has for many years. The petitioner acknowledged the treating physician, a transplant expert, should carry greater weight than the opinion of a reviewing physician.

## CONCLUSIONS OF LAW

15. By agreement between the AHCA and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Section 120.80, Florida Statutes.
16. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.
17. This hearing was held as a de novo proceeding 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 petitioner.
19. The standard of proof in an administrative hearing is by a preponderance of the evidence (See Fla. Admin. Code R. 65-2.060(1)). The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at $1201,7^{\text {th }}$ Ed.).
20. The Florida Medicaid Program is authorized by Chapter 409 Florida Statutes and Fla. Admin. Code Chapter 59G.

FINAL ORDER (Cont.)
16F-00892
PAGE-7
21. Fla. Admin. Code R. 59G-1.010(166) explains that medical or allied care, goods, or services furnished or ordered must meet the definition of medically necessary or medical necessity, and defines medical necessity as:
"Medical necessary" or "medical necessity" means that medical or allied care, goods, or services furnished or ordered must:
(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational;
4. Be reflective of the level of service that can safely be furnished, for which no equally effective and more conservative or less costly treatment is available statewide; and,
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. . .
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods or services medically necessary, or a medical necessity, or a covered service.
6. The respondent denied the petitioner's request for the prescription drug in October 2015 because there was insufficient clinical data submitted by the petitioner to determine if he met the eligibility criteria. In addition, Medicaid criteria stated that the drug had not been proven to be effective in the patients, like the petitioner. Subsequent to the respondent's decision in this matter, Medicaid criteria changed in February 2016, and now provides for the use of Harvoni in patients. However, the drug must be used in conjunction with

FINAL ORDER (Cont.)
16F-00892
PAGE - 8
another antiviral drug, cannot be used alone. In addition, Medicaid criteria includes a 12 week limitation. The petitioner's treating physician prescribed the drug for 24 weeks.
23. The petitioner argued that without and all the progress he has made will be lost. A transplant expert prescribed the drug and provided the clinical rationale. The recommendation of the transplant expert should carry greater weight than the opinion of a reviewing physician.
24. Dr. Ruiz, the only expert witness to testify during the hearing, opined that use of the drug alone has not been proven to be effective in patients and therefore is considered experimental or investigational. Medicaid rules prohibit the provision of experimental goods or services. He suggested that the petitioner try other antiviral medications.
25. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the petitioner did not meet his burden in this matter. The petitioner did not prove by a preponderance of the evidence that it is medically necessary, as the term is defined in Medicaid rule, for him to receive the drug

## 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

FINAL ORDER (Cont.)
16F-00892
PAGE-9

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 _April 2016,
in Tallahassee, Florida.


Leslie Green
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com
$\begin{aligned} & \text { Copies Furnished To: } \text { Petitioner } \\ & \text { Debbie Stokes, Area 4, AHCA Field Office Manager }\end{aligned}$

Apr 28, 2016

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

PETITIONER,
Vs.
CASE NO.
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 13 Hillsborough UNIT: AHCA

RESPONDENT.
$\qquad$
FINAL ORDER
Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on March 2, 2016 at 2:32 p.m.

|  | APPEARANCES |
| :--- | :--- |
| For the Petitioner: |  |
| For the Respondent: | Stephanie Lang, RN Specialist <br> Agency for Health Care Administration |

## STATEMENT OF ISSUE

At issue is whether the Agency properly denied Petitioner's request for prescription medication Petitioner held the burden of proof in this matter by a preponderance of the evidence.

FINAL ORDER (Cont.)
16F-00893
PAGE - 2

## 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 vas present as Petitioner's representative and
witness. Respondent's witnesses were India Smith (Grievance and Appeals Specialist), Dr. David Gilchrist (Medical Director), and Clinton Hufstetler (Clinical Appeals Coordinator) with Sunshine Health Plan.

Petitioner did not submit any documentary evidence into the record. Respondent submitted six exhibits into evidence, marked and entered as Respondent's Exhibits 1 through 6. 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 male diagnosed with He is considered treatment naïve, but had a has returned and

FINAL ORDER (Cont.)
16F-00893
PAGE - 3
caused cirrhosis. He is a member of Sunshine Health Plan's managed care plan for Medicaid recipients.
2. Petitioner's treating doctor submitted a preauthorization request to the Agency for on or about October 29, 2015.
3. The Agency, through its agent Sunshine, reviewed the submitted documentation and denied the request. The denial notice dated November 6, 2015, stated that there was not enough information. Specifically, the notice stated as follows:

4. In response to the denial, Petitioner's physician requested an expedited appeal through Sunshine. He provided clinical notes and labs to support his request. He explained in a letter that Petitioner cannot tak $\quad$ because it is contraindicated with other medications he is on, and he is not eligible for it because his hemoglobin levels are below the recommended range. Petitioner's medical records indicate he is at
5. The plan reviewed his lab results and based on the information present as of the most recent lab results (October 22, 2015), calculated his $\quad$ which

FINAL ORDER (Cont.)
16F-00893
PAGE - 4
is class B. Petitioner did not dispute this, but suggested the September results might give a different result.
6. The plan denied the preauthorization request for pecause Petitioner's condition must meet certain criteria to be approved for that particular drug. Based on the plan's review of Petitioner's medical records, his condition does not meet the

7. Petitioner requested a fair hearing to dispute the denial. He contends he should be granted the $\square$ because he cannot take

argues that his $\quad$ He also should be considered as a whole. Further, he argues that the score alone is not | indicative of $r$ | because the doctor's notes do not specifically |
| :--- | :--- |
| indicate that nor indicate $\square$ | , and there could be other uses for |

## CONCLUSIONS OF LAW

8. The Department of Children and Families Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 120.80, Florida Statutes.
9. The Florida Medicaid program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The program is administered by the Agency.

FINAL ORDER (Cont.)
16F-00893
PAGE - 5
10. This hearing was held as a de novo proceeding pursuant to Florida Administrative Code Rule 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 652.060(1).
12. 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.
13. 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.
14. Page 1-30 of the Provider Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

FINAL ORDER (Cont.)
16F-00893
PAGE-6
15. 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.
6. 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.
17. For prescription drugs, Sections 409.912(8)(a)(14) through 409.912(8)(a)(16), Florida Statutes (2015) explain the process. 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.

FINAL ORDER (Cont.)
16F-00893
PAGE-7
18. 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.
19. The Agency has the authority to manage its prior authorization process, including establishing criteria for approval. It established specific criteria fo The version of the criteria relevant to this case is included in the evidence, and was last updated April 21, 2015. Petitioner meets the initial criteria for
 but he must be denied based on his
 s and
 There is a section of the criteria which is titled "Denial Criteria." It states that "[s]afety and efficacy of have not been established in patients with
defined as a $\quad$ score greater than 6 (Class B or C), nor was it established in Petitioner meets both of these denial criteria and therefore must be denied according to the Agency's policy. There are no exceptions to the guidelines for special cases or need.
20. Petitioner argues that the medication should be approved because he needs it and cannot take $\quad$ He meets the Agency's criteria for required stage and genotype. Petitioner also suggested that the $\square$ may not accurately reflect his normal functioning. There is no evidence to support this claim, and the plan agreed to revisit the score if Petitioner submitted a new request. The most recent labs are considered an accurate representation of Petitioner's functioning in the absence of any evidence indicating otherwise. Regardless, as Petitioner had a he would be denied $\square$ based on that alone.

FINAL ORDER (Cont.)
16F-00893
PAGE - 8
21. The Agency has updated its criteria since the original decision was made ${ }^{1}$. The new criteria, effective as of February 24, 2016, do not apply to this case. However, it does not appear that Petitioner would meet the new criteria. There is only one category of criteria for a ecipient, and it requires a $\quad$ to be eligible. Petitioner's based on the most recent available information.
22. 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. The evidence shows Petitioner failed to meet the requirements of the established clinical guidelines. There is no rule or exception permitting the hearing officer to create or change Agency rules or policy to make such exceptions despite potential need.
23. Petitioner had the burden of proof in this case. Petitioner did not meet his burden of proof to show that he meets all the criteria (including lack of denial requirements) to receive this medication. He is encouraged to work with his physician and the Agency to find a medication that will meet his needs and can be approved.
24. 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.

[^13]FINAL ORDER (Cont.)
16F-00893
PAGE-9

## 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 $\quad 28$ day of April
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 |

Cotitioner

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

PETITIONER,
Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES CIRCUIT: 06 Pinellas UNIT:

## RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on March 31, 2016 at 1:08 p.m.

## APPEARANCES

For the Petitioner:
For the Respondent:
Ed Poutre, Economic Self-Sufficiency Specialist II

## STATEMENT OF ISSUE

Petitioner is appealing the Department's action of February 10, 2016 denying his application for SSI-Related Medicaid/Medically Needy due to exceeding the asset limit for the program. The petitioner also expressed concern that his disability as established by a private company should meet the eligibility requirement for Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

FINAL ORDER (Cont.)
16F-00978
PAGE - 2

## PRELIMINARY STATEMENT

The Department submitted evidence prior to the hearing. This evidence was entered as Respondent Exhibit 1.

Christiana Gopaul-Narine, hearing officer, was present as an observer with no objection.

## FINDINGS OF FACT

1. The petitioner filed an application for SSI-Related Medicaid/Medically Needy on December 31, 2015 through the Federally Facilitated Marketplace (FFM).
2. The petitioner is 55 years old. He has no minor children in his home.
3. The petitioner was established as disabled in June 2015 by a private insurance company, which is presently paying him \$500 per month. He has not been determined as disabled by the Social Security Administration or by an independent decision made by the state disability unit.
4. The petitioner applied for disability with the Social Security Administration on February 18, 2016.
5. The petitioner reported through the interview process he has approximately $\$ 97,000$ in 401 K investments, $\$ 57,000$ in a tax savings account, \$1,627.85 in a savings account, and \$853.83 in checking.
6. The petitioner confirmed during hearing the 401 K and tax savings accounts decreased a total of approximately $\$ 10,000$ since he applied for assistance, but his checking and savings accounts have increased due to his tax refund and monthly disability checks.

FINAL ORDER (Cont.)
16F-00978
PAGE-3
7. The Department explained to qualify technically for Family Related Medicaid a person must be under age 18, have a minor child in the home, or be pregnant. The petitioner does not meet these qualifications, so the Department reviewed his application for SSI-Related Medicaid.
8. The Department explained to qualify technically for SSI-Related Medicaid a person must be age 65 or older or established as disabled by Social Security or an independent state determination of disability. The petitioner does not meet either of these qualifications.
9. The Department also explained for SSI-Related Medicaid, an individual must have assets below $\$ 5,000$.
10. The petitioner expressed concern that a person could have the same amount of money invested in a house and they would be eligible. However, he feels penalized because his life savings are in liquid asset form rather than in owning a home.
11. The petitioner expressed concern that several items on his application were incorrect, including employment, race, and unemployment compensation.
12. The Department advised the reported inaccuracies of the application did not negatively affect the determination of his eligibility.

## CONCLUSIONS OF LAW

13. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

FINAL ORDER (Cont.)
16F-00978
PAGE - 4
14. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R.

65-2.056.
15. The definition of MEDS-AD Demonstration Waiver is found in Fla. Admin.

Code R. 65A-1.701 "Definitions":
(20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services.

## 16. Fla. Admin. Code R. 65A-1.711 "SSI-Related Medicaid Non-Financial

Eligibility Criteria" states in relevant part:
To qualify for Medicaid an individual must meet the general and categorical requirements in 42 C.F.R. Part 435, subparts E and F (2007) (incorporated by reference), with the exception that individuals who are neither aged nor disabled may qualify for breast and cervical cancer treatment, and the following program specific requirements as appropriate. Individuals who are in Florida temporarily may be considered residents of the state on a case-by-case basis, if they indicate an intent to reside in Florida and can verify that they are residing in Florida.
(1) For MEDS-AD Demonstration Waiver, the individual must be age 65 or older, or disabled as defined in 20 C.F.R. § 416.905 (2007) (incorporated by reference).
17. 20 C.F.R. § 416.903 "Who makes disability and blindness determinations"
states:
(a) State agencies. State agencies make disability and blindness determinations for the Commissioner for most persons living in the State. State agencies make these disability and blindness determinations under regulations containing performance standards and other administrative requirements relating to the disability and blindness determination function. States have the option of turning the function over to the Federal Government if they no longer want to make disability determinations. Also, the Commissioner may take the function away from any State which has substantially failed to make disability and blindness determinations in
accordance with these regulations. Subpart J of this part contains the rules the States must follow in making disability and blindness determinations.
(b) Social Security Administration. The Social Security Administration will make disability and blindness determinations for-
(1) Any person living in a State which is not making for the Commissioner any disability and blindness determinations or which is not making those determinations for the class of claimants to which that person belongs; and
18. 20 C.F.R. $\S 416.905$ "Basic definition of disability for adults" states in relevant part:
(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see §416.960(b)) or any other substantial gainful work that exists in the national economy.
19. The findings show the petitioner is age 55 and his disability was established by a private insurance company and receiving benefits through that program. Additionally, the findings show the Department or Social Security Administration has not established the petitioner as disabled. In accordance with the above controlling authorities, as the petitioner is not age 65, he must be established by Social Security or the Department as being disabled to meet the technical requirement for Medicaid eligibility.
20. The 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 (MEDSAD), 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.
(e) For Medically Needy, an individual or couple cannot have resources exceeding the applicable Medically Needy resource limit set forth in subsection 65A-1.716(3), F.A.C.
21. 20 C.F.R. § 416.1210 "Exclusions from resources; general" states:

In determining the resources of an individual (and spouse, if any), the following items shall be excluded:
(a) The home (including the land appertaining thereto) to the extent its value does not exceed the amount set forth in §416.1212;
(b) Household goods and personal effects as defined in §416.1216;
(c) An automobile, if used for transportation, as provided in §416.1218;
(d) Property of a trade or business which is essential to the means of selfsupport as provided in $\S 416.1222$;
(e) Nonbusiness property which is essential to the means of self-support as provided in §416.1224;
(f) Resources of a blind or disabled individual which are necessary to fulfill an approved plan for achieving self-support as provided in §416.1226;
(g) Stock in regional or village corporations held by natives of Alaska during the twenty-year period in which the stock is inalienable pursuant to the Alaska Native Claims Settlement Act (see §416.1228);
(h) Life insurance owned by an individual (and spouse, if any) to the extent provided in §416.1230;
(i) Restricted allotted Indian lands as provided in §416.1234;
(j) Payments or benefits provided under a Federal statute other than title XVI of the Social Security Act where exclusion is required by such statute; (k) Disaster relief assistance as provided in §416.1237;
(I) Burial spaces and certain funds up to $\$ 1,500$ for burial expenses as provided in §416.1231;
(m) Title XVI or title II retroactive payments as provided in §416.1233;
(n) Housing assistance as provided in §416.1238;
(o) Refunds of Federal income taxes and advances made by an employer relating to an earned income tax credit, as provided in §416.1235;
(p) Payments received as compensation for expenses incurred or losses suffered as a result of a crime as provided in $\S 416.1229$;
(q) Relocation assistance from a State or local government as provided in §416.1239;

FINAL ORDER (Cont.)
16F-00978
PAGE-7
(r) Dedicated financial institution accounts as provided in §416.1247;
(s) Gifts to children under age 18 with life-threatening conditions as provided in §416.1248;
(t) Restitution of title II, title VIII or title XVI benefits because of misuse by certain representative payees as provided in §416.1249;
(u) Any portion of a grant, scholarship, fellowship, or gift used or set aside for paying tuition, fees, or other necessary educational expenses as provided in §416.1250;
(v) Payment of a refundable child tax credit, as provided in $\S 416.1235$; and
(w) Any annuity paid by a State to a person (or his or her spouse) based on the State's determination that the person is:
(1) A veteran (as defined in 38 U.S.C. 101); and
(2) Blind, disabled, or aged.
22. Fla. Admin. Code R. 65A-1.716(3) defines the asset limit for a household of one as $\$ 5000$.
23. The findings show the petitioner has countable liquid assets, which total in excess of $\$ 100,000$. The above controlling authorities outline the opportunity to exclude resources from counting in the determination of eligibility for Medicaid. The undersigned concludes the petitioner's resources do not meet the criteria in the controlling authority to be excluded from the eligibility determination.
24. The undersigned concludes the petitioner did not meet the aged or disabled criteria for eligibility consideration for Medicaid. The undersigned further concludes the petitioner's countable assets exceed the \$5,000 asset limit for SSIRelated Medicaid eligibility. Therefore, the undersigned concludes the Department correctly denied the petitioner's Medicaid 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 21 day of _ April 2016,
in Tallahassee, Florida.


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@myffamilies.com
Copies Furnished To:
Petitioner
Office of Economic Self Sufficiency

Apr 05, 2016
STATE OF FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-00982
PETITIONER,
Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 05 Lake
UNIT: 55510

## RESPONDENT.

## FINAL ORDER OF DISMISSAL

An appeal in the above styled matter is before the undersigned hearing officer. The petitioner is appealing the Department's action to deny his SSI-Related Medicaid application.

The respondent presented a 34 page information packet that was entered into evidence as Respondent's Exhibits " 1 " through " 8 ". The undersigned took administrative notice of two pages of the Department's Policy Manual CFOP 165-22; it is now labeled as Respondent's Exhibit " 9 ".

The petitioner presented a 45 page information packet that was entered into evidence as Petitioner's Exhibits "1" through "10". The undersigned took administrative notice of one page of the Department's Policy Manual CFOP 165-22; it is now labeled as Petitioner's Exhibit " 11 ".

The petitioner submitted an online application for TCA, Food Assistance Program (FAP), and Medicaid benefits on July 13, 2015. He indicated on this application that he

FINAL ORDER OF DISMISSAL (Cont.)
16F-00982
PAGE - 2
was disabled. By notice dated August 4, 2015, the respondent notified the petitioner that he was denied Medicaid.

The petitioner filed a disability application with the Social Security Administration (SSA) on May 6, 2014. SSA denied the petitioner's disability claim on August 18, 2014. On December 4, 2014, SSA sent a Notice affirming that the first decision was correct. The petitioner filed an appeal for the SSA denial and that appeal is currently pending.

The petitioner disagreed with the diagnoses listed on the Disability Determination and Transmittal from DDD. In 15F-08269, it was determined that the Department followed rule in adopting the SSA denial from December 4, 2014 and denying the petitioner's Medicaid disability application. The diagnoses listed on the DDD transmittal are he conditions petitioner adds are PostThese are documented $b$ eferral dated March 5, 2015. The petitioner has reported all of these conditions to the SSA. These same issues were discussed and entered into evidence in appeal hearing 15F-08269.

The petitioner's argument is that more recent medical records were not considered when the Department summarily denied the disability claim based on the 2014 SSA decision; that it had been more than 12 months since the SSA denial, therefore the Department should make an independent decision. The petitioner fails to recognize that while his SSA decision is under appeal the Department is bound to accept the SSA decision (Code of Federal Regulations at 42 C.F.R. section 435.541). He pointed out that his worsening condition "is" the unread medical records and goes on to state these issues were raised with the SSA but now he has more recent information.

FINAL ORDER OF DISMISSAL (Cont.)
16F-00982
PAGE - 3
The undersigned concludes that the appeal must be dismissed on the basis of res judicata because a final order has been issued in the matter (15F-08269). The undersigned concludes that the petitioner understood his rights to appeal the service denial after receiving the 2015 initial notice and has fully exercised those rights.
"The doctrine of res judicata applies when four identities are present: (1) identity of the thing sued for; (2) identity of the cause of action; (3) identity of persons and parties to the action; and (4) identity of the quality of the persons for or against whom the claim is made." Topps v. State, 865 So.2d 1253, 1255 (Fla. 2004).

It must be shown that a final order had been issued and that it has not been overturned on appeal to the DCA; that the order involved the same parties for the same services that were previously subject to review and a final decision issued in a final order.

The same issue was ruled on and was set in the final order 15F-08269, i.e. that the respondent followed rule in adopting the SSA disability denial from December 4, 2014 and denying the petitioner's Medicaid disability application. It was not overturned on appeal to the DCA. The proponent of any attempt to change that level of service must show that there has been a material change in circumstances. There was no showing of a material change in circumstances.

Fla. Admin Code 65-2 sets forth the rules of practice and procedure which govern the Department's administrative hearing; paragraph 65-2.067, Conduct of Hearing, states in relevant part, "(10) A hearing officer shall not grant a motion for rehearing or reconsideration."

FINAL ORDER OF DISMISSAL (Cont.)
16F-00982
PAGE -4
After carefully reviewing all the evidence, the undersigned concludes that without a showing of material change, the prior order must be honored and further review is barred. The Office of Appeal Hearing cannot, by rule, rehear this matter.

The undersigned, therefore, dismisses the instant appeal as res judicata.

## NOTICE OF APPEAL RIGHTS

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 _ April 2016, in Tallahassee, Florida.


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

Copies Furnished To:
Petitioner
Office of Economic Self Sufficiency

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


PETITIONER,
APPEAL NO. 16F-01026

Apr 20, 2016

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 March 29, 2016 at 11:14 a.m.

## APPEARANCES

For the Petitioner:

For the Respondent:
Lisa Sanchez Medical Health Care Program Analyst

## ISSUE

Whether respondent's denial of a lower denture (Procedure D5214) was proper. The burden of proof was assigned to the petitioner. The burden of proof in an administrative hearing is by a preponderance of the evidence.

## PRELIMINARY STATEMENT

Petitioner was present and gave verbal permission for to act as her representative. Petitioner entered no exhibits into evidence.

FINAL ORDER (Cont.)
16F-01026
PAGE - 2

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

## FINDINGS OF FACT

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

1. Petitioner's date of birth is February 28, 1955. At all times relevant to this proceeding, petitioner was Medicaid eligible.
2. Petitioner receives Medicaid services through respondent's Statewide Medicaid Managed Care Program. Humana is petitioner's managed care provider.
3. DentaQuest is Humana's dental vendor. All requests for dental services are reviewed by DentaQuest. A licensed dentist determines whether the requested procedure is medically necessary and in compliance with pertinent rules and regulations.
4. DentaQuest must be in compliance with respondent's Florida Medicaid Dental Services Coverage and Limitations Handbook (Dental Handbook).
5. On or about January 18, 2016 DentaQuest received from petitioner's dentist an x-ray and prior authorization request for a partial lower denture.
6. The teeth that anchor a partial denture must have sufficient bone support. Bone support is determined by x-rays. The overall periodontal health of the anchor teeth must also be considered.

FINAL ORDER (Cont.)
16F-01026
PAGE - 3
7. Petitioner's dentist also requested an upper denture (Procedure D5130).
8. On January 20, 2016 DentaQuest informed petitioner's dentist the upper denture was approved.
9. On January 21, 2016 DentaQuest issued a Notice of Action which denied the request for a lower partial denture. The notice stated the partial denture was not medically necessary. The notice also stated:

In order to get a partial denture, you must have at least $50 \%$ bone support for the tooth that is still your mouth. Our dentist looked at the x-rays sent by your dentist. You have less than $50 \%$ bone support. We have also told your dentist this. Please talk to your dentist about other choices to fix your teeth.
10. On February 9, 2016 Sarah Chapa contacted the Office of Appeal Hearings and timely requested a fair hearing.
11. Upon receipt of the hearing request, a second dentist reviewed all submitted information. The reviewer upheld the original decision and wrote, in part:

To qualify for partial dentures, good long term prognosis is necessary. Based on the standard of care, education, literature and practice the bone support is inadequate to support good long term prognosis for a partial denture. The abutment teeth 20, 22, 29 need to have greater than 50\% bone support remaining to adequately support the partial, indicating good long term prognosis. The remaining mandibular anterior teeth have less than $50 \%$ bone support as well.
12. Dr. Hudson did not participate in either the initial or second review. Upon review of x-rays, Dr. Hudson is in agreement that sufficient bone support does not exist for a partial denture. An acrylic partial, however, could be considered.
13. Petitioner was not aware an upper denture was approved.

FINAL ORDER (Cont.)
16F-01026
PAGE-4

## CONCLUSIONS OF LAW

14. By agreement between the Agency for Health Care Administration and the

Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to § 120.80, Fla. Stat.
15. This is a final order pursuant to $\S 120.569$ and $\S 120.57$, Fla. Stat.
16. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R.

65-2.056.
17. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at $1201,7^{\text {th }}$ Ed.).
18. The Florida Medicaid Provider General Handbook (Provider Handbook) - July

2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin.
Code R. 59G-4. The Provider Handbook states on page 1-27:
Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.

Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee. Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.
19. Respondent's Dental Handbook is also incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code R. 59G-4.
20. The Dental Handbook states "Medicaid reimburses for services that are determined medically necessary ..."

FINAL ORDER (Cont.)
16F-01026
PAGE - 5
21. The definition of "medically necessary" is found in the Fla. Admin. Code R. 59G-
1.010, which states, in part:
(166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
(a) Meet the following conditions:

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

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

Medicaid will reimburse for medically-necessary emergency dental procedures to alleviate pain and or infection for eligible adult Medicaid recipients 21 years of age or older. Emergency dental care shall be limited to emergency problem-focused evaluations, necessary radiographs to make a diagnosis, extraction, and incision and drainage of abscess.

FINAL ORDER (Cont.)
16F-01026
PAGE-6
23. The above authority establishes, if medical necessary, a partial denture is a covered Medicaid service.
24. In regard to partial dentures, pages 2-30 through 2-33 the Dental Handbook states, in part:

For all eligible Medicaid recipients, Medicaid may reimburse for the fabrication of full and removable partial dentures ...

The standard for all dentures, whether seated immediately after extractions or following alveolar healing, is that the denture be fully functional [Emphasis Added].

Partial dentures refer to the prosthetic appliance that replaces missing teeth and is on a framework that is removed by the patient. Prior authorization is required for reimbursement of removable partial dentures and must be submitted to the dental consultant for determination of medically necessity prior to the procedure being performed.
25. The Findings of Fact establish three licensed dentists have determined sufficient bone support does not exist in those teeth which would anchor the partial denture.
26. The undersigned has assigned considerable weight to analysis completed by

DentaQuest dentists.
27. Petitioner provided no persuasive evidence establishing sufficient bone support exists in the anchor teeth. As such, the requirement that a partial be fully functional has not been satisfied.
28. Petitioner has not demonstrated respondent's action in this matter was improper.

The following condition of medical necessity has not been satisfied:
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

FINAL ORDER (Cont.)
16F-01026
PAGE -7
29. If desired, petitioner's dentist can submit a prior authorization for an acrylic partial denture.

## 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 $\qquad$ 20 day of $\qquad$ , 2016, in Tallahassee, Florida.


Frank Houston
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myfIfamilies.com

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

Apr 26, 2016
Office of Appeal Hearings
Dept. of Children and Farrilies

> APPEAL NO. 16F-01046

PETITIONER,
Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 20 Hendry
UNIT: 88521
CASE NO.

## RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on March 22, 2016 at approximately 8:50 a.m. CDT.

## APPEARANCES

For the Petitioner:


For the Respondent: Signe Jacobson, Economic Self-Sufficiency Specialist II Department of Children and Families

## STATEMENT OF ISSUE

Petitioner is appealing the Department's action of January 21, 2016 to not include his children, GC (age 17) and CC (age 15) in his Food Assistance Program (FAP) benefits. The petitioner is not in disagreement with the calculations of income used to determine his FAP benefits, but the respondent's action to exclude the children

FINAL ORDER (Cont.)
16F-01046
PAGE -2
affected the income limits causing the FAP benefit to be denied. The petitioner carries the burden of proof by the preponderance of evidence.

## PRELIMINARY STATEMENT

The respondent submitted a packet of information that was entered into evidence as Respondent's Exhibits " 1 " through " 14 ". The petitioner's son and daughter appeared and took the oath, but did not enter any testimony. The petitioner understands that he can reapply and supply documentation of household composition, if he so chooses before receiving this final order.

