Jun 29, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NOs. 15F-05390 &
15F-08869

PETITIONER,

vs.

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

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to Notice, Interim Orders, and agreement, the above-captioned appeals convened for hearing on several occasions, were consolidated, and reconvened for final hearing before Patricia C. Antonucci at approximately 1:30 p.m. on January 14, 2016. All parties and witnesses appeared via teleconference.

APPEARANCES

For the Petitioner: [redacted]

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

STATEMENT OF THE ISSUE

Prior to the actions at issue, Petitioner was authorized to receive Home Health Services (personal care, homemaker, and respite) of 30 hours per week, plus a monthly supply (one box) of a prescribed, oral nutritional supplement. Petitioner requested to increase his Home Health Service (HHS) hours by 54 hours, for a total of 84 hours per

week. He also requested continuation of the nutritional supplement (Ensure Plus). Respondent, the Agency for Health Care Administration (AHCA), through its contracted health plan, Sunshine Health ("Sunshine"), denied the increase of HHS and terminated provision of Ensure Plus.[1]

Petitioner bears the burden of proving, by a preponderance of the evidence, that Respondent was incorrect to deny the increase in HHS. Respondent bears the burden of proving, also by a preponderance of the evidence, that termination of the nutritional supplement was proper.

PRELIMINARY STATEMENT

The procedural history of this appeal has been documented in multiple Interim Orders and in several recorded proceedings since hearing initially convened in July of 2015. It is noted that Sunshine Health's failure to properly process and prepare Petitioner's case resulted in the need for resetting hearing four times (not including a separate status conference), resulting in over seven hours of testimony; however, Sunshine was subsequently able to reassess Petitioner's needs and conduct a thorough review of all evidence presented throughout the appeal process. Based upon this review, Sunshine determined that denial of the request for 84 hours remained proper, but that an increase from 30 hours to 42 hours per week was justified.

Petitioner was present at all sessions of telephonic hearing, and acted as his own representative. Respondent, AHCA, was represented by Selwyn Gossett, Medical/Health Care Program Analyst. Additional witnesses appeared, as followed:

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[1] As noted, below (*see* Preliminary Statement), Sunshine later adjusted its recommendation to a total of 42 weekly hours of HHS, thus representing a partial approval of the requested increase; however, Sunshine upheld its denial of the remaining, requested hours (84 – 42 = 42 weekly hours denied).

- At hearing on July 15, 2015:
  - [redacted]
  - For Respondent: From Sunshine Health: Paula Daley, Appeals and Grievances Coordinator; Jennifer Arteaga, Grievances and Appeals; Donna Laber, RN, Manager of Grievances and Appeals; Angela Blue, Case Manager; Tammi Swan, Case Manager Supervisor; David Gilchrist, D.O., Long Term Care Medical Director;

- At telephonic status conference on August 26, 2015:
  - [redacted]
  - For Respondent: From Sunshine Health: Donna Melogy, Executive Director; Paula Daley, Tammi Swan, David Gilchrist;

- At hearing on September 17, 2015:
  - [redacted]
  - For Respondent: From Sunshine Health: Patricia Lee, Case Manager; Donna Melogy, Paula Daley, Tammi Swan, Donna Laber, David Gilchrist;

- At hearing on November 30, 2015:
  - [redacted]
  - For Respondent: From Sunshine Health: India Smith, Grievances and Appeals; Natasha Jones, Long Term Care Supervisor; Patricia Lee, Tammi Swan, David Gilchrist; From Families Come First (HHS provider): Jennifer McKenzie; From Southern Loving Care (HHS provider): Ashley Butler;

- At hearing on December 15, 2015:
  - [redacted]
  - For Respondent: From Sunshine Health: Paula Daley, Patricia Lee, Tammi Swan, David; From Southern Loving Care: Kathie Railey; From Families Come First: Jennifer McKenzie; from Health Matters (provider): Linda Daley; and

- At hearing on January 14, 2016:
  - [redacted]
  - For Respondent: From Sunshine Health: Patricia Lee, Paula Daley, David Gilchrist, Tammy Swan.

Multiple issues were addressed over the course of these hearings, though all issues except HHS and the nutritional supplement were ultimately resolved as the proceedings progressed. Petitioner noted confusion and frustration in trying to communicate with Sunshine, who did not seem to listen to his expressed needs and/or ordered equipment other than what he requested, which he was unable to use (e.g., when Petitioner requested catheter holders and drainage bags, Sunshine denied, instead authorizing an ostomy belt; however, Petitioner does not have an ostomy/stoma).

For appeal number 15F-05390, Respondent's Exhibits 1 through 20, inclusive, and Petitioner's Exhibits 1 and 2 were accepted into evidence. For appeal number 15F-08869, Respondent's Exhibits 1 through 3, inclusive, were accepted into evidence; however, as the two appeals were later consolidated, the exhibits for 15F-08869 have been re-labeled as Exhibits 1A, 2A, and 3A. At final hearing for both appeals, additional documentation was entered as Respondent's Exhibits 1B through 5B, and Petitioner's Exhibit 1B. In total, 28 exhibits were entered by Respondent and 3 exhibits were entered by Petitioner. Administrative Notice was taken of all pertinent legal authority.

As the events and issues that comprise the instant appeals occurred over a wide expanse of time, the undersigned has considered the revised documentation and testimony from final hearing on January 14, 2016 as the best and most accurate reflection of Petitioner's current status. As such, said evidence has been given paramount importance in preparation of this Final Order, and is discussed in detail, below.

FINDINGS OF FACT

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

1. The Petitioner is a 56-year old male. He is paralyzed from his chest, down, with bilateral paralysis in his lower extremities and partial bilateral paralysis of his hands, subsequent to injury resulting from an accident at the age of 51. He is able to use his right hand to grip and eat. The Petitioner suffers from [redacted] He resides in his own home, with a friend/temporary caregiver.

2. Petitioner's current caregiver does not wish to remain living in Florida, and is attempting to return to her out-of-state family home. Petitioner's sister is able to provide Petitioner with occasional assistive care. However, because the sister lives 27 miles away, she is unable to consistently monitor Petitioner's well-being, or address his daily care needs, such as emptying his bladder bags.

3. At all times relevant to these appeals, Petitioner has been eligible for and receiving Medicaid services through a managed care service model. Petitioner's managed care plan is Sunshine Health.

4. Prior to the actions at issue, Petitioner was receiving one case of a nutritional supplement (Ensure Plus, CPT code B4152 SC) per month, and 30 hours of HHS per week.

5. On or about January 29, 2015, Petitioner requested that Sunshine increase his HHS to 84 hours per week. On or about February 11, 2015, Petitioner supplemented this request with a supporting prescription from his physician.

6. Via Notice of Case Action (NOCA) dated March 16, 2015, Sunshine denied the requested increase.

7. Petitioner timely appealed the HHS denial; however, Sunshine did not contact Petitioner prior to hearing on July 15, 2015, and was thus unaware that Petitioner wished to challenge its decision regarding HHS. As a result, Sunshine prepared an evidence packet related only to (separate) denials of durable medical equipment, with no mention of HHS hours.

8. In order to allow Sunshine opportunity to review its documentation regarding HHS, the undersigned set this matter for telephonic status conference.

9. Upon reconvening for status conference, Sunshine was still unable to establish a proper timeline of requests/decisions regarding HHS. However, following several additional reconvenes and requests for supplemental documentation, Sunshine provided sufficient information to establish a chronology of events. In consideration of this confusion, Sunshine unilaterally decided to raise Petitioner's HHS to his requested 84 hours per week, pending the outcome of his appeals.

10. In September of 2015, while engaged in appeal proceedings regarding HHS, Sunshine terminated, without notice, its provision of Petitioner's Ensure Plus. Sunshine subsequently corrected this action by reinstating its supply of the nutritional drink during the pendency of Petitioner's appeals.

11. Per Sunshine case managers, in order to determine the number of service hours and/or the type of medical equipment needed to meet any member's health care needs, Sunshine conducts a full, face-to-face assessment, referred to as a 701B. As of final hearing, Petitioner's most recent 701B was completed on November 24, 2015.

12. The health portion of Petitioner's November 24, 2015 701B notes that he suffers from [redacted] allergies, [redacted] high blood pressure, [redacted] bladder and bowel incontinence, and constant dizziness, with a medical history that includes bed sores, broken bones, UTIs, and [redacted] Petitioner is noted to have difficulty swallowing, due to mouth/tooth/denture issues, and to take at least 10 medications per day. He receives monthly, suprapubic cauterizations via skilled nursing appointments.

<u>Home Health Services</u>

13. The Functional Assessment portion of Petitioner's November, 2015 701B records his activities of daily living (ADL) needs, as follows:

- Needs total assistance (cannot do at all) for bathing, dressing, toileting, mobility;
- Needs assistance (but not total help) with transfers;
- No assistance needed with eating.

14. The Assessment also notes that Petitioner always has assistance, either paid or natural/generic, when he requires it (receiving 84 weekly HHS hours at assessment time), and clarifies that he is able to transfer from a chair to a bed, but needs assistance to lift his legs once transfer is complete.

15. In terms of instrumental activities of daily living (IADLs), the Functional Assessment reflects:

- Needs total assistance (cannot do at all) for heavy chores, light housekeeping, preparing meals, shopping, and using transportation;
- Needs assistance (but not total help) with managing money and managing medication;

- No assistance needed to use the telephone.

16. For IADLs, the Assessment again reflects that Petitioner currently has assistance whenever he needs it in order to complete his IADLs.

17. The 701B also records Petitioner's frustration with being unable to do things for himself, and notes that this puts a strain on his interaction and relationships with others. It also notates that Petitioner's caregiver currently provides 84 hours per week of assistance, and does not feel that she can continue doing so.

18. Based on this Assessment and guidelines designed to be used in conjunction with same, Sunshine estimated the duration of service needed for each ADL and IADL. The undersigned has summarized the data contained within the 701B, guidelines as to recommended minutes/day, and testimony as to what Sunshine has calculated as appropriate for each task. The chart, below, depicts this information, with the highest allotment underlined and in boldfaced font to show whether recommended/guideline-based frequency of each service is higher or lower than Sunshine's calculated rate.

Activity	Level of Impairment	Recommended Minutes/Day (and mins/wk)	Calculated Mins/Day (converted from testimony re: Hrs/Wk):	Total Weekly Minutes Calculated (Rounded)
Bathing	Total	45/bath (<u>**315/wk**</u>)	42 mins (5 hrs/wk)	300
Dressing	Total	Dressing/ undressing/ grooming 20x3 = 60mins (<u>**420/wk**</u>)	30 mins (3.5 hrs/wk)	210

Toileting	Total	4x (15 mins) (420/wk)	60 mins (7 hrs/wk)	420
Eating	Total			0
Transfers	Total	15/task	**25** mins (1.5 transfers/ day) (3 hrs/wk)	180
Ambulation	Total	30/task	**42** mins (5 hrs/wk)	300
Meal Preparation		3-75 mins (depending on number of people)	**64** mins (7.5 hrs/wk)	450
Laundry	Total	120/wk	25 mins (3 hrs/wk)	**180**
Cleaning/Housekeeping	Total	120/wk	25 mins (3 hrs/wk)	**180**
Shopping	Total	90/wk	12 mins (1.5 hrs/wk)	90
Medications	Total		10 mins (1.25 hrs/wk)	75
Totals:		~ 334 mins/day	335 mins/day (39.75 hrs/wk)	2,385 min/wk
			Amended approval = 42 hrs/wk	

19. When compared against the minutes per week for each service recommended via the assessment guidelines, Sunshine has recommended the same frequency or a higher frequency of time for toileting, transfers, ambulation, meal preparation (approximately, Petitioner also receives home delivered meals), laundry, cleaning/housekeeping, and shopping. Less time was approved for bathing (300

minutes vs. 315 minutes), and for dressing (420 vs. 210). The overall weekly allotments are about the same.

20. Petitioner, his primary caregiver, and his sister contend that Petitioner requires a minimum of 84 service hours per week/12 hours per day. His caregiver believes he needs 24-hour care. The unpaid caregiver is only able to assist Petitioner with tasks that do not require lifting or transfers, as she is a petite woman who cannot support Petitioner's weight. She empties Petitioner's bladder bags and administers his medications in the morning, at noon, at 6:00 p.m., and at 12:00 a.m.

21. Petitioner also receives home nurse visits, via Medicare, every three weeks. During these visits, the nurse changes Petitioner's catheter but provides no personal care.

22. Petitioner feels that he requires six hours of ADL and IADL care in the morning and an additional six hours of care at night. Petitioner testified this would mean he would be alone each day for periods of six hours or less, and thus, would only have to contend with potential bladder spasms, muscle spasms, filled urine bags, or inability to relieve nerve pain (via repositioning) without any assistance for six hours, at a time. He states that no HHS aide, to date, has been able to get him up, showered, and dressed within a three hour timeframe.

23. Petitioner further testified that he believes it is Sunshine's ultimate goal to place him in assisted living, and that Sunshine's denial of the increases HHS hours is part of this long-term plan.

24. Sunshine contends that the calculated hours are based upon guidelines, Petitioner's 701B assessment, and direct conversations with Petitioner's paid providers.

Sunshine notes that Petitioner's unpaid caregiver has been stating she was leaving the state for many months, and has yet to do so. It is Sunshine's position that 42 hours per week of HHS will meet Petitioner needs while his caregiver remains in the household, and that he may request a new assessment and/or additional HHS hours if and when she departs. Sunshine further notes that it does believe assisted living may be the most appropriate setting for Petitioner, but concedes that there is no requirement for assisted living if a member's needs can be met within the home.

Nutritional Supplement

25. It is Sunshine's contention that although Petitioner was receiving Ensure Plus on an ongoing basis, his prescription for the item expired August 31, 2015. As such, Sunshine states they did not "terminate" the item, but rather, stopped providing it until a renewed prescription could be obtained. Sunshine did not issue a denial or termination notice, but was aware that Petitioner wished to continue receiving Ensure, and sought to assist him in obtaining the documentation required for same.

26. Although Sunshine's initial decision to discontinue Ensure Plus was based on failure to obtain a new prescription, as of September 17, 2015, Sunshine *had* secured a renewed prescription; however, the plan then argued that because Sunshine requires both a prescription and a physician's order form to authorize provision of Ensure, the supplement would not be renewed.

27. Sunshine states that the physician's order form is approved by AHCA, and that guidelines regarding the provision of "enteral formulas" were previously published on AHCA's website, but have since been removed.

28. Sunshine's own guidelines specify requirements for both "enteral" (tube-fed) formulas, and oral nutritional supplements. The description of the latter notes:

> There are many physical conditions that cause inability to eat enough food to maintain health. Some examples are decreased appetite, difficulties in swallowing, or any type of surgery that interferes with eating. In conditions where eating is still possible, oral nutritional products can be used with the purpose of restoring or maintaining adequate nutritional status, weight, or strength for the maintenance of overall health. Many oral nutritional products are widely available through commercial retail; however there are some products that require prescription of a doctor.

29. Petitioner was initially approved to receive Ensure Plus based upon solely on a prescription for the product and/or medical records and assessments. Despite numerous contacts from both Sunshine staff and Petitioner, himself, Petitioner's prescribing physician refused to complete the specific form which Sunshine requires for authorization, stating that he did not see why said form was necessary.

30. Although Sunshine provided specific, written procedures for initial and subsequent review of requests for nutritional supplements, it does not appear that Sunshine adheres to this rather strict criteria. Indeed, Sunshine contends that if Petitioner's provider submitted the physician's order form, and that the completed form supported the need for Ensure Plus, the supplement would be approved.

31. Petitioner states that he takes his night-time medications with a can of Ensure Plus, as these prescriptions must be taken with food, and Petitioner is unable to eat late at night/early morning (around 12:00 a.m.). He also supplements his diet with Ensure on days when he has back spasms and acid [redacted] and is unable to eat or get out of bed.

CONCLUSIONS OF LAW

32. 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.

33. 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.

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

35. All hearings in these appeals were held as *de novo* proceedings, in accordance with Fla. Admin. Code R. 65-2.056.

36. The burden of proof in the instant case is split between the parties; Petitioner bears the burden to establish that denial of 84 weekly HHS hours was improper, and Respondent bears the burden to establish that it was proper to discontinue provision of Ensure.

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

38. Florida Statutes § 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. An entity that provides such services must be licensed under part III of chapter 400. These services, equipment, and supplies, or reimbursement therefor, may be limited as provided in the General Appropriations Act and do not include services, equipment, or supplies provided to a person residing in a hospital or nursing facility.
(a) The agency shall require prior authorization of home health services based on diagnosis, utilization rates, and billing rates. The home health agency must submit the recipient's plan of care and documentation that supports the recipient's diagnosis to the agency when requesting prior authorization.
…

(c) The agency may not pay for home health services unless the services are medically necessary.…

39. 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.

40. 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 his Long-Term Care needs.

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

provider network/HMO is Sunshine Health.

42. Respondent contends that its contract with Sunshine 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 Medicaid Aged and Disabled Adult Waiver Services Coverage and Limitations Handbook, was repealed on August 28, 2014. As such, the undersigned can only review Sunshine's determinations in conjunction with its contract-based guidelines, governing legal authority, and general provisions of medical necessity.

43. 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.

Home Health Services

44. 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 (at their requested frequency) are individualized/not excessive, reflective of the level of service needed, and/or furnished in a manner that is not primarily for convenience, one must look to the guidelines which govern Sunshine's review.

45. Sunshine's guidelines, as approved by AHCA, set forth a detailed procedure for review of HHS requests. As relates to the instant case, this procedure includes utilizing the 701B assessment in conjunction with guidelines that contain time ranges for each, specific ADL or IADL task. Said guidelines instruct that the plan should "[c]alculate the total number of minutes of support needed for supervision or socialization… [and c]onvert the total number of minutes to units."

46. Sunshine completed these calculations for Petitioner's needs, and arrived at a total of 39.75 weekly hours. Sunshine then amended this to a total of 42 hours per week, which they feel will meet all of Petitioner's needs, as long as he continues to have a live-in caregiver.

47. In reviewing Petitioner's assessment, along with the pertinent guidelines, the undersigned concludes that Sunshine's allotment of 42 hours of HHS per week exceeds the higher range of the total recommended hours for an individual with Petitioner's

abilities, needs, and natural and generic supports. For this reason, provision of 84 hours each week would likely be in excess of Petitioner's needs, and thus, not in keeping with Fla. Admin. Code R. 59G-1.010(166)(a), subsections (2), (4), and (5).

48. Petitioner has not met his burden of proof to show that provision of 84 weekly hours of HHS are medically necessary, such that Respondent's denial is improper.

Nutritional Supplement

49. Respondent never issued a notice to terminate Petitioner's Ensure Plus, following expiration of his prior prescription for same; however, Sunshine did previously authorize this item, and understood that Petitioner wished to continue receiving the nutritional supplement, on an ongoing basis.

50. Sunshine attempted to work with Petitioner's provider to obtain supporting documentation, so as to re-approve the Ensure. Indeed, Sunshine obtained a new prescription for the supplement, but later determined that without also receiving a physician's order form, the Ensure would not be continued.

51. Because Sunshine Health determined Ensure Plus to be medically necessary during Petitioner's prior certification period, to discontinue provision of this item, Sunshine would have to demonstrate that the supplement is no longer a medical necessity.

52. There is no allegation by Sunshine Health that Petitioner's conditions have improved, or that his medical or social status have changed in a way that renders the nutritional supplement unneeded, nor is there is any allegation that the supplement is contraindicated with Petitioner's medications and/or lifestyle.

53. While the undersigned notes that Petitioner's provider has unnecessarily frustrated the process of authorization for this supplement by refusing to fill out Sunshine's physician order form, there is nothing within governing legal authority which specifies that said form is needed in order to approve Ensure Plus. This is especially significant in the instant case, since Sunshine has a prescription from Petitioner's physician – and because a prescription is apparently all that was required for the prior authorization to occur.

54. Respondent has failed to meet its burden to show that it properly discontinued provision of the previously authorized Ensure Plus.

55. Petitioner is clearly in need of supportive services, and he is encouraged to continue working with his case managers at Sunshine Health to ensure that he obtains paid service providers with whom he is able to establish a rapport. He may wish to inquire about obtaining a Personal Emergency Response System (PERS) in the event he has a medical emergency when he is home by himself. He is further encouraged to contact his case managers, *immediately*, if and when his caregiver moves out of the home. Sunshine has agreed to respond to such notification with an expedited meeting and/or new assessment of Petitioner's needs as an individual living alone. If, at any time, Petitioner's paid providers are unable to assist Petitioner in completing all necessary ADL and IADL tasks within the allotted six care hours per day, Petitioner may request that Sunshine increase his service hours, and ask that the providers contact Sunshine to offer support for same.

56. Sunshine, in turn, is encouraged to continue working with Petitioner *and* his provider(s) in regards to the Ensure Plus. Should Petitioner's physician continue to refuse provision of supporting documentation, Sunshine may wish to facilitate Petitioner's visit to a separate physician, who can examine the Petitioner, complete the form, and make recommendations to Sunshine Health as to whether continued use of a nutritional supplement is medically necessary.

57. Should Petitioner receive any subsequent notices of termination, or should he request additional or increased services and receive a denial of same, he reserves the right to appeal those, specific actions.

DECISION

Based upon the foregoing, Petitioner's appeal is DENIED, in part, with regard to an increase in Home Health Services. Petitioner's request for 84 weekly hours is denied; however Respondent is directed to authorize HHS at their recalculated frequency of 42 hours per week, which represents an increase from Petitioner's previously authorized 30 weekly hours.

Petitioner's appeal is GRANTED with regard to Ensure Plus, which Respondent is directed to continue providing.

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 June, 2016,

in Tallahassee, Florida.

Patricia C. Antonucci
Hearing Officer
Building 5, Room 255
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Tallahassee, FL 32399-0700
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Copies Furnished To: [redacted] Petitioner
Debbie Stokes, Area 4, AHCA Field Office Manager

May 24, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

PETITIONER,

vs.

FLORIDA DEPT OF CHILDREN AND FAMILIES
CIRCUIT: 05 Marion
UNIT: 88222

RESPONDENT.
_________________________________/

APPEAL NO. 15F-07111

CASE NO

FINAL ORDER

Pursuant to notice, this matter convened for administrative hearing before Patricia Antonucci on October 8, 2015, October 27, 2015, January 27, 2016, and April 6, 2016. Final hearing on April 6, 2016 convened at approximately 3:00 p.m. All parties and witnesses appeared via teleconference.

APPEARANCES

For the Petitioner:

For the Respondent: Lori Winfield, Economic Self-Sufficiency (ESS) Regional ICP Supervisor, Department of Children and Families

STATEMENT OF ISSUE

At issue is an action taken by Respondent, the Department of Children and Families (DCF or "the Department") to increase the amount of Petitioner's patient responsibility (PR) following his recertification for Institutional Care Placement (ICP) and institutionalized Hospice Medicaid.

On or about April 27, 2015, Respondent increased Petitioner's PR; however, in July of 2015, Respondent returned the PR to $0.00. Via Notice of Action, Respondent subsequently increased the PR, again. As such, Respondent bears the burden of proving, by a preponderance of the evidence, that said increase is proper.

Specifically at issue is the proper amount of Petitioner's PR for the months of April through October of 2015. The parties agree that there is no PR for the month of November, 2015.

PRELIMINARY STATEMENT

The procedural history of this appeal has been documented in multiple Interim Orders since hearing initially convened in October of 2015. The Department caused significant delay through its failure to properly process and prepare Petitioner's case; however, Respondent was willing to recalculate Petitioner's PR based upon careful and thorough review of all evidence presented by his wife throughout the appeal process.

On November 10, 2015, Petitioner did not appear for hearing, and on February 23, 2016, Respondent failed to appear. At all other sessions, both parties participated in the hearing and presented both testimonial and documentary evidence. Due to technical issues, the recording of the hearing from January 27, 2016 was not preserved. Said hearing was largely confined to review of the Department's calculations, which were later corrected, amended, and reviewed during hearing on April 6, 2016. As such, the undersigned has considered the revised documentation and testimony from final hearing on April 6, 2016 as paramount in preparation of this final order.

At final hearing, Petitioner was represented by his widow. Respondent was represented by Lori Winfield, ESS Regional ICP Supervisor, who presented one additional witness: Carol Schwartz, ESS Eligibility Specialist. To maintain consecutive exhibit numbering and to ensure entrance of all submitted documentary evidence, all documentation previously entered was struck from the record. Petitioner's Exhibits 1 through 5, inclusive, and Respondent's Exhibits 1 through 7, inclusive, were then marked and moved into evidence to complete the record of this appeal. This Final Order follows.

FINDINGS OF FACT

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

1. Petitioner (now deceased), was admitted to a nursing home facility (NHF) under ICP coverage in 2013. When first determined eligible for ICP Medicaid, the Department calculated Petitioner's at $0.00 per month.

2. In April of 2015, Petitioner's wife/representative submitted to DCF a recertification for Petitioner's benefits. As she had done during prior years, along with the recertification, his wife included documentation of her income, Petitioner's income, and various expenses.

3. Via Notice of Case Action (NOCA) dated April 27, 2015, Petitioner was notified that his PR was reassessed at $1,334.60 per month, effective June 1, 2015. A separate NOCA in June of 2015 notified Petitioner his PR for that month was $768.97.

4. Petitioner's wife made several attempts to contact the Department in order to discuss the drastic PR increase. Following unreturned telephone calls, e-mails, and

faxes, in July of 2015, the wife went to a DCF storefront and spoke directly with a supervisor. As a result of their discussion, said supervisor reset Petitioner's PR for June, 2015 at $0.00.

5. Via NOCA in August of 2015, Petitioner was informed that his PR for August through October of 2015 was set at $1,073.53 per month.

6. In reviewing Petitioner's case for hearing, the Department discovered various DCF errors dating back to 2013. It is Respondent's position that the combination of case worker errors (such as not inputting or deleting all reported income), "glitches" with technology, and failure to properly document actions taken on the case make it impossible to piece together corrected NOCAs, or to establish an accurate history of the ICP case.

7. Petitioner's wife argues that nothing has changed since her husband was assessed a PR of $0.00, and that she cannot afford to pay the NHF a higher PR for each of the months in dispute – i.e., April through October of 2015. While this hearing was pending, on November 26, 2015, Petitioner passed away.

8. At reconvened hearing in January of 2016, Respondent set forth new calculations of Petitioner' PR, based upon income and expense information resupplied to the Department by Petitioner's wife. For these ICP budgets, Respondent utilized the wife's income from rental property and well as from self-employment; however, despite numerous letters from the wife explaining that business expenses (such as high auto fuel bills, internet, phone charges) and two mortgages (plus repair expenses and lost rent) on the rental properties reduced her income significantly, Respondent did not factor these expenses as deductions in its calculations.

9. Via Interim Order dated February 8, 2016, Respondent was ordered to review said expenses, in combination with pertinent legal authority, to determine proper deductions from the wife's income. Respondent was also instructed to contact IRS, as needed, for assistance in determining what did and did not constitute a deductible expense. Petitioner's wife was encouraged to provide the Department with any documentation, such as any tax returns she had available, to support the existence of these expenses.

10. When hearing reconvened on April 6, 2016, Respondent had reassessed Petitioner's PR. Due to the substantial costs in maintaining the rental property, the wife's rental income had been reduced to zero.

11. Ms. Schwartz walked through the budgeting process during final hearing, explaining that in the ICP program, Respondent considers both the income of the institutionalized spouse and the income of the "community" spouse. In Petitioner's case, Petitioner's income was his monthly SSA payment, in the amount of $1,606.00. As this was lower than the income standard of $2,199.00, Petitioner was eligible for ICP Medicaid. From Petitioner's income, Respondent then subtracted a standard, personal needs allowance of $105.00, to arrive at a subtotal of $1,501.00.

12. Petitioner's wife is self-employed as a [redacted] and also performs on-site [redacted] Both jobs require significant travel throughout the wife's residential and neighboring counties. Respondent calculated Petitioner's wife's (the community spouse) self-employment income using her reported data, as follows:

Month (in 2015)	From	From Work
January	$640.00	$92.51
February	$502.00	$285.41
March	$954.00	$375.09
April	$328.00	$548.17
May	$537.00	$585.72
5-month Total:	$2,961.00	$1,886.90

Respondent then added both sources of income together ($2,961.00 + $1,886.90 = $4,847.90) and divided by five ($4,947.90 ÷ 5) to get a monthly average of $969.58.

13. In terms of monthly expenses (not including those on the rental properties or credit card payments), Petitioner's wife listed the following:

(Underlined expenses are ones which Respondent used, in whole or in part, during its budgeting process.)

Insurance:

- Termite: $18.33
- Car: $84.51
- <u>Hospital (Petitioner) $166.40</u>
- Hospital (wife) $185.75
- Life (wife) $65.17
- Acc/life (both) $16.50
- <u>Home $100.50</u>
- <u>Flood $160.66</u>

Other Expenses:

- Car payment: $398.70
- <u>$41.88</u>
  (cell phone required for work)

- [redacted] $87.06
  (land phone, internet, DSL required for work)
- Average utilities: $250.00
  (electric, trash, water, etc.)
- Natural gas: $28.50
- ADT Alarm: $48.75
- Funeral Expenses: $49.09
  (Petitioner)
- Food (Approx): $300.00
- Gas for Car: $200.00
  (Closer to $300.00 in 2014)
- Onstar Navigation: $29.00
  (for work)
- [redacted] $6.58
  (web registration to get jobs)
- Property Taxes: $93.52
- Misc exp/donations: $400.00

14. Out of all noted expenses, Respondent credited Petitioner with deductions for the institutionalized spouse's hospital insurance, and for home owner's insurance, flood insurance, and property taxes. Per testimony, Respondent considered the wife's internet and phone bills, and $120.00 of her monthly utilities, as business expenses to offset her self-employment income. No testimony was given regarding gasoline, navigational system, or web registration fees, which the wife also included in her list of work expenses.

15. From the previously calculated self-employment income of $969.58, Respondent subtracted the above-referenced business deductions ($41.88 cell phone + $87.06 internet + $120.00 of utilities = $248.94). This should have resulted in an adjusted self-employment income of $720.64; however, Respondent incorrectly calculated this as

$740.64.[1] The wife's self-employment income of $740.64 was added to her monthly SSA of $633.90 to arrive at a total gross community spouse income of $1,374.54 per month.

16. DCF then added $102.48 in property taxes, $261.16 for insurance ($100.50 home owner's + $160.66 flood), and $337.00 as the Food Assistance Standard Utility Allowance. This resulted in $700.64 of subtotaled shelter costs.

17. Next, to determine how much of Petitioner's income the community spouse could retain, Respondent utilized a spousal impoverishment Minimum Monthly Maintenance Income Allowance (MMMIA) of $1,966.00. The MMMIA was then multiplied by 30%, which resulted in a $590.00 excess shelter standard. The excess shelter standard was subtracted from the total shelter costs ($700.64 - $590.00), to arrive at excess shelter costs of $110.64, which was then added to the MMMIA ($110.64 + $1,966.00), resulting in a subtotal of $2,076.64 for the Community Spouse Allowance.

18. Once it had obtained the Community Spouse Allowance, Respondent subtracted same from the community spouse's gross income of $1,374.54 to arrive at the Community Spouse Income Allowance of $702.10.

19. To complete its budgeting process and determine the PR, Respondent returned to its calculation of Petitioner's subtotal income ($1,606.00 SSA - $105.00 personal needs allowance = $1,501.00), and subtracted from same the Community Spouse Income Allowance ($1,501.00 - $702.10) for a new subtotal of $798.90. From this

[1] This will be addressed in further detail and corrected, below.

subtotal, Respondent subtracted Petitioner's hospital insurance as an uncovered medical expense ($798.90 - $166.40 insurance) to obtain a Total PR of $632.50.

20. This calculation of the PR at $632.50 was applied to the months of April, May, and June of 2015. In July of 2015, the Food Assistance Standard Utility allowance was increased from $337.00 to $345.00. Although Respondent noted this increase during testimony, review of the budgets reflects that this was not adjusted, such that $337.00 was used for all months calculated. Also in July of 2015, the MMMIA increased from $1,966.00 to $1,991.00. Said change *is* incorporated into the budgets for July through October, 2015.

21. Following review of the calculations, Petitioner stated that she could not think of any expenses which she believed Respondent had failed to consider. While she still felt that the PR should be returned to $0.00, she understood the Department was following certain rules in its budgeting process to establish PR.

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 burden of proof is assigned to the Respondent, pursuant to Fla. Admin. Code R. 65-2.060(1).

25. At issue is Respondent's determination of Petitioner's PR under ICP Medicaid.

The ICP Program is governed by the Code of Federal Regulations (*see, e.g.,* 42 C.F.R. § 435.735), and, in Florida, by its implementing provisions of the Florida Administrative Code.

26. Fla. 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…," i.e., what Petitioner must pay to the NHF.

27. Very specific rules govern determination of the PR, including how income is calculated, what deductions are permitted, and how much of their income both the institutionalized and community spouse are permitted to keep as a "personal" or "spousal" allowance.

28. Fla. Admin. Code R. 65A-1.7141, *SSI-Related Medicaid Post Eligibility Treatment of Income*, defines allowable deductions when determining PR, noting in pertinent parts:

> (1) For institutional care services and Hospice, the following deductions are applied to the individual's income to determine patient responsibility in the following order:
> (a) A Personal Needs Allowance (PNA) of $105. Individuals residing in medical institutions and intermediate care facilities shall have $105 of their monthly income protected for their personal need allowance.
> …
>
> (e) The community spouse income allowance. The Department applies the formula and policies under § 1924 of the Social-Security Act, and Rule 65A-1.716, F.A.C., to compute the community spouse income allowance after the institutionalized spouse is determined eligible for institutional care benefits.
> (f) The community spouse's excess shelter and utility expenses. The amount by which the sum of the spouse's expenses for rent or mortgage payment (including principal and interest), taxes and insurance and, in the case of a homeowner's association, condominium or cooperative, required maintenance charge, for the community spouse's principal residence and utility expense exceeds thirty percent of the amount of the Minimum Monthly Maintenance Needs Allowance (MMMNA) is allowed. The utility expense is

based on the current Food Assistance Program's standard utility allowance as referenced in subsection 65A-1.603(2) F.A.C.

…

(h) For ICP or institutional Hospice, income is protected for the month of admission and discharge, if the individual's income for that month is obligated to directly pay for their cost of food or shelter outside of the facility.

(i) Uncovered medical expense deduction. The following policy will be applied in considering medical deductions for institutionalized individuals and individuals receiving HCBS services to calculate the amount allowed for the uncovered medical expense deduction:

1. For institutionalized persons or residents of medical institutions and intermediate care facilities, the deduction includes:

a. Any premium, deductible, or coinsurance charges or payments for health insurance coverage.

b. For other incurred medical expenses, the expense must be for a medical or remedial care service and be medically necessary as specified in subsection 59G-1.010(166), F.A.C., and be recognized in state law. For medically necessary care, services and items not paid for under the Medicaid State Plan, the actual billed amount will be the amount of the deduction, not to exceed the maximum payment or fee recognized by Medicare, commercial payors, or any other third party payor, for the same or similar item, care, or service.

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

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

29. Fla. Admin. Code R. 65A-1.716, *Income and Resource Criteria*, notes, in part:

(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: MM[M]IA × 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.

30. Fla. 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 <u>$345</u> 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.

The SUA for July, 2014 through June, 2015 was $337.00.

31. In terms of the community spouse's income, 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.
> …
>
> (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.
> …
>
> (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 <u>circumstances other than those taken into account in establishing maintenance standards for spouses. An</u>

> 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. 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.
> (emphasis added)

32. The above authority explains that in order for an expense to be considered exceptional, such that the hearing officer might 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 spouse. In the instant case, the Petitioner's wife argues that with an increased PR, she will not be able to afford her household expenses. (*See* ACCESS Florida Program Policy Manual, Section 2640.0122.)

33. The undersigned notes that Petitioner's wife has listed additional business expenses, which Respondent did not include in its deductions before calculating Petitioner's PR. Although Petitioner did not specifically request an adjustment, she did express that she believes the PR should remain at $0.00. Additionally, although deductions to her income do not necessarily constitute the type of adjustment contemplated by the above-cited authority, the underlying intent of this policy is clearly to prevent undue hardship to the community spouse.

34. Portions of the ACCESS Florida Policy Manual specifically address deductions from self-employment income, as follows:

1840.0313 Self-Employment Income (MSSI, SFP)
Net earned income from self-employment is the total gross income derived from all trades and businesses as computed under the Internal Revenue Code, less deductions allowable under the code, attributable to such trades or businesses. It includes the individual's share of ordinary net income (or loss) from partnerships even though the partnership profits have not been distributed yet.

1840.0315 Verification of Self-Employment Income (MSSI, SFP)
Self-employed individuals must verify earned income at application and review. In addition, these individuals must make all business records available to the eligibility specialist. Examples of business records include documentation on:
1. income tax records necessary to determine gross income and deductible expenses,
2. purchases,
3. sales,
4. salaries,
5. capital improvements,
6. utility, transportation, and other operating costs, and
7. work calendars for tips and recording pay as received.

If the individual claims to have no business records, or that the records are inaccurate, discuss with the individual their most recent representative income. CLRC should explain how the income was determined.

35. Petitioner's wife did not provide business records or tax returns to establish deductible expenses; however, she did provide to the Department (on multiple occasions), a list of expenses, as well as several letters explaining the costs associated with conducting her business. While Respondent relied upon this expense list to establish the wife's internet, phone, and a portion of her utility bills (as well as property taxes and insurance costs), it did not take into consideration other expenses that the wife indicated were tied to her business, including fuel (for transportation), a navigational system, and registration with [redacted] to locate jobs. The wife did not specify any other expenses as directly related to business, and no testimony or

CLRC entries were proffered to explain why the expenses she did specify were not budgeted, accordingly.

36. In consideration of the above-referenced policy, the undersigned finds that inclusion of $200.00/month for fuel, $29.00/month for OnStar Navigation, and $6.58/month for [redacted] web registration are allowable business deductions. Additionally, the undersigned concludes that adjustments to Respondent's PR calculations are required to correct the utility deduction (Respondent testified to $120.00 but only deducted $100.00), and the increased SUA after July 1, 2015.

Recalculated PR

37. The wife's pre-deduction self-employment income of $969.58 per month remains correct. Revised deductions include: $41.88 cell phone + $87.06 internet + $120.00 of utilities + $200.00 fuel + $29.00 OnStar + $6.58 [redacted] = $484.52. This results in an adjusted self-employment income ($969.58 - $484.52) of $485.06. The wife's self-employment income of $485.06 added to her monthly SSA of $633.90 equals a total gross community spouse income of $1,118.96 per month.

38. Adding $102.48 in property taxes, $261.16 for insurance ($100.50 home owner's + $160.66 flood), and $337.00 as the Food Assistance Standard Utility Allowance yields $700.64 of subtotaled shelter costs. Multiplying the MMMIA of $1,966.00 by 30% results in $590.00 excess shelter standard. Subtracting this excess shelter standard from the total shelter costs ($700.64 - $590.00), produced an excess shelter costs of $110.64, which added to the MMMIA ($110.64 + $1,966.00), results in a subtotal of $2,076.64 for the Community Spouse Allowance. The Community Spouse Allowance,

minus the community spouse's gross income ($2,076.64 - $1,118.96) results in a Community Spouse Income Allowance of $957.68.

39. Returning to the (proper) calculation of Petitioner's subtotal income ($1,606.00 SSA - $105.00 personal needs allowance = $1,501.00), and subtracting from same the Community Spouse Income Allowance ($1,501.00 - $957.68) yields a new subtotal of $543.32. From this subtotal, Petitioner's hospital insurance is subtracted as an uncovered medical expense ($543.32 - $166.40 insurance) to obtain a Total PR of $376.92 per month.

40. The proper PR for the months of April through June of 2015 is $376.92 per month.

41. For the months of July through October, 2015, the same calculations are utilized; however, the changes to the SUA (increase from $337.00 to $345.00), and to the MMMIA (increase from $1,966.00 to $1,991.00) must be incorporated.

42. Starting with the revised community spouse income of $1,118.96, one then adds $102.48 in property taxes, $261.16 for insurance, and $345.00 as the (new) Food Assistance Standard Utility Allowance, to obtain $708.64 of subtotaled shelter costs. Multiplying the (new) MMMIA of $1,991.00 by 30% results in a $597.00 excess shelter standard. Subtracting this excess shelter standard from the total shelter costs ($708.64 - $597.00), produces an excess shelter costs of $111.64, which added to the MMMIA ($111.64 + $1,991.00), results in a subtotal of $2,102.64 for the Community Spouse Allowance. This Community Spouse Allowance, minus the community spouse's gross income ($2,102.64 - $1,118.96) results in a Community Spouse Income Allowance of $983.68.

43. Petitioner's subtotal income minus this Community Spouse Income Allowance ($1,501.00 - $983.68) results in a subtotal of $517.32. Again, from this subtotal, Petitioner's hospital insurance is subtracted as an uncovered medical expense ($517.32 - $166.40 insurance) to obtain a Total PR of $350.92 per month.

44. The proper PR for each month in July through October of 2015 is $350.92.

45. Respondent is directed to adjust its records in accordance with these calculations, and to advise both Petitioner's wife and the NHF of the proper PR, in writing.

46. Although the undersigned acknowledges the frustration encountered by Petitioner's wife in her attempts to communicate with the Department, and the difficulty she has experienced throughout this process, the hearing officer has no jurisdiction over customer service issues. The undersigned extends apologies for the significant delays towards resolution of this appeal, thanks Petitioner's wife for her patience, and expresses her condolences at the loss of [redacted]

47. The undersigned has adjusted the PR based upon consideration of Petitioner's wife's expenses, as presented. Should the wife encounter a change in circumstances or experience extreme hardship while paying this PR, per Fla. Admin. Code R. 65A-1.712(4)(f), she may present evidence of same to the Department and request reconsideration based upon said hardship. If an adjustment is denied, Petitioner will be notified in writing and may appeal that, specific denial.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Petitioner's appeal is DENIED in that the patient responsibility is not set at $0.00, but GRANTED in that it is reduced further that what Respondent previously calculated.

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 24 day of May, 2016, in Tallahassee, Florida.

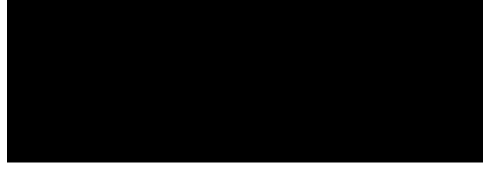
Patricia C. Antonucci
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: appeal.hearings@myflfamilies.com

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

Jun 28, 2016

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 15F-09518

PETITIONER,

vs.

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

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, a hearing convened on May 13, 2016 at approximately 3:00 p.m. before Hearing Officer Patricia C. Antonucci of the Department of Children and Families. All parties and witnesses appeared via teleconference.

APPEARANCES

For the Petitioner:

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

STATEMENT OF ISSUE

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

PRELIMINARY STATEMENT

This matter was previously scheduled to convene via teleconference on December 31, 2015 at 10:00 a.m. On the date of hearing, the hearing officer, Petitioner, and Respondent's representative were on the conference line and ready to proceed, as scheduled; however, Respondent's witness did not join the call. After waiting 15 minutes and attempting to reach the witness, Respondent verified that Petitioner's services would be maintained pending Final Order, and requested a continuance.

Via Notice of Rescheduled Hearing, the parties were informed that hearing would convene on February 23, 2016 at 3:00 p.m. On the designated date and at the designated time, the hearing officer, Respondent, and Respondent's witness were present on the conference line. After waiting 15 minutes, the undersigned noted Petitioner's failure to appear, but indicated that because this matter had been rescheduled to accommodate Respondent, a Preliminary Order of Dismissal would be issued to provide Petitioner opportunity to object to dismissal without hearing. Said Order was issued on March 17, 2016.

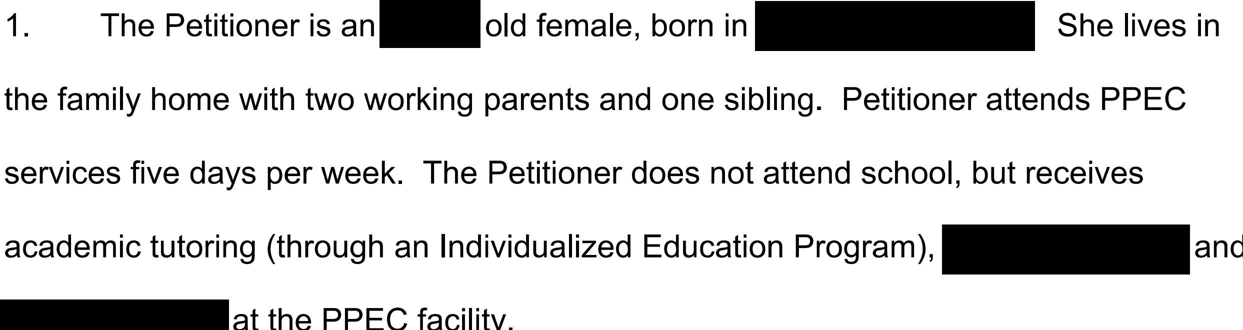
On or about April 5, 2016, [redacted] filed a Notice of Appearance on behalf of AHCA. On April 20, 2016, Petitioner's mother called the Office of Appeal Hearings to note that she had missed hearing on February 23, 2016 due to her nephew's hospitalization. The mother stated she had attempted to follow up on multiple occasions, but had the wrong contact information for the Office, finally obtaining same

from eQHealth Solutions. Petitioner did not receive the Preliminary Order of Dismissal, and requested a rescheduled hearing.

Via notice to all parties, hearing was reset for May 13, 2016 at 3:00 P.M. On May 4, 2016, Mr. Willis filed notification of his withdrawal of representation. Although Mr. Willis did not request to be released as counsel of record, Mr. Willis did not appear for hearing, and Respondent did not indicate any intent to be represented in the proceeding. The minor Petitioner was not present, but was represented by her mother. Respondent was represented by Selwyn Gossett, Medical/Health Care Program Analyst, on behalf of AHCA. Respondent presented one additional witnesses: Rakesh Mittal, M.D., Physician Reviewer with eQHealth Solutions (eQHealth).

Respondent's Exhibits 1 through 5, inclusive, were admitted into evidence. Administrative Notice was taken of Fla. Stat. § 409.905, Fla. Admin. Code R. 59G-1.001, Fla. Admin. Code R. 59G-1.010, Fla. Admin. Code R. 59G-4.260, and pertinent pages of the September 2013 Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook (PPEC Handbook).

FINDINGS OF FACT



1. The Petitioner is an [redacted] old female, born in [redacted] She lives in the family home with two working parents and one sibling. Petitioner attends PPEC services five days per week. The Petitioner does not attend school, but receives academic tutoring (through an Individualized Education Program), [redacted] and [redacted] at the PPEC facility.

2. Petitioner is and has been eligible to receive Medicaid services at all times relevant to these proceedings.

3. The Petitioner is diagnosed with [REDACTED] for which she underwent a [REDACTED] in April of 2014. Since that surgery, she has experienced a reduction in seizures, and although she still has one to five focal seizures (inclusive of 20 or more cluster seizures) during the daytime hours, the seizures last less than one minute, and have not required respiratory or other intervention for over two years. The Petitioner is [REDACTED] ambulates with an unsteady gait, uses [REDACTED] and stumbles/falls multiple times per day. She does not chew properly, is at risk of aspiration when eating, and can only feed herself finger foods. She requires monitoring and supervision throughout the day.

4. Prior to attending PPEC, Petitioner was enrolled in a school-based, special education program. Petitioner's mother does not feel that Petitioner did well in this environment, as the Petitioner was placed with a variety of special education students, some of whom presented a risk to Petitioner's safety. While in school, the Petitioner did not demonstrate much progress or development, and her seizure activity increased. The Petitioner switched to PPEC after she was hospitalized and underwent the corpus callosotomy. While participating in post-surgical, hospital home-bound education, Petitioner's mother noticed that the Petitioner seemed to retain more from one-on-one tutoring than she had while attending school. Petitioner's mother has not had success with local community or school-based resources, but is happy with Petitioner's progress at PPEC.

5. On or about October 29, 2015, Petitioner's PPEC provider submitted a request on behalf of the Petitioner, to continue her previously authorized PPEC services into the new certification period, spanning November 2, 2015 through May 2, 2016.

6. 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).

7. On November 3, 2015 the PRO reviewed Petitioner's request for services and all supporting documentation. By letter dated November 5, 2015, the PRO notified Petitioner's provider of its decision to terminate PPEC, stating, in pertinent part:

> Clinical Rationale for Decision: The patient is an [redacted] and [redacted] The patient's seizures have become better controlled requiring no skilled interventions. The patient is on an age-appropriate diet but requires supervision. The clinical information provided does not support the medical necessity of the requested services; however, 1 month will be approved to allow time to transition the patient out of PPEC. The patient does not appear to require skilled nursing. The remainder of the requested services is denied. Partial approval: PPEC Mon thru Fri 11/5/15 thru 12/4/15.

8. The November 5, 2015 letter, which eQHealth 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 November 17, 2015, Petitioner requested a hearing to challenge the PRO's determination. Petitioner's PPEC services continued at their previously authorized frequency, pending the outcome of his appeal.

10. At hearing, Dr. Mittal explained that he reviewed Petitioner's request for services in conjunction with her Plan of Care, seizure logs, and other supporting documentation. Petitioner's Plan of Care reflects safety precautions, including administration of Diastat and/or use of ventilator, for seizures lasting several minutes or requiring oxygen administration. The Petitioner does not take seizure medications while at PPEC, but is given same by her mother, twice per day.

11. Petitioner's mother asserted that the Petitioner's seizures are jackknife/drop seizures, which can cause her to fall or lose her balance. During these seizures, PPEC staff monitor the Petitioner, pick her up if she falls, and hold her/provide comfort as the seizure dissipates and for several minutes thereafter, until the Petitioner returns to normal. If Petitioner has a "meltdown" during a seizure, PPEC staff take her to a separate room, and staff consistently monitor her respiratory status.

12. The Petitioner is currently enrolled in a seizure study for CBD oil, which requires careful documentation of all seizure activity. Her mother is concerned that if Petitioner is placed in a mainstreamed school environment, her seizures will not be properly monitored, she will regress developmentally, and she will be at risk, due to her lack of safety awareness and inability to make her needs known. Petitioner's mother wants her to remain at PPEC, where she receives intensive therapies and one-to-one care.

13. Based upon his education and clinical experience as a board certified pediatrician, it is Dr. Mittal's opinion that at this time, Petitioner's main risk factors are those associated with all who experience focal seizures and developmental delays. Because the Petitioner's specific seizures are "breakthrough" in nature, there is no skilled intervention or therapy that PPEC can provide to assist in Petitioner's care; indeed, PPEC has not provided a seizure intervention in the past two years. In terms of her need for physical and speech therapy, it is Dr. Mittal's opinion that both of these services, and any other assistive service, such as home health or personal care, can be provided as distinct authorizations, outside of the PPEC environment.

14. In reviewing Petitioner's seizure logs, Dr. Mittal noted that her seizures involve loud noises/screaming, last approximately 20 seconds, and are self-limiting in nature. While Petitioner's caregivers can observe the Petitioner for signs of oncoming seizures, and keep logs of the seizures' duration and any lingering effects, Respondent asserts that these are non-medical/non-skilled nursing activities, which any trained adult can perform. Respondent contends that it is inappropriate to authorize PPEC strictly for monitoring purposes, and that, since there are no skilled nursing interventions which are provided to Petitioner on a regular basis, there is no requirement for nursing services via PPEC.