## FINDINGS OF FACT

1. On December 17, 2015, petitioner submitted an application for FAP stating that the household consisted of himself and his two oldest children, GC and CC.
2. Both children were active FAP recipients in their mother's case when this application was submitted.
3. On December 21, 2015, petitioner was pended for an interview, verification of income and of having custody of the two children.
4. A Notice of Missed Appointment was sent to petitioner December 29, 2015.
5. On December 31, 2015, the Department received a four-page communication from petitioner that was unsigned and incomplete concerning the children's custody.
6. A Notice of Case Action (NOCA) denying FAP for lack of income verification was mailed January 20, 2016. Later the same day, the Department received verification of income.
7. In response to receipt of verification of earned income, the Department averaged gross income determining that countable gross income was $\$ 2,874.06$. Since

FINAL ORDER (Cont.)
16F-01046
PAGE - 3
verification of household composition was not received, this figure was compared to the gross monthly income test standard for one, \$1,962 and the assistance group (AG) failed the gross income test.
8. On March 4, 2016, the Department received school records for both children; however, these records do not indicate parental custody, so no action was taken as no change was verified.
9. The petitioner stated on the record that the children have lived with him since November 14, 2015. The Department is not in receipt of any documentation of this information.

## 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 $\S 409.285$, Fla. Stat.
11. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 652.056.
12. The Code of Federal Regulations 7 C.F.R. § 273.1 defines household concept and states in relevant part:
(a) General household definition. A household is composed of one of the following individuals or groups of individuals, unless otherwise specified in paragraph (b) of this section:
(b) Special household requirements-(1) Required household combinations. The following individuals who live with others must be considered as customarily purchasing food and preparing meals with the others, even if they do not do so, and thus must be included in the same household, unless otherwise specified.

FINAL ORDER (Cont.)
16F-01046
PAGE -4
(ii) A person under 22 years of age who is living with his or her natural or adoptive parent(s) or step-parent(s);
13. The above controlling federal regulation sets forth who is required to be included in the household for FAP eligibility purposes. Children under age 22 living with their parent(s) must be certified with their parent(s).
14. The Code of Federal Regulations 7 C.F.R. § 273.3(a) defines residency requirements and states "no individual may participate as a member of more than one household...in any month." [emphasis added].
15. The authorities cited set forth household requirements as well as non-duplication of FAP benefits. The findings show that GC and CC were already included in their mother's case and receiving FAP benefits when the petitioner applied to have them added to his case. The controlling federal regulation is very clear that no individual may be included and receive FAP benefits in more than one household at a time; therefore, GC and CC cannot receive FAP benefits under both of their parents.
16. In careful review of the above controlling authorities and evidence, the undersigned concludes that the respondent was correct to exclude GC and CC from the petitioner's FAP eligibility determination as they were already receiving FAP benefits in their mother's case. The Department correctly established FAP benefits for the petitioner as a one-member household for the time period under appeal.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied. The Department's action is affirmed.

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 26 day of April_, 2016,
in Tallahassee, Florida.


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

Copies Furnished To
0
Office of Economic Self Sufficiency

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


APPEAL NO. 16F-01040
16F-01088
PETITIONER,
Vs.
FLORIDA DEPARTMENT
CASE NO OF CHILDREN AND FAMILIES
CIRCUIT: 20 Charlotte
UNIT: 88330

## RESPONDENT.

 1
## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on March 18, 2016 at 10:23 a.m., at the respondent's local office in North Port, Florida.

## APPEARANCES

For Petitioner:
For Respondent: Ed Poutre, Senior Worker

## STATEMENT OF ISSUE

The petitioner is appealing the Food Assistance Program (FAP) benefit level authorized by the respondent. The petitioner is also appealing the department's action to close the Qualified Medicare Beneficiaries (QMB) benefits effective February 2016. Additionally, the petitioner disagrees with the respondent's actions in regards to the

FINAL ORDER (Cont.)
16F-01040, 16F-01088
PAGE - 2
calculations of FAP benefits and Medicare Savings Programs (MSP) benefits for the Notices of Case Actions dated March 4, 2015, March 16, 2015 and July 6, 2015.

During the hearing, the burden of proof was originally assigned to the department. Upon further review, for the FAP benefits, the burden of proof by the preponderance of the evidence belongs to the petitioner and for the QMB benefits, the burden of proof by the preponderance of the evidence is assigned to the department.

## PRELIMINARY STATEMENT

This appeal had been originally scheduled to be held telephonically on March 1, 2016. The petitioner subsequently requested that the hearing be changed to an inperson forum, and the hearing was rescheduled to accommodate the petitioner's request.

The petitioner submitted two exhibits that were accepted into evidence and marked as Petitioner's Exhibits "1" and "2".

The respondent submitted 30 exhibits that were accepted into evidence and marked as Respondent's Exhibits "1" through " 30 " respectively. The record was held open until the close of business on March 28, 2016 for the respondent to supplement the record. The petitioner declined an opportunity to review any additional evidence provided by the respondent prior to closing the record. The respondent timely provided the additional documentation, which were accepted into evidence and marked as Respondent's Exhibits " 31 " through " 52 ". The record closed on March 28, 2016.

## FINDINGS OF FACT

1. The petitioner applied for FAP and Medicaid benefits on February 27, 2015. On March 4, 2015, a Notice of Case Action (NOCA) was sent to the petitioner

FINAL ORDER (Cont.)
16F-01040, 16F-01088
PAGE - 3
indicating that he was approved for Special Low-Income Medicare Part B Medicaid (SLMB) effective January 2015. On March 16, 2015, a NOCA was sent to the petitioner indicating the he was approved for FAP benefits of \$16 beginning March 2015.
2. On July 6, 2015, a NOCA was mailed indicating that the FAP benefits would increase to $\$ 42$ and that the QMB benefit were approved effective August 2015. The SLMB benefits ended in July 2015.
3. Each NOCA mailed on March 4, 2015, March 16, 2015 and July 6, 2015 provided information regarding the petitioner's appeal rights that included the statement that the petitioner has "the right to ask for a hearing before a state hearing officer" and further noted that if the petitioner wanted a hearing, he must "ask for the hearing in writing, calling the call center or coming into the office within 90 days from the mailing date at the top of [the] notice."
4. The department mailed a Notice of Eligibility Review on December 21, 2015 indicating that the FAP benefits would end on January 2016 and a new application for benefits was requested. Additionally, on December 22, 2015, the department mailed a Notice of Eligibility Review, Interim Contact Letter, indicating that in order to continue current benefits, a review must be completed.
5. The petitioner filed an application to recertify his FAP benefits and Medicaid benefits on December 29, 2015. The application noted that the petitioner receives monthly Social Security benefits of $\$ 946$. The following expenses were answered "yes": Support Payments of $\$ 150$ and Past Medical Expense for the month of April with no dollar amount of expenses listed. The following expenses were answered with a "no": Shelter, Utilities, Homeless, and Medical.

FINAL ORDER (Cont.)
16F-01040, 16F-01088
PAGE-4
6. The department mailed a NOCA on January 5, 2016 indicating that the FAP benefits would be $\$ 16$ effective February 2016 with the reason: Unearned income has increased. The NOCA also noted that the QMB benefits would end on January 31, 2016 and that the SLMB benefits was approved effective February 1, 2016.
7. The petitioner's mailing address is 33952. The petitioner acknowledged that he has received the NOCAs.
8. On February 9, 2016, the petitioner requested an appeal of his FAP benefits and his QMB benefits.
9. QMB and SLMB are Medicare Savings Programs (MSP). MSP is a Medicaid Buy-In Program in which the State of Florida pays the Medicare premium(s) for eligible individuals.
10. The petitioner, age 47, is disabled. Since January 2015, the petitioner has been receiving Social Security Disability Income (SSDI) of $\$ 1,097$ gross per month. His net SSDI benefits are $\$ 947$ due to a Child Support garnishment of $\$ 150$ that has been deducted from his monthly SSDI order signed October 8, 2014. The petitioner has been receiving Medicare benefits of Parts A and B since July 2012. The Part B premiums are $\$ 104.90$.
11. Petitioner states he is homeless and lives in his van. He pays $\$ 176$ a month for his vehicle payments.
12. The department explained that the homeless income deduction in the FAP is $\$ 143$.
13. Initially, the department determined the petitioner's FAP benefits using the $\$ 176$ vehicle payment as a shelter deduction instead of the $\$ 143$ homeless deduction.

FINAL ORDER (Cont.)
16F-01040, 16F-01088
PAGE - 5
The original budget included the petitioner's gross SSDI income of $\$ 1097$, which was reduced by the standard deduction of $\$ 155$ and the child support payment deduction of $\$ 150$ to determine the petitioner's adjusted net income of $\$ 792$. As there were no reported monthly medical expense, the $\$ 35$ medical deduction was not applied to reduce the medical expenses and the excess medical expense was $\$ 0$. No excess shelter deduction was considered as the department determined the shelter standard of $\$ 396$ (50\% of the adjusted net income of \$792), which was used to reduce the total shelter and utility costs of $\$ 213$ (vehicle payment of $\$ 176$ and the phone standard of $\$ 37$ ) for an excess shelter deduction of $\$ 0$. The department compared the adjusted net income of $\$ 792$ to the maximum net income of $\$ 981$ to determine the petitioner passed the net income test. The department counted 30 percent of the adjusted net income of $\$ 792$ as the benefit reduction amount ( $\$ 792$ * $30 \%=\$ 238$ ). The maximum allotment for a household of one is $\$ 194$. The department subtracted the benefit reduction amount of $\$ 238$ from the maximum allotment for one of $\$ 194$ to reach a monthly allotment for this household of $\$ 0$. The department determined that the petitioner was eligible for the minimum monthly FAP benefit of $\$ 16$.
14. The department submitted a new budget that included the homeless income deduction and removed the vehicle payment as the department alleged that the homeless standard was more beneficial to the petitioner. The department now determined the adjusted net income by reducing the petitioner's gross SSDI income of $\$ 1097$ by the standard deduction of $\$ 155$, the child support payment deduction of $\$ 150$ and the homeless income deduction of $\$ 143$ to determine the petitioner's adjusted net income of $\$ 649$. As there were no reported monthly medical expense, the $\$ 35$ medical

FINAL ORDER (Cont.)
16F-01040, 16F-01088
PAGE-6
deduction was not applied to reduce the medical expenses and the excess medical expense was $\$ 0$. No excess shelter deduction was considered as the department determined the shelter standard of $\$ 324$ ( $50 \%$ of the adjusted net income of $\$ 649$ ), which was used to reduce the total shelter and utility costs of $\$ 37$ (phone standard of $\$ 37$ ) for an excess shelter deduction of $\$ 0$. The department compared the adjusted net income of $\$ 649$ to the maximum net income of $\$ 981$ to determine the petitioner passed the net income test. The department counted 30 percent of the adjusted net income of $\$ 649$ as the benefit reduction amount (\$649 * 30\% = \$195). The Maximum Allotment for a household of one is $\$ 194$. The department subtracted the benefit reduction amount of $\$ 195$ from the maximum allotment for one of $\$ 194$ to reach a monthly allotment for this household of $\$ 0$. The department determined that the petitioner was eligible for the minimum monthly FAP benefit of $\$ 16$.
15. The petitioner explained that he is eligible for the following FAP deductions from his income: the standard deduction of $\$ 155$, child support deduction of $\$ 150$, the phone standard of $\$ 37$, the excess medical deduction of $\$ 35$, the Medicare premium of $\$ 105$ and the homeless deduction of $\$ 143$.
16. The State of Florida has been paying the Medicare Part B premiums of \$104.90 since January 2015 through either the QMB or SLMB program.
17. The department cited the income limits used for the January 2016 determination for the QMB program to be $\$ 981$ and the SLMB program to be $\$ 1,177$.
18. The department explained policy only allows a $\$ 20$ disregard in the QMB eligibility determination.

FINAL ORDER (Cont.)
16F-01040, 16F-01088
PAGE - 7
19. The petitioner's gross SSDI income of $\$ 1,097$ is reduced by the $\$ 20$ income disregard to equal the countable unearned income of $\$ 1,077$, which is greater than the income limit for QMB and less than the income limit for SLMB.
20. The department explained that the reason for the change in FAP benefits and the closure of the QMB benefits is due to an incorrect entry during the determination of eligibility by using the net SSDI income instead of the gross SSDI income.
21. The petitioner explained that he is eligible for the following Medicaid deductions from his income: the child support payments due to being redirected irrevocably from the source of $\$ 150$, the income deduction of $\$ 20$, and the Medicaid premium of $\$ 105$.

## CONCLUSIONS OF LAW

22. 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.
23. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
24. The standard of proof in an administrative hearing is by a preponderance of the evidence (See Fla. Admin. Code R. 65-2.060(1)). The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at $1201,7^{\text {th }}$ Ed.).

FINAL ORDER (Cont.)
16F-01040, 16F-01088
PAGE-8
25. Prior to examining the merits of these appeals, it must be determined if the petitioner timely requested an appeal for all Notices of Case Action dated between March 2015 and July 6, 2015.
26. The Fla. Admin. Code R. 65-2.046 sets a time-period to request a hearing, as follows:
(1) The appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs. Additionally, in the Food Stamp Program, a household may request a fair hearing at any time within a certification period to dispute its current level of benefits. The time period begins with the date following:
(a) The date on the written notification of the decision on an application.
(b) The date on the written notification of reduction or termination of program benefits.
(c) The date of the Department's written notification of denial or a request or other action which aggrieves the petitioner when that denial or action is other than an application decision or a decision to reduce or terminate program benefits.
(2) The time limitation does not apply when the Department fails to send a required notification, fails to take action of a specific request or denies a request without informing the appellant. If the notice is not mailed on the day it is dated, the time period commences on the date it is mailed.
27. The petitioner received notices of case action dated March 4, 2015, March 16, 2015 and July 6, 2015. All of the notices informed him of the time period in which to request an appeal.
28. The above-cited rule sets forth a time-period from the date of the written notification of the action under appeal to request a hearing. On the various dates mentioned above, the respondent mailed the petitioner notices that indicated the benefits for which he was eligible to receive. The petitioner acknowledged that he did not request an appeal of how the respondent calculated benefits until February 9, 2016.
29. Since the petitioner did not exercise his right to request an appeal within

FINAL ORDER (Cont.)
16F-01040, 16F-01088
PAGE-9
the allotted time period in which to request one, the undersigned is not permitted jurisdiction to review the merits of these notices as they were requested untimely by the petitioner. Thus, the respondent's actions at issue prevail in regards to the calculations of FA benefits and MSP benefits for the Notices of Case Actions dated March 4, 2015, March 16, 2015 and July 6, 2015.

## Food Assistance Issue

30. Federal Regulation at 7 C.F.R § 273.9, defines income in the FA
determination and in part states:
(b) Definition of income. Household income shall mean all income from whatever source ...
(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... [emphasis added]
(c) Only the following items shall be excluded from household income and no other income shall be excluded:...
(17) Legally obligated child support payments paid by a household member to or for a nonhousehold member, including payments made to a third party on behalf of the nonhousehold member (vendor payments) and amounts paid toward child support arrearages. However, at its option, the State agency may allow households a deduction for such child support payments in accordance with paragraph (d)(5) of this section rather than an income exclusion. [emphasis added]
31. The Department's Policy Manual, CFOP 165-22 (Policy Manual), passage 1810.0102 (Deduction from Gross Income), states, in part:

Some deductions withheld from gross income must be included. Examples of these deductions include:

1. premiums for Supplemental Medical Insurance (SMI/Medicare) from a

Title II (Social Security) benefit,
2. premiums for health insurance or hospitalization,
3. premiums for life insurance,
4. federal and state income taxes,
5. Social Security taxes,
6. optional deductions, and
7. a garnished or seized payment.
32. The above Federal Regulation explains SSDI benefits are included in the FA determination and that Child Support payments can be deducted as an expense rather than as an exclusion. Medicare premiums are not deducted from the gross and must be included when determining FAP eligibility.
33. Federal regulation 7 C.F.R. § 273.9(d) sets forth the specific deductions allowable in the calculation of the FAP 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 and (6) shelter expenses and (7) standard utility allowance.
(d) Income deductions. Deductions shall be allowed only for the following household expenses:
(1) Standard deduction-(i) 48 States, District of Columbia, Alaska, Hawaii, and the Virgin Islands. Effective October 1, 2002, in the 48 States and the District of Columbia, Alaska, Hawaii, and the Virgin Islands, the standard deduction for household sizes one through six shall be equal to 8.31 percent of the monthly net income eligibility standard for each household size established under paragraph (a)(2) of this section rounded up to the nearest whole dollar.
(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....Allowable medical costs are:...
(v) Medicare premiums related to coverage under Title XVIII of the Social Security Act; any cost-sharing or spend down expenses incurred by Medicaid recipients;
(5) Optional child support deduction. At its option, the State agency may provide a deduction, rather than the income exclusion provided under paragraph (c)(17) of this section, for legally obligated child support payments paid by a household member to or for a nonhousehold member, including payments made to a third party on behalf of the nonhousehold
member (vendor payments) and amounts paid toward child support arrearages...
(6) Shelter costs-(i) Homeless shelter deduction. A State agency may provide a standard homeless shelter deduction of \$143 a month to households in which all members are homeless individuals but are not receiving free shelter throughout the month. The deduction must be subtracted from net income in determining eligibility and allotments for the households. The State agency may make a household with extremely low shelter costs ineligible for the deduction. A household receiving the homeless shelter deduction cannot have its shelter expenses considered under paragraphs (d)(6)(ii) or (d)(6)(iii) of this section.
34. Federal regulation 7 C.F.R. § 273.10 "Determining household eligibility
and benefit levels" states in relevant part:
(d) Determining deductions. Deductible expenses include only certain dependent care, shelter, medical and, at State agency option, child support costs as described in §273.9.
(1) Disallowed expenses. (i) ... However, that portion of an allowable medical expense which is not reimbursable shall be included as part of the household's medical expenses.
(8) Optional child support deduction. If the State agency opts to provide households with an income deduction rather than an income exclusion for legally obligated child support payments in accordance with §273.9(d)(5), the State agency may budget such payments in accordance with paragraphs (d)(2) through (d)(5) of this section, or retrospectively, in accordance with $\S 273.21$ (b) and $\S 273.21$ (f)(2), regardless of the budgeting system used for the household's other circumstances.
(e) Calculating net income and benefit levels-(1) Net monthly income. (i) To determine a household's net monthly income, the State agency shall: (A) Add the gross monthly income earned by all household members and the total monthly unearned income of all household members, minus income exclusions, to determine the household's total gross income.
(C) Subtract the standard deduction.
(D) If the household is entitled to an excess medical deduction as provided in $\S 273.9(\mathrm{~d})(3)$, determine if total medical expenses exceed $\$ 35$. If so, subtract that portion which exceeds $\$ 35$.
(F) If the State agency has chosen to treat legally obligated child support payments as a deduction rather than an exclusion in accordance with
§273.9(d)(5), subtract allowable monthly child support payments in accordance with §273.9(d)(5).
(G) Subtract the homeless shelter deduction, if any, up to the maximum of \$143.
(2) Eligibility and benefits. (i)(A) Households which contain an elderly or disabled member as defined in $\$ 271.2$, shall have their net income, as calculated in paragraph (e)(1) of this section (except for households considered destitute in accordance with paragraph (e)(3) of this section), compared to the monthly income eligibility standards defined in §273.9(a)(2) for the appropriate household size to determine eligibility for the month.
(ii)(A) Except as provided in paragraphs (a)(1), (e)(2)(iii) and (e)(2)(vi) of this section, the household's monthly allotment shall be equal to the maximum food stamp allotment for the household's size reduced by 30 percent of the household's net monthly income as calculated in paragraph (e)(1) of this section. If 30 percent of the household's net income ends in cents, the State agency shall round in one of the following ways:
(1) The State agency shall round the 30 percent of net income up to the nearest higher dollar; or
(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.
35. The FAP standards for income and deductions appear in Appendix A-1 of the Policy Manual. Effective October 1, 2015: the maximum FAP allotment for a household size of one is $\$ 194$; the standard deduction for a household of one to three is $\$ 155$; the homeless income deduction to be $\$ 143$, the $200 \%$ gross income limit to be $\$ 1962$, and the minimum allotment for 1 or 2 member household to be $\$ 16$.
36. Policy Manual, passage 2410.0362 (Verification of Medical Expenses) states, in part that:

The amount of any medical expense shall be verified prior to certification provided the expense would actually result in a disregard. If a portion of the expense is reimbursable, the amount to be reimbursed must be verified before the non-reimbursable portion can be allowed.
37. The petitioner was credited with a standard deduction and the child support deduction. As the homeless shelter deduction was considered, no excess shelter deduction was allowed. As the petitioner's Medicare premiums are being paid through the MSP and the petitioner acknowledged no medical expenses greater than $\$ 35$ monthly, the undersigned will not consider any medical deductions. There is no indication the petitioner was eligible for any other deductions.
38. Respondent's TRANSMITTAL NO. C-13-10-0007, dated October 11, 2013, addresses FAP minimum benefit and states in part:
...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...
39. The above transmittal explains petitioner is eligible to receive the $\$ 16$ ( $\$ 194$ maximum FA for one person $\times 8 \%$ ) minimum monthly FA allotment, due to his income being less than $200 \%$ of the gross income limit. The petitioner was approved \$16 in FAP effective February 2016.
40. The respondent must follow these federal budgeting guidelines when determining eligibility. After considering the evidence, the testimony and the

FINAL ORDER (Cont.)
16F-01040, 16F-01088
PAGE - 14
appropriate authorities cited above, the undersigned concludes the petitioner is not eligible for any additional FAP benefits based on the income and expenses presented.

The hearing officer concludes that the petitioner is eligible for a monthly allotment of
$\$ 16$. As the petitioner is seeking a higher benefit level, the hearing officer cannot make a more favorable ruling in this appeal.

## Medicaid and Medicare Savings Programs Issues

41. Fla. Admin. Code R. 65A-1.701 sets forth:
(20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services.
42. There is no evidence to reflect that the petitioner is enrolled in Medicaid covered institutional care services, hospice services, or home and community based services. According to the above controlling authority, the petitioner is ineligible to receive full Medicaid as he is a Medicare recipient and does not fit one of the exclusions of a Medicare recipient. The undersigned concludes that the department was correct in its action to deny full Medicaid.
43. Federal Regulations at 20 C.F.R. $\S 416.1123$ define how unearned income is counted for SSI-Related Medicaid programs and in part states:
b) Amount considered as income. We may include more or less of your unearned income than you actually receive.
(1) We include more than you actually receive where another benefit payment (such as a social security insurance benefit) (see §416.1121) has been reduced to recover a previous overpayment. You are repaying a legal obligation through the withholding of portions of your benefit
amount, and the amount of the debt reduction is also part of your unearned income...
(2) We also include more than you actually receive if amounts are withheld from unearned income because of a garnishment, or to pay a debt or other legal obligation, or to make any other payment such as payment of your Medicare premiums. (emphasis added)
44. Federal Regulations at 20 C.F.R. § 416.1124 defines unearned income
that is not counted and in part states:
(a) General. While we must know the source and amount of all of your unearned income for SSI, we do not count all of it to determine your eligibility and benefit amount. We first exclude income as authorized by other Federal laws (see paragraph (b) of this section). Then we apply the other exclusions in the order listed in paragraph (c) of this section to the rest of your unearned income in the month. We never reduce your unearned income below zero or apply any unused unearned income exclusion to earned income except for the $\$ 20$ general exclusion described in paragraph (c)(12) of this section.
(b) Other Federal laws. Some Federal laws other than the Social Security Act provide that we cannot count some of your unearned income for SSI purposes. We list the laws and the exclusions in the appendix to this subpart which we update periodically.
(c) Other unearned income we do not count. We do not count as unearned income-
(1) Any public agency's refund of taxes on real property or food;
(2) Assistance based on need which is wholly funded by a State or one of its political subdivisions...
(3) Any portion of a grant, scholarship, fellowship, or gift used or set aside for paying tuition, fees, or other necessary educational expenses. However, we do count any portion set aside or actually used for food or shelter;
(4) Food which you or your spouse raise if it is consumed by you or your household;
(5) Assistance received under the Disaster Relief and Emergency Assistance Act and assistance provided under any Federal statute because of a catastrophe which the President of the United States declares to be a major disaster...
(6) The first $\$ 60$ of unearned income received in a calendar quarter if you receive it infrequently or irregularly...
(7) Alaska Longevity Bonus payments ...
(8) Payments for providing foster care...
(9) Any interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement which are left to accumulate and become a part of the separate burial fund...
(10) Certain support and maintenance assistance as described in §416.1157;
(11) One-third of support payments made to or for you by an absent parent if you are a child;
(12) The first $\$ 20$ of any unearned income in a month...
(13) Any unearned income you receive and use to fulfill an approved plan to achieve self-support if you are blind or disabled and under age 65 or blind or disabled and received SSI...
(14) The value of any assistance paid with respect to a dwelling unit under-
(i) The United States Housing Act of 1937;
(ii) The National Housing Act;
(iii) Section 101 of the Housing and Urban Development Act of 1965;
(iv) Title V of the Housing Act of 1949; or
(v) Section 202(h) of the Housing Act of 1959;
(15) Any interest accrued on and left to accumulate as part of the value of an excluded burial space purchase agreement...
(16) The value of any commercial transportation ticket, for travel by you or your spouse among the 50 States, the District of Columbia, the
Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands, which is received as a gift by you or your spouse and is not converted to cash. If such a ticket is converted to cash, the cash you receive is income in the month you receive the cash;
(17) Payments received by you from a fund established by a State to aid victims of crime;
(18) Relocation assistance provided you by a State or local...
(19) Special pay received from one of the uniformed services pursuant to 37 U.S.C. 310;
(20) Interest or other earnings on a dedicated account which is excluded from resources. (See §416.1247);
(21) Gifts from an organization as described in section 501(c)(3) of the Internal Revenue Code of 1986 ...
(22) Interest and dividend income from a countable resource or from a resource excluded under a Federal statute other than section 1613(a) of the Social Security Act; and
(23) AmeriCorps State and National and AmeriCorps National Civilian Community Corps cash or in-kind payments to AmeriCorps participants or on AmeriCorps participants' behalf. These include, but are not limited to: Food and shelter, and clothing allowances;
(24) Any annuity paid by a State to a person (or his or her spouse) based on the State's determination that the person is:

FINAL ORDER (Cont.)
16F-01040, 16F-01088
PAGE - 17
(i) A veteran (as defined in 38 U.S.C. 101); and
(ii) Blind, disabled, or aged.
45. In accordance with the above federal regulations, garnished child support is not listed as an income exclusion in the Medicaid program or MSP. Therefore, the respondent correctly determined the petitioner's gross income; which includes the garnishment of the child support obligation. The regulation also states that the Medicare premiums must be included as income; however, the state is currently paying for the Medicare Part B premium and that amount is not being deducted from the petitioner's gross SSDI income. Additionally, the Federal Regulations establishes a \$20 unearned income disregard. Respondent correctly deducted $\$ 20$ from the petitioner's $\$ 1,097$ SSDI to arrive at $\$ 1,077$ countable income. There is no indication the petitioner was eligible for any other deductions.
46. 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 (Q11). Under Q11 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.)...

FINAL ORDER (Cont.)
16F-01040, 16F-01088
PAGE - 18
47. Fla. Admin. Code R.65A-1.713 "SSI-Related Medicaid Income Eligibility

Criteria," states:
(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
(b) For QMB, income must be less than or equal to the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.
(g) For SLMB, income must be greater than 100 percent of the federal poverty level but equal to or less than 120 percent of the federal poverty level.
(j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. Q11 is eligible only for payment of the Part B Medicare premium through Medicaid.
48. The MSP standards for income appear in Appendix A-9 of the Policy Manual. Effective July 2015, the QMB income limit was $\$ 981$ and the SLMB income limit was $\$ 1,177$.
49. The above authorities explains that an individual must have income that is within the income limits established by the federal and state law as well as the Medicaid State plan to receive SSI-related Medicaid coverage. An individual may qualify for the QMB program if his income is less than or equal to the federal poverty level after applying exclusions to the income. The SLMB program requires income to be greater than $100 \%$ of the federal poverty level but equal to or less than $120 \%$ of the federal poverty level. The petitioner countable income of $\$ 1,077$ was greater than the QMB income limit of $\$ 981$ and less than the SLMB income limit of $\$ 1,177$. Therefore, the undersigned concludes that the department took correct action to close the QMB benefits effective January 2016 and open the SLMB benefits effective February 2016.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals
are denied.