15. Petitioner's mother contends that Petitioner fits squarely within the definition of a "medically fragile" child, who requires a heightened level of medical supervision. As such, she feels that continued PPEC services are warranted.

CONCLUSIONS OF LAW

16. 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.

17. Respondent, the Agency for Healthcare Administration, administers the Medicaid Program. Legal authority governing the Florida Medicaid Program is found in Fla. Stat., Chapter 409, and in Chapter 59G of the Florida Administrative Code.

18. 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.

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

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

21. The burden of proof in the instant case is assigned to the Respondent. The standard of proof in an administrative hearing is preponderance of the evidence. (See Fla. Admin. Code R. 65-2.060(1).)

22. 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.

23. Page 1-1 of the PPEC Handbook notes that, "[t]he purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) Services Program is to enable recipients under the age of 21 years with medically complex conditions to receive medical and therapeutic care at a non-residential pediatric center." Page 1-2 adds that "PPEC services are not emergency services," (emphasis added).

24. 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.

25. Florida Administrative Code Rule 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)

26. 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 conducts file reviews to determine the medical necessity of requested services, pursuant to the authorization requirements and limitations of the Florida Medicaid Program.

27. 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.

28. 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.

29. 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.

30. 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).

31. In the instant case, PPEC is requested to treat and ameliorate the supervisory needs which Petitioner's seizure disorder and developmental delay present. As such, in a general sense, PPEC is in keeping with Fla. Admin. Code R. 59G-1.010(166)(1). Because PPEC is a recognized Medicaid service, it is consistent with generally accepted medical standards, per Fla. Admin. Code R. 59G-1.010(166)(3).

32. 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 fulfill the requirements for PPEC, as provided in the PPEC Handbook.

33. There is little evidence to suggest that the Petitioner is dependent upon 24-hour per day medical or nursing care, or that she is dependent upon life-sustaining medical equipment. While her mother is correct to note that Petitioner requires increased supervision, thankfully, it cannot be said that "without such… [supervision, the Petitioner] is likely to expire without warning." Petitioner's need for monitoring of seizure activity does not constitute a need for "intermittent continuous therapeutic interventions or skilled nursing care," and although she does receive both speech and physical therapy at PPEC, these services are limited to provision within specific blocks of time, each week.

34. As such, Petitioner's needs do not support the authorization of PPEC, because there are alternative services, such as in-school nursing care, personal care assistance, and outpatient or in-school therapies, that are better designed to meet those needs, without being in excess of same. PPEC cannot be authorized as a substitute for school, particularly when there is no skilled nursing intervention provided at the PPEC site, nor can PPEC be continued just in case Petitioner's seizures worsen. In essence, this would constitute approval of PPEC as an emergency service, in direct violation of the PPEC Handbook (page 1-2).

35. 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 AHCA has met its burden of proof, and shown that denial of PPEC services is appropriate in the instant case.

36. Petitioner's mother is strongly encouraged to communicate with eQHealth, the Agency for Health Care Administration, and her local school board, to ensure that Petitioner makes as smooth a transition as possible out of PPEC and into a school-based setting, with all pertinent supports and auxiliary services (particularly physical and speech therapy) in place. AHCA is encouraged to contact Petitioner's mother to discuss her options, and to assist in locating resources within her community and Medicaid coverage area.

37. Should Petitioner's health change, such that she requires skilled nursing, or should she need any other services to meet her medical and developmental needs, Petitioner may request such services at any time. Upon review, she will be notified in writing of the Agency's decision, and of her right to request hearing on any, 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.

DONE and ORDERED this 28 day of June, 2016,

in Tallahassee, Florida.

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

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

May 27, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 15F-09846

PETITIONER,

Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 08 Alachua
UNIT: 88265

RESPONDENT.
________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on April 12, 2016 at 11:36 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 November 24, 2015 denying his application for SSI-Related Medically Needy due to exceeding the asset limit. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The Department submitted evidence on December 31, 2015, which was entered as Respondent Exhibit 1.

FINDINGS OF FACT

1. The petitioner submitted an application for SSI-Related Medicaid on November 12, 2015. The petitioner's household consists of himself (age 54) and his wife (age 58). The petitioner and his wife report they are disabled individuals.

2. The petitioner reports they have the home they reside in and another piece of property that his wife inherited upon her mother's death.

3. The Department excluded the petitioner's current home from the eligibility determination as homestead property.

4. The Department verified the market and assessed value of the wife's property is $8,966. The Department included this property in the eligibility determination.

5. The Department issued a Notice of Case Action on November 24, 2015 informing the petitioner the application for Medically Needy was denied as "The value of your assets is too high for this program".

6. The petitioner reported the state has notified them that the property they reside on will be taken by the state for widening the road that is currently in front of their home. The petitioner does not know if the state will pay them for the property. The petitioner does not know how long it will be before they must vacate the property.

7. The petitioner explained they will have to purchase a new home and have a well and septic installed on the property his wife owns in order to move to that property.

8. The Department reported the Asset Limit for a couple for SSI-Related Medically Needy is $6,000. The petitioner's non-homestead property valued at $8,966 exceeds this asset limit.

9. The petitioner is concerned about how to pay for their growing medical expenses. He is now on oxygen. His wife is on [redacted] three times per week. Their sole source of income is from Social Security Disability.

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

> (5) Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. §§ 1396a and 1396d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance due to their level of income or resources. The program does not cover nursing facility care, intermediate care for the developmentally disabled services, or other long-term care services.

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

> (1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is

the SSI limit specified in Rule 65A-1.716, F.A.C., with the following exceptions:
(a) For Medicaid for the Aged or Disabled Demonstration Waiver (MEDS-AD), an individual whose income is equal to or below 88 percent of the federal poverty level must not have resources exceeding the current Medically Needy resource limit specified in Rule 65A-1.716, F.A.C.
...
(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.
...
(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

14. 20 C.F.R. § 416.1201 “Resources; general” states in relevant part:

(a) Resources; defined. For purposes of this subpart L, resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance.

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

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

15. 20 C.F.R. § 416.1210 “Exclusions from resources; general” states in relevant part:

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 self-support as provided in §416.1222;
(e) Nonbusiness property which is essential to the means of self-support as provided in §416.1224;
...

(h) Life insurance owned by an individual (and spouse, if any) to the extent provided in §416.1230;
...
(l) Burial spaces and certain funds up to $1,500 for burial expenses as provided in §416.1231;
...
(q) Relocation assistance from a State or local government as provided in §416.1239;

16. The findings show the petitioner and his wife own their homestead property and a second parcel of property which has a value of $8,966. In accordance with the above controlling authorities, the homestead property is excluded from resource calculations.

17. The findings show the petitioner intends to move to the second parcel of property upon loss of the homestead property to the state. The undersigned thoroughly researched the controlling authorities and found no authority that will allow the second parcel to be excluded prior to the parcel becoming the petitioner's homestead. The undersigned concludes the Department correctly counted the value of the second parcel in the resource or asset eligibility determination.

18. Fla. Admin. Code R. 65A-1.716 "Income and Resource Criteria" states in relevant part:

(3) The resource limits for the Medically Needy program are as follows:

Family Size	Monthly Asset Level
1	$5,000
2	$6,000

19. The undersigned searched all authorities and found no exclusion allowed for a parcel of property that is not income producing or the home. The undersigned concludes the non-homestead parcel of land valued at $8,966 must be counted, as it

does not meet an exclusion. The undersigned concludes the value of the non-homestead property at $8,966 exceeds the resource or asset limit of $6,000 for a couple. The undersigned concludes the Department correctly denied the petitioner's application for Medically Needy due to exceeding the resource limitation.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 27 day of Mav, 2016,

in Tallahassee, Florida.

Melissa Roedel

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

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

Jun 10, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 15F-09860

PETITIONER,

Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 Seminole
UNIT: 88003

RESPONDENT.

_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter at 8:45 a.m. on April 27, 2016; at the Department of Children and Families,

APPEARANCES

For the Petitioner:

For the Respondent: Stefanie Camfield, Esq.
Department of Children and Families

STATEMENT OF ISSUE

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

PRELIMINARY STATEMENT

By notices dated November 3, 2015 and April 20, 2016, the respondent (or the Department) notified the petitioner she was denied Medicaid. Petitioner timely requested a hearing to challenge the denial.

Petitioner was present and provided testimony. [redacted] appeared as a witness for the petitioner. Appearing as witnesses for the respondent were Laruen Coe, Department of Health Division of Disability Determination (DDD), Program Operations Administrator and Susan Martin, ACCESS Operations Management Consultant.

Petitioner submitted 11 exhibits, entered as Petitioner Exhibits “1” through “11”. Administrative notice was taken of Federal Regulation 20 C.F.R § 404.1520 and 20 C.F.R § 404.1560. Respondent submitted eight exhibits, entered as Respondent Exhibits”1” through “8”. The record remained open through end of business day on April 27, 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 27, 2016.

FINDINGS OF FACT

1. Petitioner, age 31, has a master degree in education. Petitioner has suffered with [redacted] for years. And on May 26, 2015, petitioner suffered a severe migraine headache while at work as a daycare teacher; resulting in petitioner falling and striking her head. Consequently, petitioner suffers from [redacted] Petitioner’s last seizure was in June 2015. Petitioner also lost her long term memory; she only remembers from June 2015.

2. Petitioner's Neurologist (Dr. H) diagnosed petitioner with [redacted] and recommended further psychological evaluation. Petitioner was referred to the [redacted] met with the petitioner in August 2015 and determined that petitioner required additional testing. Also in August 2015, petitioner discovered that she no longer had medical insurance through her former employer.

3. Petitioner submitted Medicaid applications for herself on August 17, 2015 and October 15, 2015; both applications indicate petitioner is disabled. Both applications list household members as petitioner and her husband; petitioner does not have children. Petitioner moved in with her parents in August 2015; she is in the process of a divorce.

4. The Department disposed petitioner's October 15, 2015 application as duplicate; due to the August 17, 2015 application being reviewed for disability.

5. To be eligible for Medicaid without children, applicants under age 65 must be blind or considered disabled by the Social Security Administration (SSA) or DDD. DDD is responsible for determining disability eligibility on behalf of the Department.

6. Petitioner applied for disability through the SSA on August 21, 2015. The SSA denied petitioner on January 6, 2016 and again on March 14, 2016. Petitioner is appealing the SSA denial through an attorney.

7. On September 10, 2015, the Department sent the petitioner's disability documentation to DDD for review. And on October 30, 2015, DDD denied petitioner disability with code N31: non-pay capacity for substantial gainful activity - customary past work, no visual impairment.

8. On November 3, 2015, the Department mailed petitioner a Notice of Case Action (NOCA), notifying her August 17, 2015 application was denied "Reason: Your or member(s) of your household do not meet the disability requirement."

9. Petitioner's hearing was originally scheduled to convene telephonically on January 13, 2016. On January 13, 2016, both parties appeared for the scheduled hearing; petitioner requested a continuance. The continuance was granted.

10. The Department completed another DDD interview with the petitioner and determined her medical condition had worsened. And on March 9, 2016, the Department sent petitioner's documentation of her worsened condition to DDD for review.

11. Ms. Coe, respondent's witness, stated that although the SSA recently denied petitioner disability and petitioner is currently appealing the SSA denial, DDD completed an independent disability review.

12. DDD utilizes a Federal Regulation five-step sequential evaluation process in determining disability. Dr. TC, Ph.D., completed the Physical Residual Functional Capacity (PRTF) and the Mental Residual Functional Capacity (MRFC) Assessments. ZT, Disability Examiner, completed the remainder of the evaluation.

13. Ms. Coe stated that ZT is not a medical doctor and neither ZT nor Dr. TC are vocational experts. And the only requirement of individuals completing disability reviews are to be trained by DDD.

14. Ms. Coe stated medical records for the petitioner were reviewed from 2015. However, Ms. Coe did not know which medical records were reviewed or the specific

time period; as “she did not work the case”. The Hearing Officer allowed a recess for Ms. Coe to review the medical records and provide a summary of the medical records and time period of the medical records. Ms. Coe refused to provide the summary and time period stating “she only had electronic documents”.

15. The following are petitioner results (in bold) of DDD’s five-step evaluation:

> Step 1: Determines if the claimant is presently engaging in substantial gainful employment. **No**
> Step 2: Determines severity of claimant’s impairment(s). **Yes**
> Step 3: Determines if impairment(s) meet or equal listings set forth in federal regulations. **No**
> Step 4: Determines if the claimant is able to return to previous work. **NO**
> Step 5: Determines if the claimant is able to perform work in the national economy. **Yes**

16. Although Step 1 is part of the DDD process, Ms. Coe said DDD does not determine Step 1. Petitioner has not been employed since May 2015; therefore, she is presently not engaging in substantial gainful employment.

17. Petitioner’s impairments considered severe in Step 2 were: asthma, non-epileptic seizures, mental health and depression.

18. Although Step 3 indicates NO, Ms. Coe said petitioner’s impairments met or equaled listings 3.03 asthma, 11.03 seizure, 12.02 mental disorder and 12.04 depression disorder in the Federal Regulations.

19. DDD determined in Step 4 that petitioner is unable to return to her previous teacher work. DDD determined that petitioner maintains the functional capacity to perform light physical exertion work.

20. In Step 5, DDD provided the following jobs they believe the petitioner can perform:

Fruit Cutter	521.687-066
Silver Wrapper	318.687-014
Produce Weighed	299.587-010

21. Petitioner's representative disputed that 318.687-014 is a Silver Wrapper job. She provided a description of 318.687-014; Scullion, performs any combination of tasks involved in clearing ship's galley, bakery and butcher shop.

22. Ms. Coe stated that 318.687-014 is a typographic error and the correct number for Silver Wrapper is 318.687-018.

23. DDD's Case Analysis, dated April 19, 2016, in part states:

> A doctor from neurology found the movements to be non epileptic in nature, but rather [redacted] The evaluation from 7/3/15 suggests a complicated migraine history w/likely non-epileptic psychogenic seizures along with an unusual presentation of loss of biographical memory and historical information along w/new onset of stuttering. She indicates having no memory problems for new information starting from the incident w/normal short term memory as well/Multiple CT scans and MRIs of the head were read as negative for any acute abnormalities. The clmt also has PMH of asthma. According to the available MER there is not MDI for GERD or Lupus.
>
> ADLs: She is able to do her own personal care and household chores. She is able to walk for about 10 minutes before stopping and she does not use any assistive devices. She is able to lift 15-20 pounds. She is able to drive and do her own shopping. On a typical day she goes to doctor appointments.
>
> Mental: There are no mental allegations and she is not seeing a mental health doctor. MER indicates some [redacted] but the clmt is unaware of any psychiatric history. According to the PRTF by Dr. Thomas Clark the clmt has mild restriction in ability to perform ADLs and difficulty in maintaining social functioning. She has moderate difficulty in maintaining concentration, pace and persistence. There have been no episodes of decompensation lasting for an extended duration. According to her MRFC the clmt can consistently and usefully perform routine tasks on a sustained basis, with minimal (normal) supervision, and can cooperate effectively w/public and co-workers in completing simple task and instruction.

> Summary/Decision; Based on the MER and the clmt's physical condition she will be given a light RFC and would be able to return to PRW, however due to the MRFC by Dr. Thomas Clark, Ph.D. the clmt is only able to do SRTs and therefore is excluded from doing PRW as a daycare teacher…

24. On April 19, 2016, DDD denied petitioner disability. And on April 20, 2016, the Department mailed the petitioner a NOCA, notifying she was denied Medicaid.

25. Petitioner stated that she goes to bed and wakes up with a migraine every day and some days she is unable to get out of bed, due to the severity of the migraine. Petitioner said she takes medicine for her migraine which helps, but does not totally take her headache away.

26. On good days petitioner helps around the house. She cooks, cleans and can drive a short distance. And on bad days she "lays in front of the television".

27. Petitioner said she can't follow a long list of instructions at once, because she gets frustrated. She stated, "For example, if I have instruction "A" through "E", I have to be given instruction "A" and complete instruction "A" before given instruction "B" and so forth."

28. Petitioner attends [redacted] (VH) and is seeing a speech therapist. VH completed cognitive and IQ testing; test results indicate that additional medical assistance is required prior to becoming employable.

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

§ 409.285, Fla. Stat. 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. Federal Regulations at 42 C.F.R. § 435.541, Determinations of Disability in part states:

> (a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...
> (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under § 435.909.
> (b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c) (3) of this section-
> (i) **An SSA disability determination is binding on an agency until the determination is changed by SSA.** (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 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**, (emphasis added) alleges a new period of disability which meets the durational requirements of the Act. and-
> (A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or (B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility…

32. The above Federal Regulation explains the Department must make a determination of disability if "less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated".

33. The evidence submitted establishes the Department determined that the petitioner's medical condition had worsened since she applied for disability through the SSA in August 2015. And in March 2016 the Department requested DDD complete another disability determination.

34. Ms. Coe testified that although the SSA denied petitioner disability on January 6, 2016 and again in March 2016, DDD completed a five-step disability determination.

35. 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. See §416.920b.

> (4) The five-step sequential evaluation process. The sequential evaluation process is a series of five "steps" that we follow in a set order. If we can find that you are disabled or not disabled at a step, we make our determination or decision and we do not go on to the next step. If we cannot find that you are disabled or not disabled at a step, we go on to the next step. Before we go from step three to step four, we assess your residual functional capacity. (See paragraph (e) of this section.) We use this residual functional capacity assessment at both step four and at step five when we evaluate your claim at these steps. These are the five steps we follow:
>
> (i) At the first step, we consider your work activity, if any. If you are doing substantial gainful activity, we will find that you are not disabled. (*See* paragraph (b) of this section.)
>
> (ii) At the second step, we consider the medical severity of your impairment(s). If you do not have a severe medically determinable physical or mental impairment that meets the duration requirement in § 416.909, or a combination of impairments that is severe and meets the duration requirement, we will find that you are not disabled. (*See* paragraph (c) of this section.)
>
> (iii) At the third step, we also consider the medical severity of your impairment(s). If you have an impairment(s) that meets or equals one of our listings in appendix 1 to subpart P of part 404 of this chapter and meets the duration requirement, we will find that you are disabled. (*See* paragraph (d) of this section.)
> (iv) At the fourth step, we consider our assessment of your residual functional capacity and your past relevant work. If you can still do your past relevant work, we will find that you are not disabled. (See paragraph (f) and (h) 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) and (h) of this section and § 416.960(c)...

36. In accordance with the above authority, DDD utilized the five step sequential evaluation process in determining petitioner's disability.

37. Petitioner met the first step because she is not presently employed.

38. Petitioner met the second step; medical severe impartments considered were:

39. Petitioner met the third step; list of impairments petitioner met or equaled are: 3.03 11.03 12.02 and 12.04

40. Petitioner met the four step; DDD determined petitioner is unable to return to her previous teacher employment. DDD determined petitioner maintains the functional capacity to perform light physical exertion work.

41. In Step 5, DDD provided the following jobs the petitioner can perform:

Fruit Cutter	521.687-066
Silver Wrapper	318.687-018 (corrected number)
Produce Weighed	299.587-010

42. Federal Regulation 42 C.F.R. § 435.541 (#31) explains that the SSA determination is binding on the Department. And states the Department must make a determination of disability if the applicant "Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations." In petitioner's case, the SSA has not refused reconsideration, reopening of its disability decision or consider new allegations. Petitioner is currently appealing the SSA denial decision through an attorney.

43. In careful review of the cited authorities, evidence and testimonies, the undersigned concludes that the SSA denial decision overrides DDD's denial decision. Therefore, the Hearing Officer agrees with the petitioner's Medicaid Disability denial; due to the January 2016 and March 2016 SSA denial decisions.

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 10 day of June, 2016,

in Tallahassee, Florida.

Priscilla Peterson

Priscilla Peterson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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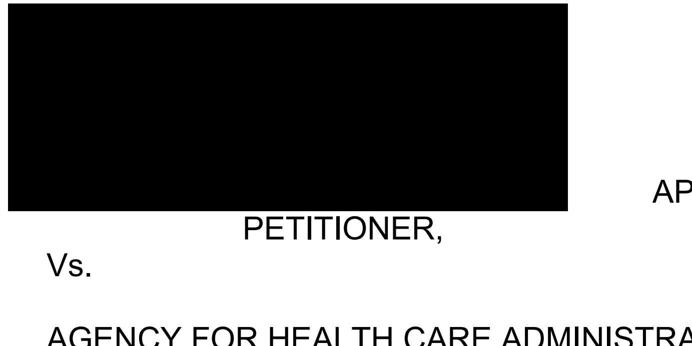
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted], Petitioner
Office of Economic Self Sufficiency
Stefanie Camfield, Esq.

May 12, 2016

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 15F-09969

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 14 Bay
UNIT: AHCA

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on April 8, 2016 at 8:33 a.m.

APPEARANCES

For the Petitioner:

For the Respondent: Willis F. Melvin, Esq.
Kevin D. Dewar, Esq.

STATEMENT OF ISSUE

Whether respondent's proposed termination of petitioner's Pediatric Extended Care (PPEC) services 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

The matter was first scheduled for January 19, 2016. On January 15, 2016

respondent's request for a continuance was received and granted. The matter was rescheduled for February 26, 2016. Prior to starting the hearing, it was determined petitioner's proposed exhibits had not been received by the undersigned. Respondent was not able to confirm receipt of the exhibits. As such, the matter was rescheduled for April 8, 2016.

Present for the petitioner was his mother, [redacted] Petitioner's exhibits "1" and "2" were accepted into evidence.

Present for the respondent from the Agency for Healthcare Administration was Dianne Soderlind, Registered Nurse Specialist. Present from eQHealth Solutions (eQHealth) was Dr. Ellyn Theophilopoulos, M.D. Respondent's Exhibits "1" and "2" were accepted into evidence.

Administrative Notice was taken of Florida Statutes §409.905; §409.913; and §409.9131; Fla. Admin. Code R. 59G-1.010 and the Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook (PPEC Handbook).

The record was held open through April 15, 2016 for respondent to provide pages 222 – 242 of their evidence packet. Information was timely received and entered as respondent's exhibit "3".

The record was held open through April 22, 2016 for petitioner to respond to the above post hearing submission and to respondent's exhibits received on April 7, 2016. A response was not received.

The record was also held open through April 22, 2016 for either party to submit a Proposed Final Order. A proposed order was received from the respondent on April 22, 2016 and from the petitioner on April 25, 2016.

FINDINGS OF FACT

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

1. Petitioner's date of birth is [redacted] He was Medicaid eligible at all times relevant to this proceeding.

2. Petitioner resides with his mother. She is employed outside of the household.

3. Petitioner receives no skilled nursing services while in the family home.

4. Petitioner's medical history includes [redacted] Such has resulted in [redacted] Petitioner is also diagnosed with [redacted]

5. To address [redacted] petitioner is prescribed medication. One dose of the medication is administered at the PPEC facility.

6. Correspondence dated March 9, 2016 from Willard Anderson, MS, ARNP from Florida Therapy Services notes a diagnosis of [redacted]

7. Petitioner recently started seeing a psychiatrist.

8. Petitioner's medical status does not include:

- A gastrostomy tube for feeding
- A tracheostomy
- Suctioning
- Oxygen therapy
- A ventilator
- The use of any type of catheter
- A colostomy or ileostomy
- Intravenous medications or fluids
- Skin ulcers or other conditions which require dressing changes

[1] A documented seizure has not occurred in at least one year.

9. Petitioner eats a regular diet; experiences nighttime urinary incontinence; and is able to independently transfer.

10. Due to his [redacted] petitioner has limited depth perception. When walking, he has an unsteady gate.

11. Although balance issues exist, petitioner is able to ambulate on both even and uneven surfaces.

12. Petitioner attends public school each weekday. He is in a specialized education program for students with an intellectual disability. At school he received physical; occupational; and speech therapies.

13. A skilled nurse does not accompany petitioner to school.

14. At time of hearing, petitioner was attending a PPEC facility each weekday after school. The approximate hours are from 2:00 p.m. to 5:00 p.m. Speech therapy was recently ordered to be received at the PPEC.

15. PPEC services are facility based and provide medical care and certain therapies for Medicaid eligible individuals under 21 years of age who have complex conditions. PPEC facilities are staffed with skilled nurses.

16. eQHealth is the Peer Review Organization contracted by the respondent to perform prior authorization reviews for PPEC services.

17. Physician reviewers at eQHealth considered a Plan of Care (POC) for PPEC Services submitted by petitioner's physician. The POC stated, in part:

> To attend PPEC part time after school and full time during school breaks and on non-contagious sick and/or recovery days while mother works.
>
> Regarding Chronic Encephalopathy: PPEC to Observe for signs indicating cerebral hypoxia and/or deteriorating cerebral status.

> PPEC to Observe for and Manage Seizures
>
> Regarding Vision: PPEC to monitor gross/fine motor skills and activities d/t limited vision in right eye causing depth perception problems resulting in potential for injury to self and others.

18. The physician also ordered regular checks of heart rate and blood pressure.

19. For the PPEC certification period dated October 3, 2015 through March 3, 2016 an eQ physician completed a review of information submitted by petitioner's PPEC provider.

20. On October 13, 2015, a Notice of Outcome – Partial Denial of Prescribed Pediatric Extended Care Services was issued to the petitioner's parent; physician; and PPEC provider. The notice sent to the physician stated, in part:

> The clinical information provided does not support the medical necessity of the requested services; however, 3 months will be approved to allow time to transition the patient out of PPEC. Partial approval, PPEC: Mon thru Fri 10/3/15 thru 1/3/16 the remainder of services is denied for following dates: 1/4/16 thru 3/3016.

21. 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.

22. Reconsideration was requested.

23. A second physician reviewer thereafter reviewed all information submitted both before and after the initial denial. On November 12, 2015 eQHealth issued a Notice of Reconsideration Determination. The original denial was upheld.

24. On November 23, 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.

25. In support of continuation services, petitioner's PPEC provider wrote, in part:

> With the continuing concern for safety, PPEC's 3:1 ratio provides an environment of diligent supervision. PPEC provides the required environment that maintains the Health, Safety and Well-Being of this compromised child.
>
> Typical day care CAN NOT provide the level of care or the supervision required to maintain the safety, health and well-being of this child. Continuity of care is lost and medical supervision is compromised if this child is required to attend a typical care setting.

26. Petitioner argues a safety risk would exist if a regular daycare facility were utilized. The petitioner will hit his head against the wall and it can be difficult to calm him down. Additionally, the family resides in a small community with limited resources.

27. Dr. Theophilopoulos was qualified as an expert witness regarding medical necessity determinations in the Florida Medicaid Fair Hearing process. Dr. Theophilopoulos agrees with the decisions rendered by other physician reviewers at eQHealth.

<u>CONCLUSIONS OF LAW</u>

28. 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.

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

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

31. 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.

32. The PPEC Handbook (September 2013) has been promulgated into rule by Fla. Admin. Code R. 59G-4.260.

33. 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.”

34. 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.

35. 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.

36. 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."

37. 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.

38. 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.

39. 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.

40. 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.

41. Petitioner’s diagnoses are not short term in nature. As such, they are considered as chronic. Based on these diagnoses, petitioner requires supervision. To qualify for PPEC services, however, petitioner must either be medically complex or medically fragile.

42. Analysis is first directed to the definition of medically complex. The Findings of Fact establish petitioner does not received skilled nursing interventions while in the family home. Additionally, he does not have a skilled nurse who accompanies him to school.

43. Evidence does not establish petitioner’s medications are to be administered only by a skilled nurse.

44. The Findings of Fact also establish petitioner has not experienced a documented seizure for at least one year. A skilled nursing intervention such as the administration of medication or oxygen has not been needed.

45. Petitioner's vision issues and corresponding ambulation concerns are noted. The greater weight of evidence does not establish a skilled medical professional must provide assistance with walking. Consequently, the level of assistance needed could be provided by any responsible adult who is both cognitively and physically able.

46. Regarding monitoring of [redacted] the POC states PPEC staff is to observe for signs of [redacted]. Compelling evidence, however, was not presented that any of these concerns have occurred and a response initiated. It is noted that page 1-2 of the PPEC Handbook states "PPEC services are not emergency services."

47. The greater weight of evidence does not establish petitioner currently meets the definition of being medically complex. This definition must be satisfied to qualify for PPEC services.

48. Regarding the definition of medically fragile, Fla. Admin Code R. 59G-1.010 (165) requires the individual be both medically complex and technologically dependent on medical equipment to sustain life.

49. The Findings of Fact establish petitioner breathes independently; does not require suctioning; takes all nutrition by mouth; does not have a colostomy or ileostomy; and has no catheters. No evidence was presented any medication is administered intravenously. Additionally, compelling evidence was not presented that petitioner

requires an advanced level of medical supervision to sustain life and the absence of such would lead to death.

50. The greater weight of evidence does not establish petitioner meets the definition prescribed by Florida Administrative Code of being either medically complex or medically fragile.

51. The undersigned notes that speech therapy was recently initiated at the PPEC. The Findings of Fact establish the therapy is also received at school. Evidence did not establish the additional speech therapy could not be provided either at another type of daycare facility or in the family home.

52. When considering the requirements of EPSDT; the PPEC Handbook; and medical necessity criteria, the respondent has met the required evidentiary burden in this matter.

53. Respondent has demonstrated that petitioner's request for continuation of PPEC services has not satisfied the following conditions of medical necessity:

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

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees 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 May, 2016,

in Tallahassee, Florida.

Frank Houston

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

Copies Furnished To:

MARSHALL WALLACE, AREA 2, AHCA FIELD OFFICE MANAGER
KEVIN DEWAR, ESQ.
WILLIS MELVIN, ESQ.
JERRILYNN HADLEY, ESQ.

May 23, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 15F-10368

PETITIONER,

Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pinellas
UNIT: 88510

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened two telephonic administrative hearings in the above-referenced matter on February 26, 2016 at 9:41 a.m.; and on April 14, 2016 at 9:02 a.m. Two continuances were granted for the petitioner.

APPEARANCES

For Petitioner:

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

STATEMENT OF ISSUE

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

PRELIMINARY STATEMENT

Petitioner was present and testified at both hearings. At the February 2016 hearing, the petitioner submitted one exhibit, which was entered and marked as Petitioner's Exhibit "1". At the April 2016 hearing, the petitioner submitted one exhibit, which was initially entered and marked as Petitioner's Exhibit "1"; however, subsequent to the hearing, the documentation was reentered and remarked as Petitioner's Exhibit "2". At the February 2016 hearing, the respondent was represented by Signe Jacobson with the Department of Children and Families (hereafter "DCF", "Respondent" or "Agency"). Ms. Jacobson testified. At the February 2016 hearing, the respondent submitted ten exhibits, which were entered and marked as Respondent's Exhibits "1" through "10". At the April 2016 hearing, the respondent was represented by Mary Lou Dahmer with DCF. At the April 2016 hearing, the respondent submitted five exhibits, which were entered and marked as Respondent's Exhibits "11" through "14".

At the April 2016 hearing, the record was left open until April 21, 2016 to allow the respondent to submit additional information. On April 18, 2016, the petitioner submitted additional information which was entered and marked as Petitioner's Exhibit "3". On April 20, 2016, the respondent submitted additional information which was entered and marked as Respondent's Exhibit "15". The record closed on April 21, 2016.

FINDINGS OF FACT

1. On July 8, 2015, the petitioner applied for Supplemental Security Income (SSI) benefits from the Social Security Administration (SSA). On September 30, 2015, SSA denied petitioner's SSI application using the code N32. N32 means "Non-pay-Capacity for substantial gainful activity – other work, no visual impairment". On November 25,

2015, the petitioner appealed the denial of her SSI application and that appeal is currently pending.

2. On October 29, 2015, petitioner submitted an application for Food Assistance (FA) and SSI-Related Medicaid benefits. FA benefits are not an issue. On the application petitioner claimed to be disabled; and having health conditions that have changed since the SSI denial.

3. On November 4, 2015, the respondent mailed petitioner a Notice of Case Action requesting she submit the following documentation: "Please read the disability pamphlet; Please complete and sign the Authorization to Disclose Information Form; and Please complete and sign the Informed Consent Form."

4. On November 5, 2015, the petitioner submitted the Authorization to Disclose Information Form.

5. On December 1, 2015, the respondent mailed petitioner a Notice of Case Action indicating her Medicaid application dated October 29, 2015 was denied as, "No household members are eligible for this program".

6. On December 28, 2015, the respondent determined petitioner required a disability phone interview as her on-line application indicated her health condition had changed since her SSI denial.

7. On December 29, 2015, the respondent mailed petitioner a Notice of Case Action requesting she complete a phone interview on or before January 4, 2016 to discuss her Department of Health Division of Disability Determination (hereafter "DDD") eligibility.

8. On March 3, 2016, the respondent completed a DDD phone interview with petitioner.

9. On March 3, 2016, the respondent submitted both the Disability Determination and Transmittal form (Respondent's Exhibit 11) and a packet of medical information to DDD to determine if petitioner met the criteria to be considered disabled.

10. On March 4, 2016, the respondent mailed petitioner a Notice of Case Action requesting the petitioner submit "verification that your new/worsening condition has been reported to the Social Security Administration" by March 14, 2016.

11. On March 9, 2016, DDD determined petitioner not disabled using the denial code N32. The Disability Determination and Transmittal form had "Hankerson 1/16 same allegations, hearing pending" handwritten on it. The document also listed petitioner's primary diagnosis as Back D/O; listed petitioner's secondary diagnosis as Sprain/Strain; and listed petitioner's age as 52 years old.

12. On April 13, 2016, the respondent mailed petitioner a Notice of Application Disposition indicating her October 29, 2015 application for "Medicaid was denied because criteria for disability was not met, Rule 65A-1.710 & 65A-1.711".

13. Sometime in March 2016, the petitioner reported her new and worsening medical condition to her attorney (Petitioner's Exhibit "2" page 5) handling her SSI appeal to forward this new information to SSA; petitioner indicated SSA has been made aware of her new and worsening condition.

14. Petitioner's new and/or worsening conditions are a [REDACTED] Subsequent to the hearing, petitioner submitted evidence that she has a new diagnosis of [REDACTED]

15. Respondent argued the medical evidence concerning the [REDACTED] was not included in the packet sent to DDD on March 3, 2016.

16. Respondent determined petitioner was not eligible for Family-Related Medicaid benefits as she had no children under the age of eighteen living with her; and was not eligible for SSI-Related Medicaid benefits as she was under the age of 65 and had not been determined disabled by SSA.

CONCLUSIONS OF LAW

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

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

19. 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…

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

21. Fla. Admin. Code R. 65A-1.711 sets forth the rules of eligibility for SSI-Related Medicaid Coverage Groups. The MEDS-AD Demonstration Waiver is a coverage group for aged and disabled individuals (or couples), as provided in 42 U.S.C. § 1396a(m). For an individual less than 65 years of age to receive Medicaid benefits, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. The regulation states, in part:

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

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

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

> (a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.
> ….
> (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under §435.909…
> (b) Effect of SSA determinations. (1) Except in circumstances specified in paragraph (c)(3) of this section—
> (i) An SSA disability determination is binding on an agency until the determination is changed by SSA.
> …
> (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…

24. Petitioner applied for SSI benefits on July 8, 2015 and was denied SSI benefits on September 30, 2015 pursuant to code N32. On October 29, 2015, the petitioner applied for Medicaid benefits with the respondent. On November 25, 2015, the petitioner appealed her SSI denial with SSA. On March 9, 2016, DDD determined petitioner not disabled by adopting a January 2016 SSI denial. On April 13, 2016, the respondent denied petitioner’s application for SSI-Related Medicaid benefits as DDD adopted a SSA decision from January 2016.

25. Petitioner is appealing her SSI denial with SSA; therefore, SSA is reconsidering its denial of petitioner's SSI application though its appeal process. Although there is insufficient evidence to support DDD's adoption of a January 2016 SSA denial, the petitioner has a current and pending appeal with SSA. At the hearing, the petitioner alleged a new condition that is known to the SSA. Subsequent to the hearing, petitioner reported a new condition that may or may not be known to SSA. There is insufficient evidence to indicate petitioner has reported the second new condition to SSA. Under these circumstances, the controlling authorities preclude the respondent from rendering an independent disability determination. Accordingly, the SSA federal determination remains binding on the respondent.

26. Therefore, the respondent was correct to adopt SSA's denial decision as the petitioner has one new medical condition known to SSA, a second new medical condition that may not be known SSA, and a SSI denial that is within twelve months of her Medicaid application.

27. In careful review of the cited authorities and evidence, the undersigned concludes that petitioner has not met her burden of proof to indicate the respondent incorrectly denied her October 29, 2015 application for SSI-Related Medicaid benefits.

28. Petitioner is encouraged to report her new medical condition to the Social Security Administration so it may be added to her pending Supplemental Security Income appeal.

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 23 day of May, 2016,

in Tallahassee, Florida.

Mary Jane Stafford

Mary Jane Stafford
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

Jun 02, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 15F-10441

PETITIONER,

Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pinellas
UNIT: 88267

RESPONDENT.
_________________________________/

FINAL ORDER

The undersigned convened two administrative hearings by phone in the above-referenced matter on January 27, 2016 at 9:12 a.m.; and on May 12, 2016 at 10:29 a.m. One continuance was granted for the petitioner and one continuance was granted for the respondent.

APPEARANCES

For Petitioner:

For Respondent: Signe Jacobson, Supervisor

STATEMENT OF ISSUE

At issue is whether respondent's action to deny petitioner's request for Family-Related Medicaid benefits for the month of November 2015 is correct. The burden of proof is assigned to the petitioner by a preponderance of the evidence.

PRELIMINARY STATEMENT

At both hearings, the petitioner was not present but was represented by [redacted] who testified. Petitioner submitted no exhibits at the hearings. At both hearings, the respondent was represented by Signe Jacobson, Supervisor, with the Department of Children and Families (hereafter "DCF", "Respondent" or "Agency"). Ms. Jacobson testified. Teresa Bowman, Revenue Specialist II, with the Department of Revenue Child Support Enforcement Unit (hereafter "CSE") appeared at the January 2016 hearing; however, she did not testify. Ms. Bowman did not appear for the May 2016 hearing. At the January 2016 hearing, the respondent submitted eight exhibits, which were accepted into evidence and marked as Respondent's Exhibits "1" through "8".

FINDINGS OF FACT

1. On October 23, 2014, the respondent received a request from the Department of Revenue Child Support Enforcement Unit (CSE) to impose a sanction on petitioner for the absent parent J.S. Petitioner's Family-Related Medicaid was terminated effective November 30, 2014.

2. On August 14, 2015, the petitioner submitted a recertification application for Temporary Cash Assistance (TCA), Food Assistance (FA), and Family–Related Medicaid benefits. TCA and FA benefits are not issues under appeal. The application listed petitioner and her three children as the only household members; and child support income and earned income as the only incomes for the household.

3. On August 17, 2015, the respondent authorized “continuous Medicaid” for the petitioner’s household. Respondent did not submit evidence explaining the meaning of “continuous Medicaid”.

4. On August 18, 2015, the respondent mailed petitioner a Notice of Case Action requesting she complete a phone interview on or before August 27, 2015 and submit “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”.

5. On August 18, 2015, the respondent mailed petitioner a Notice of Case Action indicating her August 14, 2015 Medicaid application was denied as “You or a member(s) of your household is not eligible due to failure to cooperate with child support enforcement. Your household’s income is too high to qualify for this program. No household members are eligible for this program”.

6. On August 19, 2015, the respondent had a phone interview with petitioner who indicated she wished to cooperate with CSE. Respondent never mailed petitioner a Notice of Case Action requesting she cooperate with CSE.

7. On September 2, 2015, the respondent mailed petitioner a Notice of Case Action indicating her September 1, 2015 Medicaid application was denied as “You or a member(s) of your household is not eligible due to failure to cooperate with child support enforcement. No household members are eligible for this program”.

8. Petitioner argued that on November 23, 2015, Eric McKinnis, a representative from Mr. Denman’s company went to CSE to lift petitioner’s CSE sanction. Petitioner further argued a representative from CSE, Sylvia, explained to Mr. McKinnis that

petitioner's CSE sanction was lifted. Petitioner never submitted any evidence to indicate she had cooperated with CSE on November 23, 2015.

9. Petitioner cooperated with CSE in February 2016. Neither party submitted any evidence to support she had cooperated with CSE in February 2016.

10. Respondent argued petitioner was not eligible for Family-Related Medicaid benefits for the month of November 2015 as she cooperated with CSE in February 2016 and not in November 2015.

11. Petitioner argued she should be eligible for Family-Related Medicaid benefits in November 2015 as (1) she cooperated with CSE in November 2015; and (2) the respondent never mailed petitioner a Notice of Case Action requesting she cooperate with CSE during the processing of her August 14, 2015 application.

12. A representative from CSE appeared at the January 2016 hearing; however, the representative never testified. A representative from CSE did not appear at the May 2016 hearing.

CONCLUSIONS OF LAW

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

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

15 Section 409.2572, Fla. Stat., Cooperation states, in part:

(2) Noncooperation, or failure to cooperate in good faith…

> (3) The Title IV-D staff of the department shall be responsible for determining and reporting to the staff of the Department of Children and Family Services acts of noncooperation by applicants or recipients of public assistance. Any person who applies for or is receiving public assistance for, or who has the care, custody, or control of, a dependent child and who without good cause fails or refuses to cooperate with the department, a program attorney, or a prosecuting attorney in the course of administering this chapter shall be sanctioned by the Department of Children and Family Services pursuant to chapter 414 and is ineligible to receive public assistance until such time as the department determines cooperation has been satisfactory.
>
> (4) Except as provided for in s. 414.32, the Title IV-D agency shall determine whether an applicant for or recipient of public assistance for a dependent child has good cause for failing to cooperate with the Title IV-D agency as required by this section…

16. On October 23, 2014, CSE requested the respondent sanction petitioner as she failed to cooperate; therefore, the respondent was correct to terminate petitioner's Family-Related Medicaid benefits effective November 30, 2014.

17. Federal Regulations at 42 C.F.R. § 435.610 define the assignment of rights to benefits and states, in part:

> (a) As a condition of eligibility, the agency must require legally able applicants and recipients to…
> (2) Cooperate with the agency in establishing paternity and in obtaining medical support and payments, unless the individual establishes good cause for not cooperating, and except for individuals described in section 1902 (1)(1)(A) of the Act (poverty level pregnant women), who are exempt from cooperating in establishing paternity and obtaining medical support and payments from, or derived from, the father of the child born out of wedlock; and…

18. Pursuant to the above authority, to receive Medicaid benefits for herself, the petitioner must cooperate with CSE in establishing support except when she claims good cause exists or is pregnant. Petitioner has not claimed good cause and was not

pregnant in November 2015; therefore, she was required to cooperate with CSE to receive Family-Related Medicaid benefits for the aforementioned month.

19. Federal Regulations at 7 C.F.R. § 273.2 Office operations and application processing states, in part:

> (c) Filing an application—(1) Household's right to file...
> …
> (5) Notice of Required Verification. The State agency shall provide each household at the time of application for certification and recertification with a notice that informs the household of the verification requirements the household must meet as part of the application process. The notice shall also inform the household of the State agency's responsibility to assist the household in obtaining required verification provided the household is cooperating with the State agency as specified in (d)(1) of this section. The notice shall be written in clear and simple language and shall meet the bilingual requirements designated in §272.4(b) of this chapter. At a minimum, the notice shall contain examples of the types of documents the household should provide and explain the period of time the documents should cover…

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

> (1)(c) If the eligibility specialist determines during the interview or at any time during the application process that the applicant must provide additional information or verification, or that a member of the assistance group must comply with Child Support Enforcement or register for employment services, the eligibility specialist must give the applicant written notice to provide the requested information or to comply, allowing ten calendar days from request or the interview, whichever is later. For all programs, verifications are due ten calendar days from the date of written request or the interview, or 60 days from the date of application, whichever is later…

21. Pursuant to the above authorities, the respondent must provide petitioner written notification of all verification required to determine her eligibility for Family-Related Medicaid benefits. On August 19, 2015, the respondent interviewed petitioner, but did not mail her a Notice of Case Action requesting she comply with CSE within ten

calendar days of the interview even though she indicated she wanted to cooperate with CSE.

22. Although there is sufficient evidence to support petitioner complied with CSE in February 2016 and insufficient evidence to support petitioner complied in November 2015, the respondent failed to give petitioner written notification and ten days to comply with CSE during the processing of her August 14, 2015 application. Petitioner was never afforded the opportunity to comply with CSE prior to February 2016 as no written notification was mailed to her during the months of August 2015 through October 2015. Therefore, the respondent was incorrect to deny petitioner's request to authorize Family-Related Medicaid for November 2015.

23. There is insufficient evidence to indicate if petitioner meets the factors of eligibility for either full Family-Related Medicaid or Family-Related Medicaid with a share of cost for November 2015.

24. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner met the burden of proof in establishing the respondent incorrectly denied her request to approve Family-Related Medicaid benefits for the month of November 2015 as she was never given written notification and ten days to cooperate with CSE during the processing of her August 14, 2015 application. The undersigned concludes the petitioner meets the Child Support Cooperation requirement for Medicaid eligibility. Therefore, the appeal is remanded to the respondent to determine petitioner's eligibility for Family-Related Medicaid benefits for November 2015 based on all other factors of eligibility. Once an eligibility determination is made, the

respondent is to issue written notice to the petitioner informing her of the outcome, including her appeal rights.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is GRANTED and REMANDED to the Department for corrective action as indicated in the Conclusions of Law.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 02 day of June, 2016, in Tallahassee, Florida.

Mary Jane Stafford

Mary Jane Stafford
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

May 19, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 15F-10474
16F-01321

PETITIONER,
Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 Citrus
UNIT: 88002

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 8:15 a.m. on April 25, 2016.

APPEARANCES

For the Petitioner:

For the Respondent: Cindy Sarver, ACCESS Supervisor

STATEMENT OF ISSUE

At issue is whether the respondent's action to approve petitioner: 1) $16 monthly in Food Assistance (FA) benefits and 2) Medically Needy (MN) with an $880 Share of Cost (SOC) is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

By notice dated November 12, 2015, the respondent (or the Department) notified the petitioner: 1) FA was approved, $11 in November 2015 and $16 from December 2015 through October 2017 and 2) MN was approved with an $880 SOC. Petitioner timely requested a hearing to challenge the FA amount and approval of MN with an $880 SOC.

Petitioner did not submit exhibits. Respondent submitted five exhibits, entered as Respondent Exhibits "1" through "5". The record was closed on April 25, 2016.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner received $134 in FA benefits. On November 9, 2015, the petitioner, date of birth [redacted] submitted a paper FA recertification application for himself; he was also adding Medicaid. The application lists a telephone as the only utility expense and $500 rent.

2. Petitioner receives $740 monthly Social Security Disability Income (SSDI) and $85 weekly Workers' Compensation Benefits (WCB).

3. To determine the petitioner's FA benefit amount, the Department first converted petitioner's $85 weekly WCB amount to a monthly amount by multiplying by 4.3, to arrive at $365.50 ($85 X 4.3).

4. The following is the Department's FA budget calculation:

Amount	Description
$ 740.00	SSDI
+$ 365.50	WCB
$1,105.50	total household income
-$ 155.00	standard deduction
$ 950.50	adjusted income

$ 500.00	rent/shelter
+$ 37.00	telephone utility
$ 537.00	shelter/utility costs
-$ 475.25	50% adjusted income ($950.50/2)
$ 61.75	excess shelter/deduction

$ 950.50	adjusted income
-$ 61.75	excess shelter/deduction
$ 888.75	adjusted income after deductions

30% of $888.75 = $267 round up (benefit reduction)

5. The maximum FA benefit amount for a single person household is $194; which is more than the $267 FA benefit reduction. Therefore, the petitioner is not eligible for regular FA. However, since petitioner's income is less than $1,962 (the 200% gross income limit for a household size of one) he is eligible for the $16 minimum monthly FA benefit amount. Petitioner's November 2015 FA amount was prorated to the date of application (November 9, 2015), to arrive at $11.

6. Petitioner stated his loan, clothes and food expenses were not considered in the FA determination. And due to his illness he requires special organic food.

7. Respondent's representative responded that only shelter, utilities and medical expenses (exceeding $35) are considered in the FA determination.

8. For petitioner to be eligible for full Medicaid, his monthly income cannot exceed $864. Petitioner's income exceeds $864 monthly. Therefore, petitioner is not eligible for full Medicaid. The next available Medicaid Program is MN with a SOC.

9. The following is the Department's SOC calculation:

Amount	Description
$ 740.00	SSDI
+$ 340.00	WCB ($85 weekly X 4 weeks)
$1,080.00	total household income
-$ 20.00	unearned income disregard
-$ 180.00	MN income level (MNIL)
$ 880.00	SOC

10. On November 12, 2015, the Department mailed the petitioner a Notice of Case Action, notifying: 1) FA was approved, $11 in November 2015 and $16 from December 2015 through October 2017 and 2) MN was approved with an $880 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.

FOOD ASSISTANCE ISSUE

13. Federal Regulation at 7 C.F.R § 273.9, defines income and in part states:

> (b)(2) Unearned income shall include, but not be limited to…
> (ii) Annuities; pensions; retirement, veteran's, or disability benefits; worker's or unemployment compensation…; old-age, survivors, or social security benefits…

14. In accordance with the above authority, the respondent included petitioner's monthly income in the FA budget calculation; $740 SSDI and $365.50 WCB.

15. 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…

16. In accordance with the above Federal Regulation, the Department converted petitioner's $85 WCB weekly income to monthly income using a 4.3 conversion factor to arrive at $365.50.

17. Federal Regulation at 7 C.F.R § 273.9, defines allowable deductions and in part states:

> (d) Income deductions. Deductions shall be allowed only for the following household expenses:
> (1) Standard deduction…
> (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…
> (6) Shelter costs…
> (ii) Excess shelter deduction. Monthly shelter expenses in excess of 50 percent of the household's income after all other deductions…
> (iii) Standard utility allowances. (A) With FNS approval, a State agency may develop the following standard utility allowances (standards) to be used in place of actual costs in determining a household's excess shelter deduction: an individual standard for each type of utility expense; a standard utility allowance for all utilities that includes heating or cooling costs (HCSUA); and, a limited utility allowance (LUA) that includes electricity and fuel for purposes other than heating or cooling, water, sewerage, well and septic tank installation and maintenance, telephone…

18. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, Appendix A-1, sets forth for a household size of one the following:

$ 194	maximum FA allotment
$ 16	minimum FA allotment
$ 155	standard deduction
$ 37	telephone standard
$1,962	monthly 200% gross income limit

19. 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…
> (C) Except during an initial month, all eligible one- and two-person households shall receive minimum monthly allotments equal to the minimum benefit…

20. The cited authorities set forth income and allowable deductions in the FA benefit determination. In accordance with the authorities, respondent included petitioner's monthly $740 SSDI and $365.50 WCB and allowable deductions (standard deduction, shelter and telephone) in the FA calculations. Petitioner's $267 FA benefit reduction is more than the $194 maximum FA benefit amount for a household size of one. Therefore, petitioner was not eligible for regular FA benefits.