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this $\qquad$ 21 day of $\qquad$ , 2016,
in Tallahassee, Florida.


Raymond Muraida
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

Apr 26, 2016
STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES OFFICE OF APPEAL HEARINGS

RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on March 30, 2016 at 9:04 a.m. CDT.

## APPEARANCES



For the Respondent: Ed Poutre, Economic Self-Sufficiency Specialist II Department of Children and Families

## STATEMENT OF ISSUE

Petitioner is appealing the Department's action of January 25, 2016 closing Medicaid and enrolling him in the Medically Needy Program with a Share of Cost (SOC). The petitioner carries the burden of proof by the preponderance of evidence.

FINAL ORDER (Cont.)
16F-01119
PAGE -2

## PRELIMINARY STATEMENT

The respondent submitted two packets of information which were entered into evidence as Respondent's Exhibits "1" through "15". The petitioner submitted two packets of information which were entered into evidence as Petitioner's Exhibits "1" and " 2 ".
 the petitioner.

## FINDINGS OF FACT

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

1. On November 30, 2015, the Department received an electronic recertification for Medicaid which was automatically approved by the FLORIDA System.
2. The household consists of two individuals: mother and son. The son's date of birth being $\longrightarrow$ The son is a tax dependent of his mother.
3. On January 15, 2016 and electronic application for Medicaid was received by the Department, which was approved January 21, 2016. Income reported from work was electronically verified at $\$ 746.67$ gross. The son was enrolled in Medically Needy category NO Y (coverage for 19 and 20 year olds) with a Share of Cost (SOC) of $\$ 359$.
4. The petitioner submitted an electronic change on February 19, 2016 and was pended for verification of income. Petitioner submitted income verification that was determined insufficient as it was only a handwritten note without gross pay stubs

FINAL ORDER (Cont.)
16F-01119
PAGE - 3
attached or accompanied by an income verification form showing the last four weeks income. Petitioner was re-pended for acceptable verification of earned income and subsequently submitted a completed and signed income verification form. This income averaged out to $\$ 700$ monthly gross income and the SOC approved at $\$ 313$.
5. On March 15, 2016, petitioner submitted another change of income. The average of gross income changed to $\$ 560$ resulting in a SOC of $\$ 173$.
6. For a household consisting of the petitioner and her son, the Federal Poverty Level (FPL) is $\$ 1,335$. The income standard is $\$ 241$. The budget for Medicaid MO Y, a child age 19 or 20, fails. Total income of $\$ 560$ less $\$ 146$ (standard disregard) and $\$ 67$ (Modified Adjusted Gross Income, MAGI, 5\% of FPL) equals $\$ 347$ (countable net income). It exceeds the income limit of $\$ 241$ failing the Family Related Medicaid Benefit Determination Budget.
7. The Medically Needy budget, $\$ 560$ (total income) less $\$ 387$ (Medically Needy Income Limit, MNIL) leaves a remaining \$173, which becomes the son's SOC.
8. The petitioner did not dispute the income amounts used by the Department in the eligibility process. She understands that the benefits provided by the Department are income-based, and some income limits are based on an individual's age. The petitioner believes that it is unfair for a long-term care plan determined while a child is Medicaid eligible to be jeopardized for inability to pay (loss of Medicaid eligibility) because of the change in said child's age. Petitioner argues that she has been seeking care for this problem of her son's since he was twelve and that the necessary surgery on his jaw being scheduled after he turned age 19 should not endanger/jeopardize his receipt of

FINAL ORDER (Cont.)
16F-01119
PAGE-4
care. Petitioner requests that her son be determined Medicaid eligible so his medical care can continue without interruption.

## CONCLUSIONS OF LAW

9. The Department of Children and Families, Office of Appeal Hearings has
jurisdiction over the subject matter of this proceeding and the parties, pursuant to
Section 409.285, Fla. Stat. This order is the final administrative decision of the
Department of Children and Families under Section 409.285, Fla. Stat.
10. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-

### 2.056.

11. The Family-Related Medicaid income criteria is set forth in 42 C.F.R $\S 435.603$. 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.
12. The Department's Program Policy Manual, CFOP 165-22 (The Policy Manual) at 2230.0400 Standard Filing Unit (MFAM) states:

For tax filers, the Standard Filing Unit (SFU) is the tax filing group for the tax year in which eligibility is being determined. Eligibility is determined by each individual using the tax filing group's income. Individuals cannot receive Medicaid benefits under more than one coverage group, but can have their income included in more than one SFU. For individuals who neither file a federal tax return nor are claimed as a tax dependent (nonfilers), the Standard Filing Unit consists of the individual and, if living with

FINAL ORDER (Cont.)
16F-01119
PAGE -5
the individual, their spouse, their natural, adopted, and step children under age 19 , or 19 and 20 if in school fulltime.
13. In accordance with the above controlling authorities, the Medicaid household
group is the petitioner and her 19 year-old son (two members). The findings show the
Department determined the petitioner's eligibility with a household size of two to determine his eligibility for Medicaid.
14. 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 I 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.
15. The Policy Manual at 2630.0108 Budget Computation (MFAM), states:

FINAL ORDER (Cont.)
16F-01119
PAGE -6
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 selfemployment 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).
16. The Policy Manual at Appendix A-7 indicates the Family-Related Medicaid Income Limit as $\$ 241$ and a Standard Disregard of $\$ 146$ for children 19 and 20 years old to be eligible for full Family-Related Medicaid Program. It also indicates the MNIL to be $\$ 387$.
17. In accordance with the above controlling authorities, the undersigned reviewed the Medicaid eligibility for the petitioner's son. Step 1: The total income counted in the budget is $\$ 560(\$ 210+70+140+140)$. Step 2: There are no deductions provided as there was no tax return. Step 3: The total income of $\$ 560$ less the standard disregard of $\$ 146$ is $\$ 414$. Step 4: The balance of $\$ 414$ is greater than the income limit of $\$ 241$ for a child 19 or 20 in a household of two. Step 5: The balance of $\$ 414$ less the MAGI disregard of $\$ 67$ is $\$ 347$. This amount is greater than the income limit of $\$ 241$. The

FINAL ORDER (Cont.)
16F-01119
PAGE -7
undersigned concludes that the petitioner's son is ineligible for Medicaid. The undersigned further concludes Medically Needy eligibility must be explored.
18. Fla. Admin. Code 65A-1.702 "Special Provisions" states in part:
(10) Enrollment. The enrollment period under the Medically Needy program begins with the month the individual satisfies the non-financial and resource eligibility criteria, but not earlier than the third month prior to the month of application.
(13) Determining Share of Cost (SOC). The SOC is determined by deducting the Medically Needy income level from the individual's or family's income.
19. 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.
20. Fla. Admin. Code 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 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.

FINAL ORDER (Cont.)
16F-01119
PAGE -8
22. Effective January 2015, Appendix A-7 indicates that for a child 19 years of age in a household of two the MNIL is $\$ 387$.
23. To determine the petitioner's son's SOC the respondent determined the petitioner's household income to be $\$ 560$. The medically Needy Income Level of $\$ 387$ for a standard filing unit size of two was subtracted resulting an on-going SOC of \$173.
24. The hearing officer found no exception to these calculations. It is concluded that a more favorable share of cost could not be determined. Eligibility for full Medicaid was not found. The petitioner has failed to meet her burden that her son is eligible for full Medicaid. The petitioner's arguments were noted; however, the hearing officer must make a ruling based on the evidence and applicable regulations, and does not have the authority to order Medicaid eligibility based on an individual's needs not described by controlling authority.

## DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, the 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.

FINAL ORDER (Cont.)
16F-01119
PAGE -9
DONE and ORDERED this __26 day of __ April_, 2016,
in Tallahassee, Florida.


Gregory Watson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myffamilies.com

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


PETITIONER,
Vs.
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 19 INDIAN RIVER
UNIT: AHCA
RESPONDENT,
AND

MOLINA HEALTHCARE
INTERVENER/RESPONDENT
I

## FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing on March 18, 2016 at 11:05 a.m.

## APPEARANCES

For Petitioner:

For Respondent: Lisa Sanchez
Medical Healthcare Program Analyst

## ISSUE

Whether respondent's denial of the prescription medication
was proper. The burden of proof was assigned to the petitioner. The
standard of proof in an administrative hearing is by a preponderance of the evidence.

FINAL ORDER (Cont.)
16F-01129
PAGE - 2

## PRELIMINARY STATEMENT

The petitioner was not present. Petitioner's exhibit "1" was accepted into evidence.

Ms. Sanchez appeared as both the representative and witness for the respondent. Present as witnesses from Molina Healthcare (Molina) were: Carlos Galvez, Government Contract Specialist; Dr. Alfred Romay, Pharmacy Director; and Alice Quiros, AVP of Government Contracts. Respondent's exhibit "1" was accepted into evidence.

There was no objection to Molina's request to be added as a party to this matter.
The record was held open through March 25, 2016 for respondent to provide additional information regarding the iPLEDGE process and the meaning of "Med Cert 3" on the Preferred Drug List (PDL). Information was timely received and entered as respondent's exhibit "2".

Petitioner's representative did not wish to provide a written response to respondent's 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 a 15 year old male. At all times relevant to this proceeding, he was Medicaid eligible.
2. Petitioner's Medicaid services are through respondent's Statewide Managed Medical Assistance (MMA) Program. Since August 1, 2014 Molina is the managed care entity providing petitioner's Medicaid services.

FINAL ORDER (Cont.)
16F-01129
PAGE - 3
3. Petitioner's diagnoses include
started approximately three years ago.
4. The $\square$ is prevalent on petitioner's face; head; and upper trunk. Prior treatment with four different acne medications was not effective.
5. Due to the severity of petitioner will not remove his shirt. His confidence level has diminished. He no longer wants to attend school or socialize with friends.
6. In January 2016, petitioner's dermatologist submitted a prior authorization request for $\square$ The generic name of $\square$ is
7. The medication is considered for patients with severe $\square$ when traditional treatment has not been successful.
8. Due to potential health risks, the Food and Drug Administration requires a certification process when $\square$ is prescribed. That process is called iPLEDGE. The process requires the prescribing dermatologist be registered with the iPLEDGE Program. The dermatologist then registers the patient. $\square$ must be dispensed by a pharmacy also registered with the iPLEDGE program. The process only allows a controlled supply of the medication. The patient must agree to keep all medical appointments and comply with required lab work.
9. Molina must be in compliance with respondent's Prescribed Drug Coverage, Limitations and Reimbursement Handbook (Drug Handbook).
10. The Drug Handbook requires a medication be medically necessary.
11. The above Handbook identifies a PDL of safe and cost effective medications.

Medications appearing on the PDL must first be prescribed. If unsuccessful, medications not on the PDL could then be considered.
12. appears on the PDL. To be approved, however, the patient must be registered with the iPLEDGE Program.
13. Certification has not been provided by petitioner's dermatologist that the iPLEDGE registration process has been completed.
14. Molina contacted petitioner's dermatologist and requested "chart notes including Diagnosis and Medication History related to this request including the iPledge documentation."
15. As a response was not received, on January 26, 2016 Molina issued a Notice of Action denying $\quad$ The notice stated, in part: "... there was insufficient documentation to support approval of your request for 16. On February 5, 2016 petitioner requested a Fair Hearing.
17. On January 29, 2016 Molina received additional information from the dermatologist. This information included specific diagnoses and a list of prior medication trials. The response contained no iPLEDGE documentation.
18. On February 17, 2016 Molina issued a second Notice of Action denying due to the submission of insufficient documentation.

## CONCLUSIONS OF LAW

19. 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.
20. This is a final order pursuant to $\S 120.569$ and $\S 120.57$, Fla. Stat.
21. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R.

65-2.056.

FINAL ORDER (Cont.)
16F-01129
PAGE - 5
22. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, $7^{\text {th }}$ Ed.).
23. The Florida Medicaid Program is authorized by Fla. Stat. ch 409 and Fla. Admin.

Code R. 59G. The Medicaid Program is administered by the respondent.
24. The Florida Medicaid Provider Handbook (Provider Handbook) is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Chapter 59G-4. In accordance with the above Statute, the Handbook states on page 1-27:

Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.

Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.
25. Page 1-28 of the Provider Handbook lists HMO covered services. The list includes prescribed drug services.
26. Page 1-30 of the Provider Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."
27. The Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook (Drug Handbook) has been promulgated into rule by reference in Fla. Admin. Code R. 59G-4.250. Page 2-2 states, in part: "To be reimbursed by Medicaid, a drug must be medically necessary and either (a) prescribed for medically accepted indications and dosages found in the drug labeling or drug compendia ..., or (b) prior authorized by a qualified clinical specialists approved by the Agency."
28. The definition of "medically necessary" is found in the Fla. Admin. Code R. 59G-

FINAL ORDER (Cont.)
16F-01129
PAGE-6
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.
6. As the petitioner is under 21 years of age, Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements are relevant. 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 ...
30. In regard to EPSDT requirements, The State Medicaid Manual, published by the

Centers for Medicare and Medicaid Services states, in part:
5110. Basic Requirements...

FINAL ORDER (Cont.)
16F-01129
PAGE-7
...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].
31. As prescribed medications are allowable through the Florida Medicaid Program, the issue focuses on whether the meets medical necessity criteria.
32. The Drug Handbook addresses the PDL on page 2-4 and states, in 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 none-PDL product.

Non- PDL drugs may be approved for reimbursement upon prior authorization.
33. The Findings of Fact establish the requested medication is on respondent's PDL.

Due to potential risks associated with respondent complies with FDA requirements regarding the iPLEDGE Program.
34. The Findings of Fact establish no documentation was provided that the prescribing dermatologist has completed the iPLEDGE registration process. Due to this factor, the following condition of medical necessity has not been satisfied:
3. Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational;

FINAL ORDER (Cont.)
16F-01129
PAGE - 8
35. Petitioner has not established, by the greater weight of the evidence, that respondent's denial of was improper.

## DECISION

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

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this $\qquad$ 20 day of $\qquad$ , 2016, in Tallahassee, Florida.


Frank Houston
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myffamilies.com

# STATE OF FLORIDA <br> DEPARTMENT OF CHILDREN AND FAMILIES OFFICE OF APPEAL HEARINGS 

Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 15 Palm Beach
UNIT: 88322
RESPONDENT.
CASE NO

## ORDER OF DISMISSAL

The above styled matter is before the undersigned. The petitioner submitted a request to withdraw the appeal. The undersigned therefore dismisses the appeal as withdrawn per petitioner's request. The hearing scheduled for April 27, 2016 is cancelled.

DONE and ORDERED this $\qquad$ 23 day of March , 2016, in Tallahassee, Florida.

## FILED

Mar 23, 2016
Office of Appeal Hearings
Dept. of Children and Families


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:
Petitioner
Office of Economic Self Sufficiency Marjorie Desporte,Esq.

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

PETITIONER,
Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 20 Lee
UNIT: 88521
CASE NO.

RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on February 2, 2016 at 9:06 a.m., at 2295 Victoria Avenue in Fort Myers, Florida.

## APPEARANCES

For Petitioner:

For Respondent: Christine McKee, Economic Self-sufficiency Specialist II

## STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to close her Food Assistance Program (FAP) benefits (15F-10289). During the hearing, the petitioner stated that she was also appealing the decision by the respondent to close her Medicaid benefits (16F01259). For the FAP, the respondent bears the burden of proof by a preponderance of the evidence. Prior to the closing of the record, the respondent provided the English

FINAL ORDER (Cont.)
15F-10289 and 16F-01259
PAGE - 1
translation of the Notice of Case Action (NOCA) indicating that the Medicaid was denied, not closed; therefore, for the Medicaid eligibility, the Petitioner bears the burden of proof by a preponderance of the evidence.

## PRELIMINARY STATEMENT

Serving as an interpreter during the proceedings was Laura (Operator 359), for Propio Language Services.

The Petitioner submitted five (5) exhibits which were accepted into evidence and marked as Petitioner's Exhibits " 1 " through " 5 " respectively.

The respondent submitted 10 exhibits that were accepted into evidence and marked as Respondent's Exhibits " 1 " through " 10 " respectively. The record was held open until the close of business on February 5, 2015 for the respondent to supplement the record. The Petitioner declined an opportunity to review any additional evidence provided by the respondent prior to closing the record. The respondent timely provided the additional documentation, which were accepted into evidence and marked as Respondent's Exhibits "11" through " 21 ". The record closed on February 18, 2016.

## FINDINGS OF FACT

1. The Petitioner entered the United States on April 14, 2014 on a visitor's visa as documented by her passport with the code B2. The website for United States Citizenship and Immigration Services (USCIS), a component of the United States Department of Homeland Security (DHS), states that the B2 code is for a tourist visa for tourism, pleasure or visiting. No documents were provided indicating that the Petitioner

FINAL ORDER (Cont.)
15F-10289 and 16F-01259
PAGE - 1
entered the United States (US) under any other status, including parolee, refugee, or asylee status.
2. After being in the US for over a year, the petitioner applied for the Adjustment of Status based on the Cuban Adjustment Act and was granted Permanent Residency but has no documentation stating she was ever granted Cuban/Haitian Entrant status prior to receiving Lawful Permanent Residency (LPR).
3. The petitioner applied for FAP and Medicaid on October 26, 2015 for herself.
4. The petitioner was approved for FAP in error and, once discovered, those benefits were discontinued (NOCA November 25, 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." Also, the NOCA states that the Medicaid benefits were denied with the same reason.
5. The petitioner is a non-disabled Supplemental Security Income (SSI) recipient, eligible as she is
 As she is an SSI recipient, she is also receiving Medicaid benefits effective November 2015.
6. The category code on the petitioner's Permanent Resident Card is CU6.
7. LPRs must be in the US for five years as qualified non-citizens to be eligible for FAP and Medicaid.
8. The petitioner believes that she is eligible FAP and Medicaid benefits as she (1) applied for the LPR status one year and one day from the date of entering the

FINAL ORDER (Cont.)
15F-10289 and 16F-01259
PAGE - 1
US and (2) that the CU6 category code on her Permanent Resident card (I-551) provides eligibility without any waiting period.

## CONCLUSIONS OF LAW

9. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285 Florida Statute (Fla. Stat.). This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.
10. This proceeding is a de novo proceeding pursuant to Florida Administrative Code Rule 65-2.056.
11. Federal Regulations at 22 C.F.R. § 41.31(a), Temporary visitors for business or pleasure, states in part that, "(a)n alien is classifiable as a nonimmigrant visitor for business (B-1) or pleasure (B-2) if the consular officer is satisfied that the alien qualifies under the provisions of INA 101(a)(15)(B)..."
12. Under the Definition section of the 8 U.S. Code § 1101(a)(15), it states in part that:

The term "immigrant" means every alien except an alien who is within one of the following classes of nonimmigrant aliens
(B) an alien ... having a residence in a foreign country which he has no intention of abandoning and who is visiting the United States temporarily for business or temporarily for pleasure;
13. Page 3-3 of the Refugee Program Eligibility Guide for Service Providers (01/2015), 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 l-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.

## REGARDING THE FOOD ASSISTANCE APPEAL

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 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 who 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

FINAL ORDER (Cont.)
15F-10289 and 16F-01259
PAGE - 1
during their marriage if they are still married or the spouse is deceased.
15. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 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)
4. In this case, the petitioner was admitted as a visitor, with no history of being paroled, and gained LPR status upon notice dated October 6, 2015. She has been in the country since April 14, 2014, hence she cannot claim 40 quarters of work to forego the 5-year ban.
5. Petitioner has demonstrated 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 for SSI is based on her age and not disability. Being aged is not a factor that would affect the petitioner's LPR status.
6. 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.

FINAL ORDER (Cont.)
15F-10289 and 16F-01259
PAGE - 1

## REGARDING THE MEDICAID APPEAL

19. Fla. Admin. Code R. 65A-1.301, Citizenship, states in part:
(1) The individual whose needs are included must meet the citizenship and noncitizen status established in: P.L. 104-193, The Personal Responsibility and Work Opportunity Reconciliation Act of 1996; P.L. 10533, the Balanced Budget Act of 1997; P.L. 105-185, the Agricultural Research, Extension, and Education Reform Act of 1998; P.L. 105-306, the Noncitizen Benefit Clarification and Other Technical Amendments Act of 1998; P.L. 109-171, the Deficit Reduction Act of 2005; and, the Immigration and Nationality Act....
(3) The eligibility specialist must verify the immigration status of noncitizens through the United States Citizenship and Immigration Service (USCIS), formerly the United States Bureau of Citizenship and Immigration Services. Verification will be requested electronically using the alien number, or based on a USCIS or prior Immigration and Naturalization Services (INS) document provided by the applicant. The system of verification is known as the Verification Information SystemCustomer Processing System (VIS-CPS), which is part of the Systematic Alien Verification for Entitlements (SAVE) Program...
20. Federal regulations at 42 C.F.R. $\S 435.406$, Citizenship and alienage sets
forth:
(2)(i) ... qualified aliens as described in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641) (including qualified aliens subject to the 5 -year bar) who have provided satisfactory documentary evidence of Qualified Alien status, which status has been verified with the Department of Homeland Security (DHS) under a declaration required by section 1137(d) of the Act that the applicant or beneficiary is an alien in a satisfactory immigration status.
(ii) The eligibility of qualified aliens who are subject to the 5 -year bar in 8 U.S.C. 1613 is limited to the benefits described in paragraph (b) of this section.
(b) The agency must provide payment for the services described in § 440.255(c) of this chapter to residents of the State who otherwise meet the eligibility requirements of the State plan (except for receipt of AFDC, SSI, or State Supplementary payments) who are qualified aliens subject to the 5 -year bar or who are non-qualified aliens who meet all Medicaid eligibility criteria, except non-qualified aliens need not present a social security number or document immigration status.

FINAL ORDER (Cont.)
15F-10289 and 16F-01259
PAGE - 1
21. The U.S. Code at 8 U.S.C. § 1612, Limited eligibility of qualified aliens for certain Federal programs, sets forth:
(a) Limited eligibility for specified Federal programs
(1) In general

Notwithstanding any other provision of law and except as provided in paragraph (2), an alien who is a qualified alien (as defined in section 1641 of this title) is not eligible for any specified Federal program (as defined in paragraph (3)).
(2) Exceptions
(A) Time-limited exception for refugees and asylees

With respect to the specified Federal programs described in paragraph
(3), paragraph (1) shall not apply to an alien until 7 years after the date-
(i) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act [8 U.S.C. 1157];
(ii) an alien is granted asylum under section 208 of such Act [8 U.S.C. 1158];
(iii) an alien's deportation is withheld under section 243(h) of such Act [8
U.S.C. 1253] (as in effect immediately before the effective date of section 307 of division C of Public Law 104-208) or section 241(b)(3) of such Act [8 U.S.C. 1231(b)(3)] (as amended by section 305(a) of division C of Public Law 104-208);
(iv) an alien is granted status as a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980); or (v) an alien is admitted to the United States as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 (as contained in section 101(e) of Public Law 100-202 and amended by the 9th proviso under migration and refugee assistance in title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1989, Public Law 100-461, as amended).
22. The Policy Manual at passage 1440.0106, Lawful Permanent Resident (MSSI), states in part:

A lawful permanent resident (LPR) is a noncitizen who lawfully immigrates to the U.S. and has permission to live and work in the U.S. LPRs may be eligible for Medicaid based on citizenship if they entered the U.S.:

1. prior to $8 / 22 / 96$ and have remained continuously present,
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. (Emphasis added)

FINAL ORDER (Cont.)
15F-10289 and 16F-01259
PAGE - 1

Note: LPRs who entered after 8/22/96 are subject to the five-year ban, unless otherwise noted.
LPRs who are in the five-year ban may be eligible for Emergency
Medicaid for Aliens, (EMA).
23. The above authorities and policies state that qualified non-citizens are subject to a five-year ban on receiving Medicaid unless they meet an exception. The petitioner does not meet an exception.
24. In this case, the petitioner was admitted as a visitor, with no history of being paroled, and gained LPR status upon notice dated October 6, 2015. She has been in the country since April 14, 2014.
25. Petitioner has demonstrated 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 for SSI is based on her age and not disability. Being aged is not a factor that would affect the petitioner's LPR status. Also, the petitioner's current eligibility for Medicaid is a concurrent benefit afforded an SSI recipient in the State of Florida.
26. 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 that the respondent correctly denied the Medicaid benefits.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are denied.

FINAL ORDER (Cont.) 15F-10289 and 16F-01259
PAGE - 1

## 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 _ March 2016,
in Tallahassee, Florida.


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

Copies Furnished To
Petitioner
Office of Economic Self Sufficiency

# STATE OF FLORIDA <br> DEPARTMENT OF CHILDREN AND FAMILIES OFFICE OF APPEAL HEARINGS 

## FILED

Apr 21, 2016
Office of Appeal Hearings
Dept. of Children and Families

PETITIONER,
Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 04 Duval
UNIT: AHCA
And

MOLINA HEALTHCARE
RESPONDENTS.

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing
telephonically in the above-referenced matter on April 20, 2016 at 1:13 p.m.

## APPEARANCES

For the Petitione
For the Respondent: Sheila Broderick, registered nurse specialist

FINAL ORDER (Cont.)
16F-01336
PAGE - 2

## STATEMENT OF ISSUE

At issue is the respondent's decision denying a Medicaid provider, Memorial Hospital, reimbursement for medical services rendered to the petitioner January 17, 2016 - January 18, 2016.

## 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 January 26, 2016, Molina informed the petitioner that it denied Memorial Hospital's request for medical services rendered to him January 17, 2016 January 18, 2016.

The petitioner requested a hearing on February 19, 2016 to challenge the denial decision.

There were no additional witnesses for the petitioner. The petitioner did not submit documentary evidence.

The respondent presented several witnesses from Molina: Carlos Galvez, contract specialist; Dr. Marc Bloom, chief medical officer; Elvis Leiva, manager of healthcare services; and Bonnie Blitz, director of healthcare services. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

FINAL ORDER (Cont.)

## 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 visited Memorial Hospital (Memorial) emergency room on January 17, 2016 due to chest pains. The petitioner was admitted into the hospital for additional testing. The petitioner was diagnosed with " in the upper chest with some minimum " The petitioner was discharged from the hospital on January 18, 2016
3. Memorial submitted an inpatient service authorization request to Molina on January 17, 2016. Memorial requested authorization for a full admission stay.
4. Molina determined that the petitioner's presenting symptoms could have been addressed at a lower level of care, an observational stay. Molina denied Memorial's authorization request based on the categorization of the stay only. Molina acknowledged that the petitioner needed treatment. The only issue remaining is the rate of reimbursement that Memorial will receive.
5. The petitioner's mother received a bill for services from Memorial. Molina instructed her to forward the bill to its offices for resolution. The reimbursement issue is between Memorial and Molina. Providers who accept Medicaid must accept Medicaid's reimbursement rate and cannot seek reimbursement from the Medicaid recipient.