21. The Department's TRANSMITTAL NO. C-13-10-0007, dated October 11, 2013, addresses the FA minimum amount and in part states:

> …based on recent clarification from the Food and Nutrition Service, that all one and two member assistance groups (AGs) are eligible for the minimum monthly food assistance benefit allotment, which is 8% of the maximum allotment for a one person household.
>
> Minimum Benefit Policy
> The AG is eligible for the minimum monthly food assistance benefit allotment if the assistance group meets all regular eligibility requirements and:
> The AG has income less than or equal to the 200% gross income limit…

22. Petitioner's monthly income is less than the $1,962 monthly 200% gross income limit; therefore, in accordance with the above transmittal, petitioner is eligible for the $16 minimum FA amount.

MEDICALLY NEEDY ISSUE

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

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
> (a) For MEDS-AD Demonstration Waiver, income cannot exceed 88 percent of the federal poverty level…
> (h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses…
> (4)(c) Medically Needy. The amount by which the individual's countable income exceeds the Medically Needy income level, called the "share of cost", shall be considered available for payment of medical care and services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical costs. If countable income exceeds the Medically Needy income level the department shall deduct allowable medical expenses in chronological order, by day of service…To be deducted the expenses must be unpaid, or if paid, must have been paid in the month for which eligibility is being determined or incurred and paid during the three previous calendar months to the month for which eligibility is being determined but no earlier than the three retroactive application months…

24. The above authority explains to be eligible for full Medicaid; income cannot exceed 88 percent of the federal poverty level. And MN provides coverage for individuals who do not qualify for full Medicaid due to income.

25. Policy Manual, CFOP 165-22, appendix A-9 (July 2015), identifies $864 as 88 percent of the federal poverty level for a household size of one.

26. Petitioner's $1,080 ($740 SSDI and $340 WCB) monthly income exceeds the $864 income limit to be eligible for full Medicaid. Therefore, petitioner is not eligible for full Medicaid.

27. 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…"

28. The Fla. Admin. Code R. 65A-1.716 sets forth the MNIL at $180 for a family size of one.

29. In accordance with the authorities, respondent deducted $20 unearned income and $180 MNIL from petitioner's $1,080 monthly income, to arrive at an $880 SOC.

<u>*HEARING OFFICER'S CONCLUSION*</u>

30. In careful review of the cited authorities and evidence, the undersigned agrees with the Department's action to approve petitioner: 1) $16 FA for a full month and $11 FA in November 2015 and 2) Medicaid MN with an $880 SOC.

<u>DECISION</u>

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this __19__ day of __Mav__________, 2016,

in Tallahassee, Florida.

Priscilla Peterson

Priscilla Peterson
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

Jun 24, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-00250

PETITIONER,
Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 12 Manatee
UNIT: 88326

RESPONDENT.
___________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened two administrative hearings by phone in the above-referenced matter on May 19, 2016 at 2:10 p.m.; and on May 24, 2016 at 10:04 a.m. Three continuances were granted for the petitioner.

APPEARANCES

For Petitioner:

For Respondent: Ed Poutre, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's action to enroll petitioner in the Medically Needy (MN) program effective September 2015 and ongoing is correct. Petitioner carries the burden of proof by a preponderance of the evidence.

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”). At the May 24, 2016 hearing, the respondent submitted thirteen exhibits, which were accepted into evidence and marked as Respondent’s Exhibits “1” through “13”. Subsequent to the hearing, the undersigned discovered two exhibits were marked as Respondent’s Exhibit “12”. One of the Respondent’s Exhibit “12” was remarked as Respondent’s Exhibit “13”.

On February 23, 2016, the Respondent filed a Motion to Dismiss petitioner’s appeal as untimely. On May 19, 2016, the undersigned denied respondent’s Motion to Dismiss as the petitioner never received a Notice of Case Action concerning her MN benefits during the processing of her September 11, 2015 application because the respondent suppressed the notice and did not send the proper notice. Respondent only mailed petitioner notice of her Qualified Medicare Beneficiary (QMB) Medicaid benefits.

FINDINGS OF FACT

1. On September 11, 2015, petitioner completed a recertification application for Food Assistance (FA), Medicare Savings Program (MSP), and Medicaid benefits. FA and MSP benefits are not issues under appeal. The application listed petitioner and her child as the only household members; Social Security income for petitioner and her child as the only income for the household; and petitioner not filing taxes.

2. On September 21, 2015, the respondent mailed petitioner a Notice of Case Action indicating she was eligible for QMB Medicaid benefits. The petitioner did not receive any notice concerning her MN benefits as the respondent suppressed the notice concerning petitioner’s MN benefits.

3. Petitioner's Social Security Disability Insurance (SSDI) amount is $892 (gross) per month and her child's Social Security income is $232 (gross) per month. Petitioner has Medicare Part A and B and QMB pays petitioner's Medicare premium and all of her medical co-payments.

4. Respondent determined petitioner's Family-Related Medically Needy (MN) share of cost (SOC) amount as $505 effective September 2015 and ongoing as follows:

$ 892.00	petitioner's SSDI income
$ 892.00	total countable net income
-$ 387.00	MNIL for a household of two
$ 505.00	share of cost

5. Respondent determined petitioner's SSI-Related MN SOC amount as $863 effective September 2015 and ongoing as follows:

$ 892.00	petitioner's SSDI income
+$ 232.00	child's Social Security income
$1124.00	countable net income
-$ 20.00	unearned income disregard
$1104.00	total countable income
-$ 241.00	MNIL for a household of two
$ 863.00	share of cost

6. Petitioner is requesting full Medicaid benefits because she receives daily medical treatment that only accepts Medicaid benefits. The treatment facility does not accept Medicare. Petitioner currently pays $61 every Thursday to receive this treatment and it is difficult for her to pay for the treatment as well as her other household expenses.

7. Respondent determined petitioner was not eligible for full Medicaid benefits as she currently receives Medicare Part A and B. Petitioner cannot receive both full Medicaid benefits as well as Medicare 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 § 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 Florida Administrative Code R. 65-2.056.

10. On February 23, 2016, the Respondent filed a Motion to Dismiss petitioner's appeal as untimely. Prior to addressing the merits of the appeal, the undersigned has to determine if petitioner timely requested her appeal. The Fla. Admin. Code R. 65-2.046, Time Limits in Which to Request a Hearing states:

> (1) The appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs. Additionally, in the Food Stamp Program, a household may request a fair hearing at any time within a certification period to dispute its current level of benefits. The time period begins with the date following:
> …
> (c) The date of the Department's written notification of denial or a request or other action which aggrieves the petitioner when that denial or action is other than an application decision or a decision to reduce or terminate program benefits.

11. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, section 0410.0603 Time Limits to Request Hearing (FS) states:

> The Department or its partner agency must receive the individual's appeal of an action, decision or current level of benefits within 90 days of the date a notice is mailed or hand delivered to the individual.
>
> **Exceptions:**

> 1. The time limit does not apply when the Department fails to send required notification, takes no action on a specific request or denies a request without informing the individual appealing.
> 2. A hearing request made outside the 90-day limit may only be rejected or dismissed by the Office of Appeal Hearings.
> Consider a request received after the 90-day time limit as a request for restoration of lost benefits.

12. Pursuant to the above authorities, an individual must file a request for an appeal within 90 calendar days of the date of the written notification of an action other than an application decision or a decision to reduce or terminate program benefits. Petitioner is appealing her enrollment in the MN program. On September 21, 2016, the respondent mailed petitioner a Notice of Case Action concerning her QMB Medicaid benefits; however, the respondent failed to mail petitioner notice of her MN benefits as the notice was suppressed.

13. Since petitioner never received notification of her MN benefits, petitioner's appeal is considered timely and the undersigned shall review the merits of the appeal.

<u>At issue is petitioner's eligibility for full Family-Related Medicaid benefits</u>

14. 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…

15. Pursuant to the above authority, since petitioner lives in a household with a minor child under age 18, she is eligible for Medicaid benefits under the Family-Related

Medicaid Program.

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

> …
> (d) *Household income*—(1) *General rule.* Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household.
>
> (2) *Income of children and tax dependents.* (i) The MAGI-based income of an individual who is included in the household of his or her natural, adopted or step parent and is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined, is not included in household income whether or not the individual files a tax return.
>
> (ii) The MAGI-based income of a tax dependent described in paragraph (f)(2)(i) of this section who is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined is not included in the household income of the taxpayer whether or not such tax dependent files a tax return.

17. Pursuant to the above authority, only petitioner’s SSDI income is considered in her Family-Related Medicaid budget.

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

> (a) *Basis.* This section implements section 1902(a)(10)(A)(ii)(XX) of the Act.
> (b) *Eligibility*—(1) *Criteria.* The agency may provide Medicaid to individuals who:
> (i) Are under age 65;
> (ii) Are not eligible for and enrolled for mandatory coverage under a State’s Medicaid State plan in accordance with subpart B of this part;
> (iii) Are not otherwise eligible for and enrolled for optional coverage under a State’s Medicaid State plan in accordance with section 1902(a)(10)(A)(ii)(I) through (XIX) of the Act and subpart C of this part,

based on information available to the State from the application filed by or on behalf of the individual; and
(iv) Have household income that exceeds 133 percent FPL but is at or below the income standard elected by the agency and approved in its Medicaid State plan, for the applicable family size.
(2) *Limitations.* (i) A State may not, except as permitted under an approved phase-in plan adopted in accordance with paragraph (b)(3) of this section, provide Medicaid to higher income individuals described in paragraph (b)(1) of this section without providing Medicaid to lower income individuals described in such paragraph.
(ii) The limitation on eligibility of parents and other caretaker relatives specified in § 435.119(c) of this section also applies to eligibility under this section.

19. The Policy Manual, CFOP 165-22, passage 2630.0108, Budget Computation (MFAM) states:

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

If the 5% disregard would make the individual eligible, include the disregard. Otherwise the individual is ineligible for Medicaid.

20. The Policy Manual, Appendix A-7, lists the Family-Related Medicaid Income Limits for a household size of two as follows: the Income Standard is $241 and the

Standard Disregard $146. The Medically Needy Income Limit (MNIL) for a family of two is $387. The MAGI Disregard is $67.

21. The household's countable income ($892) exceeds the income limit ($241) for petitioner to receive full Family-Related Medicaid benefits; therefore, she is correctly enrolled in the Medically Needy Program with a share of cost.

<u>At issue is petitioner's eligibility for full SSI-Related Medicaid benefits</u>

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

23. Pursuant to the above authority, since petitioner is considered disabled, she is eligible for Medicaid benefits under the SSI-Related Medicaid program.

24. Fla. Admin. Code R. 65A-1.701(20) 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.

25. Pursuant to the above authority, petitioner is not eligible for full SSI-Related Medicaid benefits as she receives Medicare Part A and B, but does not receive at the same time Institutional Care Services, hospice services, or home and community based services. Respondent correctly denied petitioner full SSI-Related Medicaid benefits and instead enrolled her in a SSI-Related MN Medicaid with a monthly SOC.

26. Respondent calculated the petitioner's monthly share of cost amount for both Family-Related and SSI-Related Medicaid benefits to determine which program would give her the lowest monthly share of cost amount. Petitioner's monthly share of cost amount for the Family-Related Medicaid is lower; therefore, the respondent correctly enrolled her in the Family-Related Medically Needy Program.

27. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner did not meet her burden of proof in establishing the respondent incorrectly enrolled her in the Family-Related Medically Needy Program with a monthly share of cost amount of $505 effective September 1, 2015 as she is not eligible for full Medicaid benefits (either Family-Related or SSI-Related).

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 24 day of June, 2016,

in Tallahassee, Florida.

Mary Jane Stafford

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

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

May 02, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-00434

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 22, 2016 at 11:30 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 the nutritional supplement Glucerna was correct. Petitioners bear the burden of proof in this matter.

PRELIMINARY STATEMENT

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

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

Respondent submitted the following documents into evidence: Exhibit 1 – Statement of Matters; Exhibit 2 - Grievance System screenshots; Exhibit 3 – Denial Notice; Exhibit 4 - Grievance and Appeals documents; Exhibit 5 - Medical Assessment form; and Exhibit 6 – Member Notes Report.

FINDINGS OF FACT

1. The Petitioner is a sixty (60) year old 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.

2. Petitioner's coverage with United Healthcare began on December 1, 2013.

3. On or about November 9, 2015, Petitioners' treating physician submitted an authorization request to United Healthcare for approval of the nutritional supplement drink called Glucerna.

4. On or about November 11, 2015, United Healthcare denied the pre-authorization request for the Glucerna. The denial notice stated the following:

> You have asked for nutrition supplements. Your weight is not too low. Your blood tests are not abnormal. Your body can use regular food. There is no sign that your body needs extra nutrition. The health plan covers supplements for people who cannot use regular food. The health

> plan does not cover supplements because you have lost your appetite. Supplements are in excess of your needs.

5. The Petitioner testified she can eat regular food but has a poor appetite. She stated she needs the Glucerna to help wounds heal which she sustained in an accident. She stated she needs protein to help the wounds heal. She also stated she received Glucerna prior to 2013 through a different Medicaid plan provider.

6. The Respondent's witness, Dr. Karver, stated that applicable medical necessity criteria require a nutritional supplement such as Glucerna only when the patient cannot eat regular food. She also stated Glucerna does not make wounds heal faster.

7. Services under the Medicaid State Plan in Florida are provided in accordance with the Respondent's Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July, 2012, and the Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook ("DME Handbook"), effective July, 2010.

CONCLUSIONS OF LAW

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

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

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

11. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the Petitioner. The standard of proof in an administrative hearing is a

preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

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

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

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

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

15. After considering all the documentary evidence and witness testimony presented, the undersigned concludes United Healthcare correctly denied Petitioners' request for the Glucerna. The Petitioner can consume regular food and Glucerna is medically necessary only when the patient cannot consume regular food. In addition, according to the evidence presented, Glucerna is not an appropriate prescription or mechanism to make wounds heal faster.

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 02 day of Mav, 2016,

in Tallahassee, Florida.

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

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

May 20, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

PETITIONER,
Vs.

APPEAL NO. 16F-00598
16F-00723
16F-01481

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 66292

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on April 19, 2016 at 9:45 a.m.

APPEARANCES

For the petitioner:

For the respondent: Susan Martin, ACCESS Operations Management Consultant

STATEMENT OF ISSUE

Petitioner is appealing the following:

I. The respondent's action to decrease her Food Assistance Program (FAP) benefits from $156.00 to $16.00 beginning February 2016. Petitioner is seeking the FAP amount of $156.00. The respondent carries the burden of proof by a preponderance of the evidence.

II. The respondent's action to remove the petitioner's son from her FAP benefits and instead, approve FAP benefits for him in his own assistance group. The petitioner carries the burden of proof by a preponderance of the evidence.

III. The respondent's action to terminate the petitioner's daughter's full Medicaid effective February 29, 2016 and enroll her in the Medically Needy (MN) Program with a share of cost (SOC) beginning March 2016. The respondent carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

By notice dated January 20, 2016, the respondent notified the petitioner that her FAP benefits were decreasing from $156.000 to $16.00 beginning February 2016. Also by notice dated January 26, 2016, the respondent notified the petitioner that her daughter's Medicaid would end as of February 29, 2016 and that she would be enrolled in the MN Program with a SOC of $128.00 effective March 1, 2016. Petitioner timely requested a hearing to challenge the Department's actions on her FAP and Medicaid benefits.

During a supervisory review, the respondent recalculated the petitioner's FAP benefits effective February 2016. The respondent determined there were errors made on the case and the petitioner continued to be eligible for $156.00 (the same FAP amount prior to the action under appeal) beginning February 2016. The petitioner already received $16 FAP benefits for February 2016; therefore, the respondent issued $140.00 additional FAP benefits to the petitioner for February 2016. The issue remained challenged, as petitioner did not have a Notice of Case Action (NOCA) to ensure the $156.00 FAP benefits would be the ongoing amount.

At the outset of the hearing, the petitioner explained that she received a NOCA in April 2016 informing her that her full Medicaid ended and that she was enrolled in the MN with a SOC. The respondent clarified that the NOCA informed the petitioner her full Medicaid benefits remained the same.

Petitioner was receiving continued FAP benefits pending the outcome of the hearing per her request.

Petitioner submitted one exhibit, entered as Petitioner's Exhibit "1". Respondent submitted three exhibits, entered as Respondent's Exhibit's "1" through "3". The record was held open until the end of business on April 29, 2016 for submission of additional evidence from the respondent. No additional evidence was received by the due date; therefore, the record closed on April 29, 2016. On May 2, 2016, additional evidence was received from the respondent. The undersigned reopened the record and entered the additional evidence as Respondent's Exhibit "4". The respondent submitted more additional information on May 2, 2016. The undersigned will not address this additional information, as it was not requested during the hearing. Therefore, said additional information dated May 2, 2016 was not accepted into evidence. The record closed on May 2, 2016.

FINDINGS OF FACT

1. Prior to the action under appeal, petitioner was receiving $156.00 FAP benefits for herself and her adult children (ages 19 and 22). Her certification period was for six months beginning December 1, 2015 through May 31, 2016. Petitioner also was receiving full Medicaid benefits for herself and her daughter. The Medicaid benefits

certification would end on November 2016[1]. Petitioner's son receives Supplemental Security Income (SSI) related Medicaid benefits. Petitioner and her son's Medicaid are not an issue.

2. On January 19, 2016, CareerSource[2] requested the respondent impose a level I FAP sanction on the petitioner's daughter for failing to complete able-bodied adults without dependents (ABAWDs) work requirements. The respondent imposed the ABAWD work sanction on the petitioner's daughter and removed her from the FAP benefits effective February 2016. This caused the petitioner's FAP benefits to decrease from $156.00 to $16.00 beginning February 2016.

3. On January 26, 2016, the petitioner contacted the Department's Customer Call Center (CCC) to find out why her FAP benefits were decreasing. The respondent explained that the FAP benefits decreased due to her daughter's ABAWD work sanction. The petitioner reported her daughter attends college; the respondent determined she met an exemption to the ABAWD work requirements; however, she would still not be eligible for FAP benefits as she was considered an "ineligible student". During this call, the petitioner also requested that her 22-year-old son's income be excluded from her FAP benefits. The respondent removed the petitioner's son from her FAP benefits effective March 2016 and approved FAP benefits for him on his own assistance group.

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[1] Medicaid Assistance Program certifications are a 12-months review period.

[2] Beginning January 1, 2016, Food Assistance applicants and recipients who are ABAWDs must meet work requirements with CareerSource unless the applicants/recipients meets an exemption or exception. Petitioner's daughter meets an exemption because she is a part-time student. Therefore, she is not required to participate with the ABAWD work requirements.

4. During the hearing, the respondent explained there were many errors made on the petitioner's case. The petitioner's daughter should not have been sanctioned as she met an exemption to the ABAWD work requirements (part-time student). In addition, the petitioner's son should not have been removed from her FAP benefits. Respondent also explained it determined the petitioner's daughter was not an "ineligible student" and she continued to be eligible for FAP benefits. The respondent corrected the petitioner's case and determined she continued to be eligible for $156.00 FAP benefits from February 2016 through May 31, 2016 (the end of her current certification period).

5. The respondent issued the petitioner an additional $140.00 FAP benefits for February 2016 (petitioner had already received $16.00) and $156.00 for March 2016 through May 31, 2016, the end of her certification period.

6. The respondent also reviewed the Medicaid Assistance budget for the petitioner's daughter. The respondent compared the household income of $614.00 (Petitioner's Social Security Disability Income) to the $303.00 income limit for a household size of three to determine if petitioner's daughter was eligible for full Medicaid. As the household income exceeded the income limit ($303.00) for full Medicaid, the respondent determined that the petitioner's daughter was not eligible for full Medicaid and enrolled her in the MN Program with a SOC.

7. To determine the SOC amount, the respondent determined the Medically Needy Income Level (MNIL) for a household size of three was $486.00, this amount was subtracted from the gross monthly income ($614.00), resulting in a SOC amount of $128.00 as follows:

ABMG FAMILY RELATED MEDICAID/MEDICALLY NEEDY BENEFIT 04/20/2016 16:22
DETERMINATION BUDGET P22839 S DEKONY
CASE: [redacted] CAT: NO Y SEQ: 1 AG NAME: [redacted] WORKER: TG4029
BEGIN: 04/01/2016 END: 05/31/2016 STATUS: ENROLLED,PASS

EARNED INCOME:+	.00	SFU SIZE:	3
UNEARNED INCOME:+	614.00	INCOME STANDARD:	.00
TOTAL REPORTED INCOME:=	614.00	MNIL:-	486.00
ALLOWABLE TAX DEDUCTIONS:-	.00	SHARE OF COST:=	128.00
MODIFIED ADJUSTED GROSS INC:=	614.00	MED INSURANCE PREMIUM:-	.00
STANDARD DISREGARD:-	.00	RECURRING MED EXPENSE:-	.00
MAGI DISREGARD(5% OF FPL):-	.00	REMAINING SOC:=	128.00
COUNTABLE NET INCOME:=	614.00	COUNT OF OOTHS:	0

AG HAS PASSED THE FAM RELATED MEDICAID/MED NEEDY BENEFIT DETERMINATION BUDGET

8. The petitioner did not dispute any of the facts presented by the respondent. She acknowledged her income. The petitioner did not understand why her daughter's full Medicaid was terminated when her income has not changed. The respondent explained that the petitioner's daughter's Medicaid ended when she turned 19 years old. The Medicaid income limits for children through age 18 are higher than the income limits for a 19-year-old child.

CONCLUSIONS OF LAW

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

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

FOOD ASSISTANCE ISSUES

11. The respondent admitted it caused an error when the petitioner's oldest son (22) was removed from her FAP benefits and assigned his own FAP benefits effective March 2016. The respondent also removed the petitioner's daughter from the petitioner's FAP benefits effective February 2016 due to an ABAWD work sanction. The respondent corrected the petitioner's case and determined the petitioner and her two adult children continued to be eligible for $156.00 FAP benefits from February 2016 through May 31, 2016, the end of her current certification period. The respondent issued the petitioner an additional $140.00 FAP benefits for February 2016 and $156.00 FAP benefits monthly for March 2016 through May 31, 2016.

12. Since the petitioner did not have a break in her FAP benefits and received the same FAP amount prior to the action under appeal ($156.00), there is no adverse action for which the undersigned can grant relief. Therefore, the FAP appeals are dismissed as MOOT.

MEDICALLY NEEDY ISSUE

13. Fla. Admin. Code R. 65A-1.703, Family-Related Medicaid Coverage Groups states:

> (1) The department provides mandatory Medicaid coverage for individuals, families and children described in Section 409.903, F.S., Section 1931 of the Social Security Act and other relevant provisions of Title XIX of the Social Security Act. The optional family-related Title XIX and Title XXI coverage groups served by the department are stated in each subsection of this rule.
> (a) Children under the age of 21 living with a specified relative who meet the eligibility criteria of Title XIX of the Social Security Act. Included in this coverage group are children who are under age 21 in intact families, provided that the children are living with both parents, unless a parent is temporarily absent from the home.

…
(3) Medicaid for children not yet age 19. To be eligible for this coverage group the child must meet the general requirements specified in Rule 65A-1.705, F.A.C. The following additional criteria apply:
(a) There is no asset limit;
(b) The total net income for children in the filing unit:
1. Up to age one is less than or equal to 185 percent of the federal poverty level;
2. Age one to age six is less than or equal to 133 percent of the federal poverty level;
3. Age six or older and not yet age 19 is less than or equal to 100 percent of the federal poverty level.
(4) Children born on or before 9/30/83 and not yet age 19 and children under age one with family income between 185 and 200 percent of the federal poverty level. Except in regard to provisions concerning health insurance coverage, eligibility for this coverage group is the same as that for children who have not yet reached age 19 as described in subsection 65A-1.703(3), F.A.C. Children in this coverage group may not be determined Medicaid eligible if they have private health insurance coverage or coverage through a state health benefits plan because of a family member's employment with a public agency in the state. Children who are eligible for coverage through a state health benefits plan, but who do not actually have such coverage, are Medicaid eligible on this factor of health insurance coverage. Limitations as to health insurance coverage are as provided in amendments to Titles XIX and XXI of the Social Security Act made by the Balanced Budget Act of 1997.
…
(6) Medically Needy. To be eligible for this coverage group the individual must meet the general requirements prescribed in Rules 65A-1.705, F.A.C.
(a) Included in this coverage group are the following groups of individuals:
1. Children under age 21 living with a specified relative…
(b) The following provisions apply to Medically Needy.
1. The individual or family must have income equal to or less than the respective Medically Needy income standards prescribed in subsection 65A-1.716(2), F.A.C. If income exceeds the Medically Needy income standards refer to subsection 65A-1.707(2), F.A.C. Refer to Rule 65A-1.713, F.A.C., for additional income criteria applicable to the Medically Needy Program.
2. The individual or family must have assets equal to or less than the respective Medically Needy Resource Standards prescribed in subsection 65A-1.716(3), F.A.C.

14. Fla. Admin. Code R. 65A-1.707, Family-Related Medicaid Income and Resource

Criteria states:

> (1) Family-related Medicaid income is based on the definitions of income, resources (assets), verification and documentation requirements as follows.
> (a) Income. Income is earned or non-earned cash received at periodic intervals from any source such as wages, self-employment, benefits, contributions, rental property, etc. Cash is money or its equivalent, such as a check, money order or other negotiable instrument. Total gross income includes earned and non-earned income from all sources.
> …
> (c) 2. The following income is considered in determining gross non-earned income of the coverage group: income of a parent living in the home with a child under age 18; or is under age 21 if in a coverage group for children under age 21;…
> (d) Income Disregards. Only the income remaining after the following disregards are applied is counted in the eligibility determination:
> …

15. The Federal Regulation at 42 C.F.R. § 435.831 Income eligibility, explains:

> The agency must determine income eligibility of medically needy individuals in accordance with this section.
> …
> (b) Determining countable income. The agency must deduct the following amounts from income to determine the individual's countable income.
>
> (1) For individuals under age 21 and caretaker relatives, the agency must deduct amounts that would be deducted in determining eligibility under the State's AFDC plan.
> (c) Eligibility based on countable income. If countable income determined under paragraph (b) of this section is equal to or less than the applicable income standard under §435.814, the individual or family is eligible for Medicaid.

16. Fla. Admin. Code R. 65A-1.716 Income and Resource Criteria sets the income

limits for full Medicaid as follows:

> (2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows:

Family Size	Income Level
1	$180
2	$241
3	$303

17. Pursuant to the above authority, the petitioner's $614.00 income is more than the $303.00 income limit; therefore, petitioner's daughter is not eligible for full Medicaid.

18. 42 C.F.R. § 435.308 discuss medically needy coverage of individuals under age 21:

> (a) If the agency provides Medicaid to the medically needy, it may provide Medicaid to individuals under age 21 (or, at State option, under age 20, 19, or 18), as specified in paragraph (b) of this section:
> (1) Who would not be covered under the mandatory medically needy group of individuals under 18 under §435.301(b)(1)(ii); and
> (2) Who meet the income and resource requirements of subpart I of this part.
> (b) The agency may cover all individuals described in paragraph (a) of this section or reasonable classifications of those individuals.

19. The above authority explains Medically Needy provides coverage for individuals who do not qualify for full Medicaid due to income.

20. The Department's Program Policy Manual (Policy Manual) Appendix A-7, Family-Related Medicaid Income Limits chart, sets forth the Medically Needy Income Level (MNIL) for a household size of three as $486.00. 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 $486.00 MNIL from $614.00 (household income) to arrive at the $128.00 SOC for the petitioner's daughter (19).

21. The Department's Program Policy Manual 2630.0500 Share of Cost (MFAM) states in part:

> 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.

22. In careful review of the cited authorities and evidence, the undersigned concludes the respondent's action to terminate the petitioner's daughter for full Medicaid effective February 29, 2016 and enroll her in the Medically Needy Program with a SOC of $128.00 effective March 2016 was within the rules of the Program.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the FAP appeals (16F-00598 & 16F-01481) are dismissed as MOOT. The Medicaid appeal (16F-00723) 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 ___20__ day of ___May__________, 2016,

in Tallahassee, Florida.

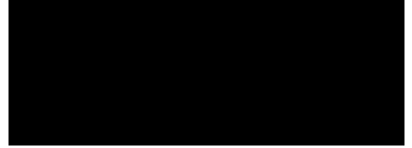
Cassandra Perez
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

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

Jun 30, 2016

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 16F-00661

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 June 14, 2016 at 1:36 p.m.

APPEARANCES

For the Petitioner: Pro se

For the Respondent: Fatima Leyva,
Senior Human Services Program Specialist,
Agency for Health Care Administration

STATEMENT OF ISSUE

The Petitioner is appealing the Agency for Health Care Administration's (AHCA) decision, through her managed care provider Humana, to deny her request for direct reimbursement for pain medication prescriptions filled December 29, 2015, January 21, 2016, and February 4, 2016. Because the issue under appeal involves a request for direct reimbursement, the Petitioner bears the burden of proof.

PRELIMINARY STATEMENT

Mindy Aikman, Grievance and Appeals Specialist for Humana, appeared as a witness for Respondent. Respondent submitted an 18-page document, which was entered into evidence and marked Respondent Exhibit 1.

FINDINGS OF FACTS

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

1. Petitioner is a 33 year-old Medicaid recipient enrolled with Humana, a Florida Health Managed Care provider.

2. On December 29, 2015, January 21, 2016, and February 4, 2016, Petitioner paid $120.00 to have an [redacted] (pain medication) prescription filled by an out-of-network pharmacy. Petitioner states it was the only pharmacy that would fill the medication at the prescribed dosage amount.

3. Petitioner states she has found an in-network CVS pharmacy that will fill the pain medication, so future out-of-pocket expenditures will no longer occur.

4. Respondent explained that a courtesy reimbursement of $120 was made to Petitioner for the December 4, 2015 out-of-pocket expenditure for [redacted]

5. Respondent also noted that a number of in-network pharmacies, as well as CVS, were able to order the medication and that Publix has it in stock.

6. Petitioner did not understand why she could not get reimbursed for her out-of-pocket expenditures since she had difficulty getting the prescription filled by an in-network pharmacy.

7. Respondent explained that Medicaid does not reimburse Medicaid members for out-of-pocket medical expenses.

CONCLUSIONS OF LAW

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

9. This proceeding is a *de novo* proceeding pursuant to 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 65-2.060(1).

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

12. Florida Administrative Code Rule 59G-5.110 provides the circumstances under which a Medicaid Recipient may be reimbursed. It provides in relevant part:

> (2) Determination Criteria. Florida Medicaid recipients may be eligible for direct reimbursement if:
>
> (a) Medical goods and services were paid for by the recipient or a person legally responsible for their bills **from the date of an erroneous denial or termination of Florida Medicaid eligibility** to the date of a reversal of the unfavorable eligibility determination [emphasis added.]
>
> (b) The goods and services were medically necessary as defined in Rule 59G-1.010, Florida Administrative Code (F.A.C.); rendered by a provider

that is qualified to perform the service including meeting any applicable certification or licensure requirements (the provider is not required to be enrolled or registered as a Florida Medicaid provider); and covered by Florida Medicaid for the recipient's eligibility group on the date of service.
(c) Reimbursement for the medical goods or services is not available through any third-party payer on the date of service for which direct reimbursement is requested.

13. Petitioner does not meet the criteria for reimbursement set out in Rule 59G-5.110 because her Medicaid was not terminated or denied. In fact, her Medicaid was active at the time she had the prescription filled.

14. Petitioner's need for the medication is not in question. However, using an out-of-network pharmacy to have the prescription filled does not create an obligation for Medicaid or the managed care plan to reimburse her for the out-of-pocket expenditures.

15. Based on the above rule and facts, the Petitioner has failed to meet her burden of proof that the Respondent erred in denying her reimbursement for her out-of-pocket prescription expenditures in December 2015, January 2016 and February 2016.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Agency's action is AFFIRMED and Petitioner's appeal is DENIED.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 30 day of June, 2016,

in Tallahassee, Florida.

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

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

May 02, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-00669

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 11:30 a.m.

APPEARANCES

For the Petitioner:

For the Respondent: 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 10, 2015 through April 3, 2016, was correct. 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 parents [redacted] The Petitioner submitted documents as evidence for the hearing, which were marked as Petitioner's Exhibit 1.

Appearing as a witness for the Respondent was Dr. Darlene Calhoun, Physician-Consultant with eQHealth Solutions, Inc. Respondent submitted documents as evidence for the hearing such as clinical notes, denial notices, and supporting information, which were marked as Respondent's Exhibit 1.

FINDINGS OF FACT

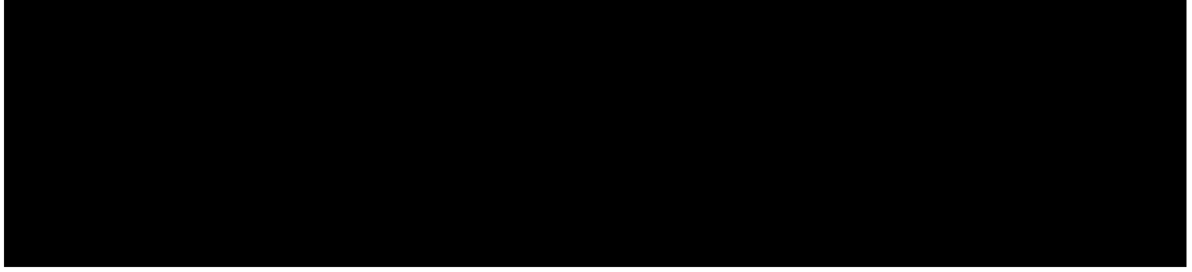
1. The Petitioner's home health agency, [redacted] (hereafter referred to as "Provider"), requested the following PCS hours for the certification period at issue: 5 hours daily Monday to Friday and 10 hours daily on Saturday and Sunday.

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

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:



5. The Petitioner's mother does not work outside the home. The Petitioner's father works 9:00 a.m. to 6:00 p.m. Monday to Friday and travels for work on the weekends.

6. The Petitioner attends school from 7:00 a.m. to 3:00 p.m., Monday to Friday. She is currently approved for 4 personal care service hours daily, seven days per week. These hours are shared with her sister. She and her sister also receive 8 hours of respite care overnight (two nights weekly each) through the Medicaid Waiver program.

7. The Petitioner's mother has physical limitations related to a performed in December, 2015. The limitations include no heavy lifting. She has follow-up visits with her doctor every four weeks, but the limitations are currently still in place.

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, toileting, range of motion/positioning, and dressing

9. A physician at eQHealth Solutions, who is board certified in pediatrics, reviewed the submitted information and denied the requested additional PCS hours. This physician-reviewer wrote, in part: "*The clinical information provided does not support the medical necessity of the additional requested hours. There have been no significant changes in the patient clinical condition. 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 19, 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 not requested in this case.

11. The Respondent's witness, Dr. Calhoun, testified there was insufficient documentation about the father's work schedule on the weekends to justify a blanket approval of additional personal care service hours on the weekends.

12. The Petitioner's mother testified that she is requesting additional personal care hours for her daughter because of her (the mother's) medical limitations related to no heavy lifting. She states her daughter needs to be flipped in her bed every hour. She also stated her mother recently moved in with the family because she had a stroke. She also mentioned her husband travels extensively for work and she is the sole caregiver for her 2 daughters three nights per week. The currently approved personal care hours are being utilized from 4:00 p.m. to 8:00 p.m. daily.

13. 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 Respondent's Home Health Services Coverage and Limitations Handbook (October 2014).

CONCLUSIONS OF LAW

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

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

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

17. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the Petitioner since the Petitioner 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, 7th Ed.).

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

19. The Petitioner has requested 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.

20. The Centers for Medicare and Medicaid Services, State Medicaid Manual makes available to all State Medicaid agencies informational and procedural material needed by the States to administer the Medicaid program. It is the method by which the Health Care Financing Administration (HCFA) issues mandatory, advisory, and optional Medicaid policies and procedures to the Medicaid State agencies.

21. The State Medicaid Manual in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services section states in part:

> 5010. Overview
> A. Early and Periodic Screening, Diagnostic and Treatment Benefit.-- Early and periodic screening, diagnostic and treatment services (EPSDT) is a required service under the Medicaid program for categorically needy individuals under age 21…
>
> 5110. Basic Requirements
>
> OBRA 89 amended §§1902(a)(43) and 1905(a)(4)(B) and created §1905(r) of the Social Security Act (the Act) which set forth the basic requirements for the program. Under the EPSDT benefit, you[1] must 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 (personal care services) is one of the

---

[1] "You" in this manual context refers to the state Medicaid agency.

services provided by the state to treat or ameliorate an individual's conditions under the State plan. Chapter 409, Fla. Stat., states, in part:

> 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.

23. The issue to be decided is the medical necessity of the service or amount of service. The State Medicaid Manual provides for limitations on services as follows:

> 5110. Basic Requirements…
> …Services under EPSDT must be sufficient in amount, duration, or scope to reasonably achieve their purpose. The amount, duration, or scope of EPSDT services to recipients may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. Appropriate limits may be placed on EPSDT services based on medical necessity.
>
> 5122. EPSDT Service Requirements
> F. Limitation of Services.--The services available in subsection E are not limited to those included in your State plan.
> Under subsection E, the services must be "necessary . . . to correct or ameliorate defects and physical or mental illnesses or conditions . . ." and the defects, illnesses and conditions must have been discovered or shown to have increased in severity by the screening services. You make the determination as to whether the service is necessary. You are not required to provide any items or services which you determine are not safe and effective or which are considered experimental.

> 5124. Diagnosis and Treatment
> B. Treatment.--
> 1. General. - You must make available health care, treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services. Treatment services may be limited as described in §5122 F.

24. Once a service has been identified as requested under EPSDT, the Medicaid program determines the amount or necessity for that service based on the State of Florida's published definition of medical necessity. The Fla. Admin. Code R. 59G-1.010 defines medical necessity:

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

25. Based upon the information submitted by the Petitioner's provider, eQHealth Solutions completed a prior authorization review to determine medical necessity for the requested personal care services.

26. In the Petitioner's case, the Respondent has determined that some personal care services are medically necessary, but has approved 4 hours daily

rather than the 5 hours daily Monday to Friday and 10 hours daily on Saturday and Sunday 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. 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:
• 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.

30. 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.

31. 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 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.

32. 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)

33. The Petitioner's physician ordered a service frequency greater than that approved by eQHealth Solutions. Rule 59G-1.010(166) (c), however, specifically states a prescription does not automatically mean the requirements of medical necessity have been satisfied.

34. The Respondent's witness, Dr. Calhoun, stated the currently approved hours are sufficient to provide the medically necessary assistance to the Petitioner.

35. The Petitioner's mother stated the Petitioner needs the additional requested services due to her medical limitations and her husband's work schedule.

36. After considering the evidence and testimony presented, the undersigned concludes the Petitioner has demonstrated that additional personal care services are currently needed due to her mother's medical limitations. However, the undersigned also agrees with the Respondent's position that the father's work schedule on the weekend is too vague to justify a blanket approval of 10 personal care hours on every weekend. The work schedule lists "extensive travel" but lacks specificity as to how long and how often the travel occurs.

37. The undersigned concludes that the Petitioner should receive 5 hours of personal care services daily, seven days per week. The Petitioner has not demonstrated that 10 hours should be approved on weekends.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is GRANTED, in part, and the Petitioner shall receive 5 hours of personal care services daily for the current certification period.

NOTICE OF RIGHT TO APPEAL

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

of the date stamped on the first page of the final order. The Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 02 day of May, 2016,

in Tallahassee, Florida.

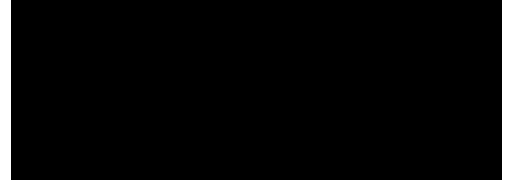
Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

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

May 23, 2016

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 16F-00711

PETITIONER,

Vs.

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

RESPONDENT.

_______________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in [redacted] [redacted] on March 10, 2016 at 10:10 a.m. The parties reconvened on April 21, 2016 at approximately 10:00 a.m.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Linda Latson
Registered Nurse Specialist

ISSUE

Whether respondent's denial of overnight respite care and overnight attendant care 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

The petitioner was not present at either hearing. On March 10, 2016 petitioner's exhibit "1" was entered into evidence. On April 21, 2016 petitioner's exhibits "2" and "3" were accepted into evidence.

Ms. Latson appeared in person for the respondent. Present telephonically from United Healthcare were Christian Laos, Senior Compliance Analyst and Dr. Marc Kaprow, Executive Director of the Long Term Care Program.

Respondent's evidence was not provided to either the petitioner or the undersigned prior to the March 10, 2016 hearing. Petitioner's representative wished to review the proposed evidence before proceeding. As such, the hearing reconvened In West Palm Beach, Florida on April 21, 2016.

On April 21, 2016 respondent's exhibits "1" through "3" were accepted into evidence.

The record was held open through April 28, 2016 to allow United Healthcare to review and, if desired, provide a written response to petitioner's exhibits "2" and "3". A response was not received.

The record was held open through May 5, 2016 for either party to submit additional closing statements. A response was not received from either party.

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 was, at all times relevant to this proceeding, Medicaid eligible. She is enrolled in respondent's Statewide Long Term Managed Care Program (LTMC Program).

2. Respondent contracts with Health Maintenance Organization to provide certain services to LTMC enrollees. Petitioner services are provided by United Healthcare.

3. Respondent does not have a promulgated Coverage and Limitations Handbook for the LTMC Program. LTMC services are defined by contract.

4. Services approved for the petitioner through the LTMC Program are:

Service:	Frequency:
Adult Day Care	45 daytime hours Monday - Friday (includes transportation time).
Personal Care	9 hours per week
Homemaker	4 hours per week
Companion	14 hours per week
Attendant Care (Unskilled)	14 hours per week
Total Weekly Approved Hours	86

5. The above services are provided during the day and/or early to mid-evening.

6. Petitioner was also approved to receive 44.5 hours of respite services during specific dates in November and December 2015.

7. For the period January 1, 2016 through December 6, 2016 100 hours of respite was approved.

8. Petitioner also receives wipes and disposable briefs through the LTMC Program.

9. Petitioner's date of birth is [redacted] She resides in a one-bedroom apartment. Petitioner's daughter/representative resides in a two-bedroom apartment in the same complex. Her residence is located several doors away from the petitioner's.

10. Petitioner is diagnosed with [redacted] with moderate to severe [redacted] She is also diagnosed with [redacted] and is considered to be [redacted]

11. A functional assessment was completed by United Healthcare in January 2016. The assessment states the petitioner lives alone. Regarding the petitioner, the assessment establishes she:

- Requires assistance and prompting with bathing
- Is not able to independently dress and perform basic grooming functions
- Requires assistance with toileting
- Ambulates and transfers independently
- Is not able to perform household duties such as cleaning; laundry; and meal preparation

12. Petitioner can be restless at night. She gets up numerous times to use the bathroom; get something to eat; or change clothing.

13. On or about January 8, 2016 petitioner requested overnight respite and attendant care; seven nights per week.

14. On January 11, 2016, United Healthcare issued a Notice of Action denying the request as not being medically necessary[1]. The notice, signed by Sloan Karver, M.D., states:

> The facts we used to make our decision are: You asked for respite at home. This includes overnight care. Overnight respite care is not provided at home. Overnight attendant care is not provided as well. The health plan will not approve the respite care at home. Nor will it approve attendant care overnight.

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[1] The notice did not identify which criteria of medical necessity were not satisfied.

15. On January 21, 2016 petitioner's representative contacted the Office of Appeal Hearings and timely requested a fair hearing.

16. On March 14, 2016 United Healthcare issued a second notice[2] which identified the following conditions of medical necessity were not satisfied:

- Must be individualized, specific, consistent with symptoms of diagnosis of illness or injury and not be in excess of the patient's needs.
- Must be able to be the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.'

17. The notice also stated:

> The facts that we used to make our decision are: You asked for attendant care at home. You asked for this seven days a week. Overnight attendant care is in excess of your needs. Care in excess of your needs is not covered. The health plan will not approve the attendant care at home. You asked for respite at home. This includes overnight care. Overnight respite care can be provided in a facility. This is safer than overnight respite at home. The health plan will cover overnight respite care in a facility. The health plan will approve the overnight respite in a facility. The plan will not approve the overnight respite care at home …

18. Petitioner's daughter/representative had attempted to have her mother sleep in her two-bedroom apartment. The mother became quite agitated and assistance from law enforcement was needed.

19. Petitioner's daughter/representative states the assessment completed in January 2016 is incorrect regarding her mother living alone. The daughter is now sleeping at night in her mother's one bedroom apartment.

20. Respondent was not aware of the above arrangement.

---

[2] Signed by Dr. Kaprow

21. Petitioner's representative asserts that due to her mother's cognitive status and visual impairment, she cannot be left alone. At present, her mother is aware of her surroundings and would not function well in a facility based respite program.

22. Dr. Kaprow is board certified in Internal Medicine and states medical necessity has not been established for the requested services.

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. 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.

26. LTMC service definitions relevant to this proceeding are:

> (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.

(5) Attendant Care — Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by state law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.

(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.

(21) Respite Care — Services provided to enrollees unable to care for themselves furnished on a short-term basis due to the absence or need for relief of persons normally providing the care. Respite care does not substitute for the care usually provided by a registered nurse, a licensed practical nurse or a therapist. Respite care is provided in the home/place of residence, Medicaid licensed hospital, nursing facility or assisted living facility.

27. Florida Medicaid, which includes the LTMC Program, only covers those services determined to be medically necessary. See § 409.905 (4) (c), Fla. Stat.

28. 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.

29. Petitioner requested either overnight attendant care or respite services. Analysis is first directed to attendant care.

30. The Findings of Fact petitioner is currently approved for 14 hours of attendant care services per week. Since the hours are approved for those parts of the day when petitioner is awake, "hands-on-care" can be provided.

31. Petitioner's supervisory needs at night are noted. The Findings of Fact establish the daughter is sleeping in petitioner's apartment. It is not clear why this was not known by the respondent. Regardless, credible evidence does not establish a hands-on service would be performed during an overnight period. Monitoring of petitioner should a situation arise is not within the scope of the service definition. Supportive

services, due to [redacted] and visual impairment, include more than monitoring/supervision during normal sleep periods.

32. In regard to overnight respite, it is noted that 144.5 respite hours have been approved since November 2015 and for future dates in 2016. The times associated with each approved time block is not known. Regardless, the contractual definition for respite specifies the service be provided “on a short-term basis.” Providing the service at or about seven nights consistently week after week does not rise to the standard of “short-term basis”.

33. Petitioner’s agitation when sleeping at the daughter’s residence and how this might also surface at a facility based overnight respite program is noted. Also noted is that no evidence was presented petitioner has experienced any agitation or adjustment issues when being transporting to or attending the Adult Day Health Care facility. How petitioner would function at a facility based respite program is speculative.

34. The burden of proof in this matter is vested with the petitioner. Petitioner must establish, by the required evidentiary standard, that the requested services are medically necessary. To do so, each condition of medical necessity must be satisfied.

35. A hearing officer must consider all evidence; evaluate credibility of testimony; and draw permissible inferences from the evidence. After reviewing documentary evidence and testimony on a comprehensive basis, petitioner has not demonstrated overnight attendant care or overnight respite care is medically necessary. The following conditions of medical necessity have not been satisfied:

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

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

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 23 day of May, 2016,

in Tallahassee, Florida.

Frank Houston

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

Copies Furnished To: [redacted] PETITIONER
JUDY JACOBS, AREA 7, AHCA FIELD OFFICE

May 02, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-00797

PETITIONER,

Vs.

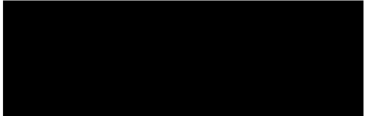
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 05 Marion
UNIT: AHCA

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on April 4, 2016 at approximately 10:30 a.m.

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 Respondent's partial approval of Petitioner's request for extraction of all four (4) wisdom teeth with I.V. sedation. Respondent approved the extraction of two (2) teeth and denied the extraction of two (2) teeth. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

Respondent presented the following witnesses:

- Melissa Stephens – Grievance and Appeals Coordinator, Prestige Health Choice
- Dr. Nicholas Kavouklis – CEO, President, and Dental Director, Argus Dental and Vision

Maggie Garrett, Quality Improvement Officer with Argus, observed the hearing. Petitioner moved Exhibit 1 into evidence at the hearing. Respondent moved Exhibits 1 through 4 into evidence at the hearing.

FINDINGS OF FACT

1. Petitioner is an 18-year-old male. Petitioner is enrolled with Prestige Health Choice ("Prestige") as his Managed Medical Assistance (MMA) plan.

2. Argus Dental and Vision ("Argus") is Prestige's dental vendor.

3. On August 18, 2015, Petitioner was referred by his dentist to an oral surgeon for evaluation of his wisdom teeth for possible extraction due to insufficient arch length. (Petitioner's Exhibit 1).

4. On December 9, 2015, Petitioner's oral surgeon submitted a prior authorization request for the extraction of all four (4) of Petitioner's wisdom teeth with sedation. Dr. Kavouklis reviewed the request. Dr. Kavouklis testified he has been a practicing general dentist for 30 years and has performed thousands of wisdom teeth extractions.

5. On December 18, 2015, Prestige issued a Notice of Action approving the extraction of tooth #17 and tooth #32 (the bottom teeth) with sedation, but denying the extraction of tooth #16 and tooth #1 (the upper teeth). (Respondent's Exhibit 2).

6. On February 10, 2016, a different dentist with Argus, Dr. Amir Boules, reviewed the request and upheld the denial.

7. Dr. Kavouklis testified he reviewed the x-ray and notes provided by Petitioner's oral surgeon in order to make his determination.

8. The oral surgeon's progress notes state that all four (4) of the wisdom teeth are impacted and are causing Petitioner severe discomfort. (Respondent's Exhibit 4).

9. Dr. Kavouklis testified the x-ray shows that the bottom wisdom teeth are not erupting properly and need to be extracted and likely are causing Petitioner pain. He said they look for different criteria to determine whether or not to extract them, such as decay, gum problems, and infection, and that Petitioner's upper wisdom teeth do not exhibit any of these characteristics.

10. Dr. Kavouklis said the upper teeth have not erupted, have no impeded path of eruption, and are not an imminent danger to the adjacent teeth. He said it is possible they will move in the future and require extraction and possible they will not. He testified it would be prophylactic at this time to extract the upper teeth.

11. Petitioner's father stated his concern about potentially having his son put under anesthesia a second time in the event the upper teeth later need to be extracted. Dr. Kavouklis concurred that the least amount of sedation used the better. However, he said upper wisdom teeth are more easily extracted than lower wisdom due to bone density and other factors. He said in the event Petitioner needs his upper wisdom teeth extracted in the future he might very well be able to do it with only a local anesthetic, as opposed to I.V. sedation.

CONCLUSIONS OF LAW

12. By agreement between the Agency for Healthcare Administration ("AHCA" or "Agency") and the Department of Children and Families ("DCF"), the Office of Appeal Hearings has jurisdiction to conduct this hearing pursuant to Section 120.80, Fla. Stat.

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

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

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

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

17. The Florida Medicaid Dental Services Covered and Limitations Handbook, November 2011, is promulgated into rule by Chapter 59G of the Florida Administrative Code.

18. Page 2-13 of the Dental Handbook describes oral surgery services as:

> Oral surgery services include extractions well as surgical and adjunctive treatment of diseases, injuries, deformities, and defects of the oral and maxillofacial regions.

19. Page 2-14 of the Dental Handbook defines a "Surgical Extraction" as:

> A surgical extraction is the removal of any erupted or unerupted tooth by the open method that includes the retraction of a mucoperiosteal flap and the removal of alveolar bone in order to extract or section a tooth.

20. The Dental Handbook requires that all services provided be medically necessary.

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

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

22. Since the Petitioner is under 21 years of age, a broader definition of medical necessity applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPDST) requirements. Section 409.905, 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.

23. Under the above statute, the Agency offers dental services as an EPSDT service to Medicaid-eligible recipients less than 21 years of age.

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

> (1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.
> (2) A state Medicaid plan must include "reasonable standards … for determining eligibility for and the extent of medical assistance" … and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.
> (3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."
> (4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."
> (5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. **The state is not required to provide medically unnecessary, albeit desirable, EPSDT services.** However, a state's provision of a required EPSDT

> benefit, such as private duty nursing services, “must be sufficient in amount, duration, and scope to reasonably achieve its purpose.”
> (6) A state “may place appropriate limits on a service based on such criteria as medical necessity.” In so doing, a state “can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis” and my present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)) (emphasis added).

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

26. Dr. Kavouklis gave credible testimony that Petitioner’s upper wisdom teeth do not need to be extracted at this time. He testified there is no evidence of gum problems, infections, decay, danger to adjacent teeth, or any other indicia that would necessitate their removal. The only evidence presented to indicate removal of the teeth is necessary is the oral surgeon’s notes that Petitioner is in pain. The pain is likely being caused by the lower wisdom teeth, which must be extracted.

27. Petitioner’s father said it would be desirable to get all four (4) wisdom teeth removed at once in order to use less anesthesia. Dr. Kavouklis concurred it is desirable to use the least amount of anesthesia, but that the upper teeth may be able to be removed using only local anesthestic.

28. Petitioner’s father’s concern for his son’s safety and exposure to anesthesia is commendable. However, the desirability of having the upper wisdom teeth removed at the same time as the lower wisdom does not equal necessity.

29. The undersigned has reviewed all pertinent rules and regulations, including EPSDT requirements. Petitioner has not met his burden to show, by the greater weight of the evidence, that the extraction of the upper wisdom teeth is medically necessary at this time.

30. Petitioner and his father are encouraged to work with his dental providers to monitor any future changes in his condition that would make extraction of the upper wisdom teeth medically necessary. If extraction appears to be necessary in the future, Petitioner can submit a new request at that time.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 02 day of Mav, 2016,

in Tallahassee, Florida.

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

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

May 02, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-00817

PETITIONER,
Vs.

CASE NO.

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

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on March 9, 2016 at 1:14 p.m. in

APPEARANCES

For Petitioner:

For Respondent: Ed Poutre, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's action to terminate petitioner's Special Low-Income Medicare Beneficiary (SLMB) benefits and to deny petitioner's application for Qualifying Individual 1 (QI1) benefits effective March 1, 2016 and ongoing is correct. The burden of proof is assigned to the respondent by a preponderance of the evidence.

PRELIMINARY STATEMENT

Petitioner was present and testified. Petitioner submitted one exhibit, which was entered and marked as Petitioner's Composite Exhibit "1". Respondent was

represented by Ed Poutre with the Department of Children and Families (hereafter "DCF", "Respondent" or "Agency"). Mr. Poutre testified. Respondent submitted ten exhibits, which were entered and marked as Respondent's Exhibits "1" through "10".

FINDINGS OF FACT

1. Petitioner's Medicare Savings Plan (MSP) Medicaid benefits were previously certified from March 2015 through February 2016.

2. On January 14, 2016, the petitioner submitted a recertification application for SSI-Related Medicaid and MSP Medicaid benefits. SSI-Related Medicaid benefits are not an issue under appeal. The application listed petitioner as the only member in the household; petitioner's Social Security Disability Insurance (SSDI) and earned income as the only income in the household; and petitioner receiving Medicare Part A and B.

3. On January 28, 2016, the respondent mailed petitioner a Notice of Case Action indicating (1) petitioner's Special Low-Income Medicare Beneficiary (SLMB) benefits terminated effective February 29, 2016 as "Your household's income is too high for this program"; and (2) petitioner's Qualifying Individual 1 (QI1) application dated January 14, 2016 was denied effective March 1, 2016 as "Your household's income is too high to qualify for this program".

4. Petitioner receives SSDI income in the amount of $929 (gross) per month.

5. Petitioner submitted the following paystubs: December 15, 2015 for $554.32 for 53.61 hours; December 29, 2015 for $497.99 for 47.42 hours; January 13, 2016 for $475.96 for 45.92 hours; January 27, 2016 for $423.57 for 38.78 hours; February 9, 2016 for $544.38 for 53.25 hours; and February 23, 2016 for $404.91 for 40.80 hours.

6. Petitioner's paystubs include tips, which vary weekly. Although petitioner works between twenty to twenty-five hours per week, she may work less than twenty hours or more than twenty-five hours per week depending on the availability of work. Furthermore, the petitioner's January 13, 2016 paystub contained the new minimum wage amount.

7. Respondent calculated petitioner's monthly earned income three different times; however, the respondent determined $949.29 was the gross monthly earned income amount that was most representative of petitioner's future earnings. Respondent used petitioner's February 9, 2016 and February 23, 2016 paystubs as representative when calculating petitioner's gross monthly earned income as $949.29.

8. Respondent determined petitioner over the income standard for MSP Medicaid benefits effective March 2016 and ongoing as follows:

$ 929.00	petitioner's SSDI income
-$ 20.00	unearned income disregard
$ 909.00	countable unearned income
$ 949.29	petitioner's earned income
-$ 65.00	earned income disregard
-$ 442.14	½ remaining disregard
$ 442.14	countable earned income
$ 442.14	countable earned income
+$ 909.00	countable unearned income
$1,351.14	**total countable income**

TheQI1 income standard for a household of one is $1,325.00 and the SLMB income standard for a household of one is $1,177.

9. Petitioner argued she cannot lose her MSP Medicaid benefits as she would not be able to afford to pay for physician visits, therapy sessions, and durable medical goods without MSP paying her Medicare premium.

10. Petitioner disagreed with the respondent's termination of her SLMB benefits and denial of QI1 benefits as she argued the respondent was not utilizing the correct income standard when it determined she was over the MSP income standards. She further argued the Social Security Administration (SSA) determined she was eligible to receive SSDI as her monthly earned income was under the Substantial Gainful Activity (SGA) monthly income standard. Therefore, since her earned income was under the SGA income standard, her earned income should be under the income level to receive MSP Medicaid benefits.

11. Respondent argued petitioner was not eligible for MSP Medicaid benefits as the combination of her earned income and SSDI income exceeds the income standards for the MSP Medicaid programs.

CONCLUSIONS OF LAW

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

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

14. The Code of Federal Regulations at 20 C.F.R. § 416.1110 defines earned income as:

> Earned income may be in cash or in kind. We may include more of your earned income than you actually receive. We include more than you actually receive if amounts are withheld from earned income because of a garnishment or to pay a debt or other legal obligation, or to make any

> other payments. Earned income consists of the following types of payments:
> (a) Wages—(1) Wages paid in cash—general. Wages are what you receive (before any deductions) for working as someone else's employee. Wages are the same for SSI purposes as for the social security retirement program's earnings test. (*See* §404.429(c) of this chapter.) Wages include salaries, commissions, bonuses, severance pay, and any other special payments received because of your employment…

15. The Code of Federal Regulations at 20 C.F.R. § 416.1121 defines unearned income as:

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

16. Pursuant to the above authorities, petitioner’s earned income and SSDI income are considered included income in the determination of petitioner’s eligibility for MSP Medicaid benefits.

17. The Fla. Admin. Code R. 65A-1.713 addresses the budgeting methods for the SSI-Related Medicaid Income Eligibility Criteria as follows:

> (4) Income Budgeting Methodologies. To determine eligibility SSI budgeting methodologies are applied except where expressly prohibited by 42 U.S.C. § 1396 (2000 Ed., Sup. IV) (incorporated by reference), or another less restrictive option is elected by the state under 42 U.S.C. § 1396a(r)(2) (2000 Ed., Sup. IV) (incorporated by reference). When averaging income, all income from the most recent consecutive four weeks shall be used if it is representative of future earnings. A longer period of past time may be used if necessary to provide a more accurate indication of anticipated fluctuations in future income.
> (a) For MEDS-AD Demonstration Waiver, Protected Medicaid, Medically Needy, Qualified Working Disabled Individual, QMB, SLMB, QI1, and to compute the community spouse income allocation for spouses of ICP individuals, the following less restrictive methodology for determining gross monthly income is followed:
> 1. When income is received monthly or more often than once per month the monthly income from that source shall be computed by first determining the

> weekly income amount and then multiplying that amount by 4. A five-week month shall not be treated any differently than a four-week month…

18. Pursuant to the above authority, petitioner's earned income must be budgeted as she receives it on a bi-weekly basis. The most recent paystubs are February 9, 2016 and February 23, 2016. Both paystubs are representative of petitioner's future earnings. Petitioner's ongoing monthly earned income is $949.29 ($544.38 + $404.91 = $949.29 divided by 2 = $474.65 x 2 = $949.29). Respondent correctly budgeted petitioner's monthly earned income amount.

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

> …
> (12) Limits of Coverage
> (a) Qualified Medicare Beneficiary (QMB). Under QMB coverage, individuals are entitled only to Medicare cost-sharing benefits, including payment of Medicare premiums.
> (b) Special Low-Income Medicare Beneficiary (SLMB). Under SLMB coverage, individuals are entitled only to payment of the Part B Medicare premium…
> …
> (d) Part B Medicare Only Beneficiary (QI1). Under QI1 coverage, individuals are only entitled to payment of their Medicare part B premium. (This is coverage for individuals who would be eligible for QMB or SLMB coverage except their income exceeds time limits for those programs.)

20. The Fla. Admin. Code R. 65A-1.713 further addresses the SSI-Related Medicaid Income Eligibility Criteria as follows:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
> …
> (b) For QMB, income must be less than or equal to the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.
> …

> (g) For SLMB, income must be greater than 100 percent of the federal poverty level but equal to or less than 120 percent of the federal poverty level.
> …
> (j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. QI1 is eligible only for payment of the Part B Medicare premium through Medicaid.

21. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, Appendix A-9, lists the SSI-Related Income Limits for a household size of one for the month of March 2016 as follows: the Income Standard for Qualified Medicare Beneficiaries (QMB) as $981; the Income Standard for Special Low Income Medicare Beneficiary (SLMB) as $1,177; and the Income Standard for QI1 as $1,325.

22. The Policy Manual, CFOP 165-22, Appendix A-9, lists the SSI-Related Income Limits for a household size of one for the month of April 2016 and ongoing as follows: the Income Standard for QMB as $990; the Income Standard for SLMB as $1,188; and the Income Standard for QI1 as $1,337.

23. 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."

24. Petitioner's SSDI and earned income exceed the income limits for all three of the aforementioned Medicare Savings Programs; therefore, the respondent correctly terminated petitioner's SLMB Medicaid benefits effective February 29, 2016 and denied petitioner's QI1 Medicaid benefits effective March 2016 and ongoing.

25. In careful review of the cited authorities and evidence, the undersigned concludes the respondent met the burden of proof indicating it correctly terminated

petitioner's SLMB Medicaid benefits effective February 29, 2016 and denied her January 14, 2016 application for the Medicare Savings Program Medicaid benefits effective March 2016 and ongoing.

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 02 day of May, 2016,

in Tallahassee, Florida.

Mary Jane Stafford

Mary Jane Stafford
Hearing Officer
Building 5, Room 255
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

May 03, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

PETITIONER,

Vs.

APPEAL NO. 16F-00861

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 66292

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing by phone in the above-referenced matter on March 10, 2016 at 8:35 a.m.

APPEARANCES

For Petitioner:

For Respondent: Stanley Jones, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's action to terminate the petitioner and his wife's Medicare Savings Programs (MSP) Medicaid benefits effective December 1, 2015 and ongoing is correct. The burden of proof is assigned to the respondent by a preponderance of the evidence.

PRELIMINARY STATEMENT

Petitioner was present and testified. Petitioner did not submit any exhibits at the hearing. Respondent was represented by Stanley Jones with the Department of

Children and Families (hereafter “DCF”, “Respondent” or “Agency”). Mr. Jones testified. Respondent submitted four exhibits, which were entered and marked as Respondent’s Exhibits “1” through “4”.

FINDINGS OF FACT

1. Petitioner and his wife’s most current Medicare Savings Program (MSP) certification period was from September 1, 2015 through August 30, 2016.

2. On October 5, 2015, the petitioner submitted a reapplication for Temporary Cash Assistance (TCA), Food Assistance (FA), Family-Related Medicaid, and MSP Medicaid benefits. TCA, FA, and Family-Related Medicaid benefits are not issues under appeal. The application listed petitioner, his wife, and their mutual child as the only members in the household; the petitioner’s, his wife’s and their child’s Social Security Disability Insurance (SSDI) as the only income in the household; and petitioner and his wife receiving Medicare Part A and B.

3. On November 5, 2015, the respondent mailed petitioner a Notice of Case Action indicating petitioner and his wife’s Qualifying Individual (QI1) benefits would end effective November 30, 2015 as “Your household’s income is too high to qualify for this program”.

4. Petitioner receives SSDI income in the amount of $1,068 (gross) per month; petitioner’s wife receives SSDI income in the amount of $763 (gross) per month; and petitioner’s son receives SSDI income in the amount of $495 (gross) per month.

5. Respondent considered only petitioner and his wife’s SSDI income when determining their eligibility for MSP Medicaid benefits.

6. Respondent determined petitioner and his wife over the income standard for MSP Medicaid benefits effective December 2015 and ongoing as follows:

$1831.00	petitioner and his wife's SSDI income
-$ 20.00	unearned income disregard
$1811.00	total countable unearned income
$1811.00	total countable income
$1793.00	QI1 income standard for a household of two

7. Petitioner argued he needs his MSP Medicaid benefits as he would not be able to pay for his prescription co-pays and other medical expenses without MSP paying his Medicare premium.

8. Petitioner argued his MSP Medicaid benefits should not be terminated because his household's monthly income has not changed.

9. Respondent argued petitioner and his wife were not eligible for the MSP Medicaid benefits because the total amount of petitioner and his wife's SSDI income was over the income limit for the aforementioned programs.

CONCLUSIONS OF LAW

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

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

12. The Code of Federal Regulations at 20 C.F.R. § 416.1121 defines unearned income as:

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

13. Pursuant to the above authority, petitioner and his wife's SSDI income are considered included income in the determination of their eligibility for MSP Medicaid benefits.

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

> …
> (12) Limits of Coverage
> (a) Qualified Medicare Beneficiary (QMB). Under QMB coverage, individuals are entitled only to Medicare cost-sharing benefits, including payment of Medicare premiums.
> (b) Special Low-Income Medicare Beneficiary (SLMB). Under SLMB coverage, individuals are entitled only to payment of the Part B Medicare premium…
> …
> (d) Part B Medicare Only Beneficiary (QI1). Under QI1 coverage, individuals are only entitled to payment of their Medicare part B premium. (This is coverage for individuals who would be eligible for QMB or SLMB coverage except their income exceeds time limits for those programs.)

15. The Fla. Admin. Code R. 65A-1.713 further addresses the SSI-Related Medicaid Income Eligibility Criteria as follows:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
> …
> (b) For QMB, income must be less than or equal to the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.
> …
> (g) For SLMB, income must be greater than 100 percent of the federal poverty level but equal to or less than 120 percent of the federal poverty level.

> …
> (j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. QI1 is eligible only for payment of the Part B Medicare premium through Medicaid.

16. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, Appendix A-9, lists the SSI-Related Income Limits for a household size of two for the month of December 2015 through March 2016 as follows: the Income Standard for Qualified Medicare Beneficiaries (QMB) as $1,328; the Income Standard for Special Low Income Medicare Beneficiary (SLMB) as $1,593; and the Income Standard for QI1 as $1,793.

17. The Policy Manual, CFOP 165-22, Appendix A-9, lists the SSI-Related Income Limits for a household size of two for the month of April 2016 and ongoing as follows: the Income Standard for QMB as $1,335; the Income Standard for SLMB as $1,602; and the Income Standard for QI1 as $1,803.

18. 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."

19. Petitioner and his wife's SSDI income exceed the income limits for all three of the aforementioned Medicare Savings Programs; therefore, the respondent correctly terminated petitioner and his wife's QI1 benefits effective December 2015 and ongoing.

20. In careful review of the cited authorities and evidence, the undersigned concludes the respondent met the burden of proof indicating petitioner and his wife's MSP Medicaid benefits were correctly terminated effective December 2015 and ongoing.

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 03 day of Mav, 2016,

in Tallahassee, Florida.

Mary Jane Stafford

Mary Jane Stafford
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

May 02, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-00890

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 01 Escambia
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 Petitioner:

For Respondent: Cindy Henline, Medicaid Health Care Program Analyst, Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Respondent's denial of Petitioner's initial request for Prescribed Pediatric Extended Care (PPEC) services for full and partial days, Monday through Friday for the certification period of December 9, 2015 to June 5, 2016 was appropriate. Because the matter under appeal is an initial request for PPEC services, the burden of proof was assigned to the Petitioner.

PRELIMINARY STATEMENT

Dr. Rakesh Mittal, board certified pediatrician and physician consultant for eQHealth Solutions, presented testimony on the Agency for Health Care Administration's (AHCA) behalf as a representative from the Agency's Quality Improvement Organization (QIO).

[redacted] Registered Nurse for Caring Hearts Pediatric Extensive Care Center, appeared as a witness for the Petitioner.

Respondent submitted two (2) documents which were entered into evidence and marked Respondent Exhibits 1 and 2.

Petitioner submitted a fourteen page document which was entered into evidence and marked Petitioner Exhibit 1.

Administrative notice was taken of Florida Administrative Code Rule 59G-1.010 and 59G-4.290 as well as AHCA's Prescribed Pediatric Extended Care (PPEC) Services Coverage and Limitations Handbook.

While no PPEC services have been administratively approved pending the outcome of this appeal, Respondent did approve PPEC services for 90 days to assess skilled needs, provide caregiver education and provide a more appropriate day program if no skilled need is noted while in PPEC.

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 7 year-old male Medicaid recipient. He is diagnosed with [redacted]

2. Petitioner has not had a seizure for one and a half years. However, the mother reported the Petitioner had a 30-40 second seizure on March 31, 2016. His seizures are sporadic and unpredictable. Petitioner's seizure medication is being lowered and the Petitioner's mother is concerned with the outcome. Petitioner is requesting nursing services in case he has a breakthrough seizure.

3. Petitioner is on a regular age appropriate diet with some texture aversions. He is incontinent and non-verbal. He is ambulatory but has an unsteady gait which causes him to trip.

4. Petitioner receives speech therapy and occupational therapy at the PPEC center.

5. Petitioner's neurologist prescribed Petitioner to continue attending PPEC where nursing staff are available to monitor Petitioner.

6. The Agency contracts with a Quality Improvement Organization (QIO) to perform medical utilization reviews for private duty nursing and personal care services through a prior authorization process for Medicaid State Plan beneficiaries. The prior authorization review determines the medical necessity of the hours requested pursuant to the requirements and limitations of the Medicaid State Plan. The Agency's QIO is eQHealth Solutions.

7. A request for service is submitted by a provider along with all information and documentation necessary for the QIO to make a determination of medical necessity for the level of service requested. A review is conducted for every new certification period

and a request for modification may be submitted by a beneficiary during a certification period.

8. On December 15, 2015, a request for PPEC full and partial day services from Monday through Friday was submitted by the provider on behalf of the Petitioner for the certification period December 9, 2015 to June 5, 2016. The request represents an initial request for PPEC services.

9. On December 18, 2015, an eQHealth Solutions physician consultant reviewed the request and partially approved the PPEC services. A "Notice of Outcome-Partial Denial Prescribed Pediatric Extended Care Services" was issued to Petitioner on December 19, 2015, which notified Petitioner that PPEC full and partial day services were partially denied The rationale for the denial was that the PPEC services were not medically necessary as defined in 59G-1.010 (166), Florida Administrative Code. The notice indicated partial and full PPEC services were approved from December 9, 2015 to March 3, 2016 and services from March 8, 2016 to July 5, 2016 were denied.

10. On December 19, 2015, a "Notice of Outcome-Partial Denial" was issued to Petitioner's provider and provided the clinical rationale as:

> There does not appear to be a skilled need and the patient does not meet the medical necessity for PPEC services.

11. A reconsideration was requested on February 1, 2016.

12. The reconsideration review was completed on February 15, 2016 and a "Notice of Reconsideration Determination-Prescribed Pediatric Extended Care Services" was sent to the Petitioner on February 18, 2016. The notice advised the partial denial was upheld.

13. A reconsideration notice was also sent to the Petitioner's on February 18, 2016 stating the medical basis for the reconsideration decision:

> There was no new information provided for this reconsideration that would reverse the previous decision.

14. On February 2, 2016, Petitioner timely requested a fair hearing.

15. The Respondent's physician consultant witness reviewed the information submitted for Petitioner's PPEC request and noted there was documentation why skilled nursing was needed. He explained that PPEC is provided to medically complex children requiring regular nursing intervention. Because Petitioner's seizure episodes cannot be predicted daily, PPEC services cannot be approved.

CONCLUSIONS OF LAW

16. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80 Fla. Stat. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

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

18. 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).

19. 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.

20. Florida Medicaid's Prescribed Pediatrics Extended Care Services Coverage and Limitations Handbook, September 2013, is promulgated into rule by Chapter 59G of the Florida Administrative Code. Page 2-2 of the Handbook 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."

21. Rule 59G-1.010 (164), Florida Administrative Code (F.A.C.) defines "medically complex" as follows:

> … 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.

22. Rule 59G-1.010 (165), Florida Administrative Code (F.A.C.) defines "medically fragile" as follows:

> …an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical

> apparatus or procedures to sustain life, e.g., requires total parenteral nutrition (TPN), is ventilator dependent, or is dependent on a heightened level of medical supervision to sustain life, and without such services is likely to expire without warning.

23. Because the Petitioner is under twenty-one-years-old, the requirements of Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT) must be considered. Florida Statute § 409.905, Mandatory Medicaid services, provides that Medicaid services for children must include:

> (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

24. 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 approved ongoing PPEC services but is providing PPEC services to the Petitioner for 90 days to allow for transition. Therefore, Respondent needs to determine that PPEC services are not medically necessary in order to be in compliance with EPSDT requirements.

25. Florida Medicaid's Prescribed Pediatrics Extended Care Services (PPEC) Coverage and Limitations Handbook (Handbook) provides the following purpose and definition of PPEC 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.

26. Page 2-1 the PPEC Handbook provides the following requirements for those who can receive PPEC services:

> To receive reimbursement for PPEC services, a recipient must meet **all** of the following criteria [emphasis added]:
>
> • 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.

27. 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, social work, developmental evaluations, and child life.

28. Petitioner’s request for PPEC services is primarily for monitoring for seizures and to provide nursing intervention if and when needed. His need for assistance with his activities of daily living, feeding and toileting, does not require nursing services. While the Petitioner receives speech and occupational therapy at the PPEC center, these services can be provided in other settings and are not part of PPEC services.

29. The Respondent’s witness explained that PPEC services cannot be approved for the child because he does not need skilled nursing.

30. The Petitioner has failed to meet his burden of proof that PPEC services are medically necessary and that he meets the definition of “medically complex” as defined by the above authorities. The Respondent has provided documentation and testimony that Petitioner does not need skilled nursing care.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 02 day of May, 2016,

in Tallahassee, Florida.

Warren Hunter
Hearing Officer
Building 5, Room 255
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Office: 850-488-1429
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Copies Furnished To: [redacted] Petitioner
Marshall Wallace, Area 1, AHCA Field Office Manager

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

May 02, 2016

Office of Appeal Hearings
Dept. of Children and Families

APPEAL NO. 16F-00901

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on March 23, 2016, at approximately 1:07 p.m. All parties appeared from separate locations.

APPEARANCES

On behalf of Petitioner:

On behalf of Respondent: Stephanie Lang, RN Specialist, Agency for Healthcare Administration ("Agency")

STATEMENT OF ISSUE

Whether the Agency was correct in denying Petitioner's request for 28 hours of personal care service and 7 hours of homemaker service (total of 35 additional hours of care) per week. Petitioner has the burden of proof on this issue by a preponderance of the evidence.

PRELIMINARY STATEMENT

Petitioner did not present any witnesses at the hearing besides her representative. Respondent's witnesses from Sunshine Health Plan were as follows: Tracy Thomas (Appeals Coordinator II), Dr. John Carter (Long Term Care Medical Director), Amanda Gosizk (Case Manager), and Jacklyn Seaton (Case Manager Supervisor).

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 and 59G-1.010; and 42 C.F.R. § 441.745.

Petitioner did not submit any exhibits during the hearing. Respondent admitted five exhibits, marked and entered as Respondent's Exhibits 1 through 5. The record closed on March 23, 2016.

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 an elderly female receiving services through Sunshine Health Plan's Long Term Care Medicaid program. She is a [redacted] She is missing her [redacted] She requires total assistance with all activities of daily living (ADLs), but only some assistance with eating. She requires frequent repositioning due to her heart condition. She requires frequent diaper changes because her medication causes frequent urination, about every two hours. Petitioner previously lived in a nursing home but her

health deteriorated so she moved home, where she is faring much better. Petitioner lives with her daughter and her son-in-law, and has a paid caregiver who assists during the day.

2. Petitioner currently receives 40 hours per week of care, which is broken down into 35 hours per week of personal service and 5 hours of homemaker service.

3. Petitioner's caregiver provides 40 hours per week of service from 8:00 a.m. to 4:00 p.m., Monday through Friday. Sometimes Petitioner's other family may come after 6:00 p.m. to assist with her care, but this is infrequent and not a guarantee.

4. Petitioner's daughter has doctors' appointments an average of three times per week. Petitioner's daughter had a heart attack in 2014 and a spinal surgery in 2009. Both of these conditions place physical restrictions on her ability to assist with Petitioner's care. Petitioner's daughter cannot lift more than five pounds and she is not permitted to bend or to sit for long periods of time. Petitioner's daughter cannot lift or change Petitioner. Petitioner's son-in-law's job schedule changes frequently and often requires travel out of town, as he is on constant call for a large region. When he is home, he often leaves the house around 6:00 a.m.

5. Sunshine received Petitioner's request for a total of additional 35 hours of care on January 4, 2016. It reviewed the request and denied it by notice dated January 14, 2016. The hours were denied because the reviewer determined Petitioner's 40 hours per week of care was adequate to meet her needs. Petitioner appealed the denial on or about February 2, 2016, but Sunshine has not made a decision on that yet because Petitioner also requested the instant fair hearing on the same day.

6. Sunshine assigned a case manager to Petitioner to complete a care assessment (also called a 701b report), which determines Petitioner's physical and mental status, and care needs. It helps to determine the appropriate array of services and hours for the Petitioner's care. Petitioner's 701b was dated February 5, 2015, which is after the plan made its decision, but the parties agree on Petitioner's limitations. Regarding ADLs, the assessment reported that Petitioner needs total assistance with bathing, dressing, toileting, transferring, and mobility. She needs some assistance, but not total help, with eating. The assessment noted that Petitioner always has assistance for these tasks. Regarding instrumental activities of daily living (IADLs), Petitioner needs some assistance, but not total help, with using the telephone. She needs total assistance with heavy chores, light housekeeping, managing money, preparing meals (three meals per day plus snacks), shopping, managing medication, and using transportation. The report noted she always has assistance with these tasks. It also noted that Petitioner is unable to care for herself, she is bedbound, and she is able to eat with assistance. She has a hoyer lift to help her transfer out of bed.

7. Based on the information found during the 701b report, a plan of care is established with the Petitioner and caregivers. The plan of care recommended 35 hours per week of personal care services because Petitioner requires 24 hour supervision and assistance with all activities of daily living and instrumental activities of daily living. It also recommended 5 hours per week of homemaking service to clean the home, do her laundry, and prepare meals. Sunshine approved the recommended services in the care plan, so Petitioner currently receives a total of 40 hours per week of home care.

8. The plan found that Petitioner always had supervision from either her caregiver or from a family member. The plan was aware of Petitioner's daughter's health condition when it made the decision. Petitioner's son-in-law, though his schedule is uncertain, is another capable adult who is often in the home to assist. As a result, the decision to deny Petitioner's request for additional hours was not changed.

9. Petitioner argues that her son-in-law should not be considered because he isn't around enough to be reliable. Additionally, her daughter is unable to help her with any physical tasks. When the caregiver leaves at 4:00 p.m., no one is available to help Petitioner's daughter until 6:00 p.m. when other family may assist. That other help is not a guarantee.

CONCLUSIONS OF LAW

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

11. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.

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

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

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

2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

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

14. The Florida Medicaid Home Health Services Coverage and Limitations Handbook (October 2014) ("Medicaid Handbook") has been incorporated by reference into Florida Administrative Code Rule 59G-4.130(2).

15. Page 1-2 of the Medicaid Handbook defines personal care services:

Personal care services provide medically necessary assistance with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL) that enable the recipient to accomplish tasks that they would normally be able to do for themselves if they did not have a medical condition or disability.

ADLs include:
- Eating (oral feedings and fluid intake);
- Bathing;
- Dressing;
- Toileting;
- Transferring; and
- Maintaining continence (examples include taking care of a catheter or colostomy bag or changing a disposable incontinence product when the recipient is unable to control his bowel or bladder functions).

16. Petitioner is enrolled in the long term care program, which offers expanded services to members in order to avoid institutionalization. Sunshine established utilization policies and procedure for this program in a document entitled "LTC (Long

Term Care) Ancillary Service Criteria" (revised June 2015) (referred to as "ancillary service criteria").

17. Petitioner's abilities are memorialized in the 701b assessment completed by a Sunshine case manager.

18. For all ancillary services, the support needed is based on the limitations a person has with their activities of daily living (ADLs), living situation, supervision needs, and support needed to complete daily tasks. Petitioner lives with family and the ancillary service criteria requires consideration of the number of days and hours that family members are not available to assist the member (page 8 of the ancillary service criteria). According to page 7 of the ancillary service criteria, a person needs maximum support with their ADLs when:

> Maximum and persistent functional impairment without available caregiver support where all of the following exist: a) Member has ADLs requiring total assistance, B0 member is non-ambulatory, c) the member transfer require one (1) to two (2) person assist, and d) the member's treating physician has certified that a), b), and c) impairments are present.

HOMEMAKER HOURS

19. The Ancillary Service Criteria (Respondent's Exhibit 5) defines housekeeping as:

> 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 services is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control may be included in this service.

20. More specific criteria is included in the ancillary service criteria beginning on page 12:

> Homemaker Services
> Members who may benefit from Homemaker Services, include those who:…

- Has someone in the home but has inadequate caregiver support.
- Temporarily require assistance to maintain a safe living environment due to functional status (i.e. Member has difficulty with standing, ambulation, or has a medical condition that affects endurance, such as a heart or breathing problem) and/or cognitive status (i.e. dementia).

  Additional criteria for specific services are outlined in Section D. Criteria for Individual Support Services.

21. Meal preparation criteria are on page 16 of the ancillary service criteria (Respondent's Exhibit 5). Petitioner typically eats three full meals per day plus snacks and requires total assistance with preparation. As Petitioner's daughter is available while the caregiver is there and has no physical limitations limiting her ability to provide meal preparation, the caregiver should not be performing this task unless the daughter is unavailable. Family members are expected to assist with care. After the caregiver leaves, the daughter is still available to provide meal preparation. As Petitioner's daughter is typically out of the home for a few hours three times per week for doctor's appointments, Petitioner would be entitled to meal preparation assistance during that time. So for one meal (lunch) and one snack requiring total assistance, Petitioner is entitled to 20 minutes for lunch and 10 minutes for a snack on those three days per week. That amounts to 90 minutes per week/1.5 hours/6 units of assistance.

22. Shopping guidelines are on page 16 of the ancillary service criteria. The guidelines differentiate between a person who lives alone and one who lives with family, and whether that family provides any support. Petitioner lives with family and there was no indication that they are unable to provide any shopping assistance. While Petitioner's daughter is unable to do much lifting, and the son-in-law is not always home, there was no evidence in the record to suggest that they are unable to shop for

Petitioner or unable to shop for themselves. Therefore, as Petitioner lives with family who is able to assist with her shopping, she is entitled to 0 minutes of assistance per the guidelines.

23. For housekeeping and chore services, pages 17-18 of the ancillary service criteria explain that these are chores that are necessary to maintain health, welfare, and safety of the member. For those members sharing a residence, such as Petitioner, housekeeping only applies to the areas that the member uses, including the member's bedroom and one bathroom. There was no testimony regarding how much assistance Petitioner's family can provide. Petitioner's daughter cannot lift or bend, so she is not to provide heavy housekeeping assistance. Petitioner's son-in-law does not have physical limitations and may assist when available. According to the guidelines, for a member who lives with family that provides a minimum or moderate amount of the member's housekeeping or chores, 15-90 minutes per week is appropriate. Therefore, Petitioner is entitled to 90 minutes/6 units/1.5 hours per week for general housekeeping based on minimum assistance from family.

24. Laundry criteria are on page 19 of the ancillary service criteria. Laundry service includes washing, drying, folding, putting away clothes, bed linens and towels, including more frequent loads for an incontinent member. Other chores could be done while clothes are being washed or dried. Petitioner's daughter has bending and lifting limitations which would impact her ability to perform frequent laundry service for Petitioner. Petitioner's son-in-law does not have physical limitations and may assist when available. According to the guidelines, for a member who lives with family that provides a minimum or moderate amount of the member's laundry service, 15-90

minutes per week is appropriate. Therefore, Petitioner is entitled to 90 minutes/6 units/1.5 hours per week for laundry based on minimum assistance from family.

25. In summary, Petitioner is entitled to 1.5 hours for meal preparation, 0 hours for shopping, 1.5 hours for general housekeeping, and 1.5 hours for laundry assistance, for a total of 4.5 hours per week of homemaker assistance. This is less than what Sunshine approved her for. Therefore, Sunshine's original decision to deny the request for an additional 7 hours of homemaker service was proper. Petitioner's service will remain at 5 hours per week of homemaker service and will not be decreased as a result of this decision.

PERSONAL CARE SERVICE HOURS

26. The Ancillary Service Criteria (Respondent's Exhibit 5) defines personal care service as:

> Personal Care Services – A service that provides assistance with eating, bathing, dressing and personal hygiene and other activities of daily living. The service includes assistance with preparation of meals, but does not include the cost of meals. The service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the member, rather than the member's family. Personal care services include the following:
>
> - Providing assistance to the member to complete personal hygiene (bathing, grooming, mouth care, etc.)
> - Assistance with bladder and bowel requirements that include assisting the member to and from the bathroom or with bedpan routines.
> - Assisting the member in following through with physician orders. The Personal Care provider cannot not [sic] administer any medications, but may bring specific medications to the member and remind the member to take the medicine at specific times.
> - Assisting with food, nutrition, and diet activities, including preparing meals, when required and other incidental services (i.e.

housekeeping chores) essential to the health and welfare of the member.

- Performing household services (changing bed linens or arranging furniture) when such services are essential to the member's health and comfort.

Personal Care workers must be supervised by a registered nurse, licensed to practice nursing in Florida and who conducts a supervisory home visit every 60 days to observe the personal care worker. The services may be provided in the member's home or other location. Family members cannot be paid for Personal Care Services.

27. More specific criteria is included in the ancillary service criteria on page 13:

Personal Care Services
Members who may benefit from Personal Care Services include those who:…

- Has someone in the home but has inadequate caregiver support
- Require assistance to maintain a safe living environment due to functional status (i.e. Member has difficulty with standing, ambulation, or has a medical condition that affects endurance, such as a heart or breathing problem) and/or cognitive status (i.e. dementia).

Additional criteria for specific services are outlined in section D. Criteria for Individual Support Services.

28. Criteria for Individual Ancillary Support Services for PCS services outlined above begin on page 14 of the ancillary service criteria.

29. Bathing guidelines are on pages 20 and 21 of the ancillary service criteria. Petitioner is elderly, and the guidelines do not recommend daily bathing for elderly people due to skin breakdown. There is not any information in the record about how often she is bathed. An individual who requires maximum assistance with 75% or more of the bathing process, requires two or more people to assist, requires the use of a mechanical lift, or is only able to receive bed baths is eligible for up to 45 minutes per bath. Petitioner is total assist with bathing. Assuming she is bathed three times per

week, rather than every day, 45 minutes three times per week (9 units/2.25 hours per week) would be sufficient according to the guidelines.

30. Dressing and grooming assistance guidelines are on pages 21-22 of the ancillary service criteria. Dressing includes selecting, putting on and removing clothes and footwear. Grooming includes brushing hair, teeth, and trimming finger nails and toe nails. A person who requires maximum assistance with dressing would be entitled to up to 20 minutes per task required for dressing and grooming, including transfer assistance. This includes regular assistance with buttons, zippers, and buckles, putting on socks and shoes, fixing hair, oral hygiene, or nail care. Petitioner needs total assistance with dressing. Petitioner did not provide any evidence explaining how often Petitioner needs assistance, with which tasks, or why she requires additional time. Petitioner would need, at least, to be dressed in the morning and to be dressed for bed. Petitioner's daughter cannot lift or bend for long; therefore she would be unable to provide the dressing assistance Petitioner would need. She would be able to provide grooming assistance, such as hair styling or nail care. At a minimum, Petitioner would be entitled to 20 minutes in the morning and 20 minutes in the evening, 7 days per week, for a total of 280 minutes which is approximately 19 units/5 hours per week for dressing.

31. Toileting assistance begins on page 23 of the ancillary service criteria. Toileting includes taking off clothes/diapers and replacing them, post-toilet hygiene, and reminders or a toileting schedule. For a person requiring maximum assistance with 75% or more of toileting activities, Sunshine's policy authorizes up to 15 minutes per task. Petitioner's daughter explained Petitioner wets her diapers approximately every

two hours. This is about 12 times in a 24 hour period, or 84 times over 7 days. Petitioner is entitled to 15 minutes of care every time she soils her diaper, which is 1260 minutes of care/21 hours/84 units per week.

32. Mobility is on pages 24-25 of the ancillary service criteria. It refers to a member's ability to move about the residence. The assessment notes that Petitioner can get around using her wheelchair in the home, but requires total assistance for mobility. The policy authorizes up to 30 minutes per task for a member who needs maximum assistance with 75% of mobility by one or more persons or is totally dependent on others for mobility, like Petitioner. There was no information in the record regarding specific mobility needs other than transferring and repositioning.

33. Transferring relates to a member's ability to move between the bed and wheelchair or toilet. Guidelines for transferring are on pages 25-26 of the ancillary service criteria. 15 minutes per task is appropriate if the member needs moderate assistance when transferring, including a one person assist with or without assistive devices, and the member may be able to bear weight or pivot. If the member needs maximum assistance with transferring, with support by one or more persons or is totally dependent on others for transferring, the policy authorizes up to 30 minutes per task. If the member is bed-bound and requires frequent turning and repositioning in bed, between 20 and 90 minutes per day is appropriate. If the member requires the use of a mechanical lift, up to 20 minutes per task is authorized. Petitioner is referred to as bed bound, but testimony stated she is transferred into her wheelchair and into other chairs around the home. A hoyer lift is available to help get her out of bed. As testimony indicated a need for frequent repositioning, 90 minutes/1.5 hours/6 units per day would

be appropriate for Petitioner's needs per the guidelines. This equals 630 minutes over a seven day week, 42 units, or 10.5 hours, and 90 minutes per day would allow for four to five repositions per day.

34. Petitioner needs some assistance with eating, but not total assistance, per the assessment. Meal assistance is discussed on page 27 of the ancillary service criteria. There is no information in the record regarding the level of hands-on assistance with eating that Petitioner requires beyond meal preparation.

35. Therefore, based on the information in the record, Petitioner would be entitled to 2.25 hours per week for bathing, 5 hours per week for grooming/dressing, 10.5 hours per week for positioning, and 21 hours per week for hygiene/continence care. This is a total of 38.75 hours per week for personal care services. Petitioner currently receives 35 hours per week. This is an increase of 3.75 hours per week of personal care services.

36. Based on the guidelines, Petitioner is entitled to 4.5 hours per week of housekeeping service, which is a decrease, but her service will stay at 5 hours.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Petitioner's appeal is partially granted, and the Agency is partially affirmed. Petitioner did not meet her burden of proof to show she is entitled to additional homemaker hours. The Agency is ordered to increase Petitioner's personal care services by 3.75 hours per week, for a total 38.75 personal care service hours 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 02 day of May, 2016,

in Tallahassee, Florida.

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

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

May 18, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-00912

PETITIONER,

Vs.

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

RESPONDENT.
________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on April 20, 2016 at approximately 3:30 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 termination of Petitioner's skilled nursing services of 24 hours per day, 7 days per week, and substitution with 12 hours per day, 7 days per week of personal care services (PCS) was correct. The burden of proof is assigned to Respondent.

PRELIMINARY STATEMENT

Petitioner's father represented him at the hearing, although he was present and provided testimony. Petitioner moved Exhibits 1 through 6 into evidence. Petitioner presented the following witnesses:

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-
-
-

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's Exhibits 1 through 5 were entered into evidence. Respondent presented the following witnesses:

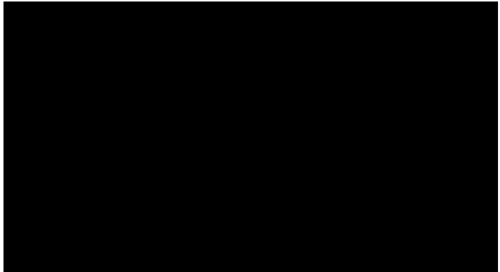
- Melody Gordon, Manager of Clinical Health Services, Aetna
- Summer Brooks, Contract Manager, Coventry/Aetna
- Dr. Darwin Caraballo, Medical Director, Florida Medicaid Long-Term Care Plan, Coventry/Aetna

Maureen McNamara, Manager of Grievance and Appeals with Aetna, observed the hearing.

FINDINGS OF FACT

1. Petitioner is a 31-year-old male. He enrolled with Coventry as his Long-Term Care ("LTC") plan in August of 2013. Joanna Marquez performed his initial 701B Comprehensive Assessment. Based upon that assessment, Petitioner was provided skilled nursing services for 24 hours per day, seven (7) days per week. Petitioner testified he has received 24/7 skilled nursing care since he was 18 years old.

2. Petitioner's medical conditions include, among others:



3. Petitioner lives with his mother and father. His father testified his work schedule can vary and that the time he arrives home is inconsistent. His mother works a traditional schedule as a school nurse, however, she is currently on a leave of absence so that she can be with her mother in North Carolina. Her mother is in hospice care.

4. Petitioner's father testified he takes He said he is not supposed to lift more than 20 pounds. He said he cannot care for Petitioner emotionally, intelligently, or physically. Petitioner tries to avoid frequent physical contact with his mother, due to concerns about the germs she brings home from her job.

5. It is undisputed that Petitioner requires total assistance with all activities of daily living ("ADLs") and instrumental activities of daily living ("IADLs"). Petitioner requires frequent oral suctioning throughout the day. His pulmonologist wants him to have a tracheotomy, but is willing to continue with oral suctioning at this time if he is monitored.

6. Dr. Caraballo testified he became the new Medical Director on January 1, 2016. He said he reviewed all of the recipients' files. He said that regardless of services being previously provided, that doesn't mean they are medically necessary now.

7. On February 10, 2016, Coventry issued a Notice of Action signed by Dr. Caraballo, Respondent's Exhibit 4, terminating Petitioner's skilled nursing hours and converting them to 12 hours per day, seven (7) days per week of PCS. The Notice stated:

> The facts that we used to make our decision are based on medical review and/or contractual guidelines: Your request for private duty nursing services 24/7 is denied. You have been approved for personal care services, 12 hours per day, 7 days a week, from 7 am to 7 pm, while your caregiver is not available. Per Florida Medicaid guidelines, 24/7 nursing services at home is only necessary when you have complex medical problems and need a skilled nurse all the time. Based on the medical notes we received, this is not your case. You need help with regular day to day activities but do not have any wounds or medications or medical equipment that only a nurse can help you with. You live with family and they can help you as well. If your family needs training to help you with your daily needs, we will review your case for nurse visits to teach them.

8. Ms. Gordon testified that the rationale for the change is that nursing care supplements care from natural caregivers, but it doesn't replace it. She said his parents should be able to take care of him from 7:00 p.m. – 9:00 p.m. and then he should not require more care until 7:00 a.m.

9. Petitioner's father stated he requires constant care every hour at night, and that he has done so before when necessary, such as when a nurse calls in sick, but that it turns into sleep deprivation if he has to do it constantly.

10. Petitioner does not have a set sleep schedule. He most frequently stays up all night until approximately 6:00 a.m. and wakes up around noon. However, he stated that his insomnia causes him to sleep at various times throughout the day and results in an inconsistent sleep schedule. Ms. Gordon stated that Coventry was not aware of the insomnia, but that he can take medication for it. She said that after 13

years of receiving 24/7 skilled nursing care, his parents should be trained to assist him by now. She said the notes from the Nursing Flow Sheets contained in Respondent's Composite Exhibit 2 indicate that the primary function of the nurses at night is generally repositioning, which can be performed by a home health aide, rather than a skilled nurse.

11. [redacted] testified that the repositioning is done frequently (approximately every hour) in order to prevent pain, and that Petitioner has to wake up to tell the nurse that he requires repositioning. She said they try to feed him orally, but he can't eat much because he has [redacted] She said when they feed him orally they have to elevate his bed to avoid choking because he has difficulty swallowing, but that elevating him increases his breathing problems, which can require suctioning. She said most of his nutrition comes from Ensure via his g-tube, and that sometimes he is able to eat more than others. Petitioner weighs approximately 78 pounds and has lost weight in the past six (6) months.

12. [redacted] testified that Petitioner requires other skilled nursing care when he is sleeping which requires a nurse, in addition to the repositioning, which could be performed by a home health aide. She said the Ensure and water (to keep him hydrated) are still being administered through the g-tube even when Petitioner is sleeping. The Ensure is given at night in addition to the daytime because Petitioner can only tolerate a small amount at a time. Regarding oral suctioning, she said that he is OK while he is sleeping, but that he needs it when he wakes up. As stated above, Petitioner's sleep schedule is erratic due to his insomnia. Petitioner testified

he takes his medication through the g-tube, not orally, and Ms. [redacted] said that one of the medications [redacted] must be taken at night.

13. Petitioner's condition is slowly deteriorating and [redacted] are all in agreement that Petitioner would require immediate institutionalization if his services are reduced to 12 hours per day.

CONCLUSIONS OF LAW

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

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

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

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

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

19. 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…."

20. 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.

21. 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.

22. Page 1-2 of the Home Health Handbook defines "Home Health Services" as:

> 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.

23. Page 1-2 of the Home Health Handbook defines "personal care services", stating:

> Personal care services provide medically necessary assistance with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL) that enable the recipients to accomplish tasks that they would normally be able to do for themselves if they did not have a medical condition or disability. Medicaid reimburses for these services provided to eligible recipients under the age of 21 years.
>
> ADLs include:
> • Eating (oral feedings and fluid intake)
> • Bathing
> • Dressing
> • Toileting
> • Transferring
> • Maintaining continence (examples include taking care of a catheter or colostomy bag or changing a disposable incontinence product when the recipient is unable to control his bowel or bladder functions)
>
> IADLs (when necessary for the recipient to function independently) include:
> • Personal hygiene
> • Light housework
> • Laundry

• Meal preparation
• Transportation
• Grocery shopping
• Using the telephone to take care of essential tasks (examples include paying bills and setting up medical appointments)
• Medication management
• Money management

Skilled interventions that may be performed only by a licensed health professional are not considered personal care services. (emphasis added).

24. Regarding who can receive in-home services, page 2-4 of the Home Health

Handbook provides:

Medicaid reimburses home health services for Medicaid recipients who are under the care of an attending physician. The recipient must meet all of the following requirements:
• Require services that, due to a medical condition, illness or injury, must be delivered at the place of residence rather than an office, clinic, or other outpatient facility because either:
− Leaving home is medically contraindicated and would increase the medical risk for exacerbation or deterioration of the condition.
− The recipient is unable to leave home without the assistance of another person.
• Require services that are medically necessary and reasonable for the treatment of the documented illness, injury or condition
• Require services that can be safely, effectively, and efficiently provided in the home
• Live in a residence other than a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF/IID) (See exceptions for ICF/IIDs in 42 CFR 483, Subpart I.)

Home health services rendered to recipients under the age of 21 years can be delivered at the recipient's place of residence or another authorized setting.

Medicaid does not reimburse home health services solely due to age, environment, convenience, or lack of transportation.

25. The Home Health Handbook provides for covered services for adults, stating:

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

26. “Skilled nursing services” are defined on page 2-17 of the Home Health Handbook as:

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
- 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 self-administered medication. (emphasis added).

27. Page 2-18 of the Home Health Handbook provides for which services may be provided by a home health aide, as opposed to a nurse:

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. (emphasis added).

28. The Home Health Handbook requires that all services provided be medically necessary.

29. 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.
(emphasis added).

30. In the instant-matter, it is undisputed that Petitioner requires total care. The main point of contention is whether or not Petitioner's parents should be required to perform 12 hours per day as caregivers and that Petitioner will be provided home health services for the other 12 hours per day.

31. Ms. Gordon testified the repositioning could be provided by a home health aide, rather than a nurse. A home health aide was neither requested nor provided, only nursing care and personal care services. The Home Health Handbook is clear that g-tube feedings must be performed by a nurse, rather than a home health aide. Petitioner receives g-tube feedings throughout the day, even when he is sleeping.

32. Because the issue turns on whether or not Petitioner's parents should be required to take care of him for 12 hours of the day, it must be determined whether or not the services would be furnished primarily for their convenience. The undersigned concludes they are not being requested primarily for their convenience.

33. Due to the nature of Petitioner's erratic sleep schedule and maintenance of his g-tube approximately every hour, it would place an undue burden on his parents for them to be required to care for him at night. His parents care for him at night when necessary, but both work outside the home. It is inconceivable that they would be able to function properly if they had to wake up approximately every hour in order to care for him.

34. The Agency has not met its burden of proof to show, by the greater weight of the evidence, that it was proper to terminate Petitioner's skilled nursing care. It is noteworthy that Petitioner has been receiving 24/7 skilled nursing care for 13 years, including over two (2) years with Coventry, based upon his initial assessment.

DECISION

Based upon the foregoing, Petitioner's appeal is GRANTED. Respondent is directed to continue providing Petitioner 24 hours per day of skilled nursing care, seven (7) days 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 18 day of May, 2016, in Tallahassee, Florida.

Rick Zimmer

Rick Zimmer
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished To: [redacted] Petitioner
Judy Jacobs, Area 7, AHCA Field Office

May 23, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

PETITIONER,
Vs.

APPEAL NO. 16F-00935

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 Dade
UNIT: 66256

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on May 13, 2016 at 10:09 a.m.