FINAL ORDER (Cont.)
16F-01336
PAGE - 4

## CONCLUSIONS OF LAW

6. Federal Medicaid Regulations at 42 C.F.R. § 431.220 states in relevant part,
"(a) The State agency must grant an opportunity for a hearing to the following: (1) Any applicant who requests it because his claim for services is denied or is not acted upon with reasonable promptness (2) Any recipient who requests it because he or she believes the agency has taken an action erroneously..."
7. The Centers for Medicare \& Medicaid Services' State Medicaid Manual, publication \#45, states in part:

## 2900 FAIR HEARINGS AND APPEALS

Section 1902(a)(3) of the Social Security Act requires that States 'provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness.' Regulations implementing this section of law are found at 42 CFR 431 Subpart E. In addition, certain court decisions further amplify and modify the law and regulations governing the provision of notices and hearings to Medicaid applicants and recipients. Where appropriate, those decisions are cited. 2900.1 Basic Responsibility (42 CFR 431.200 and 431.205).--Establish policies and procedures for assuring a system of fair hearings that meet all the requirements of the regulations and instructions.

Notify and make available to the applicant or recipient the hearing procedures required by regulations and these instructions, if any of the following events occur:

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

8. The above federal authority explains that an opportunity for a hearing must be granted when a Medicaid claim for service has been denied or when a recipient believes the agency has taken an action erroneously. The State Medicaid Manual

FINAL ORDER (Cont.)
16F-01336
PAGE - 5
further explains the recipient's right to a hearing when either Medicaid eligibility or a claim for a service under Medicaid is denied, terminated, reduced or delayed.
9. The Office of Appeal Hearings does not have jurisdiction over Medicaid provider reimbursement issues. The petitioner's issues should be directed to AHCA's Consumer Complaint Office at 1-888-419-3456.

## DECISION

The appeal is dismissed as non-jurisdictional.

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this $\qquad$ 21 day of $\qquad$ , 2016,
in Tallahassee, Florida.


Leslie Green
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myfIfamilies.com

FINAL ORDER (Cont.)
16F-01336
PAGE - 6

$$
\begin{aligned}
& \text { Copies Furnished To: } \text { Petitioner } \\
& \text { Debbie Stokes, Area 4, AHCA Field Office Manager } \\
& \text { Alice Quiros }
\end{aligned}
$$

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


PETITIONER,
Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 20 Lee
UNIT: 883DT

## RESPONDENT.



FINAL ORDER (Cont.)
16F-01358
PAGE -2

## FINDINGS OF FACT

1. The petitioner is a separated individual with no children in the household under age 18 , not pregnant, not age 65 or over who claims to be disabled.
2. To be eligible for Medicaid, an applicant must have children under age 18 living at home, be considered blind or disabled by the Social Security Administration (SSA), or be 65 or older.
3. An application was received by the Department January 7, 2016 indicating the petitioner is self-employed.
4. On July 17, 2015, the petitioner applied for Supplement Security Income (SSI)/Social Security Disability Insurance (SSDI). The Social Security Administration (SSA) denied the claim on August 27, 2015 citing reason N42, Non-pay - Capacity for substantial gainful activity - customary work, visual impairment. The petitioner appealed the SSA denial on January 21, 2016. That appeal is pending.
5. A Notice of Case Action (NOCA) was mailed January 11, 2016 requesting additional information including a disability interview. An interview was conducted on January 14, 2016 and requested documents were received by the Department the same day.
6. A NOCA was mailed on February 9, 2016 denying the Medicaid citing that "We did not receive all information needed to determine eligibility." Respondent acknowledges that the reason on this NOCA is incorrect and should have stated that the Department was adopting the SSA decision.
7. During the supervisory review prior to this proceeding, the petitioner reported a new condition. A NOCA was mailed on March 1, 2016 requesting medical records in

FINAL ORDER (Cont.)
16F-01358
PAGE - 3
lieu of a Division of Disability Determination (DDD) interview. To date, no new information has been received and Medicaid benefits remain denied through the adoption of the decision made by SSA.
7. Petitioner has retained a lawyer to represent her in her SSA appeal. She asserts that her condition is worsening, that she wants to work but is increasingly able to put in fewer and fewer hours; however, when directed by the Department she neglected to submit anything to support her claim.

## CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.
9. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 652.056.
10. The Fla. Admin. Code R. 65A-1.705 Family-Related Medicaid General Eligibility Criteria in relevant part states:
(7)(c) If assistance is requested for the parent of a deprived child, the parent and any deprived children...must be included in the SFU...For the parent to be eligible, there must be at least one child under age 18, with or without income, in the SFU, or who would be in the SFU if not receiving SSI.
11. The Fla. Admin. Code R. 65A-1.711 SSI-Related Medicaid Non Financial Eligibility Criteria states: "(1) For MEDS-AD Demonstration Waiver, the individual must be age 65 or older, or disabled as defined in 20 C.F.R. § 416.905..."

FINAL ORDER (Cont.)
16F-01358
PAGE -4
12. Title 20 Code of Federal Regulation $\S 416.903$ "Who Makes Disability and

Blindness Determination" in part states: "(b) Social Security Administration. The Social
Security Administration will make disability and blindness determinations."
13. In accordance with the above authorities, to be eligible for Medicaid an applicant must have children under the age of 18 , be age 65 or older, or considered disabled or blind by the SSA.
14. Petitioner does not have children in the home, is not age 65 or older, blind and has not been considered disabled by the SSA.
15. The Code of Federal Regulations at 42 C.F.R. § 435.541 "Determination of

Disability" in part states:
(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...
(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in $\S 435.912$ 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-

FINAL ORDER (Cont.)
16F-01358
PAGE -5
(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.
16. The above authority explains the SSA determination is binding on the

Department.
17. Respondent denied petitioner's February 9, 2016 application due to adopting the SSA August 27, 2015 denial decision.
18. The above authority states the Department must make a determination of disability if the individual "alleges a disabling condition different from, or in addition to, that considered by the SSA in making it determination."
19. Petitioner claims a deteriorating condition and new symptoms.
20. The Department's Program Policy Manual, CFOP 165-22 (The Policy Manual) at
1440.1204 states in relevant part:

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.
21. Federal Regulations at 42 C.F.R. § 431.211, Advance Notice, Fair Hearings for Applicants and Recipients, states: "The State of local agency must mail a notice at least 10 days before the date of action, except as permitted under Sec. 431.213 and 431.214 of thus subpart."
22. Federal Regulations at 42 C.F.R. § 431.213, Exception from advance notice, reads in relevant part:

The agency may mail a notice not later than the date of action if(a) The agency has factual information confirming the death of a beneficiary;
(b) The agency; receives a clear written statement signed by a beneficiary that-
(1) He no longer wishes services; or
(2) Gives information that requires termination or reduction of services and indicates that he understands that this mist be the result of supplying that information;
(c) The beneficiary has been admitted to an institution where he is ineligible under the plan for further services:
23. The above cited authorities direct the Department to notify recipients on writing prior to terminating Medicaid services. Notice of adverse action is a procedural due process issue.
24. The Department notified the petitioner by NOCA of her ineligibility for Medicaid; however, the reason on the notice was incorrect. Nevertheless, the notice did inform her of her right to appeal the Department's decision. An administrative hearing is the only remedy afforded to participants who disagree with an adverse Department decision. The petitioner fully exercised her right to a hearing regarding the denial of her Medicaid. There is no evidence that petitioner was prejudiced or harmed in any way by the misinformation on the denial notice.

FINAL ORDER (Cont.)
16F-01358
PAGE -7
25. The petitioner was not harmed by the incorrect notice and has not provided evidence of a deteriorating or new condition. In careful review of the cited authority and evidence, the undersigned concludes respondent followed Rule in denying petitioner Medicaid Disability.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and respondent'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 $\qquad$ 26 day of $\qquad$ , 2016,
in Tallahassee, Florida.


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

Copies Furnished To

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


PETITIONER,
APPEAL NO. 16F-01396
Vs.
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 05 Lake
UNIT: AHCA
RESPONDENT.
CASE NO.

## FILED

Mar 29, 2016
Office of Appeal Hearings
Dept. of Children and Families

## FINAL ORDER OF DISMISSAL

The Office of Appeal Hearings received a hearing request in the above matter on February 16, 2016. The issue appeared to focus on a denied payment to the provider. A preliminary order issued on March 11, 2016, gave Petitioner 14 calendar days to respond and establish whether there was another issue for hearing besides the denied payment to the provider. There has been no response as of the date of this order.

In accordance with the terms set forth in the Preliminary Order of Dismissal, this appeal is dismissed for lack of jurisdiction.

FINAL ORDER (Cont.)
16F-01396; 16F-01397
PAGE - 2

## 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 $\qquad$ 29 day of $\qquad$ March $\qquad$ , 2016,
in Tallahassee, Florida.


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

Mar 15, 2016
Office of Appeal Hearings
Dept. of Children and Fariiles

APPEAL NO. 16F-00678
16F-01448
PETITIONER,
Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 02 Leon
UNIT: 88313
RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on February 24, 2016 at 10:31 a.m.

## APPEARANCES

For the Petitioner:
For the Respondent: LaTonya Williams, ACCESS Supervisor Yvette Colon, Economic Self-Sufficiency Specialist II

## STATEMENT OF ISSUE

Petitioner is appealing the Department's action of January 15, 2016 decreasing her Food Assistance Program benefits effective February 1, 2016. The petitioner is also appealing the closure of her Medicaid and enrollment for her on Medically Needy effective February 1, 2016. The respondent carries the burden of proof by the preponderance of evidence.

FINAL ORDER (Cont.)
16F-00678 \& 16F-01448
PAGE - 2

## PRELIMINARY STATEMENT

The Department restored the petitioner's benefits to the January amounts on February 15,2016 pending the outcome of the hearing.

The Department submitted evidence prior to the hearing. This evidence was entered as Respondent Exhibit 1. The record was held open through March 4, 2016 for additional information from the Department. The Department submitted the additional information on February 24, 2016. This was entered as Respondent Exhibit 2.

The hearing was reconvened on March 8, 2016 at 10:03 a.m. for explanation of the additional evidence from the Department.

## FINDINGS OF FACT

1. The Department received a data exchange from Department of Economic Opportunity (DEO) on January 8, 2016 showing the petitioner receiving unemployment compensation. The data exchange reflected the petitioner received her first check on December 23, 2015 with a warrant amount of $\$ 247$ and benefit amount of $\$ 275$.
2. The Department accessed the petitioner's records with DEO to confirm the petitioner receives unemployment compensation in the gross amount of $\$ 275$ per week. The records show federal taxes withheld from the gross amount. She receives the benefit biweekly as $\$ 550$ gross and will receive the income for 17 weeks. The records confirmed the data exchange information showing the petitioner received her first check on December 23, 2015.
3. The Department updated the petitioner's case on January 14, 2016 to include the unemployment compensation in her Food Assistance and Medicaid budgets.

FINAL ORDER (Cont.)
16F-00678 \& 16F-01448
PAGE-3
4. The Department issued a Notice of Case Action on January 15, 2016 informing the petitioner of the decrease in her Food Assistance benefits to $\$ 199$ effective February 1, 2016. The same Notice informed the petitioner her full Medicaid benefits would close effective January 31, 2016. It also informed the petitioner of her enrollment in Medically Needy effective February 1, 2016 with a share of cost of $\$ 713$. (The Medicaid for the petitioner's child was unaffected by this change.)
5. The petitioner contacted the Department on approximately January 20, 2016 concerned about the changes to her benefits.
6. The Department considers data exchange information regarding unemployment compensation as verified upon receipt and does not require additional verification from the customer to take action.
7. The Department considers unemployment compensation as unearned income in both the Food Assistance and Medicaid programs.
8. The Department included the weekly benefit amount of $\$ 275$ multiplied by 4.3 to reach a gross income $\$ 1,182.50$ to include in the Food Assistance budget. The Department deducted the Standard Deduction of $\$ 155$ from the gross income to reach an adjusted income of $\$ 1,027.50$. The Department totaled the petitioner's rent of $\$ 775$ and renter's insurance of $\$ 25.84$ to get a total shelter cost of $\$ 800.84$. The Department allowed the Standard Utility Allowance (SUA) of $\$ 345$ due to the petitioner incurring electric costs to heat and cool her home. The shelter cost of $\$ 800.84$ plus the SUA of $\$ 345$ gives the petitioner a total shelter/utility cost of $\$ 1,145.84$. The Department set the petitioner's shelter standard at 50 percent of her adjusted income, which is $\$ 513.75$. ( $\$ 1,027.50 \times 50 \%=\$ 513.75$ ) The Department subtracted the shelter standard from the

FINAL ORDER (Cont.)
16F-00678 \& 16F-01448
PAGE-4
total shelter/utility cost to reach an excess shelter deduction of \$632.09. (\$1,145.84-
$\$ 513.75$ = \$632.09). However, the Department capped the shelter deduction at $\$ 504$ as there is no elderly or disabled member in the household. The adjusted income of $\$ 1,027.50$ less the shelter deduction of $\$ 504$ leaves a net adjusted income of $\$ 523.50$. The net adjusted of $\$ 523.50$ multiplied by 30 percent left a benefit reduction amount of \$158. The Department subtracted the benefit reduction amount from the maximum allotment for a two-person household of $\$ 357$ to reach a benefit allotment of $\$ 199$.
9. The Department included the weekly benefits amount of $\$ 275$ multiplied by four to reach a gross income of $\$ 1,100$ to include in the Medicaid budget. The Department compared the income less the standard disregard for two people of $\$ 146$ to reach a countable income of $\$ 954$. As $\$ 954$ is greater than the income limit of $\$ 241$ for a household of two, the Department determined that they must determine the petitioner's eligibility under Medically Needy.
10. The Department included the petitioner's monthly gross income of $\$ 1,100$, as determined for the Medicaid budget, in the Medically Needy budget. The Department subtracted the Medically Needy Income Limit of \$387 for a household of two from the monthly gross income to reach a monthly share of cost of $\$ 713$.
11. The petitioner does not believe the unemployment compensation should count in either Food Assistance or Medicaid as she earned it when she was working.
12. The petitioner does not believes she was given enough notice that her benefits would change as she had already budgeted for February based on the notice she received at the end of December regarding her benefit eligibility. In addition, she did not have time to receive the information from the HMO she was assigned to with full

FINAL ORDER (Cont.)
16F-00678 \& 16F-01448
PAGE - 5

Medicaid to get her insulin and doctor appointments taken care of before she was switched to Medically Needy.
13. The petitioner understood the policy and budgets as explained by the Department for both the Food Assistance and Medicaid programs. However, the petitioner does not believe the changes are appropriate for her household. She does not see how the Medically Needy program will help her as a

## CONCLUSIONS OF LAW

14. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.
15. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R.

65-2.056.

## Timeliness of Notification

16. Federal Food Assistance Regulation 7 C.F.R. § 273.12 "Requirements for change reporting households" states in relevant part:
(a) Household responsibility to report.
(5)(vi) State agency action on changes reported outside of a periodic report. The State agency must act when the household reports that its gross monthly income exceeds the gross monthly income limit for its household size. For other changes, the State agency need not act if the household reports a change for another public assistance program in which it is participating and the change does not trigger action in that other program but results in a decrease in the household's food stamp benefit. The State agency must act on all other changes reported by a household outside of a periodic report in accordance with one of the following two methods:
(A) The State agency must act on any change in household circumstances in accordance with paragraph (c) of this section; or
(B) The State agency must act on any change in accordance with paragraph (c)(1) of this section if it would increase the household's benefits. The State agency must not act on changes that would result in a decrease in the household's benefits unless:
(1) The household has voluntarily requested that its case be closed in accordance with §273.13(b)(12);
(2) The State agency has information about the household's circumstances considered verified upon receipt; or
(3) A household member has been identified as a fleeing felon or probation or parole violator in accord with §273.11(n);
(4) There has been a change in the household's PA grant, or GA grant in project areas where GA and food stamp cases are jointly processed in accord with §273.2(j)(2).
(c) State agency action on changes. The State agency shall take prompt action on all changes to determine if the change affects the household's eligibility or allotment.
(2) Decreases in benefits. (i) If the household's benefit level decreases or the household becomes ineligible as a result of the change, the State agency shall issue a notice of adverse action within 10 days of the date the change was reported unless one of the exemptions to the notice of adverse action in §273.13 (a)(3) or (b) applies. When a notice of adverse action is used, the decrease in the benefit level shall be made effective no later than the allotment for the month following the month in which the notice of adverse action period has expired, provided a fair hearing and continuation of benefits have not been requested. When a notice of adverse action is not used due to one of the exemptions in §273.13 (a)(3) or (b), the decrease shall be made effective no later than the month following the change. Verification which is required by $\S 273.2(\mathrm{f})$ must be obtained prior to recertification. (emphasis added)
17. Federal Medicaid Regulations found at 42 C.F.R. § 435.948 "Verifying
financial information" states:
(a) The agency must in accordance with this section request the following information relating to financial eligibility from other agencies in the State and other States and Federal programs to the extent the agency determines such information is useful to verifying the financial eligibility of an individual:
(1) Information related to wages, net earnings from self-employment, unearned income and resources from the State Wage Information Collection Agency (SWICA), the Internal Revenue Service (IRS), the Social Security Administration (SSA), the agencies administering the State unemployment compensation laws, the State-administered supplementary payment programs under section 1616(a) of the Act, and any State program administered under a plan approved under Titles I, X, XIV, or XVI of the Act; and
(2) Information related to eligibility or enrollment from the Supplemental Nutrition Assistance Program, the State program funded under part A of title IV of the Act, and other insurance affordability programs.
(b) To the extent that the information identified in paragraph (a) of this section is available through the electronic service established in accordance with §435.949 of this subpart, the agency must obtain the information through such service.
(emphasis added)
18. Florida Admin. Code R. 65A-1.205 "Eligibility Determination Process"
states in relevant part:
(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.
(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.
(b) The Department compares information found through the data exchanges with the information already on file. If the data exchange identifies new or different information than was previously available, the Department conducts a partial eligibility review to determine whether it must change benefit levels.
(c) The Department considers beneficiary and SSI benefit data from the Social Security Administration, unemployment compensation benefit data and Department of Health, Office of Vital Statistics data verified upon receipt and does not require third party verification. Other data requires third party verification before the Department takes adverse actions on a case.
(emphasis added)

FINAL ORDER (Cont.)
16F-00678 \& 16F-01448
PAGE - 8
19. The findings show the Department learned of the petitioner's unemployment compensation income through a data exchange with the Department of Economic Opportunity. The findings also show the Department took further steps to confirm the amount of benefit through the electronic access granted to them by the Department of Economic Opportunity. For both Food Assistance and Medicaid programs, the above controlling authorities show that the verification of income can take place through electronic service or data exchange. The undersigned concludes the Department's action was proper and in accordance with the above controlling authorities.
20. 7 C.F.R. § 273.13 "Notice of Adverse Action" states in relevant part:
(a) Use of notice. Prior to any action to reduce or terminate a household's benefits within the certification period, the State agency shall, except as provided in paragraph (b) of this section, provide the household timely and adequate advance notice before the adverse action is taken.
(1) The notice of adverse action shall be considered timely if the advance notice period conforms to that period of time defined by the State agency as an adequate notice period for its public assistance caseload, provided that the period includes at least 10 days from the date the notice is mailed to the date upon which the action becomes effective. Also, if the adverse notice period ends on a weekend or holiday, and a request for a fair hearing and continuation of benefits is received the day after the weekend or holiday, the State agency shall consider the request timely received.
21. 42 C.F.R. 435.919 "Timely and adequate notice concerning adverse actions" states:
(a) The agency must give beneficiaries timely and adequate notice of proposed action to terminate, discontinue, or suspend their eligibility or to reduce or discontinue services they may receive under Medicaid.
(b) The notice must meet the requirements of subpart E of part 431 of this subchapter.

FINAL ORDER (Cont.)
16F-00678 \& 16F-01448
PAGE - 9
22. 42 C.F.R. 431.211 "Advance Notice" states:"The State or local agency must send a notice at least 10 days before the date of action, except as permitted under $\S \S 431.213$ and 431.214."
23. The findings show the Department issued the petitioner a Notice of Case Action regarding the change in her benefits on January 15, 2016 with the change effective February 1, 2016. The above controlling authorities in both Food Assistance and Medicaid require notices which include adverse action be issued at least 10 days prior to the date the action becomes effective. The undersigned notes the petitioner's concern of the change occurring during the month of January 2016 with an effective date of February 2016 and feeling the Department provided untimely notification.

However, the undersigned concludes the Department issued the Notice of Case Action on January 15,2016 , which met the 10 day adverse action notification requirement.

## Food Assistance

24. 7C.F.R. 273.9 "Income and deductions" states in relevant part:
(b) Definition of income. Household income shall mean all income from whatever source excluding only items specified in paragraph (c) of this section.
(2) Unearned income shall include, but not be limited to:
(ii) Annuities; pensions; retirement, veteran's, or disability benefits; worker's or unemployment compensation including any amounts deducted to repay claims for intentional program violations as provided in §272.12; old-age, survivors, or social security benefits; strike benefits; foster care payments for children or adults who are considered members of the household; gross income minus the cost of doing business derived from rental property in which a household member is not actively engaged in the management of the property at least 20 hours a week. (emphasis added)

FINAL ORDER (Cont.)
16F-00678 \& 16F-01448
PAGE - 10
25. The findings show the income added to the petitioner's budget for Food Assistance is unemployment compensation. In accordance with the above controlling authority, the undersigned concludes the Department was correct in the addition of the unemployment compensation to the Food Assistance budget.
26. 7 C.F.R. 273.9 "Income and Deductions" identifies income deductions
beginning in (d):
(d) Income deductions. Deductions shall be allowed only for the following household expenses:
(1) Standard deduction-
(2) Earned income deduction. Twenty percent of gross earned income as defined in paragraph $(b)(1)$ of this section.
(6) Shelter costs-...(ii) Excess shelter deduction. Monthly shelter expenses in excess of 50 percent of the household's income after all other deductions in paragraphs (d)(1) through (d)(5) of this section have been allowed. If the household does not contain an elderly or disabled member, as defined in $\S 271.2$ 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, mortgage, condo and association fees, or other continuing charges leading to the ownership of the shelter such as loan repayments for the purchase of a mobile home, including interest on such payments. (B) Property taxes, State and local assessments, and insurance on the structure itself, but not separate costs for insuring furniture or personal belongings.
(iii) Standard utility allowances. (A) With FNS approval, a State agency may develop the following standard utility allowances (standards) to be used in place of actual costs in determining a household's excess shelter deduction: an individual standard for each type of utility expense; a standard utility allowance for all utilities that includes heating or cooling costs (HCSUA);
27. 7 C.F.R. § 273.10 "Determining household eligibility and benefit levels"
states in relevant part:
(c) Determining income- ...(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.
(e) Calculating net income and benefit levels-(1) Net monthly income. (i) To determine a household's net monthly income, the State agency shall:
(A) Add the gross monthly income earned by all household members and the total monthly unearned income of all household members, minus income exclusions, to determine the household's total gross income. Net losses from the self-employment income of a farmer shall be offset in accordance with §273.11(a)(2)(iii).
(C) Subtract the standard deduction.
(E) Subtract allowable monthly dependent care expenses, if any, up to a maximum amount as specified under §273.9(d)(4) for each dependent.
(H) Total the allowable shelter expenses to determine shelter costs, unless a deduction has been subtracted in accordance with paragraph (e)(1)(i)(G) of this section. Subtract from total shelter costs 50 percent of the household's monthly income after all the above deductions have been subtracted. The remaining amount, if any, is the excess shelter cost. If there is no excess shelter cost, the net monthly income has been determined. If there is excess shelter cost, compute the shelter deduction according to paragraph (e)(1)(i)(I) of this section.
(I) Subtract the excess shelter cost up to the maximum amount allowed for the area (unless the household is entitled to the full amount of its excess shelter expenses) from the household's monthly income after all other applicable deductions. Households not subject to a capped shelter expense shall have the full amount exceeding 50 percent of their net income subtracted. The household's net monthly income has been determined.
(ii) In calculating net monthly income, the State agency shall use one of the following two procedures:
(A) Round down each income and allotment calculation that ends in 1 through 49 cents and round up each calculation that ends in 50 through 99 cents; or
(B) Apply the rounding procedure that is currently in effect for the State's Temporary Assistance for Needy Families (TANF) program. If the State TANF program includes the cents in income calculations, the State agency may use the same procedures for food stamp income calculations. Whichever procedure is used, the State agency may elect to include the cents associated with each individual shelter cost in the computation of the shelter deduction and round the final shelter deduction amount. Likewise, the State agency may elect to include the cents associated with each individual medical cost in the computation of the medical deduction and round the final medical deduction amount.
(2) Eligibility and benefits. (i)...(B) In addition to meeting the net income eligibility standards, households which do not contain an elderly or disabled member shall have their gross income, as calculated in accordance with paragraph (e)(1)(i)(A) of this section, compared to the gross monthly income standards defined in §273.9(a)(1) for the appropriate household size to determine eligibility for the month.
(ii)(A) Except as provided in paragraphs (a)(1), (e)(2)(iii) and (e)(2)(vi) of this section, the household's monthly allotment shall be equal to the maximum food stamp allotment for the household's size reduced by 30 percent of the household's net monthly income as calculated in paragraph (e)(1) of this section. If 30 percent of the household's net income ends in cents, the State agency shall round in one of the following ways:
(1) The State agency shall round the 30 percent of net income up to the nearest higher dollar; or
(2) The State agency shall not round the 30 percent of net income at all. Instead, after subtracting the 30 percent of net income from the appropriate Thrifty Food Plan, the State agency shall round the allotment down to the nearest lower dollar.

## 28. The Department's Program Policy Manual, CFOP 165-22, Appendix A-1

Food Assistance Income Eligibility Standard and Deductions lists the following
standards:
Effective October 1, 2015:
Standard Deduction for a household size one to three: \$ 155
Monthly 200\% Gross Income Limit for household of two: \$2,655
Monthly 100\% Net Income Limit for household of two: \$1,328
Standard Utility Allowance \$ 345
Maximum Shelter Deduction \$ 504
(for assistance groups without elderly or disabled member)

FINAL ORDER (Cont.)
16F-00678 \& 16F-01448
PAGE - 13
Effective October 1, 2014:
Maximum Benefit Allotment for a household of two \$ 357
29. The findings show the calculation of income and benefit calculation for

Food Assistance made by the Department when adding the petitioner's unemployment compensation to the case. The above controlling authority lists the allowable deductions in the Food Assistance benefit calculation process. The undersigned concludes the Department correctly determined the petitioner's countable income as $\$ 1,182.50$, which is the gross weekly benefit amount of $\$ 275$ multiplied by 4.3 weeks. The undersigned further concludes, as shown in the findings, the Department allowed all deductions that applied in calculating the petitioner's new Food Assistance allotment of $\$ 199$ per month.

## Medicaid/Medically Needy

30. 42 C.F.R. 435.608 "Application for other benefits" states:
(a) As a condition of eligibility, the agency must require applicants and beneficiaries to take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits to which they are entitled, unless they can show good cause for not doing so.
(b) Annuities, pensions, retirement and disability benefits include, but are not limited to, veterans' compensation and pensions, OASDI benefits, railroad retirement benefits, and unemployment compensation.
31. The Department's Policy Manual, section 1830.0900 "Benefits (MFAM)"
states in relevant part:
The gross benefit amount received is considered unearned income.
Benefits are owned by the individual for whom they are intended unless the individual is not in the home and the benefits are not redirected.

## Benefits included as unearned income are:

1. railroad retirement payments including retirement, survivor, unemployment, sickness and strike benefits (Refer to the policy passage

FINAL ORDER (Cont.)
16F-00678 \& 16F-01448
PAGE - 14
titled Children and Tax Dependents, within the Standard Filing Unit
Chapter, for exceptions regarding when to count a child or tax dependent's income)
2. Unemployment Compensation Benefit payments
3. severance pay
4. Social Security Administration Benefits including Title II Social Security benefits (Refer to the policy passage titled Children and Tax Dependents, within the Standard Filing Unit Chapter, for exceptions regarding when to count a child or tax dependent's income)
5. annuities, pensions, retirement or disability payments
(emphasis added)
32. The findings show the income added to the petitioner's budget for

Medicaid or Medically Needy is unemployment compensation. In accordance with the above controlling authorities, the undersigned concludes the Department was correct in the addition of the unemployment compensation to the benefit calculation.
33. The Department's Policy Manual, section 2430.0700 "Income Conversion (MFAM)" states:

Most income is received more often than monthly; that is; it is received weekly, biweekly, or semimonthly. Since eligibility and benefit amounts are issued based on a calendar month, income received other than monthly is to be converted to a monthly amount.
The following conversion factors based on the frequency of pay are used:
Weekly income (once a week): Multiply by 4.
Biweekly income (every two weeks): Multiply by 2.
Semimonthly income (twice a month): Multiply by 2.
34. The findings show the Department included the petitioner's unemployment compensation as the weekly benefit amount of $\$ 275$ multiplied by four (4) to reach the monthly counted income amount of $\$ 1,100$. The undersigned concludes the Department correctly calculated the petitioner's income to be included in the Medicaid and Medically Needy benefit calculations.
35. 42 C.F.R. § 435.603 "Application of modified adjusted gross income
(MAGI)" states in relevant part:
(a) Basis, scope, and implementation. (1) This section implements section 1902(e)(14) of the Act.
(2) Effective January 1, 2014, the agency must apply the financial methodologies set forth in this section in determining the financial eligibility of all individuals for Medicaid, except for individuals identified in paragraph (j) of this section and as provided in paragraph (a)(3) of this section.
(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 $\S 435.916$ of this part, whichever is later.
(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 $(\mathrm{d})(2)$ through $(\mathrm{d})(4)$ 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.
(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 MAGIbased methodologies in the applicable Title of the Act, but not to determine eligibility for a particular eligibility group.
36. 42 C.F.R. $\S 435.110$ "Parents and other caretaker relatives" states in
relevant part:
(a) Basis. This section implements sections 1931(b) and (d) of the Act.
(b) Scope. The agency must provide Medicaid to parents and other caretaker relatives, as defined in $\S 435.4$, and, if living with such parent or other caretaker relative, his or her spouse, whose household income is at or below the income standard established by the agency in the State plan, in accordance with paragraph (c) of this section.
(c) Income standard. The agency must establish in its State plan the income standard as follows:
(1) The minimum income standard is a State's AFDC income standard in effect as of May 1, 1988 for the applicable family size converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act.
(2) The maximum income standard is the higher of-
(i) The effective income level in effect for section 1931 low-income families under the Medicaid State plan or waiver of the State plan as of March 23, 2010 or December 31, 2013, if higher, converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act; or
(ii) A State's AFDC income standard in effect as of July 16, 1996 for the applicable family size, increased by no more than the percentage increase in the Consumer Price Index for all urban consumers between July 16, 1996 and the effective date of such increase.
37. The Department's Policy Manual, section 1830.0000 "Family-Related

Medicaid states:
This chapter discusses policy for individuals whose income must be considered when completing a Family-Related Medicaid eligibility determination. Modified Adjusted Gross Income (MAGI) is an Internal Revenue Service (IRS) method for counting income that aligns financial eligibility across all Insurance Affordability Programs (IAP). Adjusted Gross Income (AGI) is gross income minus casualty losses, charitable contributions, medical and dental expenses, qualified retirement contributions and other miscellaneous itemized deductions. MAGI is equal to Adjusted Gross Income plus foreign earned income, employer contribution plans, and tax exempt interest accrued during the taxable year. Current point in time income will be used in the eligibility determination process when available.

Income is money received from any source such as wages, benefits, contributions, and rentals. If income is taxable, it is counted.
38. The Department's Policy Manual section 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 selfemployment 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).
*Note: Children aged 6-18 do not receive the standard disregard. They do receive the 5\% MAGI disregard, if it's needed to determine the assistance group eligible.
39. The Department's Policy Manual section 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.

FINAL ORDER (Cont.)
16F-00678 \& 16F-01448
PAGE - 18
40. The Department's Policy Manual Appendix A-7 "Family-Related Medicaid Income Limits" lists the following standards effective April 1, 2015 for a household size of two:

| Standard deduction | $\$ 146$ |
| :--- | :--- |
| Income limit for Parents | $\$ 241$ |
| Medically Needy Income Limit** | $\$ 387$ |
| MAGI disregard |  |
|  | $\$ 66$ |

** MNIL--The Medically Needy Income Limit (MNIL) includes the appropriate standard disregard. No additional disregards should be applied to establish a share of cost.
*** MAGI--The 5\% MAGI disregard is used in a budget only if it makes a "failing" individual "pass" a full coverage Medicaid group.
MAGI--The 5\% MAGI disregard is never used in a Medically Needy budget.
41. The findings show the Department compared the petitioner's monthly unemployment income of $\$ 1,100(\$ 275 \times 4=\$ 1,100)$ less the standard disregard of $\$ 146$ to reach a countable net income of $\$ 954$. The undersigned concludes the petitioner's countable net income of $\$ 954$ exceeds the income standard of $\$ 241$. The undersigned further concludes the Department correctly determined the petitioner's full Medicaid eligibility should end January 31, 2016.
42. The findings show the Department used the petitioner's monthly gross income of $\$ 1,100$ less the Medically Needy Income Limit of $\$ 387$ to determine the petitioner's share of cost as $\$ 713$. The undersigned concludes the Department, following the instructions given in the above controlling authorities, correctly determined the petitioner as eligible in the Medically Needy program and correctly computed the petitioner's share of cost.

FINAL ORDER (Cont.)
16F-00678 \& 16F-01448
PAGE - 19
43. The undersigned recognizes the petitioner's concerns regarding the reduction in her benefits while she is unemployed. The undersigned researched all applicable rules and regulations for the Food Assistance and Medicaid programs. The undersigned can find no more favorable outcome for the petitioner.

## 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 $\qquad$ 15 day of $\qquad$ , 2016, in Tallahassee, Florida.

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

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

PETITIONER,
Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES CIRCUIT: 05 Marion UNIT: 88001

RESPONDENT.
16F-01478

## CASE NO.



FINAL ORDER (Cont.)
16F-00763 \& 16F-01478
PAGE - 2
husband issues. The respondent carries the burden of proof by the preponderance of evidence for the petitioner's MN issue.

## PRELIMINARY STATEMENT

By notice dated January 21, 2016, the respondent (or the Department) notified the petitioner Medicaid MN with a $\$ 915$ SOC was approved for the petitioner and her husband. Also by notice dated January 25, 2016, the Department notified the petitioner FA was approved; \$282 for January 2016 and $\$ 771$ for February 2016 through June 2016. Petitioner timely requested a hearing to challenge the FA amount and approval of MN for her and her husband.

Petitioner submitted one exhibit, entered as Petitioner Exhibit "1". Respondent submitted seven exhibits, entered as Respondent Exhibits "1" through "7". The record remained open until March 30, 2016, for the respondent to submit an additional exhibit. The exhibit was received timely and entered as Respondent Exhibit "8". The record was closed on March 30, 2016.

## FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner received FA and full Medicaid for herself and her three minor children.
2. On October 19, 2015, the Department mailed petitioner a Notice of Eligibility Review that states in part, "This is a reminder that the last month you will get food assistance and/or cash assistance is November, 2015 unless you reapply. You or your authorized representative must reapply by the $15^{\text {th }}$ day of November, 2015 to keep getting food assistance and/or cash assistance without a break".

FINAL ORDER (Cont.)
16F-00763 \& 16F-01478
PAGE - 3
3. On December 21, 2015, the petitioner submitted a recertification application for FA and Medicaid; she also added her husband to her case. Household members listed include the petitioner, her husband and her three children. Petitioner and her husband were married in November 2015. The application lists $\$ 1,600$ public retirement for petitioner's husband, \$706 Supplemental Security Income (SSI) for one child and \$50 income from Social Security (SS) for each of the three children. The three children receive $\$ 50$ from SS due to their biological father receiving disability income from SS.
4. On December 22, 2015, the Department mailed the petitioner a Notice of Case Action (NOCA), requesting income for the last four weeks and pension verification, due by January 4, 2016.
5. The Department did not receive the verification requested by January 4, 2016. And on January 21, 2016, the Department mailed petitioner a NOCA: 1) denying petitioner's December 21, 2015, application for FA and 2) enrolling petitioner (effective February 2016) and her husband (effective December 2015) in Medicaid MN with a $\$ 915$ SOC each.
6. On January 25, 2016, petitioner called the Department and reported that her husband receives Social Security Retirement (SSR), not public retirement. The Department reopened petitioner's FA case.
7. The Department incorrectly calculated petitioner's FA budget and included only petitioner's children's income (\$706 SSI and $\$ 150$ SS). And on January 25, 2016, the Department mailed the petitioner a NOCA, notifying the household was approved FA; \$282 for January 2016 and \$771 from February 2016 through June 2016.

FINAL ORDER (Cont.)
16F-00763 \& 16F-01478
PAGE-4
8. The Department also incorrectly calculated petitioner's December 2015 FA amount (in February 2016) using the $\$ 1,600$ retirement amount for petitioner's husband listed on the December 21, 2015 application. And on February 11, 2016, the Department mailed petitioner a NOCA notifying the household would receive \$64 in FA for December 2015. 9. The Department verified the household's income from SS and corrected the FA budget calculation. The following is the corrected budget:

| $\$ 1,639$ | SSR |
| ---: | :--- |
| $+\$ 150$ | SS (\$50 each child) |
| $+\$ 706$ | SSI |
| $\$ 2,495$ | household income |
| $-\$ 197$ | standard deduction |
| $\$ 2,298$ | adjusted income |
|  |  |
| $\$ 1,250$ | shelter |
| $+\$ 345$ | standard utility allowance (SUA) |
| $\$ 1,595$ | shelter/utility costs <br> $-\$ 1,149$ |
| $\$ 40 \%$ adjusted income (\$2,298) |  |
| $\$ 2,298$ | excess shelter deduction |
| $-\$ 446$ | adjusted income <br> excess shelter deduction |
| $\$ 1,852$ | adjusted income after deductions |
| $\$ 1,852 \times 30 \%=\$ 556$ (round up) FA reduction |  |

10. The maximum FA benefit amount for a household size of five is $\$ 771$. Subtracting \$556 (FA reduction) from $\$ 771$ leaves $\$ 215$ monthly in FA.
11. The Department mailed the petitioner another NOCA, on February 11, 2016, notifying FA would decrease from \$771 to \$215 effective March 2016.
12. Respondent's representative stated that the petitioner received $\$ 282$ FA in January 2016 and was only eligible to receive $\$ 215$.

FINAL ORDER (Cont.)
16F-00763 \& 16F-01478
PAGE - 5
13. The record was held open for the respondent's representative to submit the correct December 2015 FA budget.
14. After the hearing, the respondent's representative submitted petitioner's December 2015 budget. The budget is the same as the above budget (\#9). The difference is that the $\$ 215$ monthly FA amount is prorated to December 21, 2015 (petitioner's date of application); resulting in $\$ 71$ FA for December 2015. The respondent's representative issued a $\$ 7.00$ FA auxiliary for December 2015. The petitioner already received $\$ 64$; the additional $\$ 7.00$ totals $\$ 71$ for December 2015.
15. To be eligible for full Medicaid, the petitioner and her husband's income cannot exceed $\$ 426$ monthly. Petitioner's husband's $\$ 1,639$ SSR exceeds $\$ 426$. The next available Medicaid Program is MN with a SOC. Petitioner, her husband and the children are included in the same tax filing unit. Therefore, all five were included in the MN calculation.
16. The Department calculated petitioner and her husband's SOC as follows:

| $\$ 1,639.50$ |  | SSR |
| :---: | :---: | :--- |
| $-\$$ | 684.00 | MN income limit (MNIL) for a household size of five |
| $\$$ | 955.00 | SOC (cents dropped) |
| $\$$ | .25 | Med. Insurance premium |
| $\$$ | 954 | SOC (cents dropped) |

17. The Department's February 11, 2016 NOCA also notified the petitioner that the MN SOC would increase from \$915 to \$954 (each), effective March 2016.
18. Respondent's representative stated the 25 cents included in the SOC determination is incorrect. And the SOC should be $\$ 955$ not $\$ 954$.

FINAL ORDER (Cont.)
16F-00763 \& 16F-01478
PAGE-6

## 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 $\S 409.285$, 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. 652.056.

## FOOD ASSISTANCE ISSUE

21. Federal Regulation at 7 C.F.R § 273.9, defines income in the FA determination and in part states:
(b) Definition of income. Household income shall mean all income from whatever source...
(2) Unearned income shall include, but not be limited to...
(i) Assistance payments from Federal or federally aided public assistance programs, such as supplemental security income (SSI)...
(ii) Annuities; pensions; retirement, veteran's, or disability benefits...or social security benefits...
22. In accordance with the above Federal Regulation, the Department included the petitioner's children and her husband's income in the FA determination; $\$ 706$ SSI for one child, $\$ 150$ (\$50 each) SS for the three children and $\$ 1,639$ SSR for petitioner's husband.
23. Federal Regulation at 7 C.F.R § 273.9, defines allowable deductions in the FA determination and in part states:
(d) Income deductions. Deductions shall be allowed only for the following household expenses:
(1) Standard deduction...
(6) Shelter costs...
(ii) Excess shelter deduction. Monthly shelter expenses in excess of 50 percent of the household's income after all other deductions...
(C) The cost of fuel for heating; cooling (i.e., the operation of air conditioning systems or room air conditioners); electricity or fuel used for purposes other than heating or cooling; water; sewerage; well installation and maintenance; septic tank system installation and maintenance; garbage and trash collection; all service fees required to provide service for one telephone
(iii) Standard utility allowances...Only utility costs identified in paragraph (d)(6)(ii)(C) of this section must be used in developing standards...
24. The Department's Policy Manual (Policy Manual), CFOP 165-22, at Appendix A-1, sets forth for a household size of five the following:
\$771 maximum FA benefit
\$197 standard deduction
\$345 SUA
25. Federal Regulations at 7 C.F.R. § 273.10, explains income and deduction calculations:
(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...
(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...
26. The cited authorities set forth income and allowable deductions in the FA benefit determination. In accordance with the authority, respondent subtracted allowable deductions (standard deduction, shelter and SUA) in petitioner's FA calculation.

FINAL ORDER (Cont.)
16F-00763 \& 16F-01478
PAGE - 8

## MEDICALLY NEEDY ISSUE

27. 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...
(f) Household...
(2) Basic rule for individuals claimed as a tax dependent. In the case of an individual who expects to be claimed as a tax dependent by another taxpayer for the taxable year in which an initial determination or renewal of eligibility is being made, the household is the household of the taxpayer claiming such individual as a tax dependent...
28. The above Federal Regulation explains that the petitioner, her husband and the children are counted in petitioner and her husband's Medicaid eligibility; due to all being in the same tax filing unit.
29. 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...
30. Fla. Admin. Code R. 65A-1.716 Income and Resource Criteria explains:
(2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows:
Family Size Income Level
5
\$426
31. The above authority explains for petitioner and her husband to be eligible for Family-Related Medicaid, the income for a household size of five cannot exceed \$426 monthly. Petitioner's husband's $\$ 1,639$ SSR exceeds $\$ 426$; therefore, petitioner and

FINAL ORDER (Cont.)
16F-00763 \& 16F-01478
PAGE-9
her husband are not eligible for full Medicaid. The next available Program is MN with a SOC.
32. 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...
33. The above authority explains the SOC is determined by subtracting the income level (MNIL) from the gross income.
34. Policy Manual at Appendix A-7 sets forth the MNIL at $\$ 684$ for a household size of five.
35. In accordance with the above authorities, the Department calculated petitioner and her husband's SOC by including her husband's \$1,639 SSR and then subtracted \$684 (MNIL) and $\$ .25$ (medical expense) to arrive at $\$ 954$ each.

## HEARING OFFICER'S CONCLUSION

36. In careful review of the cited authorities and evidence, the undersigned agrees with the respondent's action regarding the FA issue. The correct FA amount for the month of December 2015 is $\$ 71$ (prorated to petitioner's December 21, 2015 application) and \$215 starting January 2016.
37. Also in careful review of the cited authorities and evidence, the undersigned agrees with the respondent's action to enroll petitioner and her husband in Medicaid MN with a \$954 monthly SOC each.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are denied and the respondent's actions are affirmed.

## NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigence 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 $\qquad$ day of April $\qquad$ , 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:
Petitioner
Office of Economic Self Sufficiency

Apr 29, 2016

STATE OF FLORIDA

APPEAL NO.

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 April 12, 2016 at 11:06 a.m.

APPEARANCES
For the Petitioner:

For the Respondent:
Lisa Sanchez
Medical/Healthcare Program Analyst

## STATEMENT OF ISSUE

Whether respondent's partial denial of Pediatric Extended Care (PPEC) services was proper. The burden of proof is assigned to the petitioner ${ }^{1}$. The standard of proof in an administrative hearing is by a preponderance of the evidence.

[^14]FINAL ORDER (Cont.)

## PRELIMINARY STATEMENT

appeared both as a witness and representative. Also present was petitioner's father, Petitioner's exhibit " 1 " was accepted into evidence.

The record was held open through April 15, 2016 for petitioner to provide emergency medical protocols. Information was timely received and entered as petitioner's exhibit " 2 ".

Ms. Sanchez appeared both as a witness and representative for the respondent. Present as a witness from eQHealth Solutions (eQHealth) was Dr. Darlene Calhoun, M.D. Respondent's Exhibits " 1 " and " 2 " were accepted into evidence.

The record was held open through April 22, 2016 to allow respondent to provide a written response to letters included in Petitioner's exhibit "1" and any post hearing submissions. A response was not received.

## FINDINGS OF FACT

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

1. Petitioner's date of birth is April 23, 2015. He was Medicaid eligible at all times relevant to this proceeding.
2. Petitioner resides with his parents. His mother is both employed and attends school. His father primarily works from the home. The father's position requires sporadic absences from the residence during the course of most business days.
3. Petitioner is diagnosed with

FINAL ORDER (Cont.)
16F-01541
PAGE - 3
4. $\square$ s a genetic disorder in which the body cannot properly metabolize certain amino acids. When not properly monitored and treated, elevated amino acid levels can, in the most severe form, cause coma; brain damage; or death.
5. a chronic medical condition. As a cure does not exist, treatment and management are the accepted protocols.
6. In addition to care from his primary pediatrician, petitioner is also followed by physicians at the University of Florida's Pediatric Genetics Division.
7. PPEC services are covered by the Florida Medicaid Program for certain individuals under 21 years of age.
8. PPEC services are facility based and provide medical care and certain therapies for individuals with medically complex conditions.
9. eQHealth is the Peer Review Organization (PRO) contracted by the respondent to perform prior authorization reviews for PPEC services.
10. Upon receipt of petitioner's request for PPEC services (five days per week) an eQHealth registered nurse completed a Florida Home Health Assessment. Regarding the petitioner, the assessment establishes:

- Was hospitalized on May 15, 2015 due high amino acid levels
- Has an increased risk for hospitalization due to chronic fragile state
- Is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death
- Close monitoring required for nutritional intake and output
- Close monitoring required for increased amino acid levels
- No enteral feeding
- No seizures or spasms
- No wounds or stomas

11. A Plan of Care (POC) for PPEC Services was completed by petitioner's physician. The POC states elevated amino acid levels can cause vomiting, abnormal

FINAL ORDER (Cont.)
16F-01541
PAGE-4
neurologic findings; progressive neurodegeneration; seizures; lethargy; coma; and lead to death.
12. The POC establishes petitioner requires, for nutritional purposes, a specialized medical formula. Only limited amounts of natural protein is allowed. Weekly blood work is taken by a PPEC nurse to monitor amino acid levels. The specialized medical formula is adjusted based on the results of the weekly lab work.
13. In the POC, petitioner's physician also directs the PPEC nurse is to:

- Monitor for signs of lethargy
- Monitor for decreased oral intake
- "Strict" monitoring of all food intake and all output
- Weekly weighing
- Urine checks for ketones
- Medication management

14. An eQHealth physician reviewer thereafter reviewed all submitted information.
15. A Notice of Outcome was issued by eQHealth on November 12, 2015. The notice approved petitioner's request for PPEC services. The approval, however, was only for the period November 2, 2015 through January 30, 2016. PPEC services for the period January 31, 2016 through April 29, 2016 were denied. The approximate three month approval period was viewed as a trial period to determine whether a skilled nursing need existed. The notice also stated, in part: "The clinical information provided does not support the medical necessity of the requested services. The patient does not appear to require skilled nursing."
16. The above notice stated should the parent, provider, or physician disagree with the decision, reconsideration could be requested within 10 business days. Additional information could be provided with the request.

FINAL ORDER (Cont.)
16F-01541
PAGE - 5
17. Reconsideration was requested.
18. A second physician reviewer thereafter reviewed all information. On February 24, 2016 eQHealth issued a Notice of Reconsideration Determination. The notice stated, in part: "The information submitted for reconsideration provided no evidence to support the reversal of the previous decision. The original decision is upheld."
19. On March 1, 2016 the Office of Appeal Hearings timely received petitioner's request for a Fair Hearing. PPEC services were continued pending the outcome of this proceeding.
20. In support of PPEC services, petitioner provided a letter from Cheryl Garganta, MD. Dr. Garganta is affiliated with the University of Florida's College of Medicine. Dr. Garganta wrote, in part:

Failure to maintain concentration of these amino acids within their therapeutic goals can result in significant developmental delays, even without episodes of coma.

21. Petitioner's PPEC nurse also wrote: "Failure to recognize a buildup of the branch chain amino acids can result in seizures, coma and brain damage. Managing disease is far too complex for non-medical personnel."
22. Petitioner's representative argues the ratio of staff to recipient at the PPEC is appropriate for her son. The same staffing ratio would not exist at a regular daycare

FINAL ORDER (Cont.)
16F-01541
PAGE-6
facility. Most importantly, supervision by a medical professional exists at the PPEC.
Neither the staffing ratio nor on-site skilled nursing would exist at a regular daycare facility.

## 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. Petitioner was initially approved for PPEC services on November 11, 2015. The approval was for a three month period. Reconsideration was requested but a response was not issued until February 24, 2016. The reason for the delay is not clear.

Regardless, the action taken on respondent's behalf was based on an initial application for PPEC services. In such an instance, Florida Admin. Code R. 65-2.060 (1), directs the burden of proof be assigned to the petitioner.
26. The standard of proof in an administrative hearing is by a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at $1201,7^{\text {th }}$ Ed.).
27. The Florida Medicaid State Plan is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The program is administered by the respondent.
28. The PPEC Coverage and Limitations Handbook (PPEC Handbook) has been promulgated into rule by Fla. Admin. Code R. 59G-4.260.

FINAL ORDER (Cont.)
16F-01541
PAGE-7
29. Page 1-1 of the PPEC Handbook states: "The purpose of the Florida Medicaid

Prescribed Pediatric Extended Care (PPEC) services is to enable recipients under the age of 21 years with medically-complex conditions to received medial and therapeutic care at a non-residential pediatric center."
30. Page 2-1 of the PPEC Handbook continues by stating:

To receive reimbursement for PPEC services, a recipient must meet all of the following criteria:

- Be Medicaid eligible.
- Diagnosed with a medically complex or medically fragile condition as defined in Rule 59G-1.010, F.A.C.
- Be under the age of 21 years.
- Be medically stable and not present significant risk to other children or personnel at the center.
- Require short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care due to a medically complex condition.

31. Fla. Admin. Code R. 59G-1.010 provides the following definitions:
(164) "Medically complex" means that a person has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour-per day medical, nursing, or health supervision or intervention.
(165) "Medically fragile" means an individual who is medically complex and whose medical condition is or such a nature that he is technologically dependent requiring medical apparatus or procedures to sustain life, e.g. requires total parenteral nutrition (TPN), is ventilator dependent, or is dependent on a heightened level of medical supervision to sustain life, and without such services is likely to expire without warning.
32. The PPEC Handbook also states on page 2-2 that "Medicaid reimburses services that are determined medically necessary, and do not duplicate another provider's service."
33. Fla. Admin. Code R. 59G-1.010(166), defines medical necessity, as follows:
"Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
(a) Meet the following conditions:
34. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
35. 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;
36. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
37. 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
38. 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.
39. Since the petitioner is under 21 years-old, a broader definition of medical necessity applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPDST) requirements. Fla. Stat. § 409.905, Mandatory Medicaid services, provides that Medicaid services for children include:

## (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND

 TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.FINAL ORDER (Cont.)
16F-01541
PAGE-9
35. The undersigned notes that PPEC services are available through the Florida Medicaid Program. As such, analysis is further directed to whether, in this instant appeal, the service is medically necessary.
36. Regarding requirements found on page 2-1 of the PPEC Handbook, the Findings of Fact establish petitioner is Medicaid eligible and is under 21 years of age. Evidence was not presented that petitioner is medically unstable or poses a risk to other's at the PPEC facility. As such, analysis is directed to whether petitioner meets the definition of having a medically complex or medically fragile condition.
37. The definition of "Medically complex" requires the existence of a chronic debilitating disease which makes the individual dependent upon 24 hour medical; nursing; or health supervision or intervention.
38. The Findings of Fact establish $\square$ is a chronic disease.
39. At time of hearing, petitioner was about to turn one year of age. Based on this age, he is unable to self-monitor protein intake. Petitioner's age also prevents him from identifying and verbalizing symptoms which, if left unnoticed, could have significant medical consequences.
40. For an older child, may not rise to the level of a debilitating disease. Due to petitioner's age, the greater weight of evidence establishes a debilitating disease exists.
41. The greater weight of evidence also establishes petitioner, due to his age, is dependent on around the clock health supervision. It is noted the definition for "Medically complex" requires around the clock "medical, nursing, or [Emphasis Added] health supervision or intervention."

FINAL ORDER (Cont.)
16F-01541
PAGE - 10
42. Petitioner's representative argued that a person without medical training may not be able to effectively monitor intake and output is viewed as credible.
43. The argument that an untrained person may not recognize symptoms associated with high amino acid levels is assigned considerable weight by the undersigned. The unique nature of $\quad$ is recognized. As such, the health supervision required by the petitioner is can presently be best addressed by a medical professional.
44. Also given considerable weight is that appropriate supervision is required to prevent consumption of food being eaten by other children. This type of supervision requires a staff to recipient ratio that allows for the appropriate level of monitoring.
45. When considering relevant evidence and testimony, petitioner meets the definition of being "Medically complex" and, at this developmental stage, requires skilled nursing care.
46. Petitioner's representative has established the need for PPEC services has satisfied each condition of medical necessity.
47. When considering EPSDT; medical necessity criteria; and the requirements of the PPEC Handbook, petitioner has met the required evidentiary standard in this matter.

## DECISION

Based upon the foregoing Findings of Fact and controlling authorities, petitioner's appeal is granted.

FINAL ORDER (Cont.)
16F-01541
PAGE -11

## 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 $\qquad$ 29 day of April , 2016, in Tallahassee, Florida.


Frank Houston
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myfIfamilies.com

Copies Furnished To: JUDY JACOBS, AREA 7 , AHCA FIELD OFFICE

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

Apr 21, 2016<br>Office of Appeal Hearings<br>Dept. of Children and Families

APPEAL NO. 16F-01570
16F-01571
PETITIONER,
Vs.

## FLORIDA DEPARTMENT

OF CHILDREN AND FAMILIES
CIRCUIT: 11 Dade
UNIT: 66703
B - Benefit Recovery (BR)
RESPONDENT.
CASE NO. 11

## FINAL ORDER OF DISMISSAL

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on March 29, 2016 at 9:08 a.m. The petitioner represented himself. Guillermo Carton, Senior Human Program Specialist, represented the department. All parties appeared telephonically from different locations.

At issue is the respondent's action to establish overpayment claims of \$2,531 and $\$ 2,672$ in Food Assistance Program (FAP) benefits and $\$ 831.50$ in Medicaid benefits due to client error.