APPEARANCES

For the Petitioner:

For the Respondent: Olivia Hernandez, eligibility specialist

STATEMENT OF ISSUE

Petitioner is appealing the Department's action denying her application for SSI-Related Medicaid. The petitioner carries the burden of proof by a preponderance of the 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 26, 2016, the Department informed the petitioner that her application for SSI-Related Medicaid was denied. The notice reads in pertinent part: "No household members are eligible for this program."

The petitioner timely requested a hearing to challenge the denial decision on February 5, 2016.

The hearing was scheduled to convene on April 27, 2016, but was continued at the respondent's request. The petitioner did not object to the continuance.

The hearing convened on May 13, 2016. [redacted] with [redacted] was present as a witness for the petitioner. The petitioner did not submit documentary evidence.

Ada Torroella, operations management consultant with DCF, and Lauren Coe, program operations administrator with the Division of Disability Determination (DDD), were present as witnesses for the Department. Judy Ware, medical disability examiner with DDD, was present as an observer. The Department 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 47) filed an application for SSI-Related Medicaid with the Department on November 12, 2015.

2. The petitioner is single, she 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. The petitioner had not applied for disability with SSA as of the date of the hearing.

3. The petitioner asserted that she is disabled due to a history of stomach cancer.

4. 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 November 17, 2015.

5. DDD completes a five-step sequential analysis to determine if an applicant is disabled: 1) The individual cannot be engaging in substantial gainful activity (working and earning income that meets or exceeds set limits); 2) the alleged impairment must be severe and intended to last 12 continuous months; 3) impairment(s) meets a disability listing set forth in federal regulations; 4) individual incapable of returning to previous work; 5) individual incapable of performing any work in the national economy.

6. DDD determined that the petitioner did not meet the disability criterion at Step 5 because with her education (high school graduate with two years of college), work history (10 years as paralegal and 10 years in office management; proficient in the use of a personal computer and common office equipment), and residual functional capacity

(capable of sedentary work), she is capable of performing other work in the national economy. DDD explains its decision in the Case Analysis section of the petitioner's Disability Report:

> This is a 46 year old female. She has a history of [redacted] in 2006 and recurrence in 2012. She had a total [redacted] The clmt has been undergoing six month follow ups. The clmt was last seen 10/18/15. At this exam there was no obvious evidence of recurrent disease. The doctor states that she is now 3 years post her resection without a recurrence of the cancer. The doctor notes in the records that at that time the clmt was working. The clmt's condition is not severe enough to keep the clmt from working. The clmt is denied. N32.

7. The Department issued a denial notice to the petitioner on January 26, 2016.

8. The petitioner argued that her Medicaid application should have been approved because she is no longer able to work. The petitioner explained that only part of her stomach was removed in 2006. She was eventually able to return to work; but several life style changes were required, including a special diet.

9. The cancer recurred in 2012, the remainder of the petitioner's stomach and part of her esophagus were removed. The remainder of her esophagus is now connected to her small intestine. The petitioner asserted that she has "been falling apart" since the second surgery. She lost her job on October 30, 2015; she was not productive at work due to fatigue, nausea, vomiting, and severe diarrhea. The petitioner no longer drives due to lack of mental concentration. She has physical use of all her extremities and has no visual or hearing impairments. However, due to the symptoms described above, she is often too fatigued to do house work or perform the activities of

daily living (bathing, dressing, grooming, etc.). She leads a sedentary life. She takes Benadryl every night so she can sleep.

10. The petitioner lost her medical insurance when she was terminated from her job in October 2015. She has not seen a physician since October 18, 2015. The petitioner is concerned that her physical condition will continue to decline unless she is approved for Medicaid so she can be treated by a medical professional.

11. The petitioner asserted that she has also been suffering with [redacted] for approximately two years. She has not sought medical treatment for this issue. She never reported this impairment to the Department prior to the hearing. The petitioner explained that she did not tell anyone about the [redacted] because she was "trying to cope" with it on her own. She is no longer able to cope and believes that the [redacted] is disabling. When asked to describe the symptoms of the [redacted] the petitioner answered "fatigue and inability to concentrate." The petitioner reported no other symptoms.

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. 65-2.056.

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

15. The 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. §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. § 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.)
> (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 § 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. She last worked in October 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)). DDD concluded that the petitioner's history of [redacted] was severe. The undersigned concurs. 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 13.16 [redacted]
To meet the disability criterion under this listing an applicant must present with:

A. Carcinoma or sarcoma of the esophagus.

OR

B. Carcinoma or sarcoma of the stomach, as described in 1 or 2:

1. Inoperable, unresectable, extending to surrounding structures, or recurrent.

2. With metastases to or beyond the regional lymph nodes.

OR

C. Small-cell (oat cell) carcinoma.

21. The clinical record does not prove that the petitioner's history of [redacted] and [redacted] 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 her performing past relevant work. The petitioner worked for over 20 years as a paralegal or office administrator. Both positions require considerable mental concentration and physical stamina. Given the petitioner's digestive issues, fatigue, and concentration issues, the undersigned concludes that she is no longer capable of returning to previous work. 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 petitioner has two years of college, is proficient in the use of a personal computer and common office equipment. The petitioner has use of her extremities and no visual or hearing

impairment which prevent her from being able to work. The evidence proves that the petitioner is capable of sedentary work such as a telephone operator, telemarketer or customer service representative. The undersigned concludes that the petitioner fails the disability criterion at step five.

24. The petitioner reported depression (fatigue and inability to concentrate) during the hearing. However, the petitioner has not sought medical treatment for this issue and has no diagnosis of a condition not already reviewed by DDD.

25. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the petitioner does not meet the federal disability criteria for SSI-Related Medicaid. The petitioner did not meet her burden of proof in this matter. 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 ___23___ day of ___May___________, 2016,

in Tallahassee, Florida.

Leslie Green

____
Leslie Green
Hearing Officer
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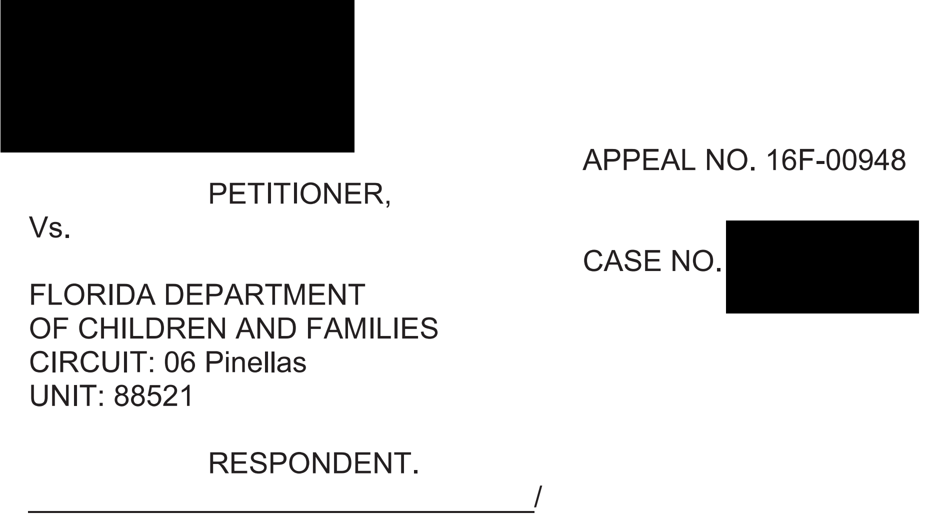
Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

May 27, 2016
Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 16F-00948

PETITIONER,
Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pinellas
UNIT: 88521

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on May 10, 2016 at 1:10 p.m.

APPEARANCES

For the Petitioner:

For the Respondent: Mary Dahmer, Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of December 30, 2015 denying his application for SSI-Related Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The Department submitted evidence on May 10, 2016, which was entered as Respondent's Exhibit 1. The record was held open for additional information from the

petitioner through May 17, 2016. The petitioner submitted information on May 17, 2016, which was entered as Petitioner's Exhibit 1.

FINDINGS OF FACT

1. The petitioner filed an application for SSI-Related Medicaid on November 9, 2015. The petitioner is a 39-year-old male with no minor children in the home. The petitioner was not established as disabled prior to this application.

2. The petitioner's application indicates he needs SSI-Related Medicaid retroactive to January 2011.

3. The Department submitted a disability packet to the Division of Disability Determinations (DDD) on the petitioner's behalf on December 14, 2015.

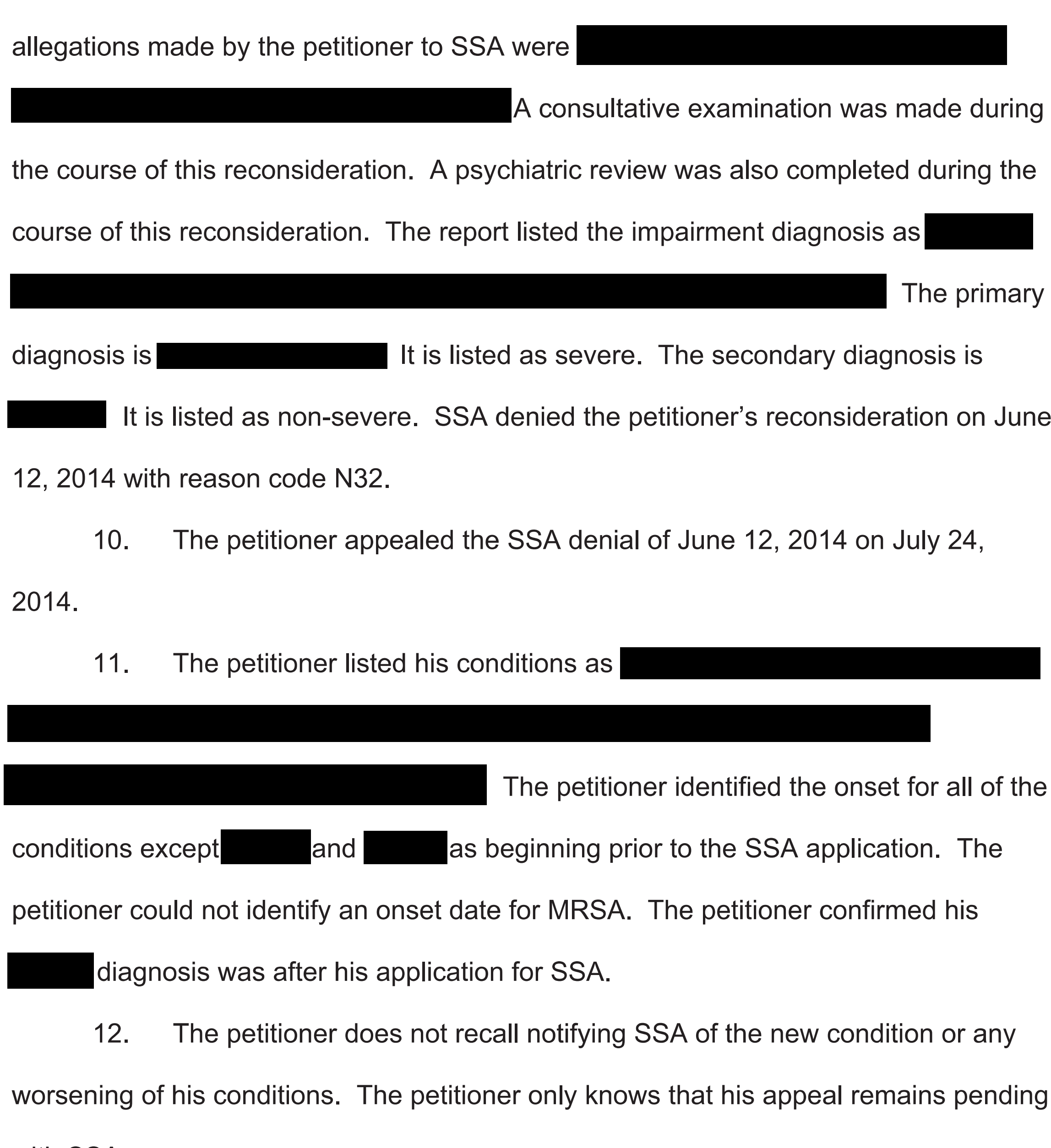
4. DDD responded to the Department on December 30, 2015. DDD adopted the decision made by the Social Security Administration (SSA) in June 2014. DDD cited the same or related allegations have been reported and an appeal of that decision was pending. The primary diagnosis listed on the transmittal was [redacted] The secondary diagnosis listed is [redacted]

5. The Department issued a Notice of Case Action to the petitioner on December 30, 2015 advising the application was denied, as "You or a member of your household do not meet the disability requirement".

6. The petitioner filed an application for Social Security disability on October 9, 2013.

7. SSA denied the petitioner's application for disability on March 5, 2014.

8. The petitioner filed an appeal of this decision.



9. SSA completed a Disability Determination Reconsideration. The allegations made by the petitioner to SSA were A consultative examination was made during the course of this reconsideration. A psychiatric review was also completed during the course of this reconsideration. The report listed the impairment diagnosis as The primary diagnosis is It is listed as severe. The secondary diagnosis is It is listed as non-severe. SSA denied the petitioner's reconsideration on June 12, 2014 with reason code N32.

10. The petitioner appealed the SSA denial of June 12, 2014 on July 24, 2014.

11. The petitioner listed his conditions as The petitioner identified the onset for all of the conditions except and as beginning prior to the SSA application. The petitioner could not identify an onset date for MRSA. The petitioner confirmed his diagnosis was after his application for SSA.

12. The petitioner does not recall notifying SSA of the new condition or any worsening of his conditions. The petitioner only knows that his appeal remains pending with SSA.

CONCLUSIONS OF LAW

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

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

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

15. The findings show the petitioner is a 39-year-old male and has no minor children in his home. Fla. Admin. Code R. 65A-1.705, Family-Related Medicaid General Eligibility Criteria, sets forth the rules to be eligible under the Family-Related Medicaid groups. The petitioner is over 21 and has no minor children in his home. The undersigned concludes he does not meet the criteria to be eligible for Medicaid under the Family-Related Medicaid Program. The undersigned further concludes the Department correctly began to review the petitioner's case for potential eligibility under the SSI-Related Medicaid Program rules.

16. The definition of MEDS-AD Demonstration Waiver is found in Fla. Admin. Code R. 65A-1.701 "Definitions":

> (20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services.

17. Fla. Admin. Code R. 65A-1.711 "SSI-Related Medicaid Non-Financial Eligibility Criteria" states in relevant part:

> To qualify for Medicaid an individual must meet the general and categorical requirements in 42 C.F.R. Part 435, subparts E and F (2007) (incorporated by reference), with the exception that individuals who are neither aged nor disabled may qualify for breast and cervical cancer treatment, and the following program specific requirements as appropriate.

> Individuals who are in Florida temporarily may be considered residents of the state on a case-by-case basis, if they indicate an intent to reside in Florida and can verify that they are residing in Florida.
> (1) For MEDS-AD Demonstration Waiver, the individual must be age 65 or older, or disabled as defined in 20 C.F.R. § 416.905 (2007) (incorporated by reference).

18. 20 C.F.R. § 416.905 "Basic definition of disability for adults" states in relevant part:

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

19. The findings show the petitioner is under age 65 and has not been established by Social Security as disabled as of the time of his application. The undersigned concludes the Department correctly determined a disability determination is required prior to establishing the petitioner as eligible for SSI-Related Medicaid.

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

> (a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.
> (1) If the agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act, the agency may not make a determination of disability when the only application is filed with SSA.
> (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under §435.909.
> (b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c)(3) of this section—

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.
(ii) If the SSA determination is changed, the new determination is also binding on the agency.
(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.

(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:
…
(4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and—
(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or
(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.
(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—
(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or
(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.
(emphasis added)

21. The findings show Social Security Administration (SSA) denied the petitioner disability June 12, 2014. According to the above controlling authorities, a decision made by SSA is controlling and binding on the state agency **until** changed by SSA.

22. The findings show SSA considered the petitioner's [redacted] The findings show

the petitioner has other diagnosis of [redacted] Of these diagnosis, only the [redacted] and [redacted] were identified as having an onset date after the petitioner's application to SSA. The petitioner could not confirm if SSA was notified of the new conditions or if SSA has refused to consider the new conditions.

23. The undersigned concludes as the SSA decision was made more than 12 months prior to application for Medicaid, the above controlling authority of 42 C.F.R. § 435.541 (4)(ii) applies to this case. The authority requires if it has been more than 12 months since an SSA decision **and** his condition has changed or deteriorated **and** alleges a new period of disability **and** has not applied to SSA for a determination with respect to these allegations, then a new determination can be made. In this instant case, the petitioner has shown that a new condition or allegation exists. The findings show the SSA decision is under appeal, which would be considered applying to SSA for a determination in respect to the allegations. The petitioner has not proven that SSA has refused to consider the new allegation. The undersigned concludes the SSA decision remains binding upon the Department. The undersigned further concludes the Department correctly adopted the SSA decision of June 12, 2014.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

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

DONE and ORDERED this 27 ay of Mav, 2016,

in Tallahassee, Florida.

Melissa Roedel

Melissa Roedel
Hearing Officer
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Email: Appeal.Hearings@myflfamilies.com

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

May 10, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-00975

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 April 12, 2016 at 1:31 p.m.

APPEARANCES

For the Petitioner: Mother

For the Respondent: Fatima Leyva,
Senior Human Services Program Specialist,
Agency for Health Care Administration

STATEMENT OF ISSUE

The Petitioner is appealing the Agency for Health Care Administration's (AHCA) decision, through its contracted health plan Humana, to deny the Petitioner's requests for reimbursement for emergency services received out of the country in October 2015. Because the issue under appeal involves a request for reimbursement for a service, the Petitioner bears the burden of proof.

PRELIMINARY STATEMENT

Dr. Ian Nathanson, Medical Director, and Mindy Aikman, Grievance and Appeals Specialist, appeared as Respondent's witnesses from Petitioner's managed care plan, Humana

Respondent submitted a 17-page document which was entered into evidence and marked Respondent Exhibit 1.

FINDINGS OF FACTS

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

1. Petitioner is a [redacted] Medicaid recipient enrolled with Humana, a Florida Health Managed Care provider.
2. On October 18, 2015, Petitioner was in Israel when he sustained an injury requiring emergency services the next day. Petitioner's parents paid for the emergency medical services which cost $317.18.
3. After returning to Florida, Petitioner's mother submitted a request on November 3, 2015 to the Respondent for reimbursement of the $317.18 emergency medical services provided in Israel.
4. Respondent denied Petitioner's claim on November 26, 2015 because Medicaid does not cover out of country medical services.
5. Petitioner filed a timely request for a fair hearing on January 21, 2016.
6. Petitioner's mother explained that she called Humana before seeking medical services for her son and asked about the policy on out of country Medicaid coverage for

emergency medical services. She understood the services would be covered by Medicaid.

7. Respondent apologized for any misinformation a Humana representative may have provided, but explained Medicaid does not cover out of country emergency medical services.

8. Petitioner’s mother agreed she would have gotten the emergency medical services for her son even if the services were not covered by Medicaid.

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 Medicaid’s Provider General Handbook (Handbook) is incorporated by reference in the Florida Administrative Rule 59G. On page 2-43 of the handbook it provides the following for recipients or providers that are out of the country:

> Medicaid does not reimburse for services provided to recipients when they are out of the United States.
>
> Medicaid does not reimburse for services rendered by providers who are not in the United States.

13. Petitioner's need for and receipt of the emergency medical services while in Israel is not disputed.

14. Medicaid reimbursement to the parents for the cost of the emergency medical services was properly denied because the Medicaid Handbook clearly states that Medicaid does not reimburse recipients when they are out of the United States.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Agency's action is AFFIRMED and 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 10 day of May, 2016,

in Tallahassee, Florida.

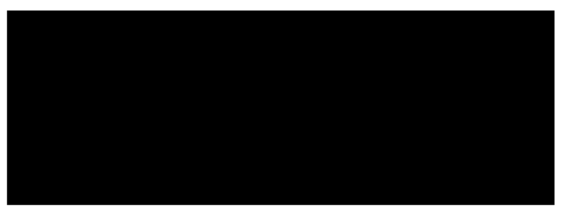
Warren Hunter
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

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

May 09, 2016

Office of Appeal Hearings
Dept. of Children and Families

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



PETITIONER,

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION APPEAL NO. 16F-00986
CIRCUIT: 01 Okaloosa
UNIT: AHCA

and

MOLINA HEALTHCARE OF FLORIDA
8300 NW 33rd Street #400
MIAMI, FL 33122-1940

RESPONDENTS.

_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on April 14, 2016, at approximately 10:00 a.m.

APPEARANCES

For Petitioner:

For Respondent: Cindy Henline, Medical/Health Care Program Analyst, Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is a decision by Respondents, the Agency for Health Care Administration (AHCA or “the Agency”) and its contracted health plan, Molina

Healthcare ("Molina"), to deny Petitioner's request for upper and lower, flexbase, partial dentures. Petitioner bears the burden of proving, by a preponderance of the evidence, that said denial was improper.

PRELIMINARY STATEMENT

At hearing, Respondent, AHCA, was represented by AHCA Medical Health Care/ Program Analyst, Cindy Henline. Respondent, Molina, was represented by Alice Quiros, Assistant Vice President of Government Contracts, and Carlos Galvez, Government Contract Specialist. Respondents also presented testimony from members of their contracted dental review agency, DentaQuest: Jacelyn Salcedo, Complaints and Grievance Specialist; Izzie Labati, Complaints and Grievances Specialist; and Susan Hudson, DMD, Dental Consultant.

Respondent's Exhibits 1 through 9, inclusive, were accepted into evidence. Administrative Notice was taken of all pertinent legal authority. This Final Order follows.

FINDINGS OF FACT

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

1. Petitioner is a Medicaid recipient, who is over 21 years of age. Petitioner receives her Medicaid-based medical care through Molina, a managed care organization/health maintenance organization (MCO/HMO), contracted by AHCA to provide medically necessary items and services to its enrollees.

2. On or about February 1, 2016, Petitioner's dentist submitted to Molina a prior authorization request, asking that Petitioner be authorized to receive dental

items/procedures coded D5225 (maxillary partial denture-flexible base, upper arch) and D5226 (mandibular partial denture-flexible base, lower arch).

3. Molina forwarded this request, along with Petitioner's supportive documentation and x-rays, to DentaQuest. DentaQuest is the dental service review agency contracted with Molina to determine whether dental services requested by Molina enrollees are covered and/or medically necessary.

4. Via Notice of Action dated February 2, 2016, Molina notified Petitioner of the plan's determination. Said Notice stated, in pertinent part:

> … After our review, this service has been: DENIED as of 2/2/2016
> - partial upper denture
> - partial lower denture
>
> We made our decision because:…
> × The requested service is not a covered benefit.

5. At hearing, Molina explained that Petitioner's plan does cover certain types of partial dentures, but does not cover the specific type that Petitioner requested. Molina referenced its contract with AHCA, the fee schedule AHCA utilizes for fee-for-service Medicaid recipients, and Molina's own Prosthodontics fee schedule, entering same into evidence.

6. Review of Molina's AHCA contract reflects that Molina must cover "denture and denture-related services and oral and maxillofacial surgery services to all enrollees," and "[provide f]ull and removable partial dentures and denture-related services…for enrollees 21 years of age and older." Molina must also comply with pertinent provisions of the Medicaid Dental services Coverage and Limitations Handbook, and cannot

impose limitations or exclusions which are more restrictive than those imposed under fee-for-service Medicaid.

7. Both Medicaid's fee-for-service fee schedule and Molina's Prosthodontics fee schedule include many codes for both upper and lower partial dentures of various materials (e.g., resin-base, cast metal framework); however codes D5225 and D5226/flex-base partials are not included as covered items for fee-for-service or Molina enrollees.

8. Petitioner's mother contends that the Petitioner needs dentures as soon as possible. The Petitioner has very few natural teeth left, and currently has difficulty eating, with food escaping from the sides of her mouth as she attempts to chew. It is the mother's contention that dentures are a medical necessity, and are not cosmetic.

CONCLUSIONS OF LAW

9. 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.

10. 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.

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

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

13. The burden of proof in the instant case is assigned to Petitioner, who has requested approval for a specific item/service.

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

15. Fla. Stat. § 409.905 addresses mandatory Medicaid services under the State Medicaid Plan. Dental services are not included in this list of services; however, Fla. Stat. § 409.912 provides that AHCA shall purchase goods and services for Medicaid recipients in the most cost-effective manner possible, consistent with the delivery of quality medical care, and further provides that AHCA shall contract on a prepaid or fixed-sum basis with appropriately licensed prepaid dental health plans to provide dental services.

16. Consistent with these requirements, the July 2012 Florida Medicaid Provider General Handbook (incorporated by reference into Fla. Admin. Code R. 59G-5), discusses managed care coverage, stating on page 1-27:

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee. Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.
> (emphasis added)

17. Echoing Molina's contract with AHCA, Page 1-30 of this Handbook also notes: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

18. Medicaid fee-for-service dental services are governed, in part, by the November 2011 Dental Services Coverage and Limitations Handbook (Dental Handbook), as promulgated by Fla. Admin. Code R. 59G-4.060(2). The Dental Handbook limits services provided to adults, noting on page 2-3:

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

19. Page 2-31 of the Dental Handbook specifies:

> 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.
> (emphasis added)

20. As the type of partials requested by Petitioner are not covered on either the fee-for-service fee schedule or Molina's own fee schedule, Molina's limitations are not more restrictive than those of fee-for-service Medicaid. As such, the only reason these specific dentures might be covered, in lieu of partials explicitly included as a member benefit, is if they are part of a medically-necessary emergency dental procedure to alleviate pain and/or infection.

21. Per Fla. Admin. Code. R. 59G-1.010(166):

> "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and <u>not in excess of the patient's needs</u>;
> 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 <u>no equally effective and more conservative or less costly treatment is available</u> 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) <u>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</u> or a medical necessity <u>or a covered service</u>.
> (emphasis added)

22. While it is acknowledged that Petitioner may well require some type of dentures to assist in eating, Petitioner has not shown that flex-base partial dentures, specifically, are not in excess of her needs, nor has she (or her dentist) excluded the types of partials covered by Molina as inappropriate for Petitioner's use (see Fla. Admin. Code R. 59G-1.010(166)(a)(2 & 4). Absent any indication that the need for D5225 and D5226 constitute an emergency, *and* absent proof that Petitioner's needs cannot be equally well met by an alternative denture, Respondent's denial remains proper.

23. Petitioner is encouraged to consult with her dentist, in conjunction with Molina, to determine which, if any, of the partial dentures covered by Molina would best meet Petitioner's needs. Should Petitioner wish to request a different type of partial, or to

submit a new request for flex-base partials after further consultation with and documentation from her dentist, she is free to do so. If any such future requests are denied, Petitioner will retain the right to appeal those, specific denials.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner's appeal is DENIED, and Respondent's action is affirmed.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 09 day of May, 2016, in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
Marshall Wallace, Area 1, AHCA Field Office Manager
Alice Quiros, AVP of Government Contracts

May 05, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01004

PETITIONER,
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 8, 2016 at 10:10 a.m.

APPEARANCES

For the Petitioner:

For the Respondent: Selwyn Gossett, healthcare analyst with AHCA

STATEMENT OF ISSUE

Whether the respondent's partial-denial of dental services requested by the petitioner was correct. The burden of proof was assigned to the petitioner.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (Agency or AHCA or respondent) administers the Florida Medicaid Program. Medicaid rules require that most recipients receive their Medicaid services through the Managed Care Plan. The Agency contracts

with numerous health care organizations to provide medical services to its program participants. United Healthcare (United) is the contracted health care organization in the instant case.

By notice dated February 1, 2016, United informed the petitioner that her request to have her four wisdom teeth (also known as third molars) removed with general anesthesia was denied in-part. United approved removal of the upper two wisdom teeth (#1 and #16) and all the requested anesthesia. United denied removal of the lower two wisdom teeth (#18 and #31).

On February 8, 2016, the petitioner timely requested a hearing to challenge the denial decision.

There were no additional witnesses for the petitioner. The petitioner did not submit documentary evidence.

Present as respondent witnesses from United: Susan Frishman, senior compliance analyst; Dr. Brittany Vodds, dental consultant; and Lori Eubanks, account manager. 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 April 11, 2016 for the submission of additional evidence. Evidence was received from the respondent and admitted as Respondent's Composite Exhibit 2.

FINDINGS OF FACT

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

1. The petitioner (age 14) is a Florida Medicaid recipient. The petitioner is enrolled with United 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 United to surgically remove her four wisdom teeth with general anesthesia. The dentist used a different procedure code for the top and bottom teeth, D7240 for the top teeth and D7241 for the bottom teeth.

4. The treating dentist's supporting clinical notes read in pertinent part:

> [Patient] was seen for a consultation regarding the surgical removal of teeth numbers 1, 16, 18, and 31 with general anesthesia. She requires general anesthesia in order to undergo surgery as the teeth are deeply impacted and require sectioning into pieces to remove. She suffers from a severe dental phobia and the amount of local anesthesia needed to numb her for such an invasive procedure is not recommended. If these teeth are not removed, her bit will be jeopardized due to overcrowding. The patient is experiencing pain from all four areas and requires surgery as soon as possible.

5. United approved removal of the top wisdom teeth and the anesthesia related to removal of all four teeth. United denied removal of the bottom wisdom teeth because it determined that the requested procedure code was too invasive and not supported by the clinical records, x-rays and case notes.

6. Dr. Vodds, dental consultant with United, explained that dental procedure codes are published in the American Dental Association Handbook (ADA Handbook), a national publication used by all American dentists. Each procedure code includes a description of the symptoms which must be present in order for the requested service to

be the best course of treatment. Procedure code D7241 requires that the surface of the tooth to be removed be fully covered by bone, not visible on the surface of the gum. Procedure code D7241 is a more invasive and time consuming dental surgery and is reimbursable by Medicaid at a higher rate. The x-rays submitted by the petitioner's treating dentist show that the surface of her bottom wisdom teeth are above the gum line and not covered by bone. United concluded that procedure code D7241 was in excess of the petitioner's needs. Medicaid rule prohibits the provision of goods and services in excess of a recipient's needs.

7. Dr. Vodds does not dispute the treating physician's conclusion that the petitioner's bottom wisdom teeth should be removed; the x-rays and clinical records show that some of her teeth are misaligned due to overcrowding and are causing the petitioner pain. Removal of the wisdom teeth would resolve the overcrowding issue. However, Dr. Vodds opinioned that the wisdom teeth can be removed with a less invasive procedure, similar to the procedure requested for the petitioner's top wisdom teeth (D7240).

8. United included the clinical rationale for its decision in the written response submitted to the petitioner's treating dentist and encouraged the provider to submit additional clinical records which support the more invasive procedure requested or to resubmit his request using the appropriate procedure code. As of the date of the hearing, there had been no response from the treating dentist.

9. The petitioner's top wisdom teeth were removed on April 1, 2016. Her mother is anxious that the bottom teeth be removed as soon as possible. Due to

misalignment of the teeth, the petitioner is unable to floss properly which is causing cavities; the cavities are painful.

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, 7th Ed.).

15. 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.

16. As the petitioner is under 21, a broader definition of medically necessary applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) requirements. Section 409.905, Florida Statutes, *Mandatory Medicaid services*, defines Medicaid services for children to include:

> (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems…

17. The Dental Handbook states on page 1-2: "The children's dental program provides full dental services for all Medicaid eligible children age 20 and below."

18. The Dental Handbook states on page 2-2: "Medicaid reimburses for services that are determined medically necessary…"

19. 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 respondent denied the petitioner's request for surgical removal of her bottom wisdom teeth because it determined that the procedure requested was in excess of the petitioner's needs and therefore prohibited by Medicaid rule.

21. Dr. Vodds, the only expert witness to appear at the hearing, opined the petitioner's needs can be met with a less invasive and less costly procedure.

22. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the petitioner did not prove by a preponderance of the evidence that the requested dental procedure (D7241) is medically necessary.

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 ___05_ day of ___May___________, 2016,

in Tallahassee, Florida.

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

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

May 10, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

PETITIONER,

Vs.

APPEAL NO. 16F-01057

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 Palm Beach
UNIT: 88701

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on April 29, 2016 at 10:09 a.m.

APPEARANCES

For the Petitioner:

For the Respondent: Mary Triplett, supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action denying her 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 27, 2016, the Department informed the petitioner that her application for SSI-Related Medicaid was denied. The notice reads in pertinent part: "You…do not meet the disability requirement."

The petitioner timely requested a hearing to challenge the denial decision on February 9, 2016.

The petitioner was present and testified. 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.

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 Department and admitted into the record as Respondent's Composite Exhibit 2. No additional evidence was received from the petitioner.

FINDINGS OF FACT

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

1. The petitioner (age 52) filed an application for SSI-Related Medicaid with the Department on December 11, 2015.

2. The petitioner is single, she 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 asserts that she is disabled due to

4. 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 29, 2015.

5. DDD completes a five-step sequential analysis to determine if an applicant is disabled: 1) The individual cannot be engaging in substantial gainful activity (working and earning income that meets or exceeds set limits); 2) the alleged impairment must be severe and intended to last 12 continuous months; 3) impairment(s) meets a disability listing set forth in federal regulations; 4) individual incapable of returning to previous work; 5) individual incapable of performing any work in the national economy.

6. DDD determined that the petitioner did not meet the disability criterion because with her education (high school graduate), work history (18 years as an alcohol and drug abuse counselor), and residual functional capacity (capable of work which requires only light exertion), she is capable of performing other work in the national economy. DDD explains its decision in the Case Analysis section of the petitioner's Disability Report:

> Primary diagnosis: [redacted] Secondary diagnosis: [redacted] disorder. Presented with palpitations. Exam: chest: normal…behavior, mood and affect normal…Clt is not seeing any psy healthcare provider. She is not on psy meds for anxiety. Clt never Baker acted. She can drive for short distances. Clt prepare meals once a day. She does shopping once weekly. She can walk 20 steps, stand 5 minutes, pays attention for ½ hour, cannot follow instructions well. No paracentesis done before…Clt is 51 y/o with 12-yr edu. Clt can do other light work: cashier, nut sorter, or lens inserter. Denial N32

7. The Department issued a denial notice to the petitioner on January 27, 2016.

8. The petitioner argued that her Medicaid application should have been approved because: she is unable to work; she is retaining large amounts of water in her abdomen wall which makes it appear that she is several months pregnant; she is weak and dizzy; she is bed bound for long periods of time and walks only to the bathroom, with a cane; she cannot drive a car, or walk more than a few steps; she is confused, unable to concentrate or focus on a task for extended periods of time; and she is jaundice.

9. The petitioner submitted medical records from [redacted] The records are dated December 3, 2015 – December 6, 2015 and read in pertinent part:

> Patient admitted with general symptoms. Patient is a 51 year old woman with known liver disease…complains of recurrent persistent cough and some shortness of breath. She attributes this to her ascites. She has known chronic liver disease from alcohol and has been on diuretics. She…has had upper endoscopy and colonoscopy done earlier this year and some polyps removed and there is no mention of varices….She was in the hospital a couple of times in the last week or so, evaluations were negative for acute pulmonary emboli and cirrhosis and fatty liver were confirmed by CT along with trace ascites and enlarged spleen…This is a well-developed female with no acute distress. She is awake. She is alert. There is no tremulousness. She is mentally quite sharp. Vital signs normal. She has minimal ascites. She does need rehabilitation/detox per patient…Discharge Condition: Stable…she was advised to follow up with her gastroenterologist and primary care physician and abstain from drinking.

10. The petitioner argued that her condition has deteriorated since she applied for Medicaid in December 2015. She is bed bound most of the time and unable to perform the activities of daily living (bathing, dressing, grooming, etc.) for days at a time.

11. The Department stands by its earlier denial decision, but encouraged the petitioner to reapply as she is ascertaining a worsening condition.

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. 65-2.056.

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

15. The 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. §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. § 404.1520 addresses the disability evaluation:

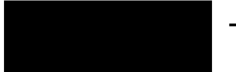
> (4) *The five-step sequential evaluation process.* The sequential evaluation process is a series of five “steps” that we follow in a set order. See paragraph (h) of this section for an exception to this rule. If we can find that you are disabled or not disabled at a step, we make our determination 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.)

> (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 § 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. She last worked in early 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 petitioner's asserted atrial fibrillation does not require medication and there is no evidence that it has more than a minimum effect on her life. The undersigned concludes that the atrial fibrillation is not severe. The petitioner's asserted anxiety disorder does not require medication or psychiatric treatment. The petitioner has concentration issues and difficulty staying on task. She has not been Baker acted or incarcerated due to her condition. The undersigned concludes that the anxiety disorder is not severe. DDD concluded and the medical evidence proves that the petitioner's [redacted] is severe. The

undersigned concludes that the petitioner meets step two criterion based on

 The analysis continues for

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 5.05 . To meet the disability criterion under this listing an applicant must present with:

A. Hemorrhaging from esophageal, gastric, or ectopic varices or from portal hypertensive gastropathy, demonstrated by endoscopy, x-ray, or other appropriate medically acceptable imaging, resulting in hemodynamic instability as defined in 5.00D5, and requiring hospitalization for transfusion of at least 2 units of blood. Consider under disability for 1 year following the last documented transfusion; thereafter, evaluate the residual impairment(s).

OR

B. Ascites or hydrothorax not attributable to other causes, despite continuing treatment as prescribed, present on at least 2 evaluations at least 60 days apart within a consecutive 6-month period. Each evaluation must be documented by:

1. Paracentesis or thoracentesis; or

2. Appropriate medically acceptable imaging or physical examination and one of the following:

a. Serum albumin of 3.0 g/dL or less; or

b. International Normalized Ratio (INR) of at least 1.5.

OR

C. Spontaneous bacterial peritonitis with peritoneal fluid containing an absolute neutrophil count of at least 250 cells/mm3.

OR

D. Hepatorenal syndrome as described in 5.00D8, with one of the following:

1. Serum creatinine elevation of at least 2 mg/dL; or

2. Oliguria with 24-hour urine output less than 500 mL; or

3. Sodium retention with urine sodium less than 10 mEq per liter.

OR

E. Hepatopulmonary syndrome as described in 5.00D9, with:

1. Arterial oxygenation (PaO2) on room air of:

a. 60 mm Hg or less, at test sites less than 3000 feet above sea level, or

b. 55 mm Hg or less, at test sites from 3000 to 6000 feet, or

c. 50 mm Hg or less, at test sites above 6000 feet; or

2. Documentation of intrapulmonary arteriovenous shunting by contrast-enhanced echocardiography or macroaggregated albumin lung perfusion scan.

OR

F. Hepatic encephalopathy as described in 5.00D10, with 1 and either 2 or 3:

1. Documentation of abnormal behavior, cognitive dysfunction, changes in mental status, or altered state of consciousness (for example, confusion, delirium, stupor, or coma), present on at least two evaluations at least 60 days apart within a consecutive 6-month period; and

2. History of transjugular intrahepatic portosystemic shunt (TIPS) or any surgical portosystemic shunt; or

3. One of the following occurring on at least two evaluations at least 60 days apart within the same consecutive 6-month period as in F1:

a. Asterixis or other fluctuating physical neurological abnormalities; or

b. Electroencephalogram (EEG) demonstrating triphasic slow wave activity; or

c. Serum albumin of 3.0 g/dL or less; or

d. International Normalized Ratio (INR) of 1.5 or greater.

OR

G. End stage liver disease with SSA CLD scores of 22 or greater calculated as described in 5.00D11. Consider under a disability from at least the date of the first score.

21. The clinical record does not prove that the petitioner's [redacted] meets the cited disability criterion. The medical records submitted by the petitioner describe her as "stable and well developed." Based on the evidence, the undersigned could not conclude that the petitioner's impairment meets or equals a listing in the federal regulation.

22. Step four of the sequential analysis for disability is to determine if the individual's impairments prevent her performing past relevant work. The petitioner is 52 years old and worked exclusively as a substance abuse counselor for 18 years. She has no other work history. Given the petitioner's recent sobriety issues and acknowledged need for alcohol rehabilitation, the undersigned concludes that she is no longer capable of returning to previous work. 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 other work in the national economy. The cumulative evidence proves that the petitioner is literate, has use of her extremities and has no visual or hearing impairment which prevents her from being able to work. The petitioner asserts a worsening condition that is not evidenced by the medical records she submitted at the hearing. The medical evidence shows the petitioner is capable of light

work. 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 did not prove by a preponderance of the evidence that she meets the SSI-Related Medicaid disability criterion. The undersigned concludes that 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 ___10___ day of ___May___________, 2016,

in Tallahassee, Florida.

Leslie Green

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

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

May 13, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01058

PETITIONER,
Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 Palm Beach
UNIT: 88701

RESPONDENT.
__________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on April 18, 2016 at 1:36 p.m.

APPEARANCES

For the Petitioner:

For the Respondent: Mary Triplett, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of February 4, 2016 denying his application for SSI-Related Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The authorized representative for the petitioner was updated from [redacted] to [redacted] due to [redacted] The Department did not object to the update.

The Department submitted evidence prior to the hearing. The evidence was entered as Respondent Exhibit #1.

FINDINGS OF FACT

1. The petitioner filed an application for SSI-Related Medicaid on January 11, 2016. The petitioner is a 54-year-old male with no minor children in the home. The petitioner was not established as disabled prior to this application.

2. The petitioner's representative did not indicate on the application the petitioner had applied for Social Security disability previously or that his conditions worsened since the application. The representative reported they were unaware of the application for Social Security benefits.

3. The Department submitted a disability packet to the Division of Disability Determinations (DDD) on January 11, 2016.

4. DDD responded to the Department on February 3, 2016. DDD adopted the decision made by the Social Security Administration in May 2015. DDD cited the same or related allegations have been reported and an appeal of that decision was pending. The conditions listed on the Disability Determination Transmittal by DDD were [redacted]

5. The Department issued a Notice of Case Action to the petitioner and representative on February 4, 2016 advising the application was denied as “You or a member(s) of your household do not meet the disability requirement”.

6. The petitioner filed an application for Social Security disability in August 2014. The petitioner’s representative is unaware of what conditions the petitioner reported to Social Security for consideration for disability.

7. Social Security denied the petitioner’s application for disability in November 2014. The petitioner appealed this decision in November 2014.

8. Social Security denied the petitioner’s appeal in May 2015.

9. The petitioner filed an appeal of the second Social Security denial on June 13, 2015.

10. In January 2016, the petitioner was hospitalized for [redacted] three times. He was hospitalized again in April 2016 for the same condition. The onset of this condition is January 2016.

11. It is unknown if the petitioner has an attorney or other authorized representative assisting with his Social Security appeal.

12. The petitioner’s representative is not aware of the petitioner notifying Social Security of the new disabling or worsening condition for consideration.

13. The representative explained as they were unaware of the Social Security application, no records have been sent to Social Security on the petitioner’s behalf.

CONCLUSIONS OF LAW

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

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

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

16. The findings show the petitioner is a 54-year-old male and has no minor children in his home. Fla. Admin. Code R. 65A-1.705, Family-Related Medicaid General Eligibility Criteria, sets forth the rules to be eligible under the Family-Related Medicaid groups. The petitioner is over 21 and has no minor children in his home. The undersigned concludes he does not meet the criteria to be eligible for Medicaid under the Family-Related Medicaid Program. The undersigned further concludes the Department correctly began to review the petitioner's case for potential eligibility under the Adult-Related Medicaid Program rules.

17. 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.

18. 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).

19. 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.

20. The findings show the petitioner is under age 65 and has not been established by Social Security as disabled as of the time of his application. The undersigned concludes the Department correctly determined a disability determination is required prior to establishing the petitioner as eligible for Adult-Related Medicaid.

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

(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.
(1) If the agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act, the agency may not make a determination of disability when the only application is filed with SSA.
(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under §435.909.
(b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c)(3) of this section—

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.
(ii) If the SSA determination is changed, the new determination is also binding on the agency.
(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.

(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:
…
(4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and—
(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or
…
(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—
(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or
(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

22. The findings show Social Security Administration (SSA) denied the petitioner disability in May 2015. 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 alleges a disabling condition different from, or in addition to, those considered by SSA in making its determination. The findings show SSA considered the petitioner's [redacted] It is unknown if any other conditions were reported to SSA for consideration in the May 2015 SSA decision.

23. The findings show the petitioner received a new diagnosis in January 2016, which is believed to be disabling. The findings also show the petitioner's SSA

decision is under appeal as of June 13, 2015. The petitioner's representative could not confirm if SSA was notified the new disabling condition or if SSA has refused to consider the new allegations. The undersigned concludes as the petitioner's SSA decision is under appeal, the above controlling authority of 42 C.F.R. § 435.541 (4)(iii) applies to this case. The authority requires if it has been less than 12 months since an SSA decision **and** the decision is under appeal **and** SSA has refused to consider the new allegation the state agency make a disability determination. In this instant case, the petitioner has shown that a new condition or allegation exists. However, the petitioner has not proven that SSA has refused to consider the new allegation. The undersigned concludes the SSA decision remains binding upon the Department. The undersigned further concludes the Department correctly adopted the SSA decision of June 13, 2015.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this __13___ day of __May____________, 2016,

in Tallahassee, Florida.

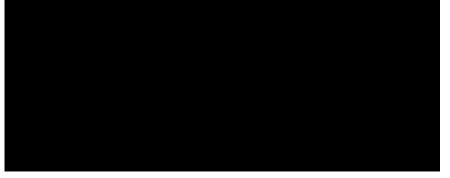
Melissa Roedel
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

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

May 25, 2016

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 16F-01070

PETITIONER,
Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 14 Bay
UNIT: AHCA

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice and agreement, Hearing Officer Patricia C. Antonucci convened hearing in the above-captioned matter on April 27, 2016 at approximately 12:00 p.m., Central Standard Time (CST). All parties and witnesses appeared via teleconference.

APPEARANCES

For the Petitioner:

For the Respondent: Cindy Henline, Medical/Health Care Program Analyst, Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is a decision by Respondent, the Agency for Health Care Administration (AHCA), through its contracted peer review organization, eQHealth Solutions, Inc., to terminate Petitioner's Prescribed Pediatric Extended Care (PPEC) services.

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

PRELIMINARY STATEMENT

Hearing was previously scheduled to convene on April 12, 2016 at 10:00 a.m. Due to confusion regarding which time zone governed the hearing's start time, and calendar restrictions of Respondent's witness, the parties agreed to reschedule for a later date. By Notice to both parties, hearing was rescheduled for April 27, 2016 at 12:00 p.m. CST.

At hearing, the minor Petitioner was not present, but was represented by his mother. Respondent was represented by Cindy Henline, Medical/Health Care Program Analyst, on behalf of AHCA. Respondent presented one additional witnesses: Rakesh Mittal, M.D., Physician Reviewer with eQHealth Solutions (eQHealth).

Respondent's Exhibits 1 through 15, inclusive, were admitted into evidence. Administrative Notice was taken of Fla. Stat. § 409.905, Fla. Admin. Code R. 59G-1.001, Fla. Admin. Code R. 59G-1.010, Fla. Admin. Code R. 59G-4.260, and pertinent pages of the September 2013 Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook (PPEC Handbook).

The record was held open for receipt of a letter from Petitioner's physician, which Petitioner's mother noted she would submit to Respondent that same day. Respondent agreed to file said documentation with the Office of Appeal Hearings, upon receipt. No further correspondence was received from either party; however, as Petitioner's mother read the letter into the record, verbatim, the undersigned has considered the content of the letter, as well as Respondent's reply to same, in preparation of this Final Order.

FINDINGS OF FACT

1. The Petitioner is a 7-year old male, born prematurely in 2009. His current diagnoses include [redacted] (for which he uses daily medication and a nebulizer, as needed). He is unsteady on his feet, cannot independently complete activities of daily living (ADLs), and is incontinent approximately three times per week.

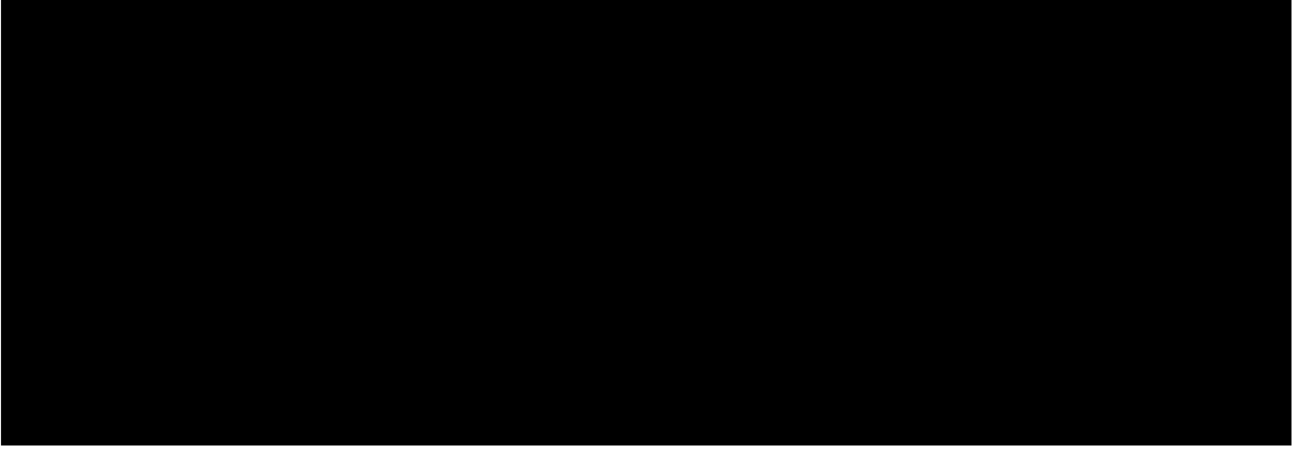
2. The Petitioner attends school Monday through Friday, from 7:25 a.m. to 2:25 p.m., where he is enrolled in an Independent Educational Program (IEP), and receives both 30 minutes of Speech Therapy (ST) and 30 minutes of Physical Therapy (PT) per week.

3. Petitioner is and has been eligible to receive Medicaid services at all times relevant to these proceedings.

4. On or about July January 21, 2016, Petitioner's PPEC provider submitted a request on behalf of the Petitioner, to continue his previously authorized PPEC services into the new certification period, spanning January 20, 2016 through July 17, 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 January 26, 2016, the PRO reviewed Petitioner's request for services and all supporting documentation. By letter dated January 28, 2016, the PRO notified Petitioner's provider of its decision to terminate PPEC, stating, in pertinent part:



7. The January 28, 2016 letter, which eQHealth 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.

8. In response to this notice, on or about February 2, 2016, Petitioner's provider requested reconsideration of the PRO's determination.

9. Via letter dated February 5, 2016, the PRO notified the provider of the results of its reconsideration review, stating, in part: "There was no new information provided for this reconsideration that would reverse the previous decision. The original decision is upheld."

10. On February 10, 2016, Petitioner requested a hearing to challenge the PRO's determination. Petitioner's PPEC services continued at their previously authorized frequency, pending the outcome of his appeal.

11. At hearing, Dr. Mittal testified based upon his 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 continues to struggle with balance and endurance, as well as impulsivity, all of which impact his coordination and ability to complete self-care. Petitioner tires easily and is shaky on his feet; however, since attending PPEC, he has not fallen, been injured, or experienced infection.

13. While the Petitioner clearly requires precautions/monitoring, the only interventions indicated on the Plan (other than follow-up from therapies) are the administration of as-needed medications/nebulizer and toileting assistance.