The respondent sent three Notices of Overpayment to the address of record reported by the petitioner, $\square$ on March 19, 2012. The petitioner requested a hearing on February 29, 2016, more than 3 years after the overpayment notices were issued.

FINAL ORDER (Cont.)
16F-01570, 01571
PAGE -2
The Fla. Admin. Code R. 65-2.046 states in part, "(1) The appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs..." The petitioner's first hearing request was February 29, 2016 after his income taxes were intercepted. The department filed a Motion to Dismiss citing the hearing request was outside of the 90 day timeframe.

The petitioner acknowledges that he did receive the Notice of Overpayment pertaining to the $\$ 2,531$ overpayment. He argues he did not receive the Notice of Overpayment's pertaining to the $\$ 2,672$ overpayment in Food Assistance Program (FAP) benefits and the $\$ 831.50$ overpayment in Medicaid benefits. The petitioner states he has lived at the reported address for over 17 years and has never had an issue with receiving his mail. The department established through its routine business practice that the notice was properly mailed. Where mail has been properly addressed, stamped, and mailed pursuant to normal office procedure, there is a presumption that the addressee received the mail. See (Brown v. Giffen Industries, Inc., 281 So. 2d 897 (Fla. 1973)). The department showed no returned mail from the postal service. It is concluded that the petitioner timely received the March 19, 2014 overpayment notice.

The petitioner has been paying monthly on the $\$ 2,531$ overpayment and he states his monthly bill has never reflected an additional FAP overpayment or Medicaid overpayment. The respondent states all overpayments are paid individually and are not reflected on the monthly bills received until the initial overpayment is paid in full.

The testimony and evidence both demonstrate that the overpayment notice was mailed to the address provided by the petitioner. After careful review, the undersigned grants the department's Motion to Dismiss on both appeals. The petitioner did not

FINAL ORDER (Cont.)
16F-01570, 01571
PAGE -3
exercise his right to a hearing within the 90 day time frame set forth in rule, therefore the undersigned has no jurisdiction to review the merits of the appeals.

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 21 day of April , 2016,
in Tallahassee, Florida.


Pamela B. Vance
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To:
Petitioner
Office of Economic Self Sufficiency

Apr 29, 2016

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

PETITIONER,
Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 12 Sarasota
UNIT: 88326

CASE NO.

## RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on April 7, 2016 and April 20, 2016, the latter at approximately 8:00 a.m. CDT.

## APPEARANCES

For the Petitioner:


For the Respondent: Signe Jacobson, Economic Self-Sufficiency Specialist II Ed Poutre, Economic Self-Sufficiency Specialist II

## STATEMENT OF ISSUE

Petitioner is appealing the Department's action of March 2, 2016 denying his application for disability-related Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

FINAL ORDER (Cont.)
16F-01770
PAGE -2

## PRELIMINARY STATEMENT

The proceedings were initially convened on April 7, 2016 at 2:30 p.m. CDT with petitioner present and Signe Jacobson representing the Department. At that time, after going on the record, it was discovered that the petitioner had not yet received the Department's evidence packet. He stated he was uncomfortable proceeding without it in front of him. The hearing was continued until April 20, 2016 with Ed Poutre representing the Department.

The respondent submitted a packet of information that was accepted into evidence as Respondent's Exhibits " 1 " through " 9 ". The Petitioner submitted two packets of information that were accepted into evidence as Petitioner's Exhibits "1" through " 4 ".

## FINDINGS OF FACT

1. The petitioner is a 51-year-old single male who claims to be disabled.
2. On February 2, 2106, he applied for Temporary Cash Assistance (TCA), Food Assistance Program (FAP) benefits and Medicaid.
3. The petitioner is not age 65 or older and there are no children under age 18 in the household or filing unit.
4. On January 14, 2016, the petitioner applied for disability benefits with the Social Security Administration (SSA).
5. The claim was denied by the SSA on February 26, 2016 citing reason code N31, "Non-Pay - Capacity for substantial gainful activity - customary past work, no visual impairment."

FINAL ORDER (Cont.)
16F-01770
PAGE - 3
6. On February 4, 2016, a Notice of Case Action (NOCA) was mailed requesting additional information and a disability interview from the petitioner.
7. The disability interview was conducted on February 4, 2016, and a transmittal was submitted to the Division of Disability Determinations (DDD) on February 9, 2016.
8. The DDD response was received by the Department February 26, 2016 denying the disability, citing the adoption of the SSA determination N31.
9. A NOCA was mailed on March 2, 2016 denying Medicaid benefits as disability criteria were not met.
10. At some time shortly after the petitioner's receipt of the SSA denial, petitioner could not recall specific date, petitioner appealed the SSA's disability denial and has engaged legal counsel for that appeal. To date, the appeal is undecided.
11. The petitioner claims no new disabling condition, affirming that current medical information has been submitted for the SSA's consideration.

## 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 Section409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.
13. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 652.056.
14. Federal Medicaid Regulations at 42 C.F.R. $\S 435.541$ "Determinations of
disability" states in part:
(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.
(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 $\S 435.912$ 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. The findings show that petitioner applied for disability benefits with the SSA and was denied as he was found not disabled. The denial date was February 26, 2016.

Petitioner applied for Medicaid with the Departments in January 2016. The SSA denial date is within 12 months of the Medicaid application date. The undersigned concludes that all of the petitioner's disabling conditions have been reviewed by the SSA; therefore, the undersigned concludes there are no new disabling conditions not known by the SSA.
16. In accordance with the above controlling authority, the undersigned concludes that the Department correctly adopted the federal SSA disability decision rather than make a duplicate independent decision on petitioner's disability request.

FINAL ORDER (Cont.)
16F-01770
PAGE -6
17. Fla. Admin. Code 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) ... (1) For MEDS-AD Demonstration Waive, the individual must be age 65 or older, or disabled as defined in 20 C.F.R. § 416.905 (2007) (incorporated by reference).
18. According to the above controlling Medicaid authority, an individual must be age 65 or older, or disabled (by either the Department or SSA), to meet the technical criteria for Medicaid in the SSI-Related Medicaid Programs. Because petitioner is under age 65 and has not yet been determined disabled by SSA, he does not meet the technical criteria to be eligible for SSI-related Medicaid; therefore, the Department correctly denied the request for Medicaid at issue.

## DECISION

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

## NOTICE OF RIGHT TO APPEAL

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

FINAL ORDER (Cont.)
16F-01770
PAGE -7
DONE and ORDERED this 29 day of April_2016,
in Tallahassee, Florida.


Gregory Watson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myffamilies.com

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

APPEAL NO. 16F-00755
16F-02045
PETITIONER,
Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 05 Hernando
UNIT: 88004
RESPONDENT.

## CASE NO.

FINAL ORDER (Cont.)
16F-00755 \& 16F-02045
PAGE - 2

## PRELIMINARY STATEMENT

By notice dated January 20, 2016, the respondent (or the Department) notified the petitioner she was ineligible for QI1 and MN. Petitioner timely requested a hearing to challenge her ineligibility of QI1 and MN.

Marek, ID \# 204327, Language Line, appeared as an interpreter for the petitioner. petitioner's friend, appeared as a witness for the petitioner. Victoria Siornicki, ACCESS Economic Self-Sufficiency Specialist II, appeared as an observer.

Petitioner submitted one exhibit, entered as Petitioner Exhibit "1". Respondent submitted six exhibits, entered as Respondent Exhibits " 1 " through " 6 ". The record was closed on March 16, 2016.

## FINDINGS OF FACT

1. Prior to the action under appeal petitioner received QI1 and MN benefits.
2. On January 15, 2016, petitioner submitted a Medicaid/Medicare Buy-In application
for herself. The application lists a savings account with a balance of \$11, 338 .
3. To be eligible for QI1 and MN, applicants cannot exceed the asset limits of each
program. The asset limit for QI1 is $\$ 7,280$ and $\$ 5,000$ for MN.
4. Petitioner submitted a letter fron
 dated February 3, 2015, that states in part:

Per our recent conversation, enclosed please find a draft in the amount of $\$ 11,674$, which represents the total seed money for your self-administered Medicare Set Aside, related to your future medical care related to your workers' compensation claim. Please note that this money must be placed in a separate interest bearing account and is to be used in relation to medical care as a result of your related injury.

FINAL ORDER (Cont.)
16F-00755 \& 16F-02045
PAGE-3
5. Petitioner does not dispute that she has over $\$ 11,000$ in savings. Petitioner also submitted a Chase Bank Statement, dated March 21, 2015 through April 21, 2015, indicating an $\$ 11,674.07$ savings balance.
6. Petitioner disputes that the Department is considering the money as an asset; because the money is strictly for medical expenses that are not covered by Medicare/Medicaid, due to a work related accident.
7. Respondent's representative explained that because the petitioner has access to the money it must be counted.
8. On January 20, 2016, the Department mailed the petitioner a Notice of Case Action, notifying that Q11 and MN were denied; "Reason: The value of your assets is too high."

## 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. 652.056 .
11. Fla. Admin Code R. 65A-1.712 SSI-Related Medicaid Resource Eligibility Criteria in part states:
(1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C...
(b) For Qualified Medicare Beneficiary (QMB), an individual cannot have resources exceeding three times the SSI resource limit with increases based on the Consumer Price Index...

FINAL ORDER (Cont.)
16F-00755 \& 16F-02045
PAGE-4
(e) For Medically Needy, an individual or couple cannot have resources exceeding the applicable Medically Needy resource limit set forth in subsection 65A-1.716(3), F.A.C...
12. Fla. Admin Code R. 65A-1.716 Income and Resource Criteria in part states:
(3) The resource limits for the Medically Needy program are as follows:

Family
Size
1

Asset
Level
\$5,000
13. The Department's Program Policy Manual, (Policy Manual), CFOP 165.22, Appendix A-9, sets forth a $\$ 7,280$ asset limit for QI1 benefits for an individual.
14. The above authorities explain that applicants cannot exceed the asset limits for QI1
and MN benefits. The asset limit for a one household member cannot exceed \$7,280
for QI1 and \$5,000 for MN.
15. Petitioner argued that her $\$ 11,674$ savings is an account set up strictly to cover her medical expenses due to a work related injury; which are not covered by Medicare/Medicaid.
16. Fla. Admin Code R. 65A-1.303 Assets in part states:
(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. (emphasis added) 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.

FINAL ORDER (Cont.)
16F-00755 \& 16F-02045
PAGE - 5
17. The Department's Memorandum, dated July 19, 2005, Asset Availability/Medicare

Set-Aside Custodial Account, in part states:
A Medicare Set-Aside Custodial Account is a medical payments trust that results from a workers' compensation settlement. The purpose of the account is to ensure that Medicare does not pay for medical expenses that result from a work-related injury covered by workers' compensation. The payer/grantor in this case is someone other than the beneficiary, beneficiary's spouse or legal representative; therefore, the trust must be evaluated under policies found in manual passage 1640.0576.03 for trusts set up by others.
If it is determined that the trust agreement is irrevocable and the beneficiary does not have direct access to the principal, exclude the funds in the custodial account as an asset.
18. Policy Manual at passage 1640.0576.03 Trusts Set Up By Others (MSSI, SFP)
states:
For trusts that are established by someone other than the individual, the individual's spouse or representative, the trust must be evaluated according to these SSI policies:

1. If the individual does not have authority to revoke or direct use of the trust, it is not considered an asset to him. Conversely, if the individual has the authority to revoke or direct use of the trust, the corpus of the trust is considered an asset to him...
2. The above authority, Department Memorandum and Policy Manual explain that assets are considered available to an individual when the individual has unrestricted access to it.
3. The evidence submitted establishes that petitioner's $\$ 11,338 / \$ 11,674$ is in a savings account in her name and she has unrestricted access to the monies.
4. In careful review of the cited authorities and evidence, the undersigned concludes the Department met its burden. The Department's action to terminate petitioner's QI1 and MN benefits due to exceeding the asset limit is proper.

FINAL ORDER (Cont.)
16F-00755 \& 16F-02045
PAGE -6

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals
are denied and the respondent's actions are affirmed.

## NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigence 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 $\qquad$ 22 day of $\qquad$ , 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

# STATE OF FLORIDA <br> DEPARTMENT OF CHILDREN AND FAMILIES OFFICE OF APPEAL HEARINGS 



PETITIONER,
Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 66292

## RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on March 14, 2016 at 9:45 a.m. and reconvened on March 24, 2016 at 8:30 a.m.

## APPEARANCES

For the petitioner: pro se
For the respondent: Marsha Shearer, ACCESS Senior Specialist

## STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to terminate her Food Assistance Program (FAP) benefits due to the respondent not receiving all the information requested to determine eligibility. The petitioner carries the burden of proof by a preponderance of the evidence.

Petitioner is also appealing the respondent's action to increase her Medically Needy (MN) Program benefits with a share of cost (SOC) from \$402.00 to \$2,309.00

FINAL ORDER (Cont.)
16F-00747
16F-02268
PAGE - 2
effective November 1, 2015. The respondent carries the burden of proof by a preponderance of the evidence.

## PRELIMINARY STATEMENT

By notice dated October 16, 2015, the respondent notified the petitioner that her FAP benefits were denied due to the respondent did not receive all the information necessary to determine eligibility. The notice also notified the petitioner that her SOC would increase from $\$ 402.00$ to $\$ 2,309.00$ as of November 1, 2015.

At the outset of the hearing, respondent admitted the petitioner requested a hearing on October 26, 2015 and on December 29, 2015; however, the Department did not take any action on petitioner's hearing request until January 29, 2016. Therefore, the undersigned concludes petitioner timely requested a hearing to challenge the termination of her FAP benefits and the increase of her SOC amount.

Petitioner submitted one exhibit, entered as Petitioner's Exhibit "1". Respondent submitted eight exhibits, entered as Respondent's Exhibits " 1 " through " 8 ".

## FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner (46) received FAP benefits for herself and her son, MN benefits with a SOC for herself and full Medicaid her son, aged 15. Her certification ended on September 30, 2015. Petitioner's son's Medicaid is not the issue. 2. On September 15, 2015, petitioner submitted an on-line application to recertify for FAP and Medicaid Assistance benefits. This was a passive redetermination; therefore, no interview was completed.
2. On September 28, 2015, the respondent sent a pending notice to the petitioner requesting the following:


The following is information about your eligibility.

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

We need the following information by October 08, 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
4. On October 8,2015 , petitioner faxed a verification of employment/loss of income form from $\longrightarrow$ a blank page and a pay check from $\square$ dated September 25, 2015. The respondent reviewed the documents submitted and determined that petitioner was not eligible for FAP benefits as the verification provided was incomplete. On October 16, 2015, the respondent sent a notice to the petitioner informing her that her application, dated September 15, 2015, for FAP benefits was denied because the respondent did not receive all the information necessary to make an eligibility determination.
5. The respondent explained the verification of employment/loss of income form was missing the second page.
6. Petitioner was not aware the second page was not received. Petitioner assumed the respondent received all the pages that were faxed on October 8, 2015. Petitioner presented a fax transmittal sheet that included two pages of the verification of employment/loss of income form and pay check dated September 25, 2015.

FINAL ORDER (Cont.)
16F-00747
16F-02268
PAGE - 4
7. The respondent admitted they erred in not sending the petitioner a new notice to inform her that there was missing information. On March 24, 2016 and on the record, the respondent reused the petitioner's September 15, 2015 application and determined her FAP eligibility. The respondent authorized the petitioner for $\$ 357.00$ FAP benefits, the maximum monthly allotment for a household size of two, beginning October 2015 through March 2016.
8. The respondent also recalculated the petitioner's MN SOC as follows:

9. The respondent included the petitioner's pay check, dated September 17, 2015, for $\$ 100.00$ from and the pay check, dated September 25, 2015, for $\$ 674.00$ from o determine the household's total monthly gross income as $\$ 774.00$.
10. On March 15, 2016, a Notice of Case Action was issued to the petitioner notifying her that she was approved for $\$ 357.00$ FAP benefits for October 2015 through March 2016, the end of her certification period. Additionally, the notice indicated her SOC was reduced from $\$ 2,309.00$ to $\$ 387.00$ beginning March 2016. The respondent explained the petitioner's SOC was corrected to $\$ 387.00$ for October 2015 through March 2016.

FINAL ORDER (Cont.)
16F-00747
16F-02268
PAGE - 5
11. Petitioner confirmed that she received the Notice of Case Action issued on March 15, 2016 and did not dispute the income budgeted on either the FAP or MN 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 $\S 409.285$, Fla. Stat.
13. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code § 65-2.056.

## FOOD ASSISTANCE ISSUE

14. As the respondent failed to notify the petitioner that the information she provided on October 8, 2015 was incomplete, it honored petitioner's September 15, 2015 application and determined her FAP eligibility for the new certification period of October 2015 through March 2016. The respondent issued petitioner $\$ 357.00$ FAP benefits monthly for October 2015 through March 2016.
15. Since petitioner did not have a break in her FAP benefits and received the maximum allotment for a household size of two, there is no adverse action for which the undersigned can grant relief. Therefore, the FAP appeal is dismissed as MOOT.

## MEDICALLY NEEDY ISSUE

16. The Code of Federal Regulations at 42 C.F.R. $\S 435.310$ discuss 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:

FINAL ORDER (Cont.)
16F-00747
16F-02268
PAGE-6
(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 $\S 435.510 \ldots$
17. 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...
(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 $\S 435.814$, the individual or family is eligible for Medicaid...
18. 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 | $\$ 241$ |

19. Pursuant to the above authority, petitioner's $\$ 774.00$ income is more than the $\$ 241.00$ income limit; therefore, she is not eligible for full Medicaid.
20. The Department's Program Policy Manual, Appendix A-7, Family-Related Medicaid Income Limits chart, sets forth the Medically Needy Income Level (MNIL) for a household size of two as $\$ 387.00$. It further indicates that the MNIL "includes the appropriate standard disregard. No additional disregards should be applied to establish a share of cost." The respondent subtracted the $\$ 387.00$ MNIL from $\$ 774.00$ (household income) to arrive at the $\$ 387.00$ SOC for the petitioner.

FINAL ORDER (Cont.)
16F-00747
16F-02268
PAGE-7
21. The undersigned is unable to conclude any better outcome for the petitioner than the Department's SOC calculation. The undersigned agrees with the respondent's action to determine petitioner's MN SOC as \$387.00 effective October 2015.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the FAP appeal (16F-00747) is dismissed as MOOT. The Medicaid appeal (16F-02268) 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 $\qquad$ day of $\qquad$ , 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@myfIfamilies.com

Aug 02, 2016

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


PETITIONER,
Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 66292

## RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on July 7, 2016 at 8:45 a.m. a $\square$

## APPEARANCES

For the petitioner:


For the respondent: Marsha Shearer, ACCESS Economic Self-Sufficiency

## Specialist II

## STATEMENT OF ISSUE

Petitioner is appealing the following:
I. The respondent's action to reduce her Food Assistance Program (FAP) benefits from $\$ 439.00$ to $\$ 194.00$ effective June 2016. Petitioner is seeking a higher amount. The petitioner carries the burden of proof by a preponderance of the evidence.

FINAL ORDER (Cont.)
16F-03649
16F-03650
PAGE-2
II. The respondent's action to terminate the Medicaid benefits for the household. The respondent carries the burden of proof by a preponderance of the evidence.

## PRELIMINARY STATEMENT

By notice dated May 4, 2016, the respondent notified the petitioner that her FAP benefits would decrease from $\$ 439.00$ to $\$ 194.00$ beginning June 2016 due to removing her children as part of her household. On May 10, 2016, the petitioner timely requested a hearing to challenge the respondent's action to remove her children as part of her household, thus causing a decrease in her FAP benefits.

The petitioner is also appealing the termination of Medicaid benefits for her household. The respondent issued a Notice of Case Action to the petitioner on December 3, 2015. Said notice indicated the Medicaid benefits were ending on December 31, 2015. The hearing request (May 10, 2016) was not made within 90 days from the date of the notice at issue. Therefore, the undersigned lacks jurisdiction to review the matter as the request was made outside of the time allowed for a timely hearing request. petitioners' friend appeared to assist and support the petitioner. Petitioner submitted two exhibits, entered as Petitioner's Exhibits "1" and "2". Respondent submitted seven exhibits, entered as Respondent's Exhibits "1" through " 7 ". The record was held open until close of business on July 15, 2016 for submission of additional evidence from the petitioner. No additional evidence was received by the due date from the petitioner; therefore, the record closed on July 15, 2016.

FINAL ORDER (Cont.)
16F-03649
16F-03650
PAGE - 3

## FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner was receiving FAP benefits of $\$ 194.00$ for herself. Her certification period ended on February 29, 2016. On March 29, 2016, the petitioner submitted an on-line application for FAP benefits for her household, which included one child.
2. The petitioner shares custody of her two children with the children's father. During the application process, said child was already active and receiving FAP benefits in the father's FAP case.
3. On March 29, 2016, the petitioner completed a telephone interview. On April 1, 2016, the respondent sent a pending notice to the petitioner requesting school records and a statement indicating the children were residing with the petitioner. Based on the information provided by the petitioner, the respondent removed the children from their father's FAP case and authorized FAP benefits for the petitioner for a household size of three beginning May 2016.
4. The respondent erred in removing the petitioner's children from their father's case. It is unknown why the respondent removed both children and added them to the petitioner's FAP case in May 2016. Once the respondent realized it had erred in removing the children from their father's case, the children were then removed from the petitioner's case and added back to their father's case effective June 2016.
5. Petitioner is disputing the removal of the children from her case. Petitioner argued the children were on her case first since September 2015 and the school records for the children show her residence as the primary address for the children. Therefore, the

FINAL ORDER (Cont.)
16F-03649
16F-03650
PAGE-4
children should remain on her case. Additionally, the petitioner explained she and the children's father have court documents showing 50/50 parenting agreement. The parents have 50/50 timeshare custody.
6. The respondent presented evidence indicating joint custody is only a factor of eligibility for Temporary Cash Assistance (TCA) and Medicaid Assistance Programs. The issue is not TCA.
7. On May 4, 2016, the respondent mailed a notice to the petitioner informing her two children were removed from her FAP case; therefore, reducing her FAP benefits beginning June 2016.

## CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to § 409.285, Fla.

Stat. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.
9. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

## MEDICAID ISSUE

10. Fla. Admin. Code R. 65-2.046 sets a 90-day time-period to request a hearing, as follows:
(1) The appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs. Additionally, in the Food Stamp Program, a household may request a fair hearing at any time within a certification period to dispute its current level of benefits. The time period begins with the date following:
(a) The date on the written notification of the decision on an application.
(b) The date on the written notification of reduction or termination of program benefits.

FINAL ORDER (Cont.)
16F-03649
16F-03650
PAGE - 5
(c) The date of the Department's written notification of denial or a request or other action which aggrieves the petitioner when that denial or action is other than an application decision or a decision to reduce or terminate program benefits.
(2) The time limitation does not apply when the Department fails to send a required notification, fails to take action of a specific request or denies a request without informing the appellant. If the notice is not mailed on the day it is dated, the time period commences on the date it is mailed.
11. According to the above authority, the individual must request a fair hearing within 90 days from the date of the notice sent by the Department. This notice informs the applicant or recipient of the decision on an application, the reduction or termination of program assistance, the denial, or other action that aggrieves the petitioner. In this case, the relevant notice was issued on December 3, 2015 to the address provided by the petitioner. The petitioner requested a hearing on May 10, 2016, which is over the 90-day limit (from the date of the notice) for requesting an appeal.
12. Based on the above authority, the undersigned does not have jurisdiction over this matter.

## FOOD ASSISTANCE ISSUE

13. The Code of Federal Regulations 7 C.F.R. § 273.1 defines household concept and states in relevant part:
(a) General household definition. A household is composed of one of the following individuals or groups of individuals, unless otherwise specified in paragraph (b) of this section:
(b) Special household requirements-(1) Required household combinations. The following individuals who live with others must be considered as customarily purchasing food and preparing meals with the other, even if they do not do so, and thus must be included in the same household, unless otherwise specified.
(ii) A person under 22 years of age who is living with his or her natural or

FINAL ORDER (Cont.)
16F-03649
16F-03650
PAGE-6
adoptive parent(s) or step-parents(s);
14. 7C.F.R. § 273.3(a) defines residency requirements and states, "no individual may participate as a member of more than one household...in any month." [Emphasis added].
15. The Department publishes a Knowledge Bank, which includes questions and answers on policy details not included in the Department's Program Policy Manual, CFOP 165-22. The relevant question and answer from the Department's Knowledge Bank is, "[Question] if parents have joint custody of a child, can the child be included in the food stamp benefits? [Answer] Yes, as long as the other parent is not receiving food stamps for the child."
16. The Department's FAP policy has no rule regarding who can receive FAP benefits for a child whose parents have joint custody; verification of custody or court order in an attempt to verify which parent is the primary caretaker is under the Temporary Cash Assistance (TCA) and Medicaid Assistance Programs Policy.
17. The authorities cited set forth household requirements as well as non-duplication of FAP benefits. The controlling federal regulation is very clear that no individual may be included and receive FAP benefits in more than one household at a time; therefore, the petitioner's children cannot receive FAP benefits in both of the parents' cases. When the petitioner applied on March 29, 2016, the children were already receiving FAP benefits in their father's household; therefore, the children should not have been included in the petitioner's FAP eligibility determination.

FINAL ORDER (Cont.)
16F-03649
16F-03650
PAGE-7
18. Petitioner argued the respondent has erred in removing the children from her FAP benefits since September 2015. On September, October and December 2015, the respondent issued NOCA's informing the petitioner her FAP benefits amounts. These NOCA's issued to the petitioner included her appeal rights to request a hearing to challenge the FAP amount. As the petitioner did not exercise her right to a hearing within 90 days from the date of those notices, the undersigned can only address the NOCA issued on May 4, 2016.
19. Based on the controlling legal authorities, testimony and evidence, the undersigned concludes that the Department's action to remove the petitioner's children from her FAP benefits and reduce the petitioner's FAP benefits effective June 2016 was correct.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Medicaid appeal (16F-03650) is dismissed as non-jurisdictional.

The FAP appeal (16F-03649) is denied and the Department's action is affirmed.

FINAL ORDER (Cont.)
16F-03649
16F-03650
PAGE - 8

## 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 $\qquad$ day of $\qquad$ , 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@myfffamilies.com

Copies Furnished To: $\begin{aligned} & \text { Office of Economic Self Sufficiency }\end{aligned}$

Aug 02, 2016

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


PETITIONER,
Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 66292

## RESPONDENT.

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on July 7, 2016 at 8:45 a.m. a $\square$

## APPEARANCES

For the petitioner:


For the respondent: Marsha Shearer, ACCESS Economic Self-Sufficiency

## Specialist II

## STATEMENT OF ISSUE

Petitioner is appealing the following:
I. The respondent's action to reduce her Food Assistance Program (FAP) benefits from $\$ 439.00$ to $\$ 194.00$ effective June 2016. Petitioner is seeking a higher amount. The petitioner carries the burden of proof by a preponderance of the evidence.

FINAL ORDER (Cont.)
16F-03649
16F-03650
PAGE-2
II. The respondent's action to terminate the Medicaid benefits for the household. The respondent carries the burden of proof by a preponderance of the evidence.

## PRELIMINARY STATEMENT

By notice dated May 4, 2016, the respondent notified the petitioner that her FAP benefits would decrease from $\$ 439.00$ to $\$ 194.00$ beginning June 2016 due to removing her children as part of her household. On May 10, 2016, the petitioner timely requested a hearing to challenge the respondent's action to remove her children as part of her household, thus causing a decrease in her FAP benefits.

The petitioner is also appealing the termination of Medicaid benefits for her household. The respondent issued a Notice of Case Action to the petitioner on December 3, 2015. Said notice indicated the Medicaid benefits were ending on December 31, 2015. The hearing request (May 10, 2016) was not made within 90 days from the date of the notice at issue. Therefore, the undersigned lacks jurisdiction to review the matter as the request was made outside of the time allowed for a timely hearing request. petitioners' friend appeared to assist and support the petitioner. Petitioner submitted two exhibits, entered as Petitioner's Exhibits "1" and "2". Respondent submitted seven exhibits, entered as Respondent's Exhibits "1" through " 7 ". The record was held open until close of business on July 15, 2016 for submission of additional evidence from the petitioner. No additional evidence was received by the due date from the petitioner; therefore, the record closed on July 15, 2016.

FINAL ORDER (Cont.)
16F-03649
16F-03650
PAGE - 3

## FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner was receiving FAP benefits of $\$ 194.00$ for herself. Her certification period ended on February 29, 2016. On March 29, 2016, the petitioner submitted an on-line application for FAP benefits for her household, which included one child.
2. The petitioner shares custody of her two children with the children's father. During the application process, said child was already active and receiving FAP benefits in the father's FAP case.
3. On March 29, 2016, the petitioner completed a telephone interview. On April 1, 2016, the respondent sent a pending notice to the petitioner requesting school records and a statement indicating the children were residing with the petitioner. Based on the information provided by the petitioner, the respondent removed the children from their father's FAP case and authorized FAP benefits for the petitioner for a household size of three beginning May 2016.
4. The respondent erred in removing the petitioner's children from their father's case. It is unknown why the respondent removed both children and added them to the petitioner's FAP case in May 2016. Once the respondent realized it had erred in removing the children from their father's case, the children were then removed from the petitioner's case and added back to their father's case effective June 2016.
5. Petitioner is disputing the removal of the children from her case. Petitioner argued the children were on her case first since September 2015 and the school records for the children show her residence as the primary address for the children. Therefore, the

FINAL ORDER (Cont.)
16F-03649
16F-03650
PAGE-4
children should remain on her case. Additionally, the petitioner explained she and the children's father have court documents showing 50/50 parenting agreement. The parents have 50/50 timeshare custody.
6. The respondent presented evidence indicating joint custody is only a factor of eligibility for Temporary Cash Assistance (TCA) and Medicaid Assistance Programs. The issue is not TCA.
7. On May 4, 2016, the respondent mailed a notice to the petitioner informing her two children were removed from her FAP case; therefore, reducing her FAP benefits beginning June 2016.

## CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to § 409.285, Fla.

Stat. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.
9. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

## MEDICAID ISSUE

10. Fla. Admin. Code R. 65-2.046 sets a 90-day time-period to request a hearing, as follows:
(1) The appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs. Additionally, in the Food Stamp Program, a household may request a fair hearing at any time within a certification period to dispute its current level of benefits. The time period begins with the date following:
(a) The date on the written notification of the decision on an application.
(b) The date on the written notification of reduction or termination of program benefits.

FINAL ORDER (Cont.)
16F-03649
16F-03650
PAGE - 5
(c) The date of the Department's written notification of denial or a request or other action which aggrieves the petitioner when that denial or action is other than an application decision or a decision to reduce or terminate program benefits.
(2) The time limitation does not apply when the Department fails to send a required notification, fails to take action of a specific request or denies a request without informing the appellant. If the notice is not mailed on the day it is dated, the time period commences on the date it is mailed.
11. According to the above authority, the individual must request a fair hearing within 90 days from the date of the notice sent by the Department. This notice informs the applicant or recipient of the decision on an application, the reduction or termination of program assistance, the denial, or other action that aggrieves the petitioner. In this case, the relevant notice was issued on December 3, 2015 to the address provided by the petitioner. The petitioner requested a hearing on May 10, 2016, which is over the 90-day limit (from the date of the notice) for requesting an appeal.
12. Based on the above authority, the undersigned does not have jurisdiction over this matter.

## FOOD ASSISTANCE ISSUE

13. The Code of Federal Regulations 7 C.F.R. § 273.1 defines household concept and states in relevant part:
(a) General household definition. A household is composed of one of the following individuals or groups of individuals, unless otherwise specified in paragraph (b) of this section:
(b) Special household requirements-(1) Required household combinations. The following individuals who live with others must be considered as customarily purchasing food and preparing meals with the other, even if they do not do so, and thus must be included in the same household, unless otherwise specified.
(ii) A person under 22 years of age who is living with his or her natural or

FINAL ORDER (Cont.)
16F-03649
16F-03650
PAGE-6
adoptive parent(s) or step-parents(s);
14. 7C.F.R. § 273.3(a) defines residency requirements and states, "no individual may participate as a member of more than one household...in any month." [Emphasis added].
15. The Department publishes a Knowledge Bank, which includes questions and answers on policy details not included in the Department's Program Policy Manual, CFOP 165-22. The relevant question and answer from the Department's Knowledge Bank is, "[Question] if parents have joint custody of a child, can the child be included in the food stamp benefits? [Answer] Yes, as long as the other parent is not receiving food stamps for the child."
16. The Department's FAP policy has no rule regarding who can receive FAP benefits for a child whose parents have joint custody; verification of custody or court order in an attempt to verify which parent is the primary caretaker is under the Temporary Cash Assistance (TCA) and Medicaid Assistance Programs Policy.
17. The authorities cited set forth household requirements as well as non-duplication of FAP benefits. The controlling federal regulation is very clear that no individual may be included and receive FAP benefits in more than one household at a time; therefore, the petitioner's children cannot receive FAP benefits in both of the parents' cases. When the petitioner applied on March 29, 2016, the children were already receiving FAP benefits in their father's household; therefore, the children should not have been included in the petitioner's FAP eligibility determination.

FINAL ORDER (Cont.)
16F-03649
16F-03650
PAGE-7
18. Petitioner argued the respondent has erred in removing the children from her FAP benefits since September 2015. On September, October and December 2015, the respondent issued NOCA's informing the petitioner her FAP benefits amounts. These NOCA's issued to the petitioner included her appeal rights to request a hearing to challenge the FAP amount. As the petitioner did not exercise her right to a hearing within 90 days from the date of those notices, the undersigned can only address the NOCA issued on May 4, 2016.
19. Based on the controlling legal authorities, testimony and evidence, the undersigned concludes that the Department's action to remove the petitioner's children from her FAP benefits and reduce the petitioner's FAP benefits effective June 2016 was correct.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Medicaid appeal (16F-03650) is dismissed as non-jurisdictional.

The FAP appeal (16F-03649) is denied and the Department's action is affirmed.

FINAL ORDER (Cont.)
16F-03649
16F-03650
PAGE - 8

## 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 $\qquad$ day of $\qquad$ , 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@myfffamilies.com

Copies Furnished To: $\begin{aligned} & \text { Office of Economic Self Sufficiency }\end{aligned}$

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

APPEAL NO. 16F-03651
APPEAL NO. 16F-03652

## CASE NO.

## FLORIDA DEPARTMENT

 OF CHILDREN AND FAMILIES CIRCUIT:UNIT: 883DT

## RESPONDENT.

## FINAL ORDER OF DISMISSAL

Pursuant to notice, the undersigned telephonically convened two administrative hearings in the above-referenced matter on July 1, 2016 at 2:30 p.m.; and on July 27, 2016 at 2:32 p.m. hereafter "petitioner") was present and testified at both hearings. Petitioner submitted no exhibits at the hearings. Respondent was represented by Fred Snedeker, Senior Human Services Program Specialist, with the Office of Public Benefits Integrity Program, Benefit Recovery Unit (hereafter "PBI", "Respondent" or "Agency") at both hearings. Mr. Snedeker testified. At the July 27, 2016 hearing, the respondent submitted two exhibits, which were accepted into evidence and marked as Respondent's Exhibits " 1 " through " 2 ".

The issues under appeal are the respondent's actions to establish a Food Assistance (FA) overpayment claim in the amount of $\$ 9,424$ for the period of March 1, 2011 through August 31, 2012; and to establish a Medicaid overpayment claim in the

FINAL ORDER OF DISMISSAL (Cont.)
16F-03651 \& 16F-03652
PAGE - 2
amount of $\$ 11,930.02$ for the period of March 1, 2011 through September 30, 2012. On July 26,2016 , the respondent submitted void requests to the claims unit for the petitioner's FA and Medicaid overpayment claims. The record was left open to allow the respondent to submit documentation that verified the petitioner's FA and Medicaid overpayment claims were voided. Respondent never submitted the requested documentation.

On August 18, 2016, a Preliminary Order of Dismissal was sent to both parties allowing an opportunity for either party to object to the dismissal. If either party had any objections, these had to be filed no later than ten (10) days from the date of the Preliminary Order of Dismissal.

On August 19, 2016, the respondent emailed the petitioner and the undersigned documentation that verified the petitioner's FA and Medicaid overpayment claims were voided. On August 22, 2016, the petitioner sent an email to the respondent and the undersigned indicating "that everything has been done and I am forever grateful".

To the date of this Order, neither party has submitted a written objection to the undersigned within the allotted timeframe. Instead, both parties submitted documentation that indicated the petitioner's two overpayment claims were voided and that the petitioner was satisfied with the outcome of her overpayment claims. As there were no objections to the dismissal and as the petitioner's Food Assistance and Medicaid overpayment claims have been voided, the appeals are hereby DISMISSED as moot as all issues have been resolved.

FINAL ORDER OF DISMISSAL (Cont.)
16F-03651 \& 16F-03652
PAGE-3

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 30 day of _ Auqust 2016,
in Tallahassee, Florida.


Mary Jane Stafford
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myfIfamilies.com

Copies Furnished To: Petitioner
Office of Economic Self Sufficiency

Aug 16, 2016
STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES OFFICE OF APPEAL HEARINGS


PETITIONER,
Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 88601

## RESPONDENT.

$\qquad$ I

## FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter on June 20, 2016 at 9:45 a.m.

## APPEARANCES

For the petitioner:

For the respondent: Marsha Shearer, ACCESS Economic Self-Sufficiency Specialist II

## STATEMENT OF ISSUE

At issue is whether the respondent's action to deny the petitioner's application and retroactive months for the Medicare Savings Plan (MSP), under the Medicaid Qualifying Individual 1 (QI1) Program was proper. The petitioner carries the burden of proof by a preponderance of the evidence.

FINAL ORDER (Cont.)
16F-03791
16F-03839
PAGE - 2
At issue is also the petitioner's enrollment in the Medically Needy (MN) Program with a share of cost (SOC). The petitioner carries the burden of proof by a preponderance of the evidence.

## PRELIMINARY STATEMENT

By notice dated May 10, 2016, the respondent notified the petitioner that his Medicaid Ql1 application dated April 22, 2016 was denied due to income. Petitioner timely requested an appeal to challenge the denial.

At the outset of the hearing, the petitioner explained he did not request a hearing regarding the MN Program. Therefore, appeal 16F-03791 is dismissed as invalid.

Petitioner did not submit any exhibits. Respondent submitted five exhibits, entered into evidence as Respondent's Exhibits " 1 " through " 5 ".

## FINDINGS OF FACT

1. On April 22, 2016, the petitioner submitted an application for MSP. Petitioner reported his sources of income were Social Security Disability Income (SSDI) and his part-time employment with Kelly Services, Inc.
2. The respondent reviewed the application for April 2016 and three retroactive months (January, February and March 2016). The respondent verified the petitioner's SSDI through the State of Florida on-line query.
3. The on-line query showed petitioner's SSDI amount was $\$ 990.00$. Petitioner submitted to the Department the following paystubs: April 8, 2016 gross pay of $\$ 56.35$, April 15, 2016 gross pay of $\$ 257.61$, April 22, 2016 gross pay of $\$ 267.66$ and April 29,

FINAL ORDER (Cont.)
16F-03791
16F-03839
PAGE-3
2016 gross pay of $\$ 265.65$. The respondent calculated his monthly earned income by adding these paystubs, which totaled $\$ 847.28$.
4. The respondent calculated the countable unearned income as $\$ 970.00$, after a
$\$ 20.00$ unearned income disregard was subtracted. The next step was the calculation of the countable earned income. The respondent calculated the earned income as $\$ 847.28$ and subtracted a $\$ 65.00$ earned income disregard. This totaled $\$ 782.28$, the Department then took $\$ 782.28$ and divided by two, the countable earned income amount was $\$ 391.14$. The respondent calculated the petitioner's total countable income as $\$ 1,361.14(\$ 970.00+\$ 391.14)$.
5. The respondent used the $\$ 1,381.14$ total countable income and calculated the $\mathrm{Q} \mid 1$ budget as follows:

| ABSB | SSI-RELATED MA ELIGIBILITY DETERMINATION |  |
| ---: | :--- | ---: | :--- |

6. The income limit for an individual to qualify for Q11 benefits was $\$ 1,325.00$ prior to

April 2016. The respondent determined that the petitioner's total countable income
$(\$ 1,361.14)$ exceeded the income limit to qualify for Medicaid Q11. However, as of April

FINAL ORDER (Cont.)
16F-03791
16F-03839
PAGE-4
2016, the income limit for an individual to qualify for Q11 benefits changed from
$\$ 1,325.00$ to $\$ 1,335.00$. The petitioner's income continues to exceed the income limit to qualify for the Medicaid Q11 Program.
7. Petitioner's representative explained the petitioner works for a school through and there are months the petitioner does not work due to the school seasonal session ending. Furthermore, the representative explained the petitioner is a teacher aid and believes his earned income should be based on annual pay and divided by a twelve-month period instead of monthly. The representative did not understand how the respondent determined the petitioner's income exceeded the income limit for the retroactive months in question.
8. The respondent explained contracted school employees' income is budgeted over a twelve-month period. Petitioner has no contract because his employment is with an employment agency for temporary assignments. The respondent explained, the petitioner could submit a new application and current paystubs; the respondent would then re-evaluate the petitioner's eligibility.

## CONCLUSIONS OF LAW

9. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to § 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.
10. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 652.056 .

FINAL ORDER (Cont.)
16F-03791
16F-03839
PAGE - 5
11. Section 409.904 , Fla. Stat., Optional payments for eligible persons addresses who qualifies for this Program and states in part:

The agency may make payments for medical assistance and related services on behalf of the following persons who are determined to be eligible subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.
(1) Subject to federal waiver approval, a person who is age 65 or older or is determined to be disabled, whose income is at or below 88 percent of the federal poverty level, whose assets do not exceed established limitations, and who is not eligible for Medicare or, if eligible for Medicare, is also eligible for and receiving Medicaid-covered institutional care services, hospice services, or home and community-based services. The agency shall seek federal authorization through a waiver to provide this coverage.
12. The above authority sets forth that the SSI-Related Medicaid Program provides medical assistance to those who are aged or disabled according to the Social Security

Act. Petitioner met the disability criteria; the next step is to determine income eligibility.
13. Fla. Admin. Code R. 65 A-1.702, Medicaid Special Provisions, in relevant part
states:
(9) Retroactive Medicaid. Retroactive Medicaid is based on an approved, denied, or pending application for ongoing Medicaid benefits.
(a) Retroactive Medicaid eligibility is effective no later than the third month prior to the month of application for ongoing Medicaid if the individual would have been eligible for Medicaid at the time of application for Medicaid covered services. (emphasis added) A request for retroactive Medicaid can be made for a deceased individual by a designated representative or caretaker relative filing an application for Medicaid assistance. The individual or his or her representative has up to 12 months after the date of application for ongoing Medicaid to request retroactive Medicaid eligibility. However, Qualified Medicare Beneficiaries (QMB's) are not eligible for retroactive Medicaid benefits under the QMB coverage group as indicated in 42 U.S.C. § 1396a(e)(8).

FINAL ORDER (Cont.)
16F-03791
16F-03839
PAGE-6
(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 (Ql1). Under Ql1 coverage, individuals are only entitled to payment of their Medicare Part B premium (This is coverage for individuals who would be eligible for QMB or SLMB coverage except their income exceeds limits for those programs.)
14. The Department of Children and Families published Transmittal No. P-15-09-0008
on September 15, 2015 relating to "Teacher and Contracted School Employee Income," it states in part:

This memorandum provides a policy change on how to budget income for teachers and other contracted school employees. This is a result of a clarification from the Food and Nutrition Service. This policy change applies to the Food Assistance, Temporary Cash Assistance and Medicaid programs.
Policy Change
The income for teachers and other contracted school employees is intended to cover a yearly period. Annual income received by contracted school employees, including teachers, must be budgeted over the 12month period.
15. Fla. Admin. Code R 65A-1.713(1) further addresses the "SSI-Related Medicaid

Income Eligibility Criteria" and explains:
(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
(j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. Q11 is eligible only for payment of the Part B Medicare premium through Medicaid.

FINAL ORDER (Cont.)
16F-03791
16F-03839
PAGE-7
16. Federal regulation at 42 C.F.R. § 435.631, General requirements for determining income eligibility in States using more restrictive requirements for Medicaid than SSI, states in part:
(a) Income eligibility methods. In determining income eligibility of aged, blind, and disabled individuals in a State using more restrictive eligibility requirements than SSI, the agency must use the methods for treating income elected under $\S \S 435.121$ and 435.230 , under $\S 435.601$. The methods used must be comparable for all individuals within each category of individuals under $\S 435.121$ and each category of individuals within each optional categorically needy group included under $\S 435.230$ and for each category of individuals under the medically needy option described under §435.800.
17. The above authorities explain that an individual must have income that is within the income limits established by federal and state laws as well as the Medicaid State Plan. The Medicare Buy-in Programs under Medicaid are QMB, SLMB and QI1. An individual must have income greater than $120 \%$ of the federal poverty level but equal to or less than $135 \%$ of the federal poverty level to be eligible for Qualifying Individual (Q|1). It only covers payment of the Part B Medicare premium through Medicaid.
18. The above-cited regulations also explain that the QI1 Program can provide state Buy-in benefits for people with income at higher levels than the other programs.
19. On April 2016, the Department's Program Policy Manual (Policy Manual),

Appendix A-9, set the Medicaid QI1 individual maximum income limit as $\$ 1,335.00$ :

Eligibility Standards for SSI-Related Programs - April 2016

| Coverage Group | Income Limit | Asset Limit |
| :--- | :--- | :--- |
| Supplemental Security Income (SSI) Individual |  |  |
| Supplemental Security Income (SSI) Couple | $\$ 733$ | $\$ 2,000$ |
| ICP/HCBS/Hospice/HCDA Individual | $\$ 1,100$ | $\$ 3,000$ |
| ICP/HCBS/Hospice/HCDA Couple | $\$ 2,199$ | $\$ 2,000$ |
| MEDS-AD/ICP-MEDS/Individual (88\% FPL) | $\$ 4,398$ | $\$ 3,000$ |
| MEDS-AD/ICP-MEDS/Couple | $\$ 872$ | $\$ 5,000$ |
| QMB Individual (100\% FPL) | $\$ 1,175$ | $\$ 6,000$ |
| QMB Couple | $\$ 990$ | $\$ 7,280$ |
| SLMB Individual (100-120\% FPL) | $\$ 1,335$ | $\$ 10,930$ |
| SLMB Couple | $\$ 1,188$ | $\$ 7,280$ |
| QI1 Individual (120-135\% FPL) | $\$ 1,602$ | $\$ 10,930$ |
| QI1 Couple | $\$ 1,337$ | $\$ 7,280$ |

20. These income standards change each year in accordance with federal law. It is unknown why the respondent determined the income limit for Q11 for an individual to be $\$ 1,325.00$ for April 2016. In comparing the household's income of $\$ 1,361.14$ and the correct Q11 income limit for an individual of $\$ 1,335.00$, the petitioner continued to exceed the $\$ 1,335.00$ Medicaid Ql1 income limit. Retroactive months for Medicaid Ql1 were denied because the petitioner was not found eligible in the month of his application (April 2016) due to his income exceeding the Medicaid Q11 income limit.
21. 20 C.F.R. $\S 416.1124(\mathrm{c})(12)$ establishes a $\$ 20$ disregard for "the first $\$ 20$ of any unearned income in a month" and unearned income can be reduced by that amount. Respondent deducted the $\$ 20$ unearned income disregard from the petitioner's $\$ 990.00$ SSDI. Petitioner's countable unearned income was $\$ 970.00$.
22. 20 C.F.R. § $416.1112(\mathrm{c})(5)(7)$ establishes "earned income we do not count. We do not count as earned income; $\$ 65$ of earned income in a month and one-half of remaining earned income in a month." After the \$65 earned income disregard (\$847.28

FINAL ORDER (Cont.)
16F-03791
16F-03839
PAGE-9

- \$65.00), the remaining balance was $\$ 782.28$. One-half of $\$ 782.28$ was $\$ 391.14$ ( $\$ 782.28$ divided by 2 ), the petitioner's countable earned income. Petitioner's total countable income of $\$ 1,361.14(\$ 970.00+\$ 391.14)$ exceeded the $\$ 1,335.00$ Medicaid QI1 income limit.

23. After careful review of the cited authorities and evidence, the undersigned concludes the respondent followed rule in denying the petitioner's April 22, 2016 application for Medicaid Q11 benefits due to his total countable income exceeding the income limit for the Program.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, appeal 16F03839 regarding the Medicaid Q11 Program is denied and the Department's action is affirmed.

Appeal 16F-03791 regarding the MN Program is dismissed as invalid.

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this $\qquad$ 16 day of $\qquad$ , 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:<br>Petitioner<br>Office of Economic Self Sufficiency

Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
CIRCUIT: 08 Bradford
UNIT: 88369
RESPONDENT.
CASE NO

## FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on July 26, 2016 at 11:37 a.m.

## APPEARANCES

For the Petitioner:
For the Respondent: Ernestine Bethune, Economic Self-Sufficiency Specialist II

## STATEMENT OF ISSUE

Petitioner is appealing the Department's action of June 7, 2016 decreasing his Food Assistance benefit, increasing his Medically Needy Share of Cost, closing his Special Low-Income Medicare Part B Medicaid (SLMB) and opening Qualifying Individuals 1 (QI 1). The petitioner carries the burden of proof by the preponderance of evidence.

FINAL ORDER (Cont.)
16F-04836, 16F-05591 and 16F-05592
PAGE - 2

## PRELIMINARY STATEMENT

The Department submitted evidence prior to the hearing that was entered as Respondent Exhibit 1. The record was held open through August 3, 2016 to allow the petitioner to provide additional information to the Department and the Department to review and provide updates to the Office of Appeal Hearings.

The Department submitted additional information on July 29, 2016. This was entered as Respondent Exhibit 2. The petitioner made no submission directly to the Office of Appeal Hearings while the record remained open.

The record closed on August 3, 2016.

## FINDINGS OF FACT

1. The petitioner filed an application for recertification on May 3, 2016. The household consists of the petitioner and his wife.
2. The petitioner is age 62 and disabled. His wife is age 59 and not disabled.
3. The petitioner receives Social Security Disability in the amount of $\$ 1,086$ per month.

4. The petitioner does not believe his tax return is an accurate record of the income and expenses. He stated this was the first time he has ever been requested to submit his business tax return.

FINAL ORDER (Cont.)
16F-04836, 16F-05591 and 16F-05592
PAGE - 3
6. The petitioner pays quarterly income tax based off a $\$ 2,000$ salary for the year. However, she does not receive that salary; it is just how they set up to pay so she could receive Social Security when she retires.
7. The petitioner explained he did not show the full amount of expenses on his tax return this year so that the business would show a small profit and he could avoid a possible audit by the Internal Revenue Service.
8. During the recertification, the Department included the gross sales as gross income earned by the business. Annual gross sales were $\$ 17,756$. The Department divided this amount by 12 to reach a monthly amount of $\$ 1,479.67$.
9. In the recertification, the Department allowed the following expenses listed in monthly amounts: IP or Insurance for the Business of \$52.08; IR or IRS Allowable Business Expense of $\$ 28.25$; BP or Business Phone Expense of $\$ 58.58$; OM or "Oper. Motor Vehicle for Bus" of $\$ 57.25$; OS or Office Supplies of $\$ 21.42$; and UT or Utilities of \$82.17. These expenses total $\$ 299.75$
10. During the recertification process, the Department calculated the gross earnings after expenses at $\$ 1,179.92$ ( $\$ 1,479.67-\$ 299.75=\$ 1,179.92$ ).
11. During the review of the case post hearing, the Department included the gross sales as gross income earned by the business. Annual gross sales were $\$ 17,756$. The Department divided this amount by 12 to reach a monthly amount of \$1,479.67.
12. In the review of the case, the Department continued to include the expenses listed in paragraph 9 above. The Department also added the following expenses in monthly amounts: AD or Advertising of $\$ 60.40$; BL or Business License of

FINAL ORDER (Cont.)
16F-04836, 16F-05591 and 16F-05592
PAGE - 4
\$59.58; and RP or "Repairs/Maint. Bus. Prop" of \$17.50. The addition of these expenses bring the total expense amount to \$437.23 (\$299.75 + \$60.40 + \$59.58 + \$17.50 = \$437.23).
13. During the review of the case, the Department calculated the gross earnings after expenses at $\$ 1,042.44(\$ 1,479.67-\$ 437.23=\$ 1,042.44)$.
14. The undersigned did not receive profit/loss statements from the petitioner to review in comparison to the tax return submitted.
15. The petitioner has reported medical expenses included in the budget of \$110.66.
16. The Department submitted the Food Assistance budget calculations post hearing based on the updates from the review. (Respondent 2, page 30)
17. The petitioner did not understand why his Special Low-Income Medicare Beneficiary Medicaid (SLMB) ended. He believe the Department would no longer pay his Medicare premium.
18. The Department explained that due to the change in income budgeted, the petitioner moved from the SLMB program to Qualifying Individuals 1 (QI1). The Department further explained both programs pay for the Medicare part B premium. The difference between the two programs is the income standard for QI 1 is higher than for SLMB.

## CONCLUSIONS OF LAW

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

FINAL ORDER (Cont.)
16F-04836, 16F-05591 and 16F-05592
PAGE-5
Section 409.285, Florida Statutes. This order is the final administrative decision of the
Department of Children and Families under Section 409.285, Florida Statutes.
20. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R.

65-2.056.

## FOOD ASSISTANCE

21. Federal Food Assistance Regulations at 7 C.F.R. § 273.9 "Income and

Deductions states in relevant part:
(b) Definition of income. Household income shall mean all income from whatever source excluding only items specified in paragraph (c) of this section.
(1) Earned income shall include: (i) All wages and salaries of an employee.
(ii) The gross income from a self-employment enterprise, including the total gain from the sale of any capital goods or equipment related to the business, excluding the costs of doing business as provided in paragraph (c) of this section. Ownership of rental property shall be considered a selfemployment enterprise; however, income derived from the rental property shall be considered earned income only if a member of the household is actively engaged in the management of the property at least an average of 20 hours a week. Payments from a roomer or boarder, except foster care boarders, shall also be considered self-employment income.
(2) Unearned income shall include, but not be limited to:
(ii) Annuities; pensions; retirement, veteran's, or disability benefits; worker's or unemployment compensation including any amounts deducted to repay claims for intentional program violations as provided in §272.12; old-age, survivors, or social security benefits; strike benefits; foster care payments for children or adults who are considered members of the household; gross income minus the cost of doing business derived from rental property in which a household member is not actively engaged in the management of the property at least 20 hours a week.
22. The findings show the petitioner has income from self-employment. The findings also show the petitioner has income from Social Security income of $\$ 1,086$.