14. Per Dr. Mittal, Petitioner's PPEC Assessments and notes reflect that Petitioner is not dependent upon mechanical devices, but does have episodic asthma/breathing difficulty and bronchospasms. Petitioner's ADLs are mostly age-appropriate, and while Dr. Mittal agrees that Petitioner requires albuterol treatments, therapeutic services, and assistance with toilet training, he does not feel these needs indicate a medical necessity for continuation of PPEC.

15. Petitioner currently receives ADL assistance, medication administration, and therapy services while he is in school, and attends PPEC from the time school ends until the time his mother finishes work and picks him up -- around 5:15 p.m., Monday through Friday. Petitioner's mother testified that Petitioner has done well at PPEC, and that she is concerned he will not be safe at an unspecialized day care and/or will regress without the level of care which PPEC provides.

16. A letter of support from Petitioner's physician, which Petitioner's mother read into the record, notes, in part:

17. It is Dr. Mittal's opinion that at this time, Petitioner does not require skilled nursing interventions on a regular basis, as his conditions have stabilized. Dr. Mittal opined that Petitioner's unsteady gait/balance issues should continue to be addressed through PT, and his communication issues should be addressed through ST, both of which Petitioner can request as a distinct service, outside of the PPEC and/or school setting.

CONCLUSIONS OF LAW

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

19. Respondent, the Agency for Health Care Administration, administers the Medicaid Program. Legal authority governing the Florida Medicaid Program is found in Fla. Stat., Chapter 409, and in Chapter 59G of the Florida Administrative Code.

20. 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.

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

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

23. 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).)

24. 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.

25. 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 <u>to receive medical and therapeutic care</u> at a non-residential pediatric center." (emphasis added)

26. 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.
> (emphasis added)

27. 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)

28. 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.

29. Fla. Admin. Code Rule 59G-1.010(166) defines medical necessity, as follows:

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

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

30. As the petitioner is under the age of 21, a broader definition of medically necessary applies, to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) requirements. Both EPSDT and Medical Necessity requirements (both cited, above) have been considered in the development of this Order.

31. EPSDT augments the Medical Necessity definition contained in the Florida Administrative Code via the additional requirement that all services determined by the agency to be medically necessary for the *treatment, correction, or amelioration* of problems be addressed by the appropriate services.

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

> (1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.
> (2) A state Medicaid plan must include "reasonable standards … for determining eligibility for and the extent of medical assistance" … and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.
> (3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."
> (4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."
> (5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to provide medically unnecessary, albeit desirable, EPSDT services. However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."
> (6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and my present its own evidence of medical necessity in disputes between the state and Medicaid patients (citations omitted).

33. In the instant case, PPEC is requested to treat and ameliorate the supervisory and monitoring needs which Petitioner's health conditions require. As such, in a general sense, PPEC is in keeping with Fla. Admin. Code R. 59G-1.010(166)(1).

Because PPEC is a recognized Medicaid service, it is consistent with generally accepted medical standards, per Fla. Admin. Code R. 59G-1.010(166)(3).

34. 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.

35. 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, assessments, and albuterol (as needed), do not constitute a need for "intermittent continuous therapeutic interventions or skilled nursing care." Tellingly, there is currently no skilled therapy or intervention provided to Petitioner at the PPEC site.

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 mother is encouraged to coordinate with AHCA, so as to determine Petitioner's options for other services, as needed. If at any point she wishes to re-request PPEC, she may work with the provider and/or her physician, and provide Respondent with any and all documentation to support the need for this service. Should Petitioner request any 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.

DONE and ORDERED this _25_ day of ___May________, 2016,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
Marshall Wallace, Area 2, AHCA Field Office Manager

May 04, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01082

PETITIONER,

Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 17 Broward
UNIT: 02555

RESPONDENT.
________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on April 8, 2016 at 3:51 p.m.

APPEARANCES

For the Petitioner:

For the Respondent: Jackie Pughsley, eligibility specialist

STATEMENT OF ISSUE

Petitioner is appealing the Department's action denying multiple applications for Institutional Care Program (ICP) Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The Department of Children and Families (DCF or respondent) determines eligibility for participation in the Florida Medicaid Program.

[redacted] business office manager with [redacted] was present as witness for the petitioner. The petitioner submitted documentary evidence which as admitted into the record as Petitioner's Composite Exhibit 1.

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.

FINDINGS OF FACT

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

1. The petitioner was admitted to [redacted] nursing facility) on August 27, 2015 for skilled nursing care after a hospitalization. Her diagnoses included [redacted] The petitioner returned to the hospital for medical treatment on September 14, 2015. She died in the hospital on October 12, 2015.

2. At the time of her death, the petitioner owed the nursing facility approximately $3,800. The petitioner's only known relative, her daughter, declined to help resolve the balance due the nursing facility or apply for ICP Medicaid. The nursing facility retained the services of Medicaid consultant [redacted] to apply for Medicaid to cover the petitioner's outstanding charges.

3. [redacted] acting as designated representative, filed an application for ICP Medicaid with the Department on August 5, 2015.

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 August 7, 2015 requesting bank statements for May 2015, June 2015, and July 2015, verification of Social Security income, and verification of income from the Veteran's Administration (VA). The verification was due by August 17, 2015.

6. The designated representative returned all of the requested verification except verification of VA income.

7. The Department denied the petitioner's application on August 28, 2015 for failure to return verification needed to determine eligibility. The Department suppressed the denial notice; the notice was not issued to the designated representative. The Department representative could not explain why the notice was suppressed. The petitioner's designated representative discovered that the application had been denied via collateral contact with the Department.

8. The designated representative filed another application for ICP Medicaid on October 8, 2015.

9. The Department issued a Notice of Case Action to the designated representative on October 9, 2015 requesting bank statements for May 2015, June 2015, and July 2015 and verification of VA income. The verification was due by October 19, 2015.

10. The designated representative returned all of the requested verification except verification of VA income.

11. The Department denied the petitioner's application in November 2015, but did not issue a denial notice to the petitioner. Again, the Department representative could not explain why a notice was not issued. Again, the designated representative discovered that the application had been denied via collateral contact with the Department.

12. The designated representative requested a hearing on February 9, 2016 to appeal the Department's denial decisions.

13. The designated representative explained that she sought the help of the petitioner's daughter in obtaining verification of the VA income, but the daughter seemed unconcerned about the Medicaid application and provided no assistance. The designated representative wrote directly to VA requesting verification of the petitioner's income, but did not receive a reply. The representative informed the Department that she was having difficulty obtaining the requested verification.

14. The designated representative submitted to the Department the only income verification she was able to obtain, a copy of the petitioner's bank statements showing income VA income deposits. The bank statements show monthly VA deposits in the amount of $174; monthly SSI deposits in the amount of $25; and monthly SSRE (SS retirement) deposits in the amount $554. The petitioner had an active SSI-Related Medicaid case (community Medicaid, not institutional Medicaid) when the ICP applications were filed with the Department. The representative argued that additional

VA income verification was not strictly required because the income had already been verified as part of the SSI-Related Medicaid application process.

15. The Department argued that its rules require verification of VA income from the source; bank statements are insufficient verification of income because the amount deposited may include deductions which the Department does not allow when determining eligibility for ICP Medicaid.

CONCLUSIONS OF LAW

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

17. This proceeding is 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 Fla. Admin. Code R. 65A-1.203(9) defines designated representative: “Authorized/Designated Representative: An individual who has knowledge of the assistance group’s circumstances and is authorized to act responsibly on their behalf.”

20. 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.

21. The cited rule explains that when the Department determines that verification is necessary, it is the applicant's (or designated representative's) responsibility to provide the verification. However, the Department is to provide as much assistance as possible obtaining the verification when requested or when it appears necessary.

22. 42 C.F.R. § 431.210 Content of notice sets forth mandatory Medicaid notice requirements, reading in pertinent part:

> A notice required under §431.206 (c)(2), (c)(3), or (c)(4) of this subpart must contain—
> …
> (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.

23. The cited federal regulation explains that the Department must provide Medicaid applicants and participants with adequate notice of adverse actions. The regulation also requires the Department to inform applicants and participants of the reasons for action taken and appeal rights.

24. The Department denied two applications for ICP Medicaid filed on the petitioner's behalf without assisting the designated representative in obtaining verification it knew was difficult for her to obtain and without issuing Notices of Decision

as required by federal regulation. After careful review, the Department is hereby ordered to reopen the petitioner's case and process an application for ICP Medicaid. The Department is ordered to assist the designated representative as much as possible in obtaining any needed verification. The Department is furthered ordered to issue a Notice of Decision upon completion which includes appeal rights bills.

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 detailed in the Conclusions of Law.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this __04__ day of __May____________, 2016,

in Tallahassee, Florida.

Leslie Green

Leslie Green
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429

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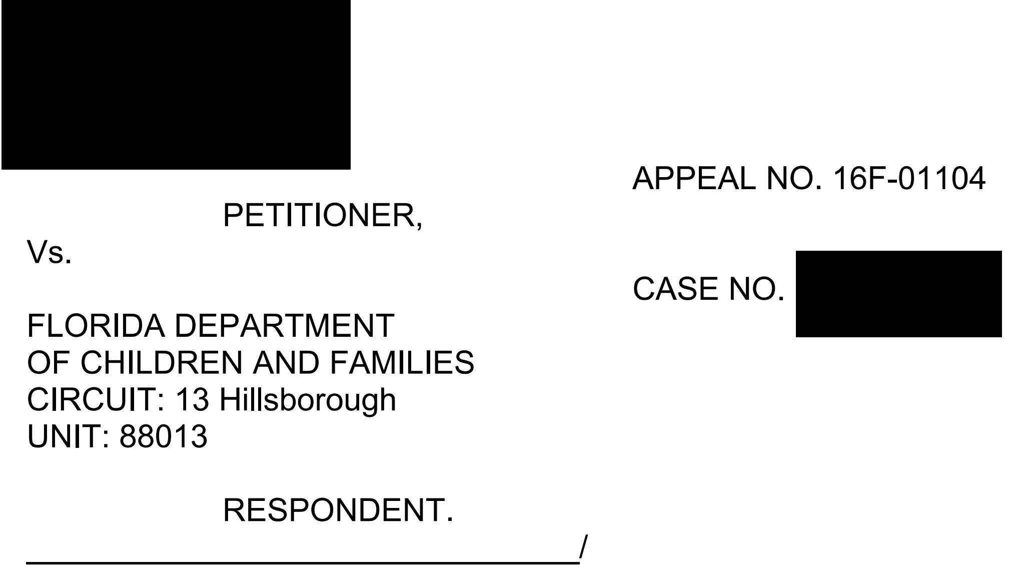
Email: Appeal.Hearings@myflfamilies.com

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

May 11, 2016

Office of Appeal Hearings
Dept. of Children and Families

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



PETITIONER,
Vs.

APPEAL NO. 16F-01104

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 13 Hillsborough
UNIT: 88013

RESPONDENT.
________________________________/

FINAL ORDER

The undersigned convened a telephonic administrative hearing in the above-referenced matter on March 21, 2016 at 11:17 a.m.

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 May 2014; October 2014; and for the time period of July 2015 through October 2015 is correct. The burden of proof is assigned to the petitioner by a preponderance of the evidence.

PRELIMINARY STATEMENT

Petitioner was not present but was represented by [redacted] owner of [redacted] who testified. Petitioner submitted no exhibits at the hearing. Respondent was represented by Signe Jacobson, Economic Self Sufficiency Specialist II with the Department of Children and Families (hereafter "DCF", "Respondent" or "Agency"). Ms. Jacobson testified. Respondent submitted four exhibits, which were accepted into evidence and marked as Respondent's Exhibits "1" through "4".

FINDINGS OF FACT

1. On October 14, 2015, the petitioner argued he applied for SSI-Related Medicaid benefits with the respondent due to a worsening medical condition and his Type 1 [redacted] Petitioner did not submit any evidence he applied for SSI-Related Medicaid benefits in 2014.

2. Respondent argued petitioner applied for SSI-Related Medicaid benefits in May 2010; October 2015; and November 2015.

3. On January 22, 2016, the respondent submitted both the Disability Determination and Transmittal form (Respondent's Exhibit 2) and a packet of medical information to the Department of Health Division of Disability Determination (hereafter "DDD") to determine if petitioner meets the criteria to be considered disabled.

4. On February 2, 2016, DDD determined petitioner not disabled using the denial code N30. N30 means "Non-pay-Slight Impairment – medical consideration alone, no visual impairment". The Disability Determination and Transmittal form had "Hankerson 2/14 same/related allegations, new initial claim pending" handwritten on it. The

document also listed petitioner's diagnosis as [redacted] listed petitioner's date of application as November 16, 2016; and listed petitioner's age as 39 years old.

5. On February 3, 2016, the respondent denied petitioner's request for SSI-Related Medicaid benefits as DDD determined petitioner not to be disabled.

6. DDD determined petitioner applied for Supplemental Security Income (SSI) in December 2013 and was denied by Social Security Administration (SSA) in February 2014. Petitioner argued he did not timely appeal his February 2014 SSI application denial.

7. State of Florida SSA State On-Line Query (Respondent's Exhibit 3) indicated petitioner applied for SSI on January 20, 2016 and was denied on March 3, 2016 using code N36; however, the Query did not indicate if petitioner appealed his March 2016 SSI denial with the SSA. N36 means "Non-pay – Insufficient or no medical data furnished".

8. Petitioner's January 2016 SSI application was pending when DDD determined he was not disabled. Respondent argued that when a SSI application is pending with SSA, DDD is to complete an independent disability review on that individual.

9. Petitioner requested DDD complete an independent disability review on him as DDD did not consider his worsening medical condition and his [redacted] when it determined he was not disabled. Petitioner argued his Type 1 [redacted] diagnosis is similar, but not the same diagnosis, as his [redacted]

CONCLUSIONS OF LAW

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

13. According to the above authority, to be eligible for Family-Related Medicaid benefits, petitioner must have a minor child under age 18 living in the household with him. Since petitioner does not have a minor child under age 18 living in the household, he does not meet the technical requirements to be eligible for Family-Related Medicaid benefits.

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

meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905 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.

15. Pursuant to the above authority, to be eligible for SSI-Related Medicaid, petitioner must be deemed disabled by DDD as he is under the age of 65 and is currently not considered disabled by the SSA.

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

> (a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.
> ….
> (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under §435.909.
>
> (b) *Effect of SSA determinations.* (1) Except in the circumstances specified in paragraph (c)(3) of this section—
>
> (i) An SSA disability determination is binding on an agency until the determination is changed by SSA.
>
> (ii) If the SSA determination is changed, the new determination is also binding on the agency.
> **(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…** (Emphasis added)

17. Pursuant to the above authority, DDD must conduct an independent disability determination if (1) an individual applies to both SSI and State Medicaid at the same time; and (2) an SSI disability determination has not been made within 90 days of the date of the State Medicaid application.

18. DDD determined petitioner applied for SSI in December 2013 and his SSI application was denied in February 2014 pursuant to code N30.

19. Petitioner applied for SSI on January 20, 2016 and SSA denied his SSI application on March 3, 2016. On January 22, 2016, the respondent submitted the necessary information to DDD to determine if petitioner was disabled. On February 2, 2016, DDD determined petitioner not disabled by adopting the denial of petitioner's February 2014 SSI application. DDD was incorrect in adopting SSA's February 2014 SSI denial and in not completing an independent disability review as petitioner's SSI-Related Medicaid application and new January 2016 SSI application were pending at the same time.

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

> (c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:
> …
> (4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and—

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

21. Pursuant to the above authority, DDD is to complete an independent disability determination if petitioner alleges a new or worsening medical condition. DDD determined petitioner not disabled by adopting SSA's February 2014 denial; however, the evidence does not indicate that DDD considered petitioner's worsening medical condition and his new diagnosis of [redacted] when it determined he was not disabled.

22. Respondent was incorrect to deny petitioner's application for SSI-Related Medicaid benefits as DDD should have completed an independent disability determination on petitioner as the SSA denial was over a year old and petitioner has a new diagnosis of [redacted]

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

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

24. Pursuant to the above authority, Medicaid eligibility includes three months prior to the month of application. Petitioner argued he applied for retroactive SSI-Related Medicaid benefits on October 14, 2015. Respondent argued petitioner applied for retroactive SSI-Related Medicaid benefits in May 2010; in October 2015; and in

November 2015. The three retroactive months for October 2015 are July 2015; August 2015; and September 2015. A retroactive month for November 2015 is October 2015.

25. Respondent incorrectly denied petitioner's request for retroactive SSI-Related Medicaid benefits for the months of July 2015 through October 2015 as petitioner applied for SSI-Related Medicaid benefits in October 2015 and in November 2015, which are applications that precede petitioner's requested retroactive Medicaid months by at least three months.

26. In careful review of the cited authorities and evidence, the undersigned concludes petitioner has met his burden of proof to indicate the respondent incorrectly denied his request for retroactive SSI-Related Medicaid benefits for the months of July 2015 through October 2015.

27. Respondent correctly denied petitioner's request for retroactive SSI-Related Medicaid benefits for the months of May 2014 and October 2014 as the evidence does not indicate petitioner applied for SSI-Related Medicaid benefits in 2014. If petitioner provides proof he applied for SSI-Related Medicaid benefits in 2014, the respondent can explore petitioner's eligibility for retroactive SSI-Related Medicaid benefits for the months of May 2014 and October 2014.

28. In careful review of the cited authorities and evidence, the undersigned concludes petitioner has not met his burden of proof to indicate the respondent incorrectly denied his request for retroactive SSI-Related Medicaid benefits for the months of May 2014 and October 2014.

29. Therefore, the undersigned remands the case to the respondent for further development. In accordance with the controlling legal authorities, the respondent is

hereby ordered to complete an independent disability review on petitioner for the time period of July 2015 through October 2015. 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 PARTIALLY GRANTED and REMANDED to the Department for further development for the retroactive months of July 2015 through October 2015. Once the new review is completed, the respondent is to issue written notice to the petitioner, including 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 __11__ day of __May__________, 2016,

in Tallahassee, Florida.

Mary Jane Stafford

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

May 09, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01116

PETITIONER,

Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 Brevard
UNIT: 88999

RESPONDENT.
__________________________________/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 9:35 a.m. on March 4, 2016.

APPEARANCES

For the Petitioner:

For the Respondent: Yavellie Cervantes, ACCESS Supervisor

STATEMENT OF ISSUE

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

PRELIMINARY STATEMENT

By notice dated January 8, 2016, the respondent (or the Department) notified the petitioner his October 6, 2015, Medicaid application was denied. Petitioner timely requested a hearing to challenge the denial.

Petitioner submitted one exhibit, entered as Petitioner Exhibit “1”. Respondent submitted five exhibits, entered as Respondent Exhibits “1” through “5”. Petitioner did not receive the respondent’s exhibits and elected to proceed with the hearing without the exhibits. The record was closed on March 4, 2016.

FINDINGS OF FACT

1. On October 6, 2015, petitioner, age 50, submitted a SSI-Related Medicaid application for himself.

2. To be eligible for SSI-Related Medicaid petitioner must be over age 65 or considered disabled by the Social Security Administration (SSA) or the Division of Disability Determination (DDD).

3. Petitioner applied for disability through the SSA in September 2015. The SSA denied petitioner on January 7, 2016; SSA is currently reconsidering petitioner’s disability. If the SSA denies petitioner again, he plans on retaining legal counsel to appeal their decision.

4. The Department forwarded petitioner’s documents to the DDD for disability eligibility determination. DDD reviewed petitioner’s disability documentation and denied Medicaid disability on January 7, 2016; due to adopting the SSA denial decision.

5. On January 8, 2016, the Department mailed petitioner a Notice of Case Action, notifying his Medicaid application, dated October 6, 2015, was denied.

6. Petitioner described his disabilities as

Petitioner does not have new medical conditions that have not been reported to the SSA. Although, petitioner claims his medical conditions are worsening and believes the SSA will consider his worsening condition during their reconsideration review.

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 Code of Federal Regulations at 42 C.F.R. § 435.541, Determination of Disability in part states:

> (a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...
> (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under § 435.909.
> (b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c) (3) of this section-
> (i) An SSA disability determination is binding on an agency until the determination is changed by SSA.
> (ii) If the SSA determination is changed, the new determination is also binding on the agency.
> (2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except In cases specified in paragraph (c) (4) of this section.
> (c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist…
> (4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA. and-
> (i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or
> (ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated

> since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.
> (iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act. and-
> (A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or
> (B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility…

10. In accordance with the above authority, the respondent denied petitioner's October 6, 2015, Medicaid application; due to adopting the SSA January 7, 2016, denial decision.

11. 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".

12. Petitioner does not have different medical conditions that have not been reported to the SSA. Petitioner argued that his medical conditions are worsening and he believes the SSA will consider his worsening condition during their reconsideration review.

13. In careful review of the cited authority and evidence, the undersigned agrees with the Department's action to deny petitioner Medicaid, due to adopting the SSA disability denial decision.

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 ___09___ day of ___May___________, 2016,

in Tallahassee, Florida.

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

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

May 18, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01128

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 18 Seminole
UNIT: AHCA

AND

SUNSHINE STATE HEALTH PLAN, INC.,

CO-RESPONDENTS.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on April 18, 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 Co-Respondents' partial denial of Petitioner's request for additional hours of Personal Care to 24 hours per day, 7 days per week, was correct. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

Petitioner's daughter [redacted] represented him at the hearing. She may sometimes be referred to hereinafter as "Petitioner's representative" or "Petitioner's daughter." 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:

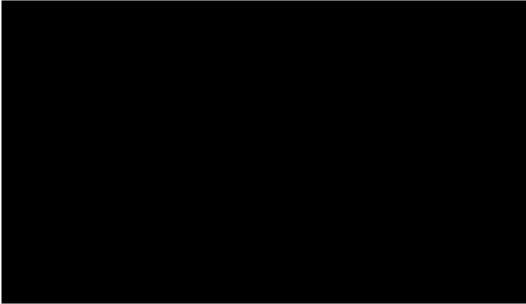
- Dr. John Carter – Long Term Care Medical Director – Sunshine Health
- Paula Daley – Grievance and Appeals Coordinator II – Sunshine Health
- Heidi Oehler – Case Manager – Sunshine Health
- Jane Weigl – Long Term Care Supervisor – Sunshine Health
- Donna Melogy – Director of Operations – Sunshine Health

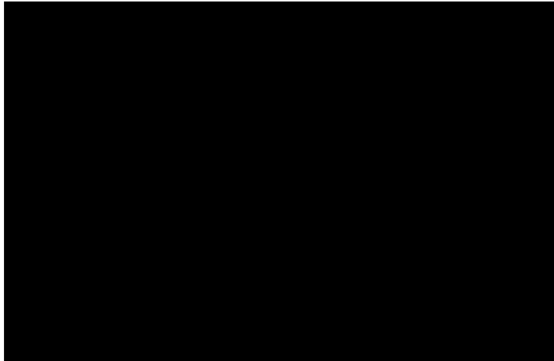
Petitioner's representative gave oral testimony, but did not move any exhibits into evidence. Respondent's Exhibits 1 through 7 were entered into evidence at the hearing. There was a Motion to Intervene submitted by Sunshine Health ("Sunshine"). The Motion is GRANTED and Sunshine is officially added as a Co-Respondent.

FINDINGS OF FACT

1. Petitioner is a 94-year-old male. Petitioner is a dual-enrolled Medicare/Medicaid recipient with Sunshine as his Long Term Care ("LTC") plan and his Managed Medical Assistance ("MMA") plan.

2. Petitioner's medical history includes:





3. Petitioner lives in his home with his wife and daughter. Petitioner's wife is also enrolled in Sunshine's LTC plan and is her case manager.

4. Petitioner suffered a fall in his home and fractured his hip. He was hospitalized from December 19, 2015 through December 24, 2015. Petitioner was then transferred to a Skilled Nursing Facility ("SNF") until February 9, 2016, when he went home. He received physical and occupational therapy, which have since discontinued.

5. Petitioner's representative requested 24 hours per day, seven (7) days per week of Personal Care for her father. On February 5, 2016, Sunshine issued a Notice of Action, Respondent's Exhibit 2, which stated in pertinent part:

> Sunshine Health has reviewed your request for 24 hours a day for Personal Care (The person who helps bathe, dress and feed you), which we received on 2/5/2016. After our review, this service has been: PARTIALLY DENIED as of 2/5/2016. Ref# OP0404771841
>
> You were approved for 28 hours per week of Personal Care…, 14 hours per week of Homemaker Service (The person that cleans for you), and 5 hours per week of Companion Care (The person that helps assist and watch over you) for a total of 47 hours per week from 2/9-3/13.
>
> On 3/14/2016, your hours will be reduced to 21 hours of personal care, 7 hours per week [of homemaker service], and 5 hours of Companion per week.
>
> ….

The facts that we used to make our decision are: Sunshine Health Policy LT.UM.09 Ancillary Service Criteria.

6. Petitioner's total home health services are 33 hours per week as of March 14, 2016. Dr. Carter testified that the reason the 47 hours of care were originally provided was to help Petitioner transition out of the SNF. He determined that, after the transition, 33 hours per week would be sufficient to meet Petitioner's needs.

7. In addition to the home health services, Petitioner has a personal emergency response system ("PERS") and two (2) home delivered meals, five (5) days per week. He also receives various medical supplies.

8. Petitioner's LTC Plan of Care, Effective August 1, 2013, included six (6) hours per week of Homemaker Service, nine (9) hours per week of Companion Care, and 17 hours per week of Personal Care, for a total of 32 hours per week of home health services. (Respondent's Exhibit 5).

9. Petitioner's daughter is his primary caregiver. She is also the primary caregiver for her mother. She does not work outside the home. She said she spends between 40 and 50 hours per week caring for them. She said it is difficult to care for them because of her own health problems, which include which are severe enough to require surgery. There is no other family in the area available to assist.

10. On Petitioner's most recent 701B Comprehensive Assessment ("701B"), noted that Petitioner's daughter "is burned out, and was tearful during today's visit." (Respondent's Exhibit 7). Petitioner's daughter was there and helped provide answers to the assessment. listed her as being in both emotional and physical crisis.

Petitioner's daughter also helps take care of a 39-year-old male living in a group home who she referred to as her "child," although he is not a biological or adopted child. Rather, he is close family friend who Petitioner's daughter considers her child for all intents and purposes.

11. [redacted] said the 701B was performed when Petitioner was still in the SNF. She orally testified as to the changes she would make now that Petitioner is back home. She stated the 701B would now read as follows:

Activities of Daily Living Section

How much assistance do you need with the following tasks?

Task	No assistance needed	Uses assistive device	Needs supervision or prompt	Needs assistance (but not total help)	Needs total assistance (cannot do at all)
Bathing				X	
Dressing				X	
Eating				X	
Using the bathroom				X	
Transferring			X		
Walking/Mobility			X		

How much assistance do you have with the following tasks?

Task	No assistance needed	Always has assistance	Has assistance most of the time	Rarely has assistance	Never has assistance
Bathing		X			
Dressing		X			
Eating		X			
Using the bathroom			X		
Transferring			X		
Walking/Mobility			X		

Instrumental Activities of Daily Living Section

How much assistance do you need with the following tasks?

Task	No assistance needed	Uses assistive device	Needs supervision or prompt	Needs assistance (but not total help)	Needs total assistance (cannot do at all)
Heavy Chores					X
Light Housekeeping					X
Using the telephone				X	
Managing Money					X
Preparing Meals					X
Shopping					X
Managing Medication				X	
Using transportation				X	

How much assistance do you have with the following tasks?

Task	No assistance needed	Always has assistance	Has assistance most of the time	Rarely has assistance	Never has assistance
Heavy Chores		X			
Light Housekeeping		X			
Using the telephone		X			
Managing Money		X			
Preparing Meals		X			
Shopping		X			
Managing Medication		X			
Using transportation		X			

12. Regarding the oral changes made to the 701B, the section on how much assistance Petitioner has with all of his ADLs was previously "Always has assistance." [redacted] changed using the bathroom, transferring, and walking/mobility to "Has assistance most of the time."

13. Sunshine's Policy and Procedure LT.UM.09 defines Personal Care Services as:

> A service that provides assistance with eating, bathing, dressing and personal hygiene and other activities of daily living. The service includes assistance with preparation of meals, but does not include the cost of meals. The service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the member, rather than the member's family. Personal care services include the following:
>
> - Providing assistance to the member to complete personal hygiene (bathing, grooming, mouth care, etc.)
> - Assistance with bladder and bowel requirements that include assisting the member to and from the bathroom or with bedpan routines.
> - Assisting the member in following through with physician orders. The Personal Care provider cannot administer medications, but may bring

medications to the member and remind the member to take the medicine at specific times.

- Assisting with food, nutrition, and diet activities, including preparing meals, when required and other incidental services, (i.e. housekeeping chores) essential to the health and welfare of the member.
- Performing household services (changing bed linen or arranging furniture), when such services are essential to the member's health and comfort.

Personal Care workers must be supervised by a registered nurse, licensed to practice nursing in Florida and who conducts a supervisory home visit every 60 days to observe the personal care worker. The services may be provided in the member's home or other location. Family members cannot be paid for Personal Care Services.

14. Adult Companion Care is defined as:

Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discreet services. The provision of companion services does not entail hands-on nursing care. 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.

15. Homemaker Services are defined as:

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

16. Companion Care, Homemaker Services, and Personal Care Services are all ancillary home health services under Sunshine's Policy and Procedure. Sunshine considers the level of support needed when determining the amount of services needed. The services are intended to "augment and support the existing informal care

and community services being provided to allow the member to remain safely in their home."

17. One of the level of support considerations is the recipient's living situation. Sunshine considers whether or not someone lives alone or with family, and whether or not those family members are able to assist. Someone who lives alone would need more care than someone who lives with family who can assist them. Sunshine also considers whether the recipient requires Minimum, Moderate, or Maximum support to complete their daily tasks. Sunshine does not dispute that Petitioner requires assistance. The dispute regards the total number of hours required to meet his needs.

18. Regarding the level of support needed, the Policy and Procedure states, in pertinent part:

> a) Support needed based on limitations of Activities of Daily Living (ADL) as follows:
>
> - Independent where member is able to provide the task without support, with or without assistive devices.
> - Minimal functional impairment where the ADLs require one of the following: a) at least minimum assistance, or b) the member ambulates with assistance of a person or a device, or c) the member transfers require at least minimum assistance.
> - Moderate functional impairment where two of the follow apply: a) The member has ADLs requiring at least minimal assistance, or b) the member ambulates with assistance of a person or device, or c) the member transfers require at least minimum assistance.
> - Maximum and persistent functional and persistent functional impairment without available caregiver support where all of the following exist: a) Member has ADLs requiring total assistance, b) member is non-ambulatory, c) the member transfers require one (1) to two (2) person assist, and d) the member's treating physician has certified that a), b), and c) impairments are present.

19. The 701B indicates that Petitioner can ambulate using a walker, although he requires hands-on support to do so. He also does not require total assistance with any

ADLs, although he does require total assistance with some IADLs. Based upon the guidelines, Petitioner falls under the Moderate level of support.

20. The Policy and Procedure includes time guidelines for the services, based upon the recipient's level of support needs. One unit of time is 15 minutes. Petitioner resides with family that is limited in their ability to assist him. The following paraphrased list contains the maximum amount of time for each service for Petitioner's living situation, per the guidelines:

1. Supervision and Socialization Support:
Lives with family who provide a minimum or moderate amount of supervision of the member's daily needs and/or socialization: 75 minutes per week.

2. Meal Preparation Assistance: breakfast, lunch, dinner, and additional meal alone (assuming no family member is in the home at his meal times): 75 minutes per day, 7 days per week = 525 minutes per week.

3. Shopping Criteria:
Lives with family who provide a minimum or moderate amount of the member's shopping: 75 minutes per week.

4. Housekeeping and Chore Services:
Lives with family who provide a minimum or moderate amount of the member's housekeeping or chores: 90 minutes per week.

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

6. Bathing Criteria:
The member needs moderate support by receiving step-by-step cueing or supervision with the entire bathing process or hands-on assistance with 50% to 75% of the bathing process: up to 30 minutes per bath. Assuming one bath per day results in 210 minutes per week.

7. Dressing and Grooming Criteria:
Moderate assistance: 15 minutes per task. Number of tasks (6): dressing, undressing, hair care, shaving, oral hygiene, nail care, for a total of 90 minutes per day, 7 days per week = 630 minutes per week.

8. Toileting, Mobility, and Transfer Criteria
Moderate assistance: 15 minutes per task. Petitioner is incontinent of bowel and bladder and requires assistance with toileting. Assuming Petitioner gets up and moves around once an hour during all waking hours (16 hours per day) whether to use the toilet or engage in any activity, the result is 240 minutes per day, 7 days per week = 1,680 minutes per week.

9. Eating and Feeding Criteria:
Moderate assistance: 15 minutes per meal, 4 meals per day: 60 minutes per day, 7 days per week = 420 minutes per week.

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

21. The sum total of the maximum guidelines for all services is 3,855 minutes per week, which is 64.25 hours per week. This number assumes Petitioner has little or no assistance from family members. This number also assumes transferring, toileting, and mobility 15 minutes of every waking hour, which is unlikely.

22. Petitioner requested a hearing on February 12, 2016. Sunshine filed a Motion to Intervene on April 18, 2016, which is GRANTED, as stated above.

CONCLUSIONS OF LAW

23. 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.

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

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

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

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

28. 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….”

29. 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.

30. 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.

31. 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.

32. 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.

33. Petitioner's daughter was present for the 701B Assessment. The answers provided indicate that Petitioner always has assistance with all of his ADLs and IADLs, except for using the bathroom, transferring, and walking/mobility, where he has assistance most of the time.

34. The change in services resulted in an increase of one (1) hour of home health services from what Petitioner was receiving prior to the hip fracture. He was receiving 32 total hours, and now he receives 33.

35. Of particular note, Petitioner's new array of services includes 21 hours of Personal Care, when he previously had 17. The increase in Personal Care hours may address Petitioner's needs regarding using the bathroom, transferring, and mobility, since these services require hands-on care.

36. The 64.25 calculated home health hours assumed Petitioner required the maximum amount of time for every service, and assumed Petitioner would need assistance either

using the bathroom, transferring, or mobility for 15 minutes of every waking hour during the week. It also assumes little or no help from family members. Petitioner's daughter testified she helps care for her father between 40 and 50 hours per week, although it is clear she is having great difficulty providing that much care.

37. Because the generously calculated maximum amount of time is 64.25 hours, Petitioner has not met his burden of proof to show that he requires home health services 24 hours, seven (7) days per week, which is 168 hours.

38. Sunshine temporarily increased Petitioner's services while he was transitioning from the skilled nursing facility back into his home, then reduced his hours back down to approximately what he was receiving prior to the hip fracture. The change actually resulted in an increase of one (1) hour per week. Home health services are designed to supplement, but not replace care provided by family or other caregivers.

39. Petitioner's daughter is clearly very devoted to her family. She is understandably stressed and burned out between all the help she provides to her father, mother, and child. If she can no longer care for her parents, she may want to consider placing them in an assisted living facility or nursing home.

40. In the event the increase in Personal Care hours does not solve the problem of Petitioner sometimes not having assistance with toileting, transferring, and mobility, his daughter is encouraged to work with his case manager to find a solution to the problem. Perhaps Petitioner may require some additional home health hours, but 24/7 care is in excess of his needs.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 18 day of May, 2016, in Tallahassee, Florida.

Rick Zimmer

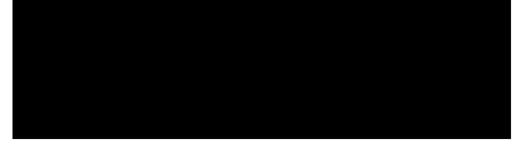
Rick Zimmer
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Judy Jacobs, Area 7, AHCA Field Office
Jennifer M. Guy

Jun 24, 2016

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 16F-01131

PETITIONER,
Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION (AHCA)
CIRCUIT: 07 Volusia
UNIT: AHCA

RESPONDENT.
___________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 31, 2016 at 10:14 a.m. The hearing could not be completed because the petitioner exceeded the monthly minutes allotted in his pre-paid cellular phone service. The hearing reconvened telephonically on June 22, 2016 at 10:14 a.m.

APPEARANCES

For the Petitioner:

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

STATEMENT OF ISSUE

Whether the petitioner is eligible to receive a lower false teeth/lower denture through Medicaid. The petitioner holds the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (Agency or AHCA or respondent) administers the Florida Medicaid Program. The Agency contracts with numerous health care organizations to provide medical services to Medicaid enrollees. United Healthcare is the contracted HMO in the instant case.

By notice dated October 21, 2015, United informed the petitioner that his request for lower false teeth/lower dentures was denied because “[t]his service exceeds the maximum count allowed per period.”

The petitioner timely requested a hearing to challenge the denial decision.

The matter was scheduled to be heard initially on April 11, 2016, but was postponed due to office closure. The matter was next scheduled to be heard on May 3, 2016, but was rescheduled because the petitioner stated that he did not receive the hearing notice. The hearing convened on May 31, 2016.

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.

Present as witnesses for the respondent from United: Susan Frishman, senior compliance analyst; Dr. Brittany Vo, dental consultant and; Lori Eubanks, account manager. The respondent submitted documentary evidence which was admitted into the record as Respondent’s Composite Exhibit 1 and Respondent’s Composite Exhibit 2.

The record was held open until close of business on the day of the hearing for the submission of additional evidence. Evidence was receive from the respondent and admitted as Respondent's Composite Exhibit 3.

FINDINGS OF FACT

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

1. The petitioner (age 59) is a Florida Medicaid recipient.

2. The petitioner is enrolled with United HMO.

3. In July 2015, Economy Dentures, the petitioner's dental provider at that time, submitted an authorization request to United to extract the petitioner's remaining lower teeth, shave bone spurs resulting from extraction of teeth and to fit him with lower false teeth/lower dentures.

4. United approved the service request in its entirety on July 29, 2015.

5. The petitioner received the lower false teeth/lower dentures in August 2015. (The petitioner already had upper false teeth/upper dentures.)

6. Economy Dentures referred the petitioner to an oral surgeon, the Offices of [redacted] in October 2015, for removal of tori (removal of bony ridges on the gum not related to shaving of bone spurs after extraction of teeth).

7. [redacted] submitted a request for lower false teeth/lower dentures to United on October 16, 2015.

8. United denied the request on October 21, 2015, citing coverage limitations as the reason for the denial.

9. Dr. Brittany Vo, United dental consultant, explained that Medicaid provides one lower denture per enrollee per lifetime. The petitioner received a lower denture through Economy Dentures in August 2015; he cannot receive a second lower denture through Medicaid. Medicaid rule prohibits provision of services in excess of coverage limitations.

10. The petitioner asserted that he did not know the lower dentures he received in August 2015 were permanent dentures. He thought they were temporary dentures to be used until he could be fitted with permanent dentures.

11. The petitioner was dissatisfied with the service he received from Economy Dentures. Per the petitioner, the dentures did not fit properly and would fall out of his mouth when he tried to eat or speak because the dentist did not perform the bone shaving required to smooth his gum surface. The petitioner asserted that the provider billed Medicaid for services it did not provide. The petitioner alleged further that bits of bone and root were left in his lower gum, causing him pain. The petitioner argued that the dental office provided substandard care which he would like addressed and remedied. He would like for Medicaid to provide him with new lower false teeth.

12. The petitioner filed a provider complaint against Economy Dentures with United. United reached out to the provider to address the petitioner’s allegations. The provider stated that all the billed serviced were provided. The petitioner must wear the dentures as instructed. The provider is willing work with the petitioner and adjust the fit of the dentures.

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, 7th Ed.).

18. The Florida Medicaid Program is authorized by Chapter 409 Florida Statutes and Fla. Admin. Code Chapter 59G.

19. The Dental Services Coverage Handbook defines coverage limitations for receipt of dentures on page 4:

> **Prosthodontic Services**
> Florida Medicaid reimburses for prosthodontic services to diagnose, plan, rehabilitate, fabricate, and maintain dentures as follows:
> − One upper, lower, or complete set of full or removable partial dentures per recipient
> − One reline, per denture, per 366 days, per recipient
> − One all-acrylic interim partial (flipper) for the anterior teeth, per recipient under the age of 21 years

20. The cited authority explains that Medicaid will reimburse for one lower denture per recipient. There are no noted exceptions to this coverage limitation.

21. The petitioner received a lower denture in August 2015. The petitioner requested a second lower denture in October 2015. The respondent, through its agent United, denied the petitioner's request because the coverage limit for this service had been reached.

22. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the respondent's decision in this matter was correct. Medicaid rule provides for one lower denture per recipient. The petitioner has received the maximum coverage limit for this service.

23. The petitioner alleges that a Medicaid dental provider billed for services he did not receive and provided substandard care.

24. 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…"

25. 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

26. 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.

27. The Office of Appeal Hearings does not have jurisdiction over Medicaid provider relations issues or billing issues. The petitioner's issues regarding provider quality of care and provider billing practices should be directed to AHCA's Consumer Complaint Office at 1-877-254-1055.

DECISION

The appeal is denied. The respondent's decision in this matter is upheld.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 24 day of June, 2016,

in Tallahassee, Florida.

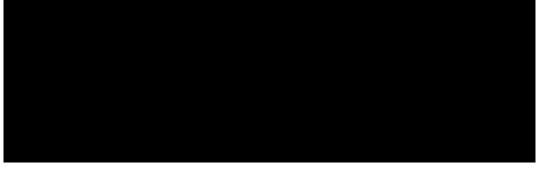
Leslie Green
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

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

Jun 03, 2016

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 16F-01132

PETITIONER,

Vs.

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

RESPONDENT.
__________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in West Palm Beach, Florida on May 2, 2016 at 10:12 a.m.

APPEARANCES

For the Petitioner:

For the Respondent: Linda Latson
Registered Nurse Specialist

ISSUE

Whether the denial of petitioner's request for additional service hours through the Long Term Managed Care Program (LTMC Program) was proper. The burden of proof was assigned to the petitioner. The standard of proof in an administrative hearing is by a preponderance of the evidence.

PRELIMINARY STATEMENT

Petitioner was not present. Petitioner's representative entered no exhibits into evidence.

Ms. Latson appeared as both a representative and witness for the respondent. Present telephonically from Coventry Health Care of Florida (Coventry) were Mellody Gordon, Utilization Manager; Dr. Darwin Caraballo, Medical Director; Sommer Brooks, Contract Manager; and Maureen McNamara, Manager of Grievance and Appeals. Respondent's exhibit "1" was accepted into evidence.

The record was held open through May 9, 2016 for respondent to provide the contract definition for Adult Day Care. A response was not received. In anticipation of a response from the respondent, petitioner was allowed through May 16, 2016 to respond in writing to any post hearing submission.

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 91 years of age and resides with her great-nephew. The great-nephew is, in this matter, Petitioner's representative. He is employed outside the household and works approximately 40 hours per week.

2. Petitioner's diagnoses includes

3. An assessment completed by Coventry establishes petitioner requires total assistance with bathing and dressing.

4. Petitioner ambulates with a walker. She also has the use of a manual wheelchair.

5. Petitioner experiences occasional incontinence.

6. Petitioner was, at all times relevant to this proceeding, Medicaid eligible. She is enrolled in respondent's LTMC Program.

7. Respondent administers Florida's Medicaid Program and contracts with Health Maintenance Organizations (HMOs) to provide comprehensive, cost-effective medical services to Medicaid recipients enrolled in the LTMC Program.

8. Petitioner's LTMC services are provided by Coventry.

9. Petitioner is also enrolled in respondent's Participant Directed Option (PDO) Program. The program allows family members to be paid for caregiver service. Mr. Dorsett is petitioner's representative for the PDO Program.

10. LTMC services are defined by contract.

11. Coventry authorized petitioner to attend an Adult Day Health Care six days a week. The hours are approximately 8:30 a.m. to 6:30 p.m.

12. Petitioner is also approved for five hours per week of personal care assistance. Petitioner's representative was not aware of this approval. As such, personal care hours have not recently been accessed.

13. On January 28, 2016 Coventry received petitioner's request for seventeen services hours through the PDO Program. Mr. Dorsett wishes to be the provider for the requested hours.

14. The additional hours are to provide personal care assistance to the petitioner.

15. On February 1, 2016 Coventry issued a Notice of Action which denied the request. The rationale for denial was that the requested service was not medically necessary.

16. On February 12, 2016 petitioner's representative timely contacted the Office of Appeal Hearings and requested a fair hearing.

17. Previously, at unspecified time, petitioner was approved to receive two hours of personal care services; seven days per week. The agency providing the service performed poorly and the service was terminated.

18. Petitioner argues 12 hours of personal care services; six days a week was all that was requested

CONCLUSIONS OF LAW

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

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

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

22. Florida Statute § 409.978 states:

> (1) … the agency shall administer the long-term care managed care program …
>
> (2) The agency shall make payments for long-term care, including home and community-based services, using a managed care model.

23. Regarding the LTMC Program, Coventry and the respondent entered into a contractual relationship. The contract defines required services.

24. Definitions for the LTMC Program are found on respondent's website at:

http://www.fdhc.state.fl.us/medicaid/statewide_mc/pdf/Contracts/2015-11-01/Exhibit_II-B-Long-term_Care_LTC_Program_2015-11-01.pdf

25. Definitions relevant to this proceeding are:

(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.

26. Florida Medicaid, which includes the LTMC Program, only covers those services determined to be medically necessary. See § 409.905 (4) (c), Fla. Stat.

27. 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.

28. The Findings of Fact establish petitioner attends an Adult Day Health Care program six days a week. Based on the contractual definition of the service, her personal care needs are addressed while in attendance.

29. The Findings of Fact also establish petitioner requires total assistance with bathing and dressing. It is not clear why petitioner's representative was not aware of the approval of five hours of personal care services.

30. It is noted that Coventry denied "seventeen service hours". Petitioner states 12 hours of personal care is needed. The rationale for this conflicting information is also not clear. It is presumed, therefore, an additional 7 hours a week is desired.

31. The need for personal care is not disputed. Coventry recognized such by approving five hours per week. The role of a hearing officer, however, is not to

independently select the number of medically necessary service hours. The undersigned must consider relevant facts, what was documented as requested, and what was denied or approved.

32. The issue before the undersigned is not who can provide personal care services. Rather, the issue focuses on whether petitioner has established additional personal care hours are medically necessary.

33. In an administrative hearing, the definition of medically necessary is not based on a personalized interpretation. The undersigned must follow the definition as established by Florida Administrative Code.

34. Petitioner's personal care needs are addressed at the Adult Day Health Care program six days a weeks. The Findings of Fact establish the daily hours are approximately 8:30 a.m. to 6:30 p.m. Because 12 hours per week of personal care was authorized at a past date does not fully establish that frequency remains appropriate. Credible evidence does not establish an additional 7, 12, or 17 hours of personal care is medically necessary.

35. Petitioner has not established, in a preponderant manner, that respondent's action in this matter was improper. 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;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider…

36. Should petitioner's medical or functional status change, either more personal care or other appropriate services offered through the LTMC Program can be requested.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this __03__ day of __June__________, 2016,

in Tallahassee, Florida.

Frank Houston

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

Copies Furnished To: [redacted] PETITIONER
JUDY JACOBS, AREA 7, AHCA FIELD OFFICE

May 12, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01151

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT:
UNIT: AHCA

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on May 11, 2016 at 1:13 p.m.

APPEARANCES

For the Petitioner: pro se

For the Respondent: Sheila Broderick, registered nurse specialist

STATEMENT OF ISSUE

At issue is the respondent's decision denying a Medicaid provider, Shands Medical Center (Shands), reimbursement for medical services rendered to the petitioner February 4, 2016 – February 5, 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. United Healthcare (United) is the contracted health care organization in the instant case.

By notice dated February 8, 2016, United informed the petitioner that it denied Shands's reimbursement request for medical services rendered to her February 4, 2016 – February 5, 2016.

The petitioner requested a hearing on February 15, 2016 to challenge the denial decision.

[redacted] petitioner's mother, was present as a witness for the petitioner. The petitioner did not submit documentary evidence.

Present as a respondent witness from United: Susan Frishman, senior compliance analyst. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

FINDINGS OF FACT

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

1. The petitioner (age 52) is a Florida Medicaid recipient. The petitioner is enrolled with United HMO.

2. The petitioner was transported by ambulance to Shands emergency room on February 4, 2016 due to chest pains. The petitioner was admitted into the hospital for additional testing because she has a history of [redacted] The petitioner was discharged from the hospital on February 5, 2016.

3. All Medicaid goods and services must be medically necessary. Some services require prior or post service authorization which is completed by the Agency, the HMO or another designee. Shands submitted a service authorization request to United on February 4, 2016.

4. United approved the emergency room charges for February 4 2016. United determined there was insufficient medical evidence to support a full admission stay. United concluded that the petitioner's needs could have been met at a lower level of care such as an observational admission. United denied the provider's inpatient charges for February 4, 2016 - February 5, 2016.

5. The petitioner has not received a bill from Shands, but is concerned that she will be responsible for the charges if United does not pay the bill. Providers who accept Medicaid must accept Medicaid's reimbursement rate and cannot seek reimbursement from the Medicaid recipient. The petitioner is not responsible for the bill. The petitioner was instructed to call AHCA or United if she receives a bill from Shands regarding this matter.

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:
>
> - 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

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 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 respondent denied a provider's reimbursement request for medical services rendered to the petitioner. The Office of Appeal Hearings does not have jurisdiction over Medicaid provider reimbursement issues.

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 12 day of May, 2016, in Tallahassee, Florida.

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

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

May 11, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01172

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT:
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 11:31 a.m.

APPEARANCES

For Petitioner:

For Respondent: Dianne Soderlind, Registered Nurse Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Respondent's partial denial of Petitioner's continued request for Prescribed Pediatric Extended Care (PPEC) services for full and partial days, Monday through Friday, for the certification period of January 30, 2016 to July 27, 2016 is appropriate. Because the matter under appeal is a reduction in PPEC services for the Petitioner, the burden of proof was assigned to the Respondent.

PRELIMINARY STATEMENT

Dr. Darlene Calhoun, 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 (2) documents which were entered into evidence and marked Respondent Exhibits 1 and 2.

Administrative notice was taken of Florida Administrative Code Rules 59G-1.010, 59G-4.290, as well as AHCA's Prescribed Pediatric Extended Care (PPEC) Services Coverage and Limitations Handbook.

FINDINGS OF FACT

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

1. The Petitioner is a two year-old male Medicaid recipient. He is diagnosed with [redacted] He had knee surgery ([redacted]) on September 23, 2015 and is scheduled for a second surgery on November 1, 2016.

2. Petitioner takes [redacted] as needed for pain.

3. Petitioner is on a regular age appropriate diet and is ambulatory. He is speech delayed and receives therapy at the PPEC care center.

4. The Agency contracts with a Quality Improvement Organization (QIO) to perform medical utilization reviews for PPEC services through a prior authorization process for Medicaid State Plan beneficiaries. The prior authorization review determines the medical necessity of the hours requested pursuant to the requirements and limitations of the Medicaid State Plan. The Agency's QIO is eQHealth Solutions.

5. A request for services is submitted by a provider along with all information and documentation necessary for the QIO to make a determination of medical necessity for the level of service requested. A review is conducted for every new certification period, and a request for modification may be submitted by a beneficiary during a certification period.

6. The Petitioner continues to receive PPEC full and partial day services, Monday through Friday, pending the outcome of this appeal. Full day services are no more than twelve hours in a day and partial day services are up to five hours of care in a day.