FINAL ORDER (Cont.)
16F-04836, 16F-05591 and 16F-05592
PAGE - 6
The undersigned concludes the Department correctly included both incomes in determination of eligibility.
23. 7 C.F.R. § 273.11 "Action on households with special circumstances"
states in relevant part:
(a) Self-employment income. The State agency must calculate a household's self-employment income as follows:
(1) Averaging self-employment income. (i) Self-employment income must be averaged over the period the income is intended to cover, even if the household receives income from other sources. If the averaged amount does not accurately reflect the household's actual circumstances because the household has experienced a substantial increase or decrease in business, the State agency must calculate the self-employment income on the basis of anticipated, not prior, earnings.
(2) Determining monthly income from self-employment. (i) For the period of time over which self-employment income is determined, the State agency must add all gross self-employment income (either actual or anticipated, as provided in paragraph (a)(1)(i) of this section) and capital gains (according to paragraph (a)(3) of this section), exclude the costs of producing the self-employment income (as determined in paragraph (a)(4) of this section), and divide the remaining amount of self-employment income by the number of months over which the income will be averaged. This amount is the monthly net self-employment income. The monthly net self-employment income must be added to any other earned income received by the household to determine total monthly earned income.
(3) Capital gains. The proceeds from the sale of capital goods or equipment must be calculated in the same manner as a capital gain for Federal income tax purposes. Even if only 50 percent of the proceeds from the sale of capital goods or equipment is taxed for Federal income tax purposes, the State agency must count the full amount of the capital gain as income for SNAP purposes. For households whose selfemployment income is calculated on an anticipated (rather than averaged) basis in accordance with paragraph (a)(1) of this section, the State agency must count the amount of capital gains the household anticipates receiving during the months over which the income is being averaged. (b) Allowable costs of producing self-employment income. (1) Allowable costs of producing self-employment income include, but are not limited to, the identifiable costs of labor; stock; raw material; seed and fertilizer; payments on the principal of the purchase price of income-producing real estate and capital assets, equipment, machinery, and other durable

FINAL ORDER (Cont.)
16F-04836, 16F-05591 and 16F-05592
PAGE - 7
goods; interest paid to purchase income-producing property; insurance premiums; and taxes paid on income-producing property.
(2) In determining net self-employment income, the following items are not allowable costs of doing business:
(i) Net losses from previous periods;
(ii) Federal, State, and local income taxes, money set aside for retirement purposes, and other work-related personal expenses (such as transportation to and from work), as these expenses are accounted for by the $\mathbf{2 0}$ percent earned income deduction specified in §273.9(d)(2);
(iii) Depreciation;
(emphasis added)
24. The findings show upon review of the petitioner's self-employment income of $\$ 1,479.67$ and allowable expenses, which total $\$ 437.23$, the petitioner's selfemployment income gross monthly income, is $\$ 1,042.44$. The petitioner did not submit any documentation to dispute the calculated income to the hearing officer. The undersigned cannot find a more favorable outcome.
25. The undersigned concludes the household's total income is $\$ 2,128.44$ (\$1,086 + \$1,042.44).
26. 7C.F.R. § 273.9 "Income and Deductions states in relevant part:
(d) Income deductions. Deductions shall be allowed only for the following household expenses:
(1) Standard deduction-
(2) Earned income deduction. Twenty percent of gross earned income as defined in paragraph (b)(1) of this section. Earnings excluded in paragraph (c) of this section shall not be included in gross earned income for purposes of computing the earned income deduction, except that the State agency must count any earnings used to pay child support that were excluded from the household's income in accordance with the child support exclusion in paragraph (c)(17) of this section.
(3) Excess medical deduction. That portion of medical expenses in excess of $\$ 35$ per month, excluding special diets, incurred by any household member who is elderly or disabled as defined in §271.2. Spouses or other persons receiving benefits as a dependent of the SSI or disability and

FINAL ORDER (Cont.)
16F-04836, 16F-05591 and 16F-05592
PAGE - 8
blindness recipient are not eligible to receive this deduction but persons receiving emergency SSI benefits based on presumptive eligibility are eligible for this deduction.
(6) Shelter costs...
(ii) Excess shelter deduction. Monthly shelter expenses in excess of 50 percent of the household's income after all other deductions in paragraphs (d)(1) through (d)(5) of this section have been allowed. If the household does not contain an elderly or disabled member, as defined in §271.2 of this chapter, the shelter deduction cannot exceed the maximum shelter deduction limit established for the area. For fiscal year 2001, effective March 1, 2001, the maximum monthly excess shelter expense deduction limits are $\$ 340$ for the 48 contiguous States and the District of Columbia, $\$ 543$ for Alaska, $\$ 458$ for Hawaii, $\$ 399$ for Guam, and $\$ 268$ for the Virgin Islands. FNS will set the maximum monthly excess shelter expense deduction limits for fiscal year 2002 and future years by adjusting the previous year's limits to reflect changes in the shelter component and the fuels and utilities component of the Consumer Price Index for All Urban Consumers for the 12 month period ending the previous November 30.
(A) Continuing charges for the shelter occupied by the household, including rent, mortgage, condo and association fees, or other continuing charges leading to the ownership of the shelter such as loan repayments for the purchase of a mobile home, including interest on such payments. (B) Property taxes, State and local assessments, and insurance on the structure itself, but not separate costs for insuring furniture or personal belongings.
(iii) Standard utility allowances. (A) With FNS approval, a State agency may develop the following standard utility allowances (standards) to be used in place of actual costs in determining a household's excess shelter deduction: an individual standard for each type of utility expense; a standard utility allowance for all utilities that includes heating or cooling costs (HCSUA);
27. 7C.F.R. § 273.10 "Determining Eligibility and Benefit Levels" states in
relevant part:
(e) Calculating net income and benefit levels-(1) Net monthly income. (i) To determine a household's net monthly income, the State agency shall:
(A) Add the gross monthly income earned by all household members and the total monthly unearned income of all household members, minus income exclusions, to determine the household's total gross income. Net

FINAL ORDER (Cont.)
16F-04836, 16F-05591 and 16F-05592
PAGE - 9
losses from the self-employment income of a farmer shall be offset in accordance with §273.11(a)(2)(iii).
(B) Multiply the total gross monthly earned income by 20 percent and subtract that amount from the total gross income; or multiply the total gross monthly earned income by 80 percent and add that to the total monthly unearned income, minus income exclusions....
(C) Subtract the standard deduction.
(D) If the household is entitled to an excess medical deduction as provided in $\S 273.9$ (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 $(e)(1)(\mathrm{i})(\mathrm{G})$ of this section. Subtract from total shelter costs 50 percent of the household's monthly income after all the above deductions have been subtracted. The remaining amount, if any, is the excess shelter cost. If there is no excess shelter cost, the net monthly income has been determined. If there is excess shelter cost, compute the shelter deduction according to paragraph $(e)(1)(i)(I)$ of this section.
(I) Subtract the excess shelter cost up to the maximum amount allowed for the area (unless the household is entitled to the full amount of its excess shelter expenses) from the household's monthly income after all other applicable deductions. Households not subject to a capped shelter expense shall have the full amount exceeding 50 percent of their net income subtracted. The household's net monthly income has been determined.
(ii) In calculating net monthly income, the State agency shall use one of the following two procedures:
(A) Round down each income and allotment calculation that ends in 1 through 49 cents and round up each calculation that ends in 50 through 99 cents; or
(B) Apply the rounding procedure that is currently in effect for the State's Temporary Assistance for Needy Families (TANF) program. If the State TANF program includes the cents in income calculations, the State agency may use the same procedures for food stamp income calculations. Whichever procedure is used, the State agency may elect to include the cents associated with each individual shelter cost in the computation of the shelter deduction and round the final shelter deduction amount. Likewise, the State agency may elect to include the cents associated with each individual medical cost in the computation of the medical deduction and round the final medical deduction amount.
(2) Eligibility and benefits. (i)(A) Households which contain an elderly or disabled member as defined in §271.2, shall have their net income, as calculated in paragraph (e)(1) of this section (except for households considered destitute in accordance with paragraph (e)(3) of this section),

FINAL ORDER (Cont.)
16F-04836, 16F-05591 and 16F-05592
PAGE-10
compared to the monthly income eligibility standards defined in §273.9(a)(2) for the appropriate household size to determine eligibility for the month.
(B) In addition to meeting the net income eligibility standards, households which do not contain an elderly or disabled member shall have their gross income, as calculated in accordance with paragraph (e)(1)(i)(A) of this section, compared to the gross monthly income standards defined in §273.9(a)(1) for the appropriate household size to determine eligibility for the month.
(C) For households considered destitute in accordance with paragraph (e)(3) of this section, the State agency shall determine a household's eligibility by computing its gross and net income according to paragraph (e)(3) of this section, and comparing, as appropriate, the gross and/or net income to the corresponding income eligibility standard in accordance with §273.9(a) (1) or (2).
(D) If a household contains a member who is fifty-nine years old on the date of application, but who will become sixty before the end of the month of application, the State agency shall determine the household's eligibility in accordance with paragraph (e)(2)(i)(A) of this section.
(E) If a household contains a student whose income is excluded in accordance with $\S 273.9(c)(7)$ and the student becomes 18 during the month of application, the State agency shall exclude the student's earnings in the month of application and count the student's earnings in the following month. If the student becomes 18 during the certification period, the student's income shall be excluded until the month following the month in which the student turns 18.
(ii)(A) Except as provided in paragraphs (a)(1), (e)(2)(iii) and (e)(2)(vi) of this section, the household's monthly allotment shall be equal to the maximum food stamp allotment for the household's size reduced by 30 percent of the household's net monthly income as calculated in paragraph (e)(1) of this section. If 30 percent of the household's net income ends in cents, the State agency shall round in one of the following ways:
(1) The State agency shall round the 30 percent of net income up to the nearest higher dollar; or
(2) The State agency shall not round the 30 percent of net income at all. Instead, after subtracting the 30 percent of net income from the appropriate Thrifty Food Plan, the State agency shall round the allotment down to the nearest lower dollar.
(B) If the calculation of benefits in accordance with paragraph (e)(2)(ii)(A) of this section for an initial month would yield an allotment of less than \$10 for the household, no benefits shall be issued to the household for the initial month.
(C) Except during an initial month, all eligible one- and two-person households shall receive minimum monthly allotments equal to the minimum benefit and all eligible households with three or more members

FINAL ORDER (Cont.)
16F-04836, 16F-05591 and 16F-05592
PAGE-11
which are entitled to $\$ 1, \$ 3$, and $\$ 5$ allotments shall receive allotments, of $\$ 2$, \$4, and \$6, respectively, to correspond with current coupon book determinations.
28. The Department's Program Policy Manual, CFOP 165-22, Appendix A-1
"Food Assistance Income Eligibility Standards and Deductions" effective October 1,
2015 lists the following income limits and standards for a household size of two:
Monthly $200 \%$ Gross Income Limit is $\mathbf{\$ 2 , 6 5 5}$. Monthly $\mathbf{1 0 0 \%}$ Net Income Limit is
$\$ 1,328$. The Standard Deduction is $\$ 155$. The Standard Utility Allowance is $\$ 345$.
Effective October 1, 2014 the Maximum Benefit amount for a two-person household is
$\$ 357$. The Minimum Allotment for a one or two member household is $\$ 16$.
29. The Department's Policy Transmittal C-13-10-0007 "Food Assistance

Minimum Benefit" dated October 11, 2013 states in relevant part:
The AG is eligible for the minimum monthly food assistance benefit allotment if the assistance group meets all regular eligibility requirements and:

- The AG has income less than or equal to the $\mathbf{2 0 0 \%}$ gross income limit or
- The AG contains an elderly or disabled member and does not pass the $200 \%$ gross income test but does have income less than or equal to the $100 \%$ of the net income limit or
- The AG contains an individual disqualified for an intentional program violation, felony drug trafficking, fleeing felon, or serving an employment and training sanction and has income less than or equal to the $130 \%$ gross and the $100 \%$ net income limits.

30. The findings show the petitioner is disabled. The petitioner has reported medical expenses of $\$ 110.66$. The petitioner has not verified any additional expenses. The above controlling authorities explain the amount of medical expenses exceeding $\$ 35$ is allowed as an excess medical expense. The petitioner's medical expenses of \$110.66 less $\$ 35$ leaves an excess medical expense of $\$ 75.66$.

FINAL ORDER (Cont.)
16F-04836, 16F-05591 and 16F-05592
PAGE-12
31. The undersigned reviewed the Food Assistance benefit calculations as follows: The household's monthly gross earned income $\$ 1,042.44$ multiplied by 20 percent equals the earned income disregard of $\$ 208.48$. The household's total income of $\$ 2,128.44$ less the earned income disregard of $\$ 208.48$ and the standard deduction of $\$ 155$ and the excess medical expense of $\$ 75.66$ leaves an adjusted income of $\$ 1,689.30$. The adjusted income of $\$ 1,689.30$ multiplied by 50 percent gives a shelter standard of $\$ 844.65$. The petitioner's shelter costs are reported at $\$ 129.21$. The petitioner was given the Standard Utility Allowance (SUA) as he has the ability to heat and cool his home. The shelter cost of $\$ 129.21$ added to the SUA of $\$ 345$ totals $\$ 474.21$. As the shelter standard of $\$ 844.65$ exceeds the total of the shelter and utility costs of $\$ 474.21$, the undersigned concludes there is no deduction for excess shelter expense. The adjusted net income is the same as the adjusted income or $\$ 1,689.30$. The undersigned concludes the petitioner's adjusted net income exceeds the net income allowance of $\$ 1,328$.
32. The adjusted net income of $\$ 1,689.30$ was multiplied by 30 percent to reach the benefit reduction amount of $\$ 507$. The maximum monthly allotment of Food Assistance benefits is $\$ 357$. As the benefit reduction amount of $\$ 507$ exceeds the maximum monthly allotment of $\$ 357$, the petitioner is not eligible for Food Assistance. The undersigned concludes as the petitioner's household is a two-person household, the above controlling authority allows the petitioner to receive the minimum allotment for a one or two-person household which is $\$ 16$. The undersigned can find no more favorable outcome.

ADULT RELATED MEDICALLY NEEDY AND MEDICARE BUY-IN PROGRAMS

FINAL ORDER (Cont.)
16F-04836, 16F-05591 and 16F-05592
PAGE - 13
33. Fla. Admin. Code R. 65A-1.702 "Special Provisions states in part:
(12) Limits of Coverage.
(a) Qualified Medicare Beneficiary (QMB). Under QMB coverage, individuals are entitled only to Medicare cost-sharing benefits, including payment of Medicare premiums.
(b) Special Low-Income Medicare Beneficiary (SLMB). Under SLMB coverage, individuals are entitled only to payment of the Part B Medicare premium. If eligible, AHCA shall pay the premium for up to three months retroactive to the month of application.
(d) Part B Medicare Only Beneficiary (QI1). Under QI1 coverage, individuals are only entitled to payment of their Medicare Part B premium. (This is coverage for individuals who would be eligible for QMB or SLMB coverage except their income exceeds limits for those programs.)
34. Fla. Admin. Code R. 65A-1.713 "SSI-Related Medicaid Income Eligibility

Criteria" states in relevant part:
(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
(b) For QMB, income must be less than or equal to the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.
(g) For SLMB, income must be greater than 100 percent of the federal poverty level but equal to or less than 120 percent of the federal poverty level.
(h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses.
(j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. Ql1 is eligible only for payment of the Part B Medicare premium through Medicaid.
35. 20 C.F.R. § 416.1121 "Types of unearned income" states in relevant part:
"(a) Annuities, pensions, and other periodic payments. This unearned income is usually
related to prior work or service. It includes, for example, private pensions, social security

FINAL ORDER (Cont.)
16F-04836, 16F-05591 and 16F-05592
PAGE - 14
benefits, disability benefits, veterans benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits."
36. 20 C.F.R. § 416.1124 "Unearned income we do not count" states in relevant part:
(c) Other unearned income we do not count. We do not count as unearned income-
(12) The first $\$ 20$ of any unearned income in a month other than income in the form of in-kind support and maintenance received in the household of another (see §416.1131) and income based on need. Income based on need is a benefit that uses financial need as measured by your income as a factor to determine your eligibility.
37. The findings show the petitioner has $\$ 1,086$ in social security benefits.

The above controlling authority requires $\$ 20$ of this income be disregarded. The undersigned concludes only $\$ 1,066$ of the petitioner's social security is countable in his eligibility determination for Medically Needy and Medicare Buy-In.
38. Federal Regulations at 20 C.F.R. § 416.1111 "How we count earned income" states in relevant part:
(b) Net earnings from self-employment. We count net earnings from selfemployment on a taxable year basis. However, we divide the total of these earnings equally among the months in the taxable year to get your earnings for each month. For example, if your net earnings for a taxable year are $\$ 2,400$, we consider that you received $\$ 200$ in each month. If you have net losses from self-employment, we divide them over the taxable year in the same way, and we deduct them only from your other earned income.
39. The findings show upon review of the petitioner's self-employment income of $\$ 1,479.67$ and allowable expenses which total $\$ 437.23$, the petitioner's selfemployment income gross monthly income is $\$ 1,042.44$.

FINAL ORDER (Cont.)
16F-04836, 16F-05591 and 16F-05592
PAGE-15
40. 20 C.F.R. § 416.1112 "Earned income we do not count" states in relevant part:
(c) Other earned income we do not count. We do not count as earned income-
(1) Any refund of Federal income taxes you receive under section 32 of the Internal Revenue Code (relating to earned income tax credit) and any payment you receive from an employer under section 3507 of the Internal Revenue Code (relating to advance payment of earned income tax credit);
(4) Any portion of the $\$ 20$ monthly exclusion in §416.1124(c)(10) which has not been excluded from your unearned income in that same month; (5) $\$ 65$ of earned income in a month;
(7) One-half of remaining earned income in a month;
41. The above controlling authority requires that the gross monthly selfemployment income of $\$ 1,042.44$ have the following deductions applied. The undersigned notes the $\$ 20$ exclusion was used completely on the unearned income. The self-employment income of $\$ 1,042.44$ less $\$ 65$ earned income disregard is $\$ 977.44$. One-half of the remaining self-employment income of $\$ 977.44$ is disregarded as well ( $\$ 977.44 / 2=\$ 488.72$ ). The undersigned concludes the countable earned income after all disregards is $\$ 488.72$.
42. The undersigned concludes the unearned income of $\$ 1,066$ added to the self-employment income of $\$ 488.72$ equals a total countable income of $\$ 1,554.72$.
43. The Department's Program Policy Manual, CFOP 165-22, Appendix A-9 effective April 1, 2016 lists the income limit for a couple to receive QMB as $\$ 1,335$, SLMB as $\$ 1,602$ and Q11 as $\$ 1,803$.

FINAL ORDER (Cont.)
16F-04836, 16F-05591 and 16F-05592
PAGE - 16
44. Fla. Admin. Code R. 65A-1.716 "Income and Resource Criteria" (2) lists the Medicaid income and payment eligibility standards and Medically Needy income level for a household size of two as $\$ 241$.
45. The undersigned concludes the petitioner's countable income of $\$ 1,554.72$ is less than the income standard for the petitioner to receive SLMB. The undersigned notes the Department has already corrected the petitioner's case to be eligible for SLMB rather than QI 1. The undersigned notes there was no loss of program benefits in the instant case as the QI 1 program also pays the Medicare Part B premium.
46. The petitioner's countable income of $\$ 1,554.72$ less the Medically Needy Income level of $\$ 241$ leaves a share of cost of $\$ 1,313$. The undersigned notes the Department also corrected the case to reflect the correct share of cost. The undersigned can find no more favorable outcome.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied. The Department's actions are affirmed.

## NOTICE OF RIGHT TO APPEAL

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

FINAL ORDER (Cont.)
16F-04836, 16F-05591 and 16F-05592
PAGE-17
DONE and ORDERED this $\qquad$ 31 day of $\qquad$ Auqust 2016, in Tallahassee, Florida.

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: Petitioner
Office of Economic Self Sufficiency

Apr 08, 2016
STATE OF FLORIDA


PETITIONER,
Vs

RESPONDENT.

## FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned on March 22, 2016, at 9:02 a.m. at $\square$

## APPEARANCES

For the Petitioner:
For the Respondent:


## ISSUE

At issue is the facility's intent to discharge the petitioner because the "safety of the other individuals in the facility is endangered." 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 $\S 400.0255$, Fla. Stat.

FINAL ORDER (Cont.)
16N-00002
PAGE -2

## PRELIMINARY STATEMENT

At the hearing, the respondent presented one exhibit which was entered into evidence and marked as Respondent's Composite Exhibit 1. The petitioner presented one exhibit which was entered into evidence and marked as Petitioner's Composite Exhibit 1.

A letter dated February 10, 2016, from the Agency for Health Care Administration (AHCA) was sent to the undersigned. It stated that a representative from AHCA completed an unannounced visit ai of Life on February 1, 2016 and did not find the facility in violation. This was entered into evidence and marked as Hearing Officer Exhibit 1.

Also present for the petitioner was manager.

Also present for the respondent

## FINDINGS OF FACT

1. The petitioner was admitted to the respondent's nursing facility on June 11, 2004. At the time of admission, there was no smoking policy.
2. On May 30, 2014, the nursing facility introduced a smoking policy and began implementing it. The facility held monthly meetings to educate the residents about its smoking policy. The petitioner was given a copy of the facility's smoking policy. The facility's smoking policy stated that staff must maintain all smoking materials (e.g. cigarettes, pipes, lighters etc.) for residents who smoke. Residents are prohibited from possessing cigarettes and lighters on their person or in their rooms. Residents are only

FINAL ORDER (Cont.)
16N-00002
PAGE -3
allowed to smoke during designated times and in designated areas (outside on the patio). A staff member must be present during smoking periods. The petitioner acknowledged being aware of the smoking policy. The petitioner was a member of the weekly safe smoking committee.
3. On December 2, 2015, the petitioner reported to a social worker that she obtained a small burn from smoking while unsupervised the prior week. The facility's progress notes for the petitioner was documented on the same date.
4. On December 2, 2015, the petitioner was no longer classified as a safe smoker.
5. On December 3, 2016, the petitioner was assigned to wear an apron while smoking. She refused to wear the assigned apron.
6. On January 13, 2016, a Transfer and Discharge notice was issued to the petitioner. The reason listed on the discharge notice was "the health of other individuals in this facility is endangered and the safety of other individuals in this facility is endangered." There was a brief explanation "failure to comply with smoking policy". The notice was not signed by a physician, but an order dated January 13, 2016, was signed by the facility's physician and it supplemented the Discharge notice. The physician stated the petitioner was to be discharged from facility for failure to comply with the smoking policy and thus endangered other individuals in the facility. 7. On January 13,2016 , the petitioner requested a hearing to challenge the respondent.
8. On February 16, 2016, the petitioner was found to have three packs of cigarettes and two lighters in her room.

FINAL ORDER (Cont.)
16N-00002
PAGE -4
9. The respondent believes the petitioner's unsupervised smoking is a danger to others and is fearful the petitioner will continue to smoke while unsupervised which may cause a fire.
10. The petitioner wishes to remain in the facility as she has been at the facility for eleven years and feels safe there. She admitted to having possessed cigarettes, lighters and smoking while unsupervised. She also acknowledged the receipt of the facility's smoking policy. The petitioner does not wish to quit smoking.

## CONCLUSION 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 section $400.0255(15)$, Fla. Stat. In accordance with that section, this order is the final administrative decision of the Department of Children and Families.
12. A nursing facility must inform the residents of all rules and regulations. That information must be done both orally and in writing. In accordance with 42 C.F.R. § 483.10.
(b) Notice of rights and services.
(1) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under section 1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

FINAL ORDER (Cont.)
16N-00002
PAGE -5
13. The petitioner was given the facility's smoking policy and attended smoking committee meetings.
14. The Code of Federal Regulation at 42 C.F.R. § 483.12 , limits the reasons a
nursing facility may discharge a Medicaid or Medicare patient.
(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--
(iii) The safety of individuals in the facility is endangered;
(iv) The health of individuals in the facility would otherwise be endangered;
(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;...
(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;

FINAL ORDER (Cont.)
16N-00002
PAGE -6
(v) The name, address and telephone number of the State long term care ombudsman;
15. In this case, the petitioner was given a notice on January 13, 2016, indicating
that she would be discharged from the facility as "The safety of other individuals in this facility is endangered". The above-cited authorities set forth the conditions which must exist for a nursing home to involuntarily discharge a resident.
16. Section 400.0255, Fla. Stat., Resident transfer or discharge; requirements and procedures; hearings, states in relevant part:
(3) When a discharge or transfer is initiated by the nursing home, the nursing home administrator employed by the nursing home that is discharging or transferring the resident, or an individual employed by the nursing home who is designated by the nursing home administrator to act on behalf of the administration, must sign the notice of discharge or transfer...
(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.
17. The respondent's reason for discharge is the safety of other individuals being endangered. This is one of the reasons given in the above federal and state law to permit discharge from a facility. According to the above authorities, this discharge reason would require documentation from the resident's physician. A physician was required to sign the discharge notice or a physician's order accompany the discharge

FINAL ORDER (Cont.)
16N-00002
PAGE -7
notice was required. The discharged notice was not signed by a physician but it was accompanied by a physician's order dated January 13, 2016.
18. The respondent's sole reason for the discharge was the petitioner's violation of their smoking policy, which included smoking unsupervised at non-designated times and having smoking materials in her room or on herself. The petitioner was found to obtain a burn from smoking while unsupervised and she was found in possession of smoking materials on a different date. During weekly safe smoking committee meetings, the dangers of smoking and the facility's smoking policy were explained. 19. After careful review of the entire record as well as the controlling authorities, the undersigned concludes the nursing facility has correctly established that the safety of individuals in the facility would be endangered. This is included as one of the reasons provided in federal regulation (42 C.F.R. § 483.12) for which a nursing facility may involuntarily discharge a resident.
20. Establishing the reason for a discharge being 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.
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

FINAL ORDER (Cont.)
16N-00002
PAGE -8
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 Conclusion of Law 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.

FINAL ORDER (Cont.)
16N-00002
PAGE -9
DONE and ORDERED this $\qquad$ 08 day of $\qquad$ 2016, in Tallahassee, Florida.
Christens Gepaul Marine

Christian 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:



[^0]:    Rafael Centurion
    Hearing Officer
    Building 5, Room 255
    1317 Winewood Boulevard
    Tallahassee, FL 32399-0700

[^1]:    ${ }^{1}$ This model contract can be found at:
    https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2015-11-01/Exhibit_II-B-Long-term_Care_LTC_Program_2015-11-01.pdf

[^2]:    ${ }^{1}$ For clarification, AHCA received the updated information from the Petitioner. AHCA then forwarded the information to the Petitioner's plan, Better Health, who then forwarded it to their dental vendor, DentaQuest. This updated information was requested by the hearing officer at the fair hearing.

[^3]:    1 "You" in this manual context refers to the state Medicaid agency.

[^4]:    ${ }^{1}$ See 42 C.F.R. §431.230 and §431.231.

[^5]:    ${ }^{1}$ Said redaction will be discussed in further detail, below.

[^6]:    1 "You" in this manual context refers to the state Medicaid agency.

[^7]:    ${ }^{1}$ "You" in this manual context refers to the state Medicaid agency.

[^8]:    ${ }^{1}$ As the cited link is not functional, for the parties' convenience, a better direct link for preferred drug list information is: http://ahca.myflorida.com/medicaid/Prescribed Drug/preferred drug.shtml

[^9]:    Rafael Centurion
    Hearing Officer
    Building 5, Room 255
    1317 Winewood Boulevard
    Tallahassee, FL 32399-0700
    Office: 850-488-1429

[^10]:    ${ }^{1}$ As the cited link is not functional, for the parties' convenience, a better direct link for preferred drug list information is: http://ahca.myflorida.com/medicaid/Prescribed Drug/preferred drug.shtml

[^11]:    ${ }^{1}$ "You" in this manual context refers to the state Medicaid agency.

[^12]:    ${ }^{1}$ Prescription drug criteria for may be found on AHCA's website, at http://ahca.myflorida.com/Mealcala/rrescribed_Drug/drug_criteria_pdf/Harvoni_Criteria.pdf (last accessed March 2, 2016).

[^13]:    ${ }^{1}$ Prescription drug criteria for may be found on AHCA's website, at http://ahca.myflorida.com/Medicaid/Prescribed_Drug/drug_criteria_pdf/Harvoni_Criteria.pdf (last accessed March 2, 2016).

[^14]:    ${ }^{1}$ At hearing, the undersigned assigned the burden of proof to the respondent. Upon further analysis, the proper assignment is to the petitioner. See Conclusions of Law for explanation.