7. On January 29, 2016, a request for PPEC full and partial day services, Monday through Friday, was submitted by the provider on behalf of the Petitioner for the certification period January 30, 2016 to July 27, 2016. The request represents a continuation of PPEC services received in the preceding certification period.

8. On February 3, 2016, an eQHealth Solutions physician consultant reviewed the request and partially approved the PPEC services. A "Notice of Outcome-Partial Denial Prescribed Pediatric Extended Care Services" was issued to Petitioner on February 5, 2016, which notified Petitioner that PPEC full and partial day services were partially denied. The rationale for the denial was that the PPEC services were not medically necessary as defined in 59G-1.010 (166), Florida Administrative Code. The notice

indicated partial and full PPEC services were approved from January 30, 2016 to February 28, 2016 and services from February 29, 2016 to July 27, 2016 were denied.

9. On February 5, 2016, a "Notice of Outcome" was issued to Petitioner's provider and provided the following clinical rationale:

10. A reconsideration was not requested.

11. On February 15, 2016, Petitioner's mother timely requested a fair hearing.

12. The Respondent's physician consultant witness reviewed the Petitioner's medical condition (see paragraph 1 above) and his medication regimen (see paragraph 2 above). She reviewed the documentation submitted by the provider in support of the request for PPEC services and noted that the Petitioner did not have a need for skilled nursing services. She explained that the medication can be given to the Petitioner before or after school. She further explained that Petitioner's need for oxygen appeared most related to his exercise which is predictable and the oxygen can be provided as expected.

13. The mother explained that her son has done better while in PPEC and anticipates his health deteriorating without nursing oversight.

14. The respondent’s witness explained that PPEC services cannot be approved if there are no skilled nursing services needed. She stated therapy services can be provided separately from PPEC.

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 Chapter 120.80 Fla. Stat. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

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

17. Because the issue under appeal is based on a termination of services, the burden of proof was assigned to the respondent, pursuant to Fla. Admin. Code R. 65-2.060(1).

18. 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).

19. 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.

20. In the Prescribed Pediatrics Extended Care Services Coverage and Limitations Handbook, page 2-2, it 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."

21. Rule 59G-1.010 (164), Florida Administrative Code (F.A.C.) defines "medically complex" as follows:

> … 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.

22. Rule 59G-1.010 (165), Florida Administrative Code (F.A.C.) defines "medically fragile" as follows:

> …an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, e.g., requires total parenteral nutrition (TPN), is ventilator dependent, or is dependent on a heightened level of medical supervision to sustain life, and without such services is likely to expire without warning.

23. Because the Petitioner is under twenty-one-years-old, the requirements of Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT) must be considered. Florida Statute § 409.905, Mandatory Medicaid services, provides that Medicaid services for children must include:

> (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

24. 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 approved ongoing PPEC services but is providing PPEC services to the Petitioner administratively, pending outcome of this appeal. Therefore, Respondent needs to determine that PPEC services are not medically necessary in order to be in compliance with EPSDT requirements.

25. The Prescribed Pediatrics Extended Care Services (PPEC) Coverage and Limitations Handbook provides the purpose and definition of PPEC on page 11:

> 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.

26. Page 2-1 the PPEC Handbook provides the following requirements for those who can receive PPEC services:

> To receive reimbursement for PPEC services, a recipient must meet **all** of the following criteria [emphasis added]:
>
> • 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.

27. 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, social work, developmental evaluations, and child life.

28. The mother argued that her son does better at PPEC because they have the ability to separate or isolate patients as needed. She feels her son benefits from nurses' monitoring his oxygen need.

29. The Respondent's witness explained that PPEC services cannot be approved because the child must need skilled nursing interventions. The evidence fails to show Petitioner meets the definition of "medically complex" or "medically fragile" as defined by the above cited authority.

30. The undersigned concludes that the Respondent has met its burden of proof to show that PPEC services are not medically necessary for the Petitioner. The Petitioner's medical conditions do not require ongoing skilled nursing intervention.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner's appeal is DENIED and the Respondent's action is AFFIRMED.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 11 day of May, 2016,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
Marshall Wallace, Area 2, AHCA Field Office Manager

May 09, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01197

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT:
UNIT: AHCA

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on April 15, 2016 at 10:10 a.m.

APPEARANCES

For the Petitioner:

For the Respondent: Sheila Broderick, registered nurse specialist

STATEMENT OF ISSUE

At issue is the respondent's decision denying the petitioner's request for the prescription drug The petitioner holds the burden of proof at the level of preponderance of the evidence.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (Agency or AHCA or respondent) administers the Florida Medicaid Program. Medicaid rules require that most recipients receive their Medicaid services through the Managed Care Plan. The Agency contracts with numerous health care organizations to provide medical services to its program participants. Molina Healthcare of Florida (Molina) is the contracted health care organization in the instant case.

By notice dated February 19, 2016, Molina informed the petitioner that his request for the prescription drug was denied. The notice reads in pertinent part: in children under 5 years of age; therefore is not medically necessary at this time."

The petitioner timely requested a hearing in February 2016 to challenge the denial decision.

There were no additional witnesses for the petitioner. The petitioner's mother did not submit into the record documentary evidence she sent to Appeal Hearings because it was duplicative of documents already provided by the respondent.

The respondent presented three witnesses from Molina: Alice Quiros, assistant vice president of government contracts; Dr. Alfred Romay, director of pharmacy services; Dr. Luis Ruiz, clinical pharmacist; and Adeel Ali, supervisor of pharmacy. 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 2) is a Florida Medicaid recipient. The petitioner is enrolled with Molina HMO.

2. The petitioner has a history of which began when he was approximately two months old. His symptoms include

3. The petitioner has tried several medications which failed to adequately address his medical problems, including

4. On February 12, 2016, the petitioner's pulmonologist requested authorization from Molina to treat his with the drug The request reads in pertinent part: patient 12/1/2015 to present."

5. 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.

6. Dr. Alfred Romay, director of pharmacy services with Molina, explained that the Food and Drug Administration (FDA), a federal agency that regulates prescription drugs, guidelines specify that the age limit for is12 and over. AHCA guidelines are more relaxed, setting the age limit at 5 and over.

7. Dr. Romay asserted that was insufficient medical evidence to prove that [redacted]s safe for the petitioner's age group and therefore the drug is considered experimental. Medicaid rules prohibit provision of goods and services which are experimental.

8. Molina denied the petitioner's request as not medically necessary because the requested drug is not consistent with generally accepted professional medical standards as determined by AHCA.

9. The petitioner's mother argued that it is medically necessary that he receive [redacted] The petitioner's [redacted] has been severe throughout his life. Prior to [redacted] he regularly required emergency medical attention, two or three times a week, due to difficulty breathing. He was often unable to sleep at night, which caused him to be lethargic the following day. He was often too ill to attend day care.

10. The petitioner's medical condition has improved significantly since he began using [redacted] in October 2015. He has not required emergency medical attention, he sleeps better during the night, and is alert and active during the day. His doctor continues to provide free samples pending the outcome of the hearing.

CONCLUSIONS OF LAW

11. By agreement between the AHCA and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Section 120.80, Florida Statutes.

12. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.

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

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

15. The standard of proof in an administrative hearing is by a preponderance of the evidence (See Fla. Admin. Code R. 65-2.060(1)). The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th 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.

18. 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 Statutes, *Mandatory Medicaid services*, defines Medicaid services for children to include:

> (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems…

19. The respondent denied the petitioner's request for the prescription drug [REDACTED] to treat his [REDACTED] because state and federal guideline do not recommend use of the drug for children in the petitioner's age group.

20. The petitioner tried several medications which failed to adequately address his medical problems, as a result he required emergency medical attention two or three days per week. [REDACTED] has been effectively treating the petitioner's [REDACTED] for six months (October 2015 – April 2016). The petitioner has not required emergency medical attention during this time period. He is no longer awake throughout the night due to difficulty breathing. He is alert and active during the day because he is able to sleep at night.

21. An expanded definition of medical necessity is applicable for children under age 21. EPSDT mandates provide health care necessary treat physical illnesses and conditions, whether or not such services are covered under State plan Medicaid. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the petitioner proved by a preponderance of the evidence that it is medically necessary for him to receive the prescription drug [redacted] The drug is necessary to treat the petitioner's [redacted]

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is GRANTED. The respondent is hereby ordered to approve the drug [redacted]

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this __09__ day of __May__________, 2016,

in Tallahassee, Florida.

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

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

Jun 21, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT:
UNIT: 88324

RESPONDENT.
________________________________/

APPEAL NO. 16F-01204

CASE NO.

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on April 27, 2016 at 9:03 a.m.

APPEARANCES

For the Petitioner:

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

STATEMENT OF ISSUE

Petitioner is appealing the Department's action on January 5, 2016 to deny her application for SSI-Related Medicaid due to not meeting the disability requirement.

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

PRELIMINARY STATEMENT

The hearing was originally scheduled to convene on April 5, 2016. The respondent requested a continuance to review information recently submitted by the petitioner's representative. The petitioner's representative did not object and the hearing was scheduled to convene on April 27, 2016 at 9:00 a.m.

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

The record was held open until 5:00 p.m. on March 12, 2016 to allow the respondent and the petitioner to submit evidence. Evidence was received and entered as the Respondent's Exhibit 3 and the Petitioner's Exhibits 1 through 3. The record was closed on March 12, 2016 at 5:00 p.m.

FINDINGS OF FACT

1. On December 2, 2015, the petitioner's daughter applied for SSI-Related Medicaid for the petitioner (age 48).

2. The Department's records show that the petitioner completed an application for Social Security disability on October 9, 2015 and was still pending at the time of the completed application for SSI-Related Medicaid in December 2015. The Department's records show that there was no disability report and denied the petitioner's application on January 4, 2016 *(Respondent's Exhibit 2, page 11)*.

3. On January 12, 2016, the petitioner's daughter completed another application for SSI-Related Medicaid. This application was denied due to not meeting the disability requirements.

4. The Department's most current records show that the petitioner's Social Security disability claim was denied on March 24, 2016, with a code "N18", which was defined as "Non-pay-failure to cooperate". The Department adopted the SSA denial.

5. The petitioner's daughter does not agree with the Department's denial. The petitioner's daughter argues that she was informed by the Department that the petitioner would have to be deemed disabled in order to be approved for Medicaid. The petitioner's daughter believes she sent all of the petitioner's medical records to show that she is disabled.

6. The petitioner's daughter argues that the petitioner has [redacted] The petitioner was admitted into [redacted] where she had surgery that caused her lose oxygen to her brain; she suffered a stroke. The petitioner has permanent [redacted] The petitioner cannot walk, has a [redacted] The petitioner's daughter contends that the petitioner's medical condition is permanent and that there is nothing the doctors can do. The physicians are trying to make her comfortable for the rest of her days. They are hoping she gets better on her own but there is no type treatment that can be done to correct her brain damage.

7. The petitioner's daughter explained that the petitioner is currently residing in a facility in [redacted] The original plan was for the petitioner to be in the facility in [redacted] for 25 days for treatment and return to Florida to be placed in a long-term care facility. The petitioner's daughter is also residing in [redacted] The petitioner remains in [redacted] because her insurance company and current facility

cannot find a long-term care facility in Florida that will care for a patient as young as she is or who has a [redacted] that cannot be removed within 100 days. The petitioner's daughter has not applied for Medicaid in [redacted] because it is a difficult process. The petitioner's daughter is seeking Medicaid coverage for the petitioner beginning December 2015.

8. The petitioner's daughter contends that the petitioner is a Florida resident and has an apartment in Florida; she was only transferred to [redacted] to receive treatment. The petitioner's daughter explained that the petitioner was transferred from the hospital in Florida by the [redacted] to the [redacted]. The petitioner's daughter explained that the facility where the petitioner currently resides will not discharge her until a facility can be found in Florida.

9. The Department contends that the petitioner is not eligible for Medicaid because she is under age 65, does not have children under the age of 18, has not been deemed disabled, has been denied SSA, and has had an SSA appeal that was denied.

10. The petitioner's daughter asserts that the SSA is reviewing the petitioner's medical conditions and is waiting to receive a status of the review of the petitioner's current pending application. Post-hearing, the petitioner's daughter provided an award letter from the SSA. The Petitioner's Exhibit 1 includes the SSA "Retirement, Survivors and Disability Insurance Notice of Award" dated May 6, 2016. The Notice of Award states: E.A.B. is entitled to monthly disability benefits beginning May 2016." The Notice

of Award includes paragraph titled "The Date You Became Disabled" and states, "We found E.A.B. became disabled under our rules on November 20, 2015."

CONCLUSIONS OF LAW

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

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

13. Federal Regulation at 42 CFR § 435.403 State residence states:

> (a) *Requirement*. The agency must provide Medicaid to eligible residents of the State, including residents who are absent from the State. The conditions under which payment for services is provided to out-of-State residents are set forth in § 431.52 of this chapter.
> (b) *Definition*. For purposes of this section—*Institution* has the same meaning as *Institution* and *Medical institution*, as defined in § 435.1010 of this chapter.
> (d) *Who is a State resident.* A resident of a State is any individual who:
> (1) Meets the conditions in paragraphs (e) through (i) of this section; or
> …
> (4) Where a placement is initiated by a State because the State lacks a sufficient number of appropriate facilities to provide services to its residents, the State making the placement is the individual's State of residence for Medicaid purposes.

14. Federal Regulations at 42 CFR § 435.1010 Definitions relating to institutional status states:

> For purposes of FFP, the following definitions apply:
> …
> *Medical institution* means an institution that—

> (a) Is organized to provide medical care, including nursing and convalescent care;

15. The above authorities explain that the state making a placement to another state is the individual's state of residence for Medicaid purposes. A medical institution is defined as an institution that provides medical care, including a nursing and convalescent care facility. In this case, the findings show that the petitioner was transferred by the state of Florida to another medical institution (Select Specialty Hospital) in the state of North Carolina for the purpose of receiving medical treatment. The findings show that the petitioner is still residing in North Carolina due to not being able to locate a facility equipped to medically treat her condition in the state of Florida. Therefore, the undersigned concludes that the petitioner is a resident of the state of Florida and is potentially eligible to receive Medicaid in Florida.

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

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

17. The findings show the petitioner is 48 years old. In this case, before Medicaid eligibility can be determined, petitioner must meet the federal definition of disabled.

18. Additionally, 42 C.F.R. § 435.541 **Determination of Disability**, states:

(a) *Determinations made by SSA.* The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...
(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.911 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under 435.909.
(b) *Effect of SSA determinations.*
(1)…
(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.

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

(7) Re-evaluating Medicaid Adverse Actions. The department shall re-evaluate any adverse Medicaid determination upon a showing of good cause by the individual that the previous determination was incorrect and that the individual did not request a hearing within the time prescribed in Chapter 65-2, Part IV, F.A.C. This provision applies only when benefits were terminated or denied erroneously or a share of cost or patient responsibility was determined erroneously.
(a) Good cause exists if evidence is presented which shows any of the following:
…
3. New and Material Evidence – The department's determination was correct when made but new and material evidence that the department did not previously consider establishes that a different decision should be made.

20. The above authority explain that the Department must re-evaluate a previous adverse action related to the Medicaid program if the applicant presents new medical

evidence not previously considered that may result in a different determination. The findings show that the petitioner has been determined disabled by the SSA as of November 2015. Therefore, the undersigned concludes that the Department action to deny the petitioner's applications for December 2015 and January 2016 is incorrect. The Department is remanded with instructions to re-evaluate the previous Medicaid applications for December 2015 and January 2016 and the retroactive month of November 2015. Once a determination is made, the Department is to issue notice to both petitioner and the representative.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, appeal is granted and is remanded with instructions as set forth in the above Conclusions of Law for the re-evaluation of the applications for December 2015, January 2016, and the retroactive month of November 2015. Once a determination is made, the Department is to issue a notice to both petitioner and the representative.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 21 day of June, 2016,

in Tallahassee, Florida.

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

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

May 10, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01210

PETITIONER,

Vs.

CASE NO

FLORIDA DEPARTMENT
F CHILDREN AND FAMILIES
CIRCUIT:
UNIT: 88232
RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on March 29, 2016, at 10:18 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner:

For the Respondent: Eric Eckhardt, supervisor

STATEMENT OF ISSUE

The petitioner is appealing the denial of full Medicaid and the enrollment in the Medically Needy Program with an estimated share of cost. The petitioner carries 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 one exhibit which was entered into evidence and marked as Petitioner's Composite Exhibit 1.

FINDINGS OF FACT

1. On January 4, 2016, the petitioner submitted an application Food Assistance and Medicaid for himself and his children. The petitioner's household consists of himself (age 55), and his two children ███ age 13, and ██ age 13. He was determined disabled and receives Social Security Disability Income (SSDI) of $1,057 monthly. His two children each receive $165 of Social Security and $295 adoption subsidy monthly. These amounts were verified by the state online inquiry system and a history printout of the children's adoption subsidy. He began receiving Medicare parts A and B in April 2014. The Department approved Special Low Income Medicare SLMB Part B Medicaid retroactive to the date of his application in January 2016 and pays for the petitioner's Medicare Part B premium. The petitioner is responsible to for co-payments to doctors' visits. He listed no tax deductions and does not have any tax dependents in another household.

2. On February 3, 2016, the respondent denied regular Medicaid for the petitioner but approved regular Medicaid for his children. The reason given for the denial was that he did not cooperate with child support enforcement and his household income exceeded the income limit for regular (full) Medicaid benefits.

3. On February 12, 2016, the petitioner requested a hearing to challenge the Department's decision to deny him regular Medicaid.

4. The Department reviewed the petitioner case and removed the child support enforcement sanction. The petitioner was still determined ineligible for regular (full) Medicaid as his income was over the limit for regular Medicaid.

5. The Department then determined eligibility in the Medically Needy Program and performed the following budget calculations. His SSDI was added to the children's income, resulting to $1,977.80 as the monthly household income. The Medically Needy Income Limit of $486 for a household size of three was subtracted resulting to the petitioner's SOC of $1,491.

6. On March 9, 2016, the respondent notified the petitioner his Medically Needy application was approved and he was eligible for an estimated SOC of $1,491 effective January 2016.

7. The petitioner explained he is disabled and cannot afford the co-payments for his doctors, therefore he is not able to go to his doctors.

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 petitioner has been determined disabled by Social Security. His Medicaid eligibility was determined under the Family Related Medicaid as it was advantageous for the petitioner.

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

> (a) *Basis.* This section implements section 1902(a) (10) (A) (ii) (XX) of the Act.
> (b) *Eligibility*—(1) *Criteria.* The agency may provide Medicaid to individuals who:
> (i) Are under age 65;
> (ii) Are not eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part;
> (iii) Are not otherwise eligible for and enrolled for optional coverage under a State's Medicaid State plan in accordance with section 1902(a)(10)(A)(ii)(I) through (XIX) of the Act and subpart C of this part, based on information available to the State from the application filed by or on behalf of the individual; and
> (iv) Have household income that exceeds 133 percent FPL but is at or below the income standard elected by the agency and approved in its Medicaid State plan, for the applicable family size.
> (2) *Limitations.* (i) A State may not, except as permitted under an approved phase-in plan adopted in accordance with paragraph (b)(3) of this section, provide Medicaid to higher income individuals described in paragraph (b)(1) of this section without providing Medicaid to lower income individuals described in such paragraph.
> (ii) The limitation on eligibility of parents and other caretaker relatives specified in § 435.119(c) of this section also applies to eligibility under this section.

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

> (a) (2) Effective January 1, 2014, the agency must apply the financial methodologies set forth in this section in determining the financial eligibility of all individuals for Medicaid, except for individuals identified in paragraph (j) of this section and as provided in paragraph (a)(3) of this section.
> (3) In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid coverage to begin on or before December 31, 2013, application of the financial methodologies set forth in this section will not be applied until March 31, 2014 or the next regularly-scheduled renewal of eligibility for such individual under §435.916 of this part, whichever is later.
> (b) *Definitions.* For purposes of this section—
> *Child* means a natural or biological, adopted or step child.
> *Code* means the Internal Revenue Code.

Family size means the number of persons counted as members of an individual's household. In the case of determining the family size of a pregnant woman, the pregnant woman is counted as herself plus the number of children she is expected to deliver. In the case of determining the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted, at State option, as either 1 or 2 person(s) or as herself plus the number of children she is expected to deliver….
(c) *Basic rule.* Except as specified in paragraph (i), (j), and (k) of this section, the agency must determine financial eligibility for Medicaid based on "household income" as defined in paragraph (d) of this section.
(d) *Household income*—(1) *General rule.* Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household.
(2) *Income of children and tax dependents.* (i) The MAGI-based income of an individual who is included in the household of his or her natural, adopted or step parent and is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined, is not included in household income whether or not the individual files a tax return.
(ii) The MAGI-based income of a tax dependent described in paragraph (f)(2)(i) of this section who is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined is not included in the household income of the taxpayer whether or not such tax dependent files a tax return.
(3) In the case of individuals described in paragraph (f)(2)(i) of this section, household income may, at State option, also include actually available cash support, exceeding nominal amounts, provided by the person claiming such individual as a tax dependent.
(4) Effective January 1, 2014, in determining the eligibility of an individual using MAGI-based income, a state must subtract an amount equivalent to 5 percentage points of the Federal poverty level for the applicable family size only to determine the eligibility of an individual for medical assistance under the eligibility group with the highest income standard using MAGI-based methodologies in the applicable Title of the Act, but not to determine eligibility for a particular eligibility group.

13. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 1830.0101 Income (MFAM) states:

…**Taxable Unearned income** is income for which there is no performance of work or services. Taxable unearned income may include:

> 1. Retirement, disability payments, unemployment/workers' compensation, etc.;
> 2. Annuities, pensions, and other regular payments;
> 3. Alimony and spousal support payments;
> 4. Dividends, interest, and royalties;
> 5. Prizes and awards;
> 6. Social Security and Social Security Disability Income.
>
> **Excluded income** is income (earned or unearned) that is not counted when determining eligibility.

14. The Policy Manual at passage 1830.0800 assistance from government agencies (MFAM) states that adoption subsidies and foster care payments are excluded as unearned income.

15. The above states that adoption subsidies are excluded income; therefore, based on the above, the petitioner's children adoption subsidies are exempt as income in the petitioner's SOC budget.

16. The Policy Manual at passage 2630.0108 Budget Computation (MFAM) states:

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

> Individuals determined ineligible for Medicaid will be enrolled in Medically Needy and referred, as appropriate, to Florida Kid Care and/or the Federally Facilitated Marketplace (FFM).

17. The Policy Manual at Appendix A-7 indicates the Family-Related Medicaid Income Limit for a parent in a household size of three is $303, the Standard Disregard is $183, the Medically Needy Income Limit (MNIL) is $486 and the MAGI Disregard is $84.

18. In accordance with the above controlling authorities, the undersigned calculated Medicaid eligibility for the petitioner but did not find him eligible for full Medicaid as his modified adjusted gross income is more than the income limit of $303 for a household of three. Step 1: The petitioner's SSDI of $1,057 was added to his two children's Social Security of $165 each resulting to $1,387 as the modified adjusted gross income. Step 2: There are no deductions provided, as there was no tax return. Step: 3: The total income of $1,387 less the standard disregard of $183 is $1,204. Step 4: The total countable net income of $1,204 was compared with the income standard for three of $303. Step 5: Since it was greater than the income standard, the MAGI disregards of $84 was subtracted, resulting to $1,120. This was compared to the income limit of $303 for full Medicaid. The petitioner's income was greater than the income limit for full Medicaid. The undersigned concludes the petitioner is ineligible for full Medicaid. The undersigned further concludes Medically Needy eligibility must be explored for the petitioner.

The Medically Needy share of cost will now be addressed

19. 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".

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. Fla. Admin. Code R. 65A-1.702 addresses when eligibility of Medicaid and states in parts:

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

22. The Department's Transmittal No. P-15-09-0009, dated September 18, 2015, addresses Medically Needy Budgeting for Family-Related Medicaid and states:

> **SFU/Counting Income for Medically Needy**
> Staff will continue to determine the Medicaid Standard Filing Unit (SFU) based on expected tax filing information as provided by the individual. If an assistance group (AG) is ineligible for full Medicaid coverage due to income, eligibility for Medically Needy coverage must be determined.
> A child with countable income must be excluded from the Family-Related Medically Needy AG if inclusion is not beneficial to the individual whose eligibility is being determined…
> If the AG's countable income is less than or equal to the Medically Needy Income Limit (MNIL) for the remaining household size, open the AG for Medically Needy with a $0 share of cost.

> If the AG's countable income is greater than the MNIL for the remaining household size, enroll the AG in Medically Needy with a share of cost as determined by the remaining countable income.
> **Note: Do not exclude a child(ren) with countable income from a full coverage Medicaid AG. This policy only applies to the Family-Related Medically Needy Program.**

23. The above transmittal explains that the child's income is excluded in the petitioner's Medically Needy budget.

24. The undersigned carefully reviewed the Department's determination of the petitioner's SOC budget and found the petitioner eligible for a lower SOC than the Department's calculation. The monthly income of his and his children's combined SSDI of $1,387 was used as the modified adjusted gross income. The MNIL of $486 was subtracted to get $901 as the petitioner's SOC.

25. The undersigned concludes the respondent's action to deny full Medicaid benefits and to enroll the petitioner in the Medically Needy Program with a SOC was correct; however, the SOC is overstated.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is partially denied as the petitioner is not eligible for full Medicaid benefits. It is granted in part as the petitioner is correctly enrolled in the Medically Needy Program but the SOC was overstated. The Department is ordered to take corrective action to correct the petitioner's SOC to $901.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 10 day of May, 2016,

in Tallahassee, Florida.

Christiana Gopaul Narine

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

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

Jun 17, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01224

PETITIONER,

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT:
UNIT: AHCA

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, Hearing Officer Patricia C. Antonucci convened hearing in the above-captioned matter on April 13, 2016 at approximately 11:04 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 or "the Agency"), through its contracted health plan, United Healthcare (United) to partially deny Petitioner's request for therapy services. Petitioner bears the burden of proving, by a preponderance of the evidence, that this partial denial is improper.

PRELIMINARY STATEMENT

The Agency for Health Care Administration is responsible for administering Florida's Medicaid Program. AHCA contracts with managed care plans to provide services, including therapy services, to Medicaid recipients residing in the State of Florida. The managed care plans, in turn, provide prior authorization reviews for all requested goods and services.

Consistent with this arrangement, Petitioner submitted a request for therapy services to her managed care plan, United. United then reviewed this request to determine whether the specific services requested were ones covered by the plan and/or whether they were medically necessary to meet Petitioner's needs.

At hearing, the Petitioner was present, and acted as her own representative. Respondent was represented by Selwyn Gossett, Medical/Health Care Program Analyst, on behalf of AHCA. Respondent also presented two witnesses from United: Susan Frishman, Senior Compliance Analyst, and Eina Fishman, M.D., Chief Medical Officer.

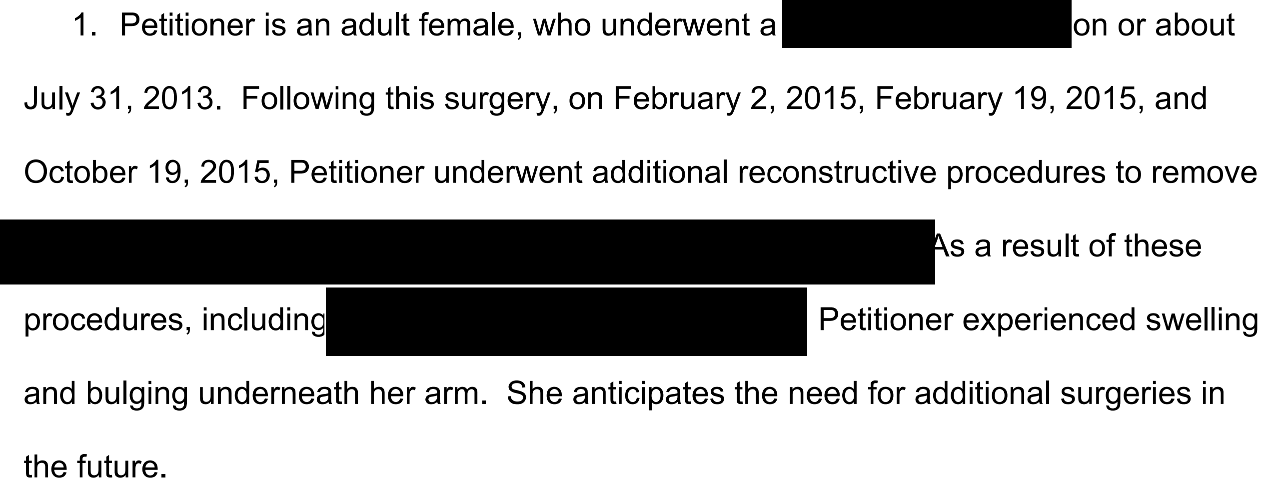
Petitioner's Exhibit 1 and Respondent's Exhibits 1 through 6, inclusive, were admitted into evidence. The record was held open for Respondent to supplement the record with additional documentation, and for Petitioner to file a written response after receiving and reviewing same; however, Respondent did not supplement the record by the assigned deadline.

An Interim Order was issued to secure the requested supplemental material. In response to said Order, on or about May 5, 2016, the Agency submitted a supplemental, 13-page evidence packet. This packet, along with its one-page cover

sheet (14 total pages), has been entered into evidence as Respondent's Composite Exhibit 7. No further correspondence from Petitioner was received.

FINDINGS OF FACT

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



1. Petitioner is an adult female, who underwent a on or about July 31, 2013. Following this surgery, on February 2, 2015, February 19, 2015, and October 19, 2015, Petitioner underwent additional reconstructive procedures to remove As a result of these procedures, including Petitioner experienced swelling and bulging underneath her arm. She anticipates the need for additional surgeries in the future.

2. At all times relevant to this proceeding, Petitioner has been eligible for and receiving Medicaid services, through United Healthcare.

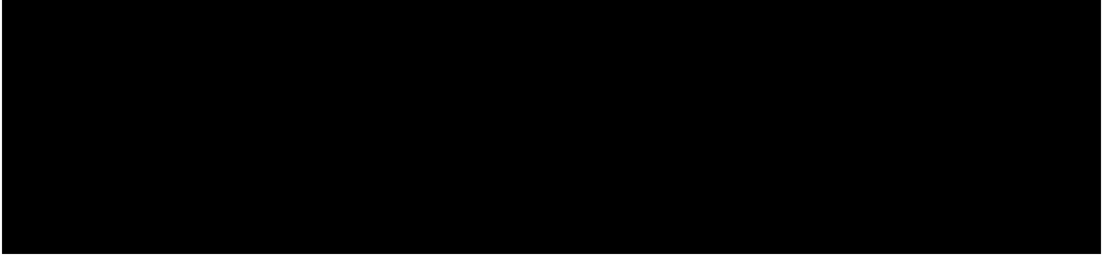
3. On or about February 9, 2016, Petitioner's treating physicians at the submitted to United a preauthorization request for " noting that Petitioner needed an appointment for scar massage and right-side range of motion exercises. Specifically, Petitioner's provider requested authorization for:

- 97001 (physical therapy evaluation)
- 97110 × 5 (therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and range of motion and flexibility)

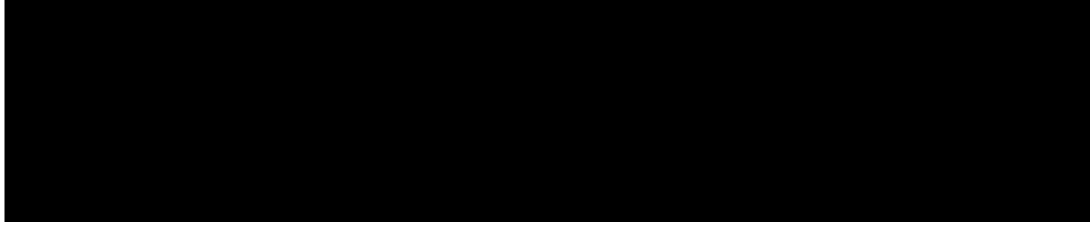
- 97140 × 5 (manual therapy techniques; e.g., mobilization/manipulation, manual lymphatic drainage, manual traction; 1 or more regions, each 15 minutes)
- 93702 × 5 (bio-impedance spectroscopy, extracellular fluid analysis for lymphedema assessments)
- 97535 × 5 (self-care/home management training; e.g., activities of daily living and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment; direct one-on-one contact, each 15 minutes)

4. Along with this request, Petitioner's physician provided clinical notes of Petitioner's office visits.

5. Following review of the request and all supporting documentation, United summarized its review within its own case file, noting:



6. Via letter dated February 11, 2016, United notified Petitioner of its decision to approve the physical therapy (PT) evaluation and five PT visits, but deny the remaining requested services. United explained, in pertinent part:



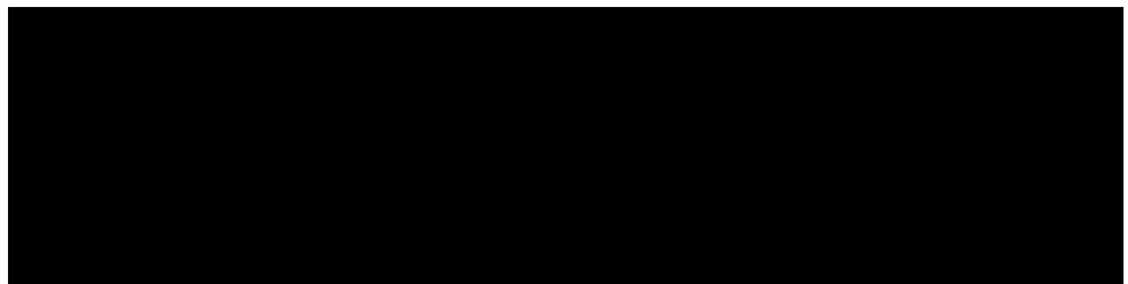
7. Also on February 11, 2016, United notified Petitioner's physician of its decision, stating:

> One visit for physical therapy evaluation and 5 visits for outpatient physical therapy (CPT code 97110) are authorized as medically necessary. These

> are APPROVED. CPT codes 97140, 93702, and 97353 x 5 visits each are not authorized as this code is not found in the Florida Medicaid Therapy Coverage Services and Limitations Handbook. This is a NONCOVERED BENEFIT.

8. On February 17, 2016, Petitioner filed a hearing request to challenge United's partial denial.

9. In support of her challenge, Petitioner submitted a letter from her physician, who noted, in pertinent part:



10. At hearing, Dr. Fishman (United) testified that, with regard to the denied services (97140, 93702, 97535), it was her medical opinion that components of these services, such as range of motion exercises and instruction on self-care, should be included within the scope of approved CPT code 97110, i.e., physical therapy. Dr. Fishman also conducted a medical necessity review of denied service 93702, and noted that this therapy does not have a clear and direct medical link to resolution of lymphedema.

11. Dr. Fishman opined that all components of PT could be completed within the timeframe authorized (5 sessions of 15 minutes each). As such, United did not authorize additional sessions of 97110 to offset the 15 sessions requested for the denied CPT codes, noting instead that if Petitioner wished to request more PT sessions, she was free to do so at any point.

12. United was not familiar with any alternate covered services which might meet Petitioner's needs, stating only that Petitioner's options were governed by the Medicaid Therapy and Outpatient Services Handbooks.

13. Following hearing, at the request of the undersigned, Respondent supplemented the record with a copy of pertinent portions of AHCA's MMA contract with United, specifications as to MMA required benefits, a copy of expanded/additional MMA benefits, therapy service fee schedules, and portions of the Therapy Services Coverage and Limitations Handbook as well as the Hospital Services Handbook, all of which have been considered in preparation of this Final Order.

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 120.80, Florida Statutes.

15. The Florida Medicaid program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. It is administered by AHCA.

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

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

18. Section 409.912, Florida Statutes, provides that AHCA shall purchase goods and services for Medicaid recipients in the most cost-effective manner possible, consistent with the delivery of quality medical care. To this end, the Agency has

contracted with managed care organizations to provide medical coverage to enrolled recipients. In the instant case, Petitioner's managed care plan is United.

19. The July 2012 Florida Medicaid Provider General Handbook ("Provider Handbook") is incorporated by reference into Fla. Admin. Code R. 59G-5.020. 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. <u>In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services</u> for this monthly Medicaid fee. <u>Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section</u>.
> (emphasis added)

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

21. All Medicaid covered services must be "medically necessary" as defined by law. 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.

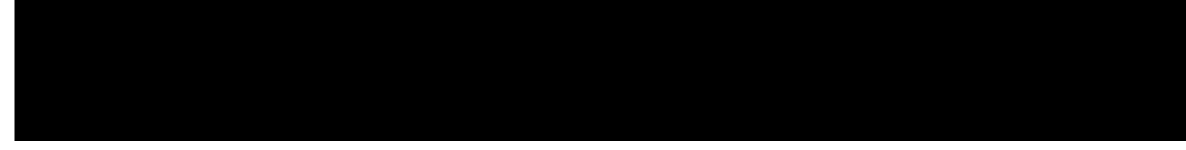
22. In order to aid determination of the medical necessity of specific goods and services, the Agency has formulated certain guidelines, which govern its reviews. These guidelines are “consistent with generally accepted professional medical standards… and [are] not experimental or investigational.”

23. As United’s own guidelines cannot be more restrictive than those that govern fee-for-service Medicaid, review of AHCA’s guidelines is appropriate to establish a baseline for service provision.

24. Prior to AHCA’s transition to managed care, only fee-for-service Medicaid recipients under the age of 21 were eligible to receive most PT services. Although largely limited to coverage for minors, the August 2013 Florida Medicaid Therapy Services Coverage and Limitations Handbook, (“Therapy Handbook”), incorporated by reference into Fla. Admin. Code 59G-4.320(2), includes a fee schedule of covered therapy services. Said fee schedule explicitly lists CPT codes 97001 and 97110 as covered services, but does not list the remainder of the services requested by Petitioner.

25. The December 2011 Florida Medicaid Hospital Services Coverage and Limitations Handbook (“Hospital Handbook”), promulgated by Fla. Admin. Code R. 59G-

4.160, at Appendix A, lists outpatient PT services for adults (including "other physical therapy"), noting that coverage is provided for:



26. Appendix A of the Hospital Handbook also lists "alternative therapy services," including massage therapy, which may be covered in specialized inpatient or outpatient units; however, CPT codes 97140, 93702, and 97535 are not included within the appendix.

27. In terms of expanded benefits -- i.e., those in addition to what is required under fee-for-service Medicaid -- AHCA's contact with United specifies, in part:

> The Managed Care Plan shall provide physical therapy services. Physical therapy (PT) is a specifically prescribed program to develop, improve or restore neuro-muscular or sensory-motor function, relieve pain, or control postural deviations to attain maximum performance. <u>PT services include evaluation and treatment of range-of motion, muscle strength, functional abilities and the use of adaptive and therapeutic equipment</u>. Examples are <u>rehabilitation through exercise, massage, the use of equipment and habilitation</u> through therapeutic activities.
> (*See* AHCA Contract, Exhibit II-A, section V.A.1.a. (27)(a), emphasis added.)

28. In keeping with both AHCA/managed care plan contractual agreements and the above-cited portions of the Provider Handbook, AHCA has also published a "List of Approved State Plan Expanded Benefits," formatted as a Microsoft Excel spreadsheet,

which is accessible via the Agency's website.[1] Under the "Therapies" tab of said spreadsheet, Pet, Art, and Activity Therapies (G0176) are included as covered benefits, and under the "Outpatient" tab, multiple expanded therapy coverage is noted. Again, however, there is no reference to coverage for codes 97140, 93702, or 97535.

29. Absent evidence that these codes/services are (or must be) offered by United, *and* absent any evidence to suggest that Petitioner's provider would recommend additional sessions of code 97110 (following evaluation under code 97001), in lieu of the non-covered benefits, the undersigned is unable to conclude that Respondent's partial denial was improper.

30. Petitioner has undergone lengthy medical intervention, endured several surgical procedures, and is clearly dedicated to pursuing a full recovery. Her fortitude is to be commended. Petitioner is strongly encouraged to continue working with her providers and with United, to request case management through United, as needed, and to continue seeking therapy options that best match her needs. United is encouraged to assist Petitioner in finding covered benefits and/or in requesting/obtaining a frequency of PT that is medically necessary. Should Petitioner wish to submit a new request for any service, she is free to do so at any time. If her request is denied, she will be notified in writing, and will retain the right to appeal that, specific denial.

DECISION

Based upon the foregoing, Respondent's denial is AFFIRMED, and Petitioner's appeal is hereby DENIED.

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[1] Said list is available at: http://portal.flmmis.com/FLPublic/Provider_ManagedCare/Provider_ManagedCare_Support/Provider_Expanded%20Benefits/tabId/138/Default.aspx (last accessed June 10, 2016).

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 17 day of June, 2016, in Tallahassee, Florida.

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

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

May 17, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01258

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT:
UNIT: AHCA

And
MOLINA HEALTHCARE OF FLOIRDA, INC.

RESPONDENTS.
_________________________________/

FINAL ORDER

Pursuant to notice, a telephonic administrative hearing was convened in this matter before the undersigned hearing officer on April 18, 2016 at 10:04 a.m. Eastern Standard Time.

APPEARANCES

For the Petitioner:

For the Respondent: Diane Soderlind,
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 Molina Healthcare of Florida, to deny Petitioner's request for an out-of-network, and out-of-state, consultation with Because the issue under appeal involves a request for services, Petitioner bears the burden of proof.

PRELIMINARY STATEMENT

Appearing as witnesses from Molina Healthcare of Florida were: Dr. Marc Bloom, Chief Medical Officer; Alice Quiros, Assistant Vice-President for Government Contracts; Bonnie Blitz, Director of Health Care Services; and Elvis Leva, Manager for Health Care Services. Margaret Kavandish and Tracy Alvarez appeared as observers from the Agency for Health Care Administration (AHCA).

Appearing as witnesses for the Petitioner were [redacted] his father; and [redacted]

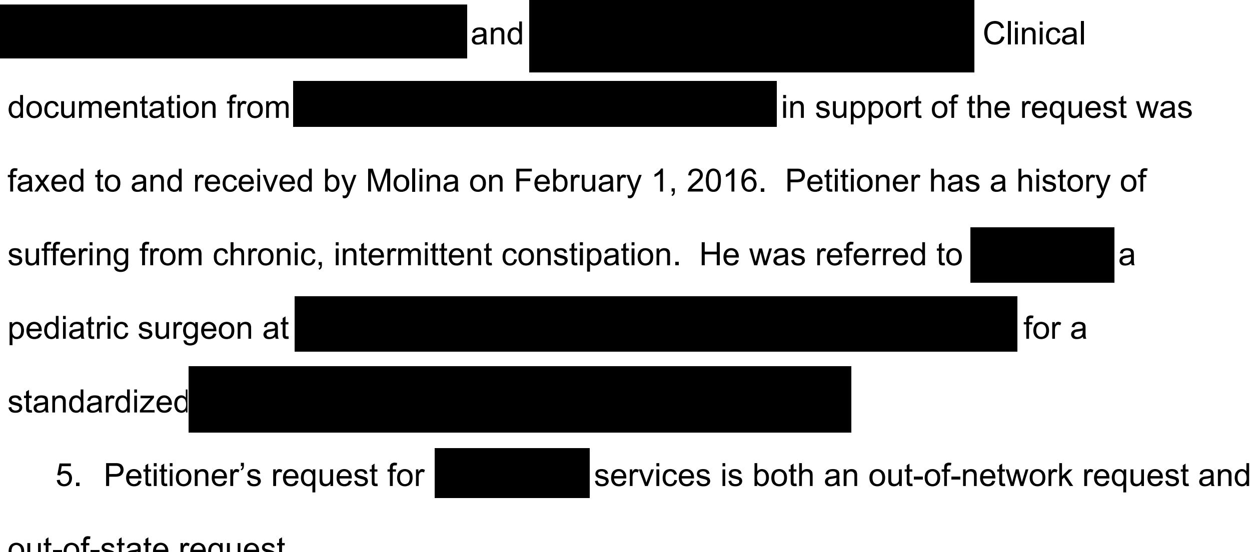
Respondent submitted four sets of documents, which were entered into evidence and marked Respondent Exhibits 1 to 4.

Administrative notice was taken of Florida Statutes 409.963, 409.965, 409.971, 409.972 and 409.973.

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 12 year-old male Medicaid recipient enrolled with Molina Healthcare of Florida (Molina), a Florida Health Managed Care provider. He is diagnosed with [redacted]
2. Molina requires prior authorization for services out-of-network.
3. Florida Medicaid requires prior authorization for out-of-state services.
4. On January 22, 2016, Molina received an authorization request from Petitioner's primary care physician, [redacted] for routine outpatient services with [redacted] Petitioner's diagnoses were



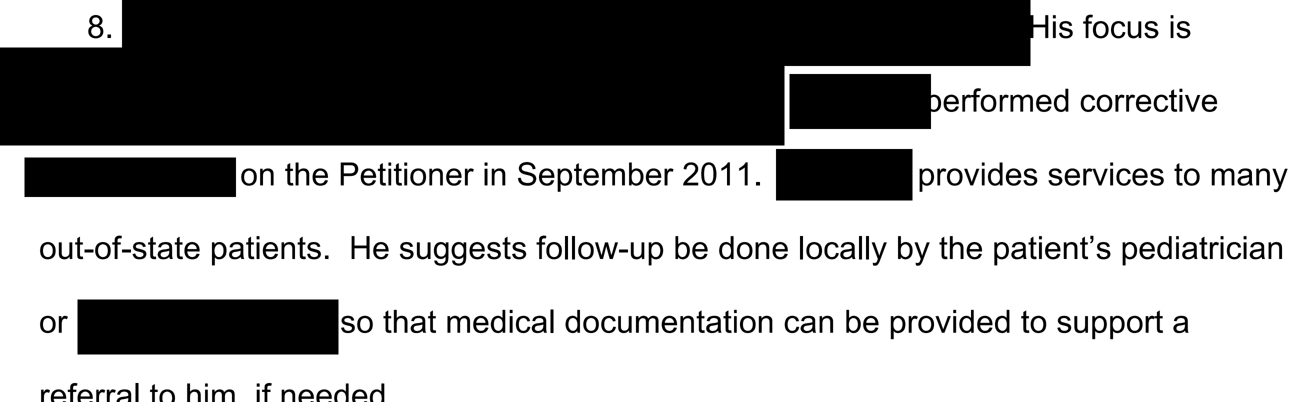
and Clinical documentation from in support of the request was faxed to and received by Molina on February 1, 2016. Petitioner has a history of suffering from chronic, intermittent constipation. He was referred to a pediatric surgeon at for a standardized

5. Petitioner's request for services is both an out-of-network request and out-of-state request.

6. On February 2, 2106, Molina denied the request and sent a Notice of Action to the Petitioner on February 4, 2016. The notice explains the basis for the denial:

> The asked for non-participating provider is not approved. Using standard and accepted rules a Molina Healthcare doctor has looked at this request. There are participating providers within the Molina Network that can treat your condition. Please call member services if you need the names of participating providers in your area….
>
> The facts that we used to make our decision are: Medical Records and clinical documentation submitted by your doctor and Criteria referenced use to make the determination Non-Participating provider and not listed in the Molina Provider Directory.

7. The Petitioner filed a timely request for a fair hearing on February 17, 2016.



8. His focus is erformed corrective on the Petitioner in September 2011. provides services to many out-of-state patients. He suggests follow-up be done locally by the patient's pediatrician or so that medical documentation can be provided to support a referral to him, if needed.

9. Petitioner had been doing better until this past year, when his got worse. Petitioner has missed 50 school days and has been pulled from class 48 times.

10. Petitioner's mother stated she has taken her son to many specialists, including in where they prescribed She stated this is a

Petitioner is considered an established patient of

11. Respondent's medical officer explained that Petitioner needs to go to a network If appropriate, the network then needs to provide documentation and an explanation as to why Petitioner would be referred to an out-of-network provider. Molina has not received any such documentation for the Petitioner.

CONCLUSIONS OF LAW

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

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

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

15. Florida Statutes 409.971 – 409.973 establishes the requirement for Medicaid recipients to be enrolled in the statewide managed medical assistance program and the minimum benefits the managed care plans shall cover.

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

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

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

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

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

19. The Florida Medicaid Provider General Handbook (Handbook) provides the following introductory comment about out-of-state services on 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 [emphasis added].
> ….
>
> 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** [emphasis added]. The physician must request and obtain prior authorization before the recipient receives out-of-state services.

20. The required documentation for out-of-state prior authorization is provided on page 2-36 of the Handbook:

> The out-of-state prior authorization request must include:

- A completed Out-of-State Prior Authorization Request Form, 2000-0016, filled out by the recipient's Florida Medicaid enrolled primary care or specialist physician;
- Documentation that justifies the medical necessity for the service, such as medical history, lab reports, etc.;
- 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;
- **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** [emphasis added];
- The Current Procedural Terminology (CPT) codes for the procedure(s) being requested;
- The name and address of the out-of-state provider;
- The name and telephone number of the out-of-state provider's contact person.

> The request will not be processed without the above information.

21. Because the Petitioner is under twenty-one-years-old, the requirements of Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT) must be considered. Florida Statute § 409.905, Mandatory Medicaid services, provides that Medicaid services for children must include:

> (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

22. The Petitioner's medical need for a s not disputed.

23. Petitioner is requesting who performed corrective surgery on him in 2011 and specializes in malformations and

24. Petitioner has not provided documentation that a has been seen.

25. Respondent states a referral to a non-network provider needs to be made by a network pediatric with documentation in support of the referral.

26. Florida Medicaid requires similar documentation to accompany a prior authorization for out-of-state services.

27. Petitioner has failed to meet his burden of proof that it is medically necessary that provide his medical services. Respondent has provided testimony that medical necessity for cannot be determined because no network pediatric has seen the Petitioner. A network provider who determines he/she

is not able to address the Petitioner's medical needs can refer the Petitioner to another network provider in Florida or a non-network provider along with the necessary documentation in support of the referral. Respondent's determination that medical necessity cannot be determined complies with the requirements of the EPSDT program.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 17 day of May, 2016,

in Tallahassee, Florida.

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

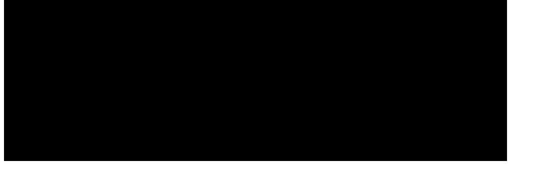
Copies Furnished To: [redacted] Petitioner
Marshall Wallace, Area 1, AHCA Field Office Manager

FILED

Jun 03, 2016

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 16F-01260

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT:
UNIT: AHCA

RESPONDENT.

________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on April 18, 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 Petitioner's request for reimbursement from his health plan for his out-of-pocket payments for physical therapy services. The Petitioner has the burden of proving his case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The Petitioner submitted documents for the hearing consisting of a list of his physical therapy payments and a note from his doctor, which were marked as Petitioner Exhibit 1.

Appearing as witnesses for the Respondent were Lourdes Gayo, Grievance and Appeals Director, and Dr. Francisco Hernandez, Medical Director, from Better Health, which is the Petitioner's managed health care plan.

Respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Exhibits: Exhibit 1 – Statement of Matters and Reimbursement Request; Exhibit 2 – Physical Therapy Notes; Exhibit 3 – Medical Director Review Form; Exhibit 4 – Denial Notice; and Exhibit 5 – Member Handbook provisions.

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. He receives services under the plan from Better Health.

2. The Petitioner stated he had wrist surgery in February, 2015 and had a cast on his wrist for three months. He needed physical therapy on his wrist beginning around June, 2015 after the cast was removed since his doctor wanted him to start therapy as soon as possible. He stated he attempted to get physical therapy services from his health plan (Better Health) but was told it was a covered service only for minors. He

thereafter paid out-of-pocket for 11 weeks of physical therapy (3 times weekly), paying a total of $1,100 for those services. He was subsequently approved for physical therapy through Better Health beginning around September of 2015. He is seeking reimbursement from Better Health for his out-of-pocket payments for physical therapy.

3. Respondent's witness, Ms. Gayo, stated Better Health denied the request for reimbursement because the Petitioner utilized a non-participating provider under the Better Health plan and that provider never submitted a prior authorization request to render services. She also stated Better Health subsequently approved physical therapy services through a participating plan provider.

CONCLUSIONS OF LAW

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

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

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

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

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

9. The undersigned concludes that the Petitioner has not demonstrated that Better Health should have approved his request for reimbursement of his physical therapy payments. Although the Petitioner may have needed for physical therapy to start as soon as possible and there may have been some miscommunication regarding whether Better Health covered physical therapy for adults, the Petitioner still needed to comply with the plan provisions concerning obtaining services from participating providers and the provider needed to submit a prior authorization request to Better Health. Since the services were rendered by a non-participating provider in the Better Health network of providers and that provider never submitted a prior authorization request, the undersigned cannot make a determination that Better Health had an obligation to reimburse the Petitioner for his payments to that provider.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this __03__ day of __June________, 2016,

in Tallahassee, Florida.

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

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

May 12, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01283

PETITIONER,

Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT:
UNIT: 02555

RESPONDENT.
___________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on April 5, 2016 at 10:15 a.m.

APPEARANCES

For the Petitioner:

For the Respondent: Susan Lee, supervisor.

STATEMENT OF ISSUE

The petitioner is appealing the denial of full Medicaid for her son and the enrollment in the Medically Needy Program with an estimated share of cost (SOC). She is seeking full Medicaid for her son. The petitioner carries the burden of proof appeal by the preponderance of evidence.

PRELIMINARY STATEMENT

The Department presented one exhibit which was entered into evidence and marked as Respondent's Composite Exhibit 1. The petitioner did not present any

exhibits at the hearing. The record was held open until April 15, 2016, for the petitioner to provide medical expenses for her son. No evidence was received by April 15, 2016. The record was closed on April 15, 2016.

FINDINGS OF FACT

1. On February 24, 2016, the petitioner submitted an application for Medicaid. The petitioner's household consists of herself (age 39) and her son (age 8). The petitioner is employed with the [redacted] and earns $1,519.23 biweekly. These amounts were verified by two checks provided by the petitioner. They were dated January 29, 2016 for $1,519.23 and February 12, 2016 for $1,519.23. Her son receives Social Security (SS) benefits as a child receiving from a parent (C1) of $1,083.

2. The respondent determined the petitioner's household income exceeded the income limit of $1,776, for full Medicaid benefits for a child eight years old. It proceed to enroll the petitioner's son in the Medically Needy Program with a SOC.

3. The respondent calculated the petitioner's Medically Needy SOC by adding her two paychecks resulting in her monthly gross income (her son's SS was excluded). The Medically Needy Income Limit of $387, for a household size of two was subtracted from the monthly gross income resulting to $2,651 as her SOC.

4. On February 18, 2016, the petitioner requested a hearing to challenge the Department's decision to deny full Medicaid benefits.

5. By notice dated February 26, 2016, the petitioner was informed that her son was eligible for the Medically Needy benefits.

6. The petitioner explained her son is very ill and needs multiple medical services. The petitioner has no other tax dependents other than her son.

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

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

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

> (a) *Basis.* This section implements section 1902(a) (10) (A) (ii) (XX) of the Act.
> (b) *Eligibility*—(1) *Criteria.* The agency may provide Medicaid to individuals who:
> (i) Are under age 65;
> (ii) Are not eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part;
> (iii) Are not otherwise eligible for and enrolled for optional coverage under a State's Medicaid State plan in accordance with section 1902(a)(10)(A)(ii)(I) through (XIX) of the Act and subpart C of this part, based on information available to the State from the application filed by or on behalf of the individual; and
> (iv) Have household income that exceeds 133 percent FPL but is at or below the income standard elected by the agency and approved in its Medicaid State plan, for the applicable family size.
> (2) *Limitations.* (i) A State may not, except as permitted under an approved phase-in plan adopted in accordance with paragraph (b)(3) of this section, provide Medicaid to higher income individuals described in paragraph (b)(1) of this section without providing Medicaid to lower income individuals described in such paragraph.
> (ii) The limitation on eligibility of parents and other caretaker relatives specified in § 435.119(c) of this section also applies to eligibility under this section.

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

> (a) (2) Effective January 1, 2014, the agency must apply the financial methodologies set forth in this section in determining the financial eligibility of all individuals for Medicaid, except for individuals identified in paragraph (j) of this section and as provided in paragraph (a)(3) of this section.
> (3) In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid coverage to begin on or before December 31, 2013, application of the financial methodologies set forth in this section will not be applied until March 31, 2014 or the next regularly-scheduled renewal of eligibility for such individual under §435.916 of this part, whichever is later.
> (b) *Definitions.* For purposes of this section—
> *Child* means a natural or biological, adopted or step child.
> *Code* means the Internal Revenue Code.
> *Family size* means the number of persons counted as members of an individual's household. In the case of determining the family size of a pregnant woman, the pregnant woman is counted as herself plus the number of children she is expected to deliver. In the case of determining the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted, at State option, as either 1 or 2 person(s) or as herself plus the number of children she is expected to deliver….
> (c) *Basic rule.* Except as specified in paragraph (i), (j), and (k) of this section, the agency must determine financial eligibility for Medicaid based on “household income” as defined in paragraph (d) of this section.
> (d) *Household income*—(1) *General rule.* Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household.
> (2) *Income of children and tax dependents.* (i) The MAGI-based income of an individual who is included in the household of his or her natural, adopted or step parent and is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined, is not included in household income whether or not the individual files a tax return.
> (ii) The MAGI-based income of a tax dependent described in paragraph (f)(2)(i) of this section who is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined is not included in the household income of the taxpayer whether or not such tax dependent files a tax return.

(3) In the case of individuals described in paragraph (f)(2)(i) of this section, household income may, at State option, also include actually available cash support, exceeding nominal amounts, provided by the person claiming such individual as a tax dependent.
(4) Effective January 1, 2014, in determining the eligibility of an individual using MAGI-based income, a state must subtract an amount equivalent to 5 percentage points of the Federal poverty level for the applicable family size only to determine the eligibility of an individual for medical assistance under the eligibility group with the highest income standard using MAGI-based methodologies in the applicable Title of the Act, but not to determine eligibility for a particular eligibility group.

11. The Policy Manual at passage 1830.0101 Income (MFAM) states:

…Taxable Unearned income is income for which there is no performance of work or services. Taxable unearned income may include:
1. Retirement, disability payments, unemployment/workers' compensation, etc.;
2. Annuities, pensions, and other regular payments;
3. Alimony and spousal support payments;
4. Dividends, interest, and royalties;
5. Prizes and awards;
6. Social Security and Social Security Disability Income.
Excluded income is income (earned or unearned) that is not counted when determining eligibility.

12. The Policy Manual at passage 2630.0108 Budget Computation (MFAM) states:

Financial eligibility for Family-Related Medicaid is determined using the household's Modified Adjusted Gross income (MAGI). The MAGI is the household's adjusted gross income as calculated by the Internal Revenue Service plus any foreign earned income and interest income exempt from tax.
In computing the assistance group's eligibility, the general formula is:
Step 1 - (Gross Unearned + Gross Earned) = (Total Gross Income).
Step 2 - Deduct any allowable income tax deductions (lines 23-35 from 1040). Deduct any allowable deductions for financial aid or self-employment to obtain the Modified Adjusted Gross Income.
Step 3 - Deduct the appropriate standard disregard. This will give the countable net income.
Step 4 - Compare the total countable net income to the coverage group's income standard.
If less than or equal to the income standard* for the program category, **STOP**, the individual is eligible. If greater than the income standard for the program category, continue to **Step 5.**

> **Step 5 -** Apply a MAGI deduction (5% of the FPL based on SFU size). If the 5% disregard would make the individual eligible, include the disregard. Otherwise the individual is ineligible for Medicaid. Individuals determined ineligible for Medicaid will be enrolled in Medically Needy and referred, as appropriate, to Florida Kid Care and/or the Federally Facilitated Marketplace (FFM).

13. The Policy Manual at Appendix A-7 indicates the Family-Related Medicaid Income Limit for a child age 8 through 18 in a household size of two as $1,776, the Medically Needy Income Limit (MNIL) as $387 and the MAGI Disregard as $67.

14. In accordance with the above controlling authorities, the undersigned calculated eligibility for Medicaid for the petitioner's son and did not find him eligible for full Medicaid as the modified adjusted gross income is more than the income limit of $1,776 for a child between ages six through eighteen and household of two. Step 1: The undersigned added the petitioner's pay January 29, 2016 of $1519.23, February 12, 2016 of $1519.23 and the son's SS of $1,083 to get the modified adjusted gross income of $4,121.46. Step 2: There are no deductions provided, as there was no tax return. Step: 3: The total income of $4,121.46 is the net income. Step 4: The total countable net income of $4,121.46 was compared with the income standard for two of $1,776. Step 5: Since it was greater than the income standard, the MAGI disregard of $67 was subtracted, resulting to $4,054.46.46. This was compared to the income limit of $1,776 for full Medicaid. The household's income was greater than the income limit for full Medicaid. The undersigned concludes the petitioner's son is ineligible for full Medicaid. The undersigned further concludes Medically Needy eligibility must be explored.

<u>The Medically Needy SOC will now be addressed</u>

15. Fla. Admin. Code R. 65A-1.701 (30) defines 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.”

16. The Policy Manual at passage 2630.0500, SOC (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.

17. Fla. Admin. Code R. 65A-1.702 addresses when eligibility of Medicaid and states in parts:

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

18. The Department’s Transmittal No. P-15-09-0009, dated September 18, 2015, addresses Medically Needy Budgeting for Family-Related Medicaid and states:

> **<u>SFU/Counting Income for Medically Needy</u>**
> Staff will continue to determine the Medicaid Standard Filing Unit (SFU) based on expected tax filing information as provided by the individual. If an assistance group (AG) is ineligible for full Medicaid coverage due to income, eligibility for Medically Needy coverage must be determined.
> A child with countable income must be excluded from the Family-Related Medically Needy AG if inclusion is not beneficial to the individual whose eligibility is being determined…

If the AG's countable income is less than or equal to the Medically Needy Income Limit (MNIL) for the remaining household size, open the AG for Medically Needy with a $0 share of cost.
If the AG's countable income is greater than the MNIL for the remaining household size, enroll the AG in Medically Needy with a share of cost as determined by the remaining countable income.
Note: Do not exclude a child(ren) with countable income from a full coverage Medicaid AG. This policy only applies to the Family-Related Medically Needy Program.

19. The above transmittal explains that the child's income is excluded in the Medically Needy budget.

20. The undersigned carefully reviewed the Department's determination of the son's SOC budget and did not find any errors with the calculation of the SOC. The Department used only the petitioner's income of $3,038.46 to determine the SOC. The MNIL of $387 was subtracted to get $2,651, resulting in the petitioner's son's SOC of $2,651.

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

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law the appeal is denied. The Department's action to deny full Medicaid and enrolled the petitioner's son in the Medically Needy Program is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay

the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 12 day of May, 2016,

in Tallahassee, Florida.

Christiana Gopaul Narine

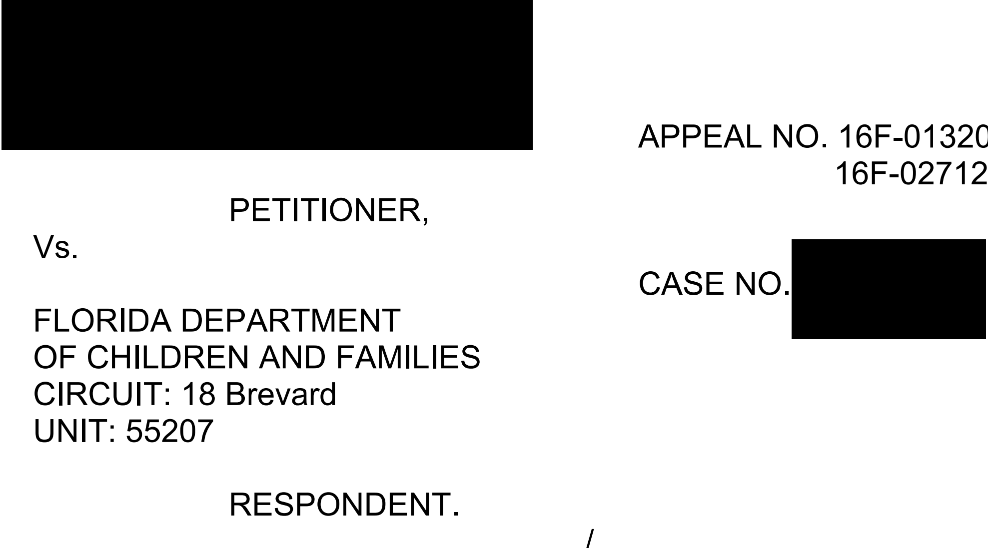
Christiana Gopaul-Narine
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

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

May 12, 2016

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 16F-01320
16F-02712

PETITIONER,
Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 Brevard
UNIT: 55207

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter, at 1:35 p.m. on April 6, 2016, at the Department of Children and Families in Cocoa, Florida. The hearing was telephonically reconvened on April 18, 2016, at 10:35 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: 1) terminate the petitioner's daughter's full Medicaid and instead approve Medicaid Medically Needy (MN) with a Share of Cost (SOC) and 2) terminate Medicaid MN for the petitioner is proper. The respondent carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

By notice dated December 22, 2015, the respondent (or the Department) notified the petitioner his daughter was approved for MN with a $275 SOC, effective February 2016. Also by notice dated January 20, 2016, the Department notified the petitioner his MN would end on January 31, 2016. Petitioner timely requested a hearing to challenge approval of MN for his daughter and termination of MN for himself.

[redacted] petitioner's wife, appeared as a witness for the petitioner. Petitioner did not submit exhibits. Respondent submitted nine exhibits, entered as Respondent's Exhibits "1" through "9". The record was closed on April 18, 2016.

FINDINGS OF FACT

1. Prior to the action under appeal, petitioner was enrolled in MN with a $561 SOC and petitioner's daughter received full Medicaid. Petitioner receives Medicare; the monthly Medicare premium is paid by the State.

2. On December 18, 2015, the petitioner submitted a redetermination application for Food Assistance and Medicaid for his household. Household members include the petitioner, his wife and daughter (age 19); all three members are in the same tax filing unit. The application indicates household income is petitioner's $761 Social Security Disability Income (SSDI). The application also indicates petitioner's daughter is not employed and attends school (school name not listed). Medicaid for the petitioner and his daughter are at issue.

3. Petitioner's daughter is no longer eligible for full Medicaid due to her age. The next available Program is MN with a SOC. The following is the Department's first SOC calculation for petitioner's daughter; based on the December 18, 2015 application:

$761	petitioner's SSDI
-$486	MN income limit (MNIL) for a household size of three
$275 SOC	

4. On December 22, 2015, the Department mailed petitioner a Notice of Case Action (NOCA), notifying petitioner's daughter was approved for MN with a $275 SOC. Petitioner was not approved for MN; instead, the Department requested the petitioner complete a Financial Release form.

5. On January 20, 2016, the Department mailed petitioner a NOCA notifying his MN would end on January 31, 2016, due to not receiving the required Financial Release form.

6. On January 22, 2016, the petitioner called the Department's Customer Call Center (CCC), regarding Medicaid for himself and his daughter. Petitioner also reported that his daughter is a full-time college student.

7. On February 5, 2016, the petitioner called the CCC regarding his FA; he also reported that his daughter is in a Work Study Program. The CCC generated a change report and requested the petitioner provide his daughter's employment verification.

8. On February 16, 2016, the petitioner called the CCC and requested a hearing. The CCC generated an add application to add FA and Medicaid.

9. Also on February 16, 2016, the petitioner faxed the Department a letter that states, "Please note that I do not wish to request a hearing at this time." Petitioner's hearing was cancelled.

10. On February 18, 2016, the Department received petitioner's signed Financial Release form.

11. The following is the Department's calculation of petitioner's SOC:

$761	SSDI
-$ 20	unearned disregard
-$180	MNIL for a household size of one
$561	SOC

12. On February 19, 2016, the Department mailed the petitioner a NOCA, notifying petitioner was approved for MN with a $561 SOC, effective February 2016.

13. On March 2, 2016, the petitioner contacted the Office of Appeal Hearings to rescind his February 16, 2016 hearing withdrawal. Petitioner's appeal was rescheduled.

14. On or about February 3, 2016, the Department received petitioner's daughter work study employment verification and calculated her income at $924 to arrive at $1,199 SOC.

15. On or about February 8, 2016, the Department received another work study employment verification for petitioner's daughter and calculated her income at $231 to arrive at $506 SOC.

16. In March 2016, the Department received verification that petitioner's daughter works 20 hours per week at $8.25 an hour. The following is the Department's final SOC calculation for petitioner's daughter:

$ 660	20 hours X $8.25 X 4weeks
+$ 761	petitioner's SSDI
$1,421	total income
-$ 486	MNIL for a household size of three
$ 935	SOC

17. On April 8, 2016, the Department mailed the petitioner a NOCA, notifying petitioner's daughter's SOC was $506 for February 2016 and $935 for March 2016.

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

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

20. Medicaid eligibility is based on Federal Regulations. There are two categories of Medicaid that the Department determines eligibility for: (1) Family-Related Medicaid for parents and children, and pregnant women, and (2) Adult-Related (referred to SSI-Related Medicaid) for disabled adults and adults 65 or older. Petitioner's daughter is considered under the Family-Related Medicaid and petitioner is considered under the SSI-Related Medicaid.

PETITIONER'S DAUGHTER'S FAMILY-RELATED MEDICAID

21. 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…
> (3) (b) Family size means the number of persons counted as members of an individual's household…
> (c) Basic rule. Except as specified in paragraph (i), (j), and (k) of this section, the agency must determine financial eligibility for Medicaid based on "household income" as defined in paragraph (d) of this section.
> (d) Household income—(1) General rule. Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the

> sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household.
> (f) Household…
> (2) Basic rule for individuals claimed as a tax dependent. In the case of an individual who expects to be claimed as a tax dependent by another taxpayer for the taxable year in which an initial determination or renewal of eligibility is being made, the household is the household of the taxpayer claiming such individual as a tax dependent…

22. The above Federal Regulation explains that the petitioner, his wife, their daughter and the household income are counted in petitioner's daughter's Medicaid eligibility.

23. 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…

24. Fla. Admin. Code R. 65A-1.716 Income and Resource Criteria explains:

> (2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows:

Family Size	Income Level
3	$303

25. The above authority explains for petitioner's daughter to be eligible for Family-Related Medicaid, the income for a household size of three cannot exceed $303 monthly. Petitioner's $761 unearned SSDI and petitioner's daughter's $660 earned income exceeds $303; therefore, petitioner's daughter is not eligible full Medicaid. The next available Program is MN with a SOC.

26. 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…

27. The above authority explains the SOC is determined by subtracting the income level (MNIL) from the gross income.

28. The Department's Program Policy Manual, CFOP 165-22, at Appendix A-7, sets forth the MNIL at $486 for a household size of three.

29. In accordance with the above authorities, the Department calculated petitioner's daughter's SOC by including petitioner's $761 unearned SSDI and petitioner's daughter's $660 earned income; to arrive at $1,421 and then subtracted $486 MNIL (for a household size of three) to arrive at a $935 SOC.

PETITIONER'S SSI-RELATED MEDICAID

30. 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.

31. Section 409.904, Fla. Stat., Optional payments for eligible persons in part states:

> (1) Subject to federal waiver approval, a person who is age 65 or older or is determined to be disabled, whose income is at or below 88 percent of the federal poverty level, whose assets do not exceed established limitations, and who is not eligible for Medicare or, if eligible for Medicare, is also eligible for and receiving Medicaid-covered institutional care services, hospice services, or home and community-based services. The agency shall seek federal authorization through a waiver to provide this coverage.

32. In accordance with the above authority petitioner is not eligible for full Medicaid because he is Medicare eligible and is not receiving "Medicaid-covered institutional care services, hospice services, or home and community-based services".

33. 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"…

34. The above authority explains MN provides coverage for individuals who do not qualify for full Medicaid due to income.

35. 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…"

36. The Fla. Admin. Code R. 65A-1.716 sets forth the MNIL at $180 for a family size of one.

37. In accordance with the authorities, the Department deducted $20 unearned income and $180 MNIL from petitioner's $761 SSDI to arrive at a $561 SOC.

HEARING OFFICER'S CONCLUSION

38. In careful review of the citied authorities and evidence, the undersigned concludes that the Department met its burden of proof. The undersigned agrees with the Department's action to: 1) enroll petitioner's daughter in the MN Program with a $935 SOC and 2) continue petitioner's enrollment in the MN Program with a $561 SOC.

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 12 day of May, 2016,

in Tallahassee, Florida.

Priscilla Peterson

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

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

May 12, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01332

PETITIONER,

Vs.

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

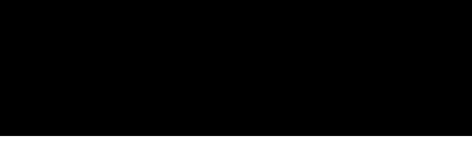
RESPONDENT.

________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing on April 6, 2016 at 9:09 a.m.

APPEARANCES

For the Petitioner: 

For the Respondent: Stephanie Lange
Register Nurse Specialist

STATEMENT OF ISSUE

Whether respondent's denial of a wearable defibrillator (Life Vest) 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

The hearing was scheduled by Hearing Officer Danielle Murray. The hearing requested was thereafter re-assigned to the undersigned.

Petitioner was not present for the proceeding. A written authorization appointing [redacted] as his representative was provided. Petitioner's exhibit "1" was entered into evidence.

Mr. Lang appeared both as a witness and representative for the respondent. Present from Amerigroup RealSolutions (Amerigroup) were: Carlene Brock, Quality Operations Nurse; Dr. Mary Jones, Medical Director; and Dr. Marisabel Bravo, Medical Director. Respondent's exhibit "1" was entered into evidence.

Administrative notice was taken of Florida Statute Chapter 409; Fla. Admin. Code Rules 59G-1.001; 1.010; 4.070; and the Florida Medical Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook (DME Handbook).

Petitioner's representative did not receive respondent's evidence packet. The representative, however, wished to proceed with the hearing. Respondent agreed to send the packet. The record was held open through April 15, 2016 for petitioner's representative to provide a written response to respondent's exhibit "1". The record was also held open through April 15, 2016 for the representative to provide additional guidelines regarding the use of a wearable defibrillator. 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 date of birth is April 8, 1955. As all times relevant to this proceeding, he was Medicaid eligible.

2. Petitioner's Medicaid services are provided through respondent's Statewide Medicaid Managed Care Program. Specifically, the Managed Medical Assistance (MMA) Program.

3. Since February 2, 2016, Amerigroup is the managed care entity responsible for petitioner's Medicaid services.

4. A LifeVest is one of two types of cardioverter defibrillators. An implantable cardioverter defibrillator (ICD) is surgically inserted into the recipient's chest. A Life Vest is worn outside the body. Each type provides continuous monitoring of heart rhythms. When necessary, each provides an electrical shock directly to the heart.

5. In the Florida Medical Program, a Life Vest is considered to be durable medical equipment.

6. On December 6, 2015 petitioner experienced chest pain and went to a local emergency room. He was admitted into the hospital's cardiac intensive care unit.

7.

8. An EF of 50% to 70% is considered to be normal.

9.

10. A Life Vest is often used as a bridge to see if heart function improves in response to medication therapy and other medical procedures. If sufficient improvement occurs, an ICD would not be needed. During this evaluation period, the Life Vest is an added precaution.

11. After surgery and medication treatment,

12. On or about December 17, 2015 petitioner received a Life Vest.

13. At time of hearing, petitioner was awaiting implantation of an ICD.

14. On February 4, 2016 a request was made to Amerigroup for a Life Vest. The Life Vest would be rented on a monthly basis.

15. Dr. Bravo then reviewed all received medical information. Dr. Bravo also considered Amerigroup's internal policy for wearable cardioverter defibrillators. A wearable defibrillator is medically necessary when the following criteria has been satisfied:

> 1. Individuals must meet the medical necessity criteria for an ICD;
>
> AND
>
> 2. Individuals must have ONE of the following documented medical contraindications to ICD implantation:
>
> a. Those awaiting a heart transplantation – on waiting list and meet medical necessity criteria for heart transplantation, or
> b. Those with a previously implanted ICD that requires explantation due to infection with waiting period before ICD reinsertion; or
> c. Those with an infectious process or other <u>temporary condition</u> that precludes initial implantation of an ICD.
> …
>
> The wearable cardioverter defibrillator (WDC) is considered investigational and not medically necessary for all other indications …

16. On February 12, 2016 Amerigroup issued a Notice of Action which denied a Life Vest. The notice stated the Life Vest was not medically necessary. The notice also contained, in part, the following narrative:

> The facts that we used to make our decision are: We cannot cover the vest your doctor ordered to shock your heart if needed (wearable defibrillator). This would happen if your heart did not beat right. We know you have a weak heart. We do not know if you are on medicine for this. We do not know if you are on a heart transplant list. We do not know why your doctor cannot put in a machine under your skin to do the same thing (implantable cardioverter defibrillator (ICD) …

17. On February 19, 2016 petitioner's representative contacted the Office of Appeal Hearings and timely requested a fair hearing.

18. Petitioner's argues the Life Vest is needed to prevent sudden cardiac death. The device is recommended by the American Heart Association and the Centers for Medicare and Medicaid Services (CMS).

19. Ms. Sambuco's educational background is in English writing.

20. Dr. Bravo is a physician who is board certified in internal medicine.

CONCLUSIONS OF LAW

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

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

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

24. Section 409.973, Fla. Stat. addresses the minimum benefits provided under Medicaid managed care plans and states, in part:

> (1) MINIMUM BENEFITS. – Managed care plans shall cover, at a minimum, the following services:
> (p) Medical supplies …

25. Fla. Admin. Code R. 59G-1010(163) defines medical supplies as "medical or surgical items that are consumable, expendable, disposable or non-durable and that are used for treatment or diagnosis of a patient's specific illness, injury, or condition…"

26. It is noted petitioner became eligible for the MMA Program in February 2016. It is not clear who may be responsible for the Life Vest rental prior to that date.

27. The Findings of Fact establish a Life Vest is consider to be durable medical equipment. As such, respondents Durable Medical Equipment/Medical Supply Services Coverage and Limitations Handbook (DME Handbook) is relevant to this proceeding.

28. The DME Handbook has been promulgated into rule by Fla. Admin. Code R. 59G-4.070.

29. The DME Handbook requires medical supplies provided to a Medicaid recipient be medically necessary.

30. 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.

31. Petitioner's artery bypass graft surgery is noted. Also noted, is the low EF both before and after the surgical procedure.

32. Florida Administrative Code Rule 59G-1.010(166) (a) 3 permits the Medicaid Program to establish medical standards.

33. Based on the guidelines used in this matter, the undersigned was unable to make a Finding of Fact that petitioner that petitioner satisfied any of the following criteria:

- Is awaiting a heart transplant
- Was previously implanted with an ICD
- A documented medical reason which prevented initial implantation of an ICD

34. The record was held open to allow petitioner to provide documentary evidence regarding guidelines which contradict those provided by the respondent. A response, however, was not received.

35. After weighing both testimony and evidence, the undersigned assigns more weight to respondent's position.

36. Petitioner has not established, in a preponderant manner, that respondent's action in this matter was improper. The greater weight of evidence does not establish the following conditions of medical necessity have been satisfied:

> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this __12__ day of __May__________, 2016,

in Tallahassee, Florida.

Frank Houston

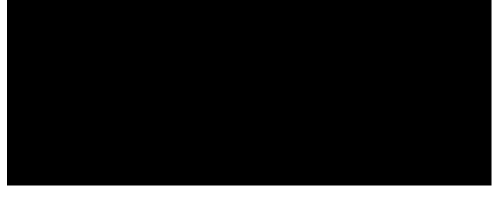
Frank Houston
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] PETITIONER
DON FULLER, AREA 6, AHCA FIELD OFFICE MANAGER
[redacted]

May 19, 2016

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 16F-01337

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 April 6, 2016 at 8:52 a.m.

APPEARANCES

For the Petitioner:

For the Respondent: Fatima Leyva,
Senior Human Services Program Specialist,
Agency for Health Care Administration

STATEMENT OF ISSUE

The Petitioner is appealing the Agency for Health Care Administration's (AHCA) decision, through DentaQuest, to deny Petitioner's request for dental procedures D7240-removal of impacted tooth, completely bony for tooth 1 and 16; D7230-removal of impacted tooth, partially bony for tooth 17 and 32; D9220-deep sedation/general anesthesia, first 30 minutes; D9221-deep sedation/general anesthesia, each additional

15 minutes; and D9999-unspecified adjunctive procedure by report. Because the issue under appeal involves a request for services, Petitioner bears the burden of proof.

PRELIMINARY STATEMENT

Appearing as Respondent's witness from Humana Healthcare (Humana) was Mindy Aikman, Grievance and Appeals Specialist. Appearing as Respondent's witnesses from DentaQuest were Dr. Frank Manteiga, Dental Consultant and Jackelyn Salcedo, Complaints and Grievance Specialist.

Respondent submitted a 20-page document which was entered into evidence and marked Respondent Exhibit 1. Petitioner submitted a 12-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 17 year-old female 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 sent a prior authorization request for dental procedures: D7240-removal of impacted tooth, completely bony for tooth 1 and 16; D7230-removal of impacted tooth, partially bony for tooth 17 and 32; D9220-deep sedation/general anesthesia, first 30 minutes; D9221-deep sedation/general anesthesia, each additional 15 minutes; and D9999-unspecified adjunctive procedure by report. DentaQuest received this request on October 23, 2015.

4. On October 27, 2015, DentaQuest made its determination denying all the requested dental procedures. On December 11, 2015, a Notice of Action was sent to the provider providing the denial reasons:

PROCEDURE	DENIAL REASON
D7240-removal of impacted tooth, completely bony-tooth 16	There is no sign of infection or other medical reason for tooth removal.
D7240-removal of impacted tooth, completely bony-tooth 1	There is no sign of infection or other medical reason for tooth removal.
D7230-removal of impacted tooth, partially bony-tooth 17	There is no sign of infection or other medical reason for tooth removal.
D7230-removal of impacted tooth, partially bony-tooth 32	There is no sign of infection or other medical reason for tooth removal.
D9220-deep sedation/general anesthesia, first 30 minutes	Anesthetic services are only covered when the associated services are approved.
D9221-deep sedation/general anesthesia, each additional 15 minutes (2 requests)	Anesthetic services are only covered when the associated services are approved.
D9999-unspecified adjunctive procedure, by report.	Please resubmit with a narrative describing

5. The Petitioner filed a timely request for a fair hearing on February 19, 2016.

6. Respondent conducted a second review prior to this hearing. The review was done by a second dental director who did not have updated information submitted by the Petitioner.

7. Petitioner's mother explained the primary pediatric dentist observed one of Petitioner's wisdom teeth erupting sideways and that her mouth was developing pockets and cavities in her wisdom teeth. Petitioner was referred to an oral surgeon who noted she was developing pericoronitis creating gum disease and swelling. Petitioner has difficulty effectively brushing her teeth. Because the Petitioner was experiencing pain

wearing her retainers, she returned to the orthodontist who did her braces. The orthodontist adjusted the retainers to accommodate the shifting caused by the erupting wisdom teeth. Petitioner expressed concern that past correction of her teeth alignments with braces and current use of retainers, will be undone if she has to keep her wisdom teeth. Petitioner alleges all three of her dental professionals (dentist, oral surgeon and orthodontist) have recommended her wisdom teeth be removed.

8. Petitioner also feels extraction of the wisdom teeth will prevent future dental problems and other health concerns. Petitioner included a Washington Post article that states in relevant part:

> Young adults who keep their wisdom teeth often quickly develop gum disease, which appears to increase the risk of pregnancy complications and possibly other health problems…
>
> The research…should prompt more dentists and patients to closely monitor the extra molars - consider removing them - even if they are not impacted or causing obvious problems, experts said.

(See page 6 of Petitioner Exhibit 1.)

9. Respondent’s dental consultant witness is the third reviewer of Petitioner’s request. He explained that extraction of third molars (wisdom teeth) are reviewed for one of three conditions: infection, any type of pathology, or bad positioning. He noted that three of the teeth have no infection, pathology, or bad positioning. For these teeth, there is no medical necessity for removal. However, with the new information that tooth 1 is laying on its side, the dental consultant approved removal of the tooth. In response to Petitioner’s concern about pericoronitis, the dental consultant explained this is a slight inflammation of the tissues toward the back of the lower molars. There is no gum disease or bone loss but if the extra tissue is left a long time (years) it can lead to

disease. Sometimes the tissue is removed and this can be done when the dentist addresses Petitioner's cavities.

10. The dental consultant explained that there is sufficient space for the wisdom teeth to erupt through the gums. He noted that teeth are always pushing forward to the midline, putting pressure on the teeth to shift. In his practice, the dental consultant recommends to his patients to have a permanent retainer put in the mouth from canine to canine which will eliminate crowding and shifting of the anterior teeth after braces are done.

CONCLUSIONS OF LAW

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

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

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

14. 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.

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

16. 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:
>
> 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.

18. 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 and describes the purpose of the program on page 1-1:

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

19. On page 2-26 of the Handbook, Preventive Services are described:

> For eligible recipients under the age of 21, preventive services, including oral prophylaxis, topical fluoride application, oral hygiene instruction, sealants, and space maintainers, are reimbursable services.

20. Because the Petitioner is under twenty-one-years-old, the requirements of Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT) must be considered. Florida Statute § 409.905, Mandatory Medicaid services, provides that Medicaid services for children must include:

> (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be **medically necessary** for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations [emphasis added].

21. The Petitioner indicated that three dental professionals recommended her wisdom teeth 1, 16, 17 and 31 be removed due to their observation that there is insufficient space for the teeth to erupt. No dental professional or medical expert, on behalf of Petitioner, appeared at the hearing.

22. Respondent has had three dental consultants from the Agency review Petitioner's request for removal of her four wisdom teeth. The dental consultant witness has authorized the extraction of tooth 1 because the new information from the Petitioner

shows it is lying on its side. The dental consultant witness, however, upholds the two previous denials because he has reviewed the x-rays and determined there is sufficient space for the wisdom teeth to erupt. The undersigned finds this medical expert testimony fully credible and sufficient weight is being given to it.

23. The evidence shows three of Petitioner's teeth have no infection, pathology, or bad positioning. For these teeth, there is no medical necessity for removal.

24. Petitioner expressed concerns that past correction of her teeth alignments with braces and current use of retainers will be undone if she has to keep her wisdom teeth. However, the above cited authority makes clear Medicaid services cannot be furnished in a manner primarily for the convenience of the recipient or in excess of one's needs. Furthermore, the Agency dental consultant opined, once braces are done, a permanent retainer put in the mouth from canine to canine will eliminate crowding and shifting of the anterior teeth. Petitioner should explore such an option with her provider.

25. Respondent has provided medical testimony that the extraction of tooth 16, 17 and 32 is not medically necessary, but has approved extraction of tooth 1.

26. Respondent's determination complies with the EPSDT requirement that medical necessity must be assessed. In view of the above, Petitioner has failed to meet her burden of proof that the extraction of tooth 16, 17, and 32 is medically necessary.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED IN PART as it relates to extraction of tooth 16, 17, and 32 and GRANTED in part as it relates to extraction of tooth 1.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this __19__ day of __May__, 2016,

in Tallahassee, Florida.

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

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

Jun 06, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01368

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 19 Martin
UNIT: AHCA

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in West Palm Beach, Florida on April 14, 2016 at 9:03 a.m. The parties reconvened by telephone on May 20, 2016 at 9:03 a.m.

APPEARANCES

For the Petitioner:

For the Respondent: Linda Latson, R.N.
Fair Hearing Coordinator

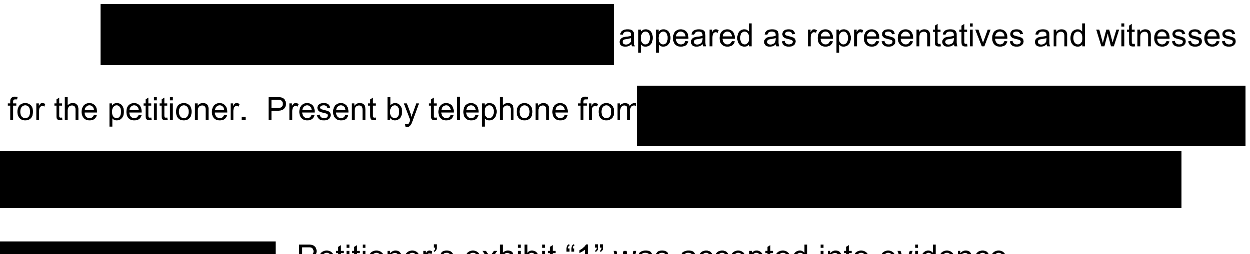
Marielisa Amador
Medical/Healthcare Program Analyst

STATEMENT OF ISSUE

Whether respondent's denial of petitioner's request for inpatient hospitalization services was proper. The burden of proof was assigned to the petitioner. The standard of proof in an administrative hearing is by a preponderance of the evidence.

PRELIMINARY STATEMENT

A telephonic hearing was first scheduled for March 30, 2016. On March 2, 2016, petitioner requested a face to face hearing. The matter was rescheduled for April 14, 2016.



appeared as representatives and witnesses for the petitioner. Present by telephone from

Petitioner's exhibit "1" was accepted into evidence.

Ms. Latson appeared as both a representative and witness for the respondent. Present by telephone from Sunshine Health was Tracy Thomas, Appeals Coordinator II. Present from Cenpatico were Toby Pina, Clinical Director; Dr. William Homes, Medical Director for Child Welfare, and Dr. Narendra Patel, Medical Director. Respondent's exhibit "1" was accepted into evidence.

The record was held open through April 21, 2016 for respondent to provide medical necessity criteria as outlined by Florida Admin Code R. 59G-1.010 (166) and a position memorandum regarding Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). Information was timely received and entered as respondent's exhibit "2".

The record was held open through April 28, 2016 to allow respondent to respond to four letters found in Petitioner's Exhibit "1" and to provide a list of appropriate treatment facilities in the state of Florida. A response was not received.

Petitioner's representatives wished to respond to post-hearing submission during a reconvened telephonic hearing. The parties reconvened on May 20, 2016. Mr. and

were present for the petitioner. Respondent was represented by Marielisa Amador. Present from Sunshine Health were Tracy Thomas and Kizzy Alleyene, Paralegal. Present from Cenpatico were Toby Pina and Dr. Patel.

The record was held open through May 27, 2016 for respondent to provide a written list of residential treatment programs in Florida. Although named during the reconvened hearing, a written 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 October 20, 2004. He was Medicaid eligible at all times relevant to this proceeding.

2. Petitioner is enrolled in respondent's Statewide Medicaid Managed Care Program. Services are provided by Sunshine Health.

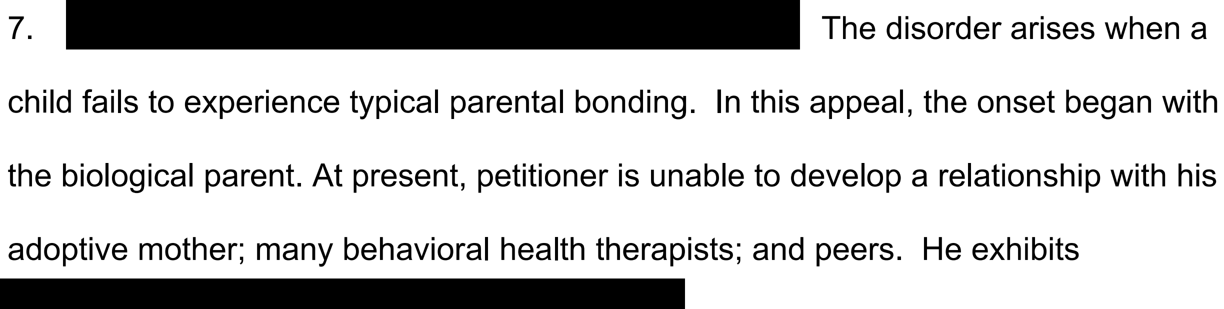
3. Sunshine Health contracts with Cenpatico to review requests for psychiatric residential treatment programs.

4. Due to severe neglect and abuse, petitioner and his twin sister were removed from their biological parent. Neglect included a lack of parental nurturing. Physical abuse included a broken nose at three years of age.

5. Petitioner experienced three foster care placements. He was eventually placed with who, thereafter, adopted both the petitioner and his sister.

6. Petitioner's diagnoses include: and

7. The disorder arises when a child fails to experience typical parental bonding. In this appeal, the onset began with the biological parent. At present, petitioner is unable to develop a relationship with his adoptive mother; many behavioral health therapists; and peers. He exhibits



8. A limited number of community based mental health professionals are trained in the appropriate treatment protocols for children with

9. A limited number of residential treatment programs have programs focused on treatment of individuals diagnosed with

10. Community-based treatment for started in October 2012. Treatment consisted of weekly/biweekly therapy sessions with petitioner and his mother. The therapist specialized in treatment of Significant progress did not occur.

11. Due to the unique nature of in January 2016, petitioner's parents enrolled him at and is not part of Sunshine Health's provider network.

12. is a residential program that specializes in the treatment of . In addition to treatment, provides an academic program.

13. Petitioner's parents have assumed financial responsibility for payment of services rendered by

14. Treatment at consists of weekly therapist-led group; individual; and family therapy. Additionally, petitioner participates in a weekly psycho-educational group. He also receives canine, milieu, and recreational therapies.

15. Petitioner's treatment plan addresses the following:

-
-
-
-
-
-

16. On or about February 15, 2016 Cenpatico received a prior authorization request for inpatient services at The submission included a “Single Case Agreement for Behavioral Health Services” at

17. In certain situations, Cenpatico will negotiate a single case agreement with an out-of-network residential program provider.

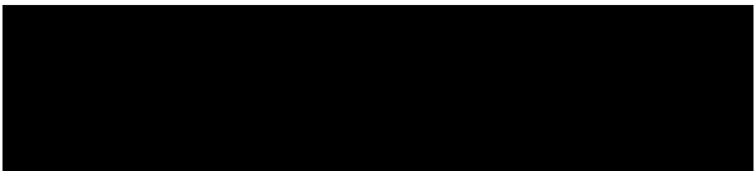
18. On February 16, 2016, a Notice of Action from Sunshine Health and Cenpatico was issued. Inpatient services were denied. The reason is recorded as not being medically necessary. The specific medical necessity criteria not satisfied, however, was not identified. The notice stated, in part:

> Based on the clinical information provided, Dalton no longer meets the criteria for this level of care. At the time of the review, Dalton shows no signs of being a threat to himself or others. There are no signs of suicidal or homicidal thoughts with plan or intent. Dalton’s behavior is not aggressive or threatening and is compliant with his medications. There are no reported hallucinations. It appears that Dalton can be safely treated at a lower level of care for any remaining symptoms related to his diagnosis of Reactive Attachment Disorder and Attention Hyperactivity Disorder.

19. The above notice also identified the use of InterQual Behavior Health Criteria. The decision was made by a licensed psychiatrist.

20. On February 20, 2016 the Office of Appeal Hearings timely received petitioner’s request for a fair hearing.

21. At the reconvened hearing, Cenpatico provided the following community-based programs:



22. No documentary evidence was submitted that the above community-based treatment centers have therapist(s) familiar with treatment.

23. Respondent does not dispute treatment is medically necessary. Petitioner's treatment, however, should be community-based.

24. Petitioner argues community based treatment with a specialist was not successful. A residential program which specializes in treatment offers the best chance of success. In support of this position, letters from various medical professionals were provided. Specifically, a letter dated December 15, 2015 from stated, in part:

CONCLUSIONS OF LAW

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

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

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

28. Services covered under Medicaid must be "medically necessary". The definition is found in Fla. Admin. Code R. 59G-1.010 and states:

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

29. As the petitioner is under 21 years of age, Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements apply to the evaluation of his eligibility for inpatient services. Section 409.905, Fla. Stat., *Mandatory Medicaid services*, defines Medicaid services for children to include:

> (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems …

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…
> …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.

31. Regarding inpatient hospitalization for psychiatric/mental health treatment, Fla. Admin. Code 65A 1-702 states:

> (16) Statewide Inpatient Psychiatric Program (SIPP) waiver. This program provides inpatient mental health treatment and comprehensive case management planning to enable discharge to less restrictive settings in the community for children under the age of 18 who are placed in an inpatient psychiatric program …

32. Inpatient psychiatric services are a covered service under the Florida Medicaid Program for individuals under the age of 18. The Findings of Fact establish petitioner is under the age of 18. Analysis, therefore, focuses on whether the request for inpatient services satisfies medical necessity criteria.

33. Florida Administrative Code Rule 59G-4.120 promulgates the Florida Medicaid Statewide Inpatient Psychiatric Coverage Policy, (SIPP Policy) December 2015. The policy contains general and specific criteria regarding inpatient services. The general criteria are the minimum standards for coverage under a managed care plan. While the majority of the 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. The Findings of Fact establish petitioner is enrolled in respondent's Statewide Medicaid Managed Care Program

34. The SIPP Policy states, in relevant part:

> **1.0 Introduction**
>
> **1.1 Description**
> Florida Medicaid's Statewide Inpatient Psychiatric Program (SIPP) services provide extended residential psychiatric treatment, with the goal of facilitating successful return to treatment in a community-based setting.
>
> **1.1.2 Statewide Medicaid Managed Care Plans**
> This Florida Medicaid policy provides the minimum requirements for all providers of SIPP services. This includes providers who contract with Florida Medicaid managed care plans (i.e., provider service networks and health maintenance organizations). Providers must comply with the coverage requirements outlined in this policy, unless otherwise specified in the Agency for Health Care Administration's (AHCA) contract with the Medicaid managed care plan. The provision of services to recipients in a Medicaid managed care plan must not be subject to more stringent coverage than specified in Florida Medicaid policies.
>
> **2.2 Who Can Receive**
> 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

Some services may be subject to additional coverage criteria as specified in section 4.0.

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid reimburses services that:

• Are determined medically necessary.
• Do not duplicate another provider's service.
• Meet the criteria as specified in this policy.

4.2 Specific Criteria

4.2.1 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.

35. Regarding admission for inpatient treatment, Florida Admin. Code R. 65E-9.008

(4) states:

(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.

36. The definitions of "emotional disturbance" referenced in the above Rule are found in Fla. Stat. § 394.492 and state:

> (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 behaviors are not considered to be a temporary response to a stressful situation.

37. Petitioner's psychiatrist, [redacted] treated petitioner for approximately two years and identified two diagnostic categories. Community-based treatment for [redacted] was utilized. [redacted] assement identified a lack of progress with this type of treatment. As such, inpatient treatment at an appropriate facility was recommended.

38. Neither evidence nor testimony established petitioner is experiencing a "temporary response to a stressful situation."

39. The greater weight of evidence establishes petitioner's behaviors have, at a minimum, substantially impacted his ability to function within his family.

40. No challenge to [redacted] credentials was presented.

41. Inpatient psychiatric services are inherently more restrictive than outpatient treatment. The Findings of Fact establish, however, community-based treatment was not productive. As such, the likely success of community-based treatment is, at this time, suspect.

42. Due to the unique nature of petitioner's diagnosis, the greater weight of evidence establishes appropriate treatment is needed to prevent further progression of RAD. Petitioner's current Inpatient treatment is individualized. The greater weight of evidence does not establish inpatient services are in excess of the petitioner's need nor is the treatment either experimental or investigational.

43. The greater weight of evidence establishes the only alternative is community based therapy. Such has proven ineffective.

44. Neither evidence or testimony has established that inpatient services are for parental convenience.

45. The level of proof in an administrative hearing does not rise to either "clear or convincing" or "beyond a reasonable doubt" evidentiary standards. A preponderance of the evidence requires, when considering the totality of evidence, one party's position is more likely to be true than not true.

46. When considering EPSDT; medical necessity; and applicable authorities, the undersigned concludes petitioner has met the required evidentiary burden. The greater weight of evidence establishes inpatient psychiatric treatment is, at this time, medically necessary. This type of treatment can reasonably be expected to addresses relevant diagnoses.

47. The issue before the undersigned is not who must provide inpatient services.

The issue focuses on whether inpatient psychiatric treatment is medically necessary.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 06 day of June, 2016,

in Tallahassee, Florida.

Frank Houston

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

Copies Furnished To: [redacted], PETITIONER
JUDY JACOBS, AREA 7, AHCA FIELD OFFICE

May 16, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01394

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 April 4, 2016, at 8:30 a.m.

APPEARANCES

For the Petitioner:

For the Respondent: Dianna Chirino, Senior Program Specialist

STATEMENT OF ISSUE

At issue is the Agency action partially denying the Petitioner's request for additional home health services (homemaker services 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 did not submit any documents as evidence for the hearing. Letters concerning the Petitioner's daughter's medical limitations were already included in the Respondent's evidence packet.

Appearing as witnesses for the Respondent were Dr. David Gilchrist, Medical Director, Paula Daley, Grievance and Appeals Manager, Glenny Trejos, Case Manager, and Cynthia Morisaki, Supervisor, from Sunshine Health Plans, 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 – Fair Hearing Summary; Exhibit 2 – Notice of Action (personal care); Exhibit 3 – Notice of Action (homemaker); Exhibit 4 – Medical Assessment; Exhibit 5 – Plan of Care; Exhibit 6 – LTC Criteria; and Exhibit 7 – Medical Letters (regarding daughter).

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

FINDINGS OF FACT

1. The Petitioner is eighty-two (82) years of age and lives with her daughter and her daughter's husband. She suffers from [redacted] She fractured both her hips in 2013 and cannot walk. She weighs 200 pounds and needs more than one person to handle her. She also utilizes an electric lift.

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 Sunshine Health Plans.

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

4. The Petitioner currently receives a total of twenty-eight (28) hours weekly of home health services through Sunshine, which is allocated as follows: twenty-one (21) hours weekly of personal care assistance and seven (7) hours weekly of homemaker services. The home health aide comes to the home at 10:00 a.m., stays for about 2 hours, and bathes the Petitioner. She returns at 9:00 p.m. for about an hour. The homemaker aide helps with things such as cleaning her room and washing clothes. The Petitioner also receives eight (8) hours weekly of respite care.

5. On or about January 22, 2016, the Petitioner made a request to Sunshine for 14 additional hours of personal care services weekly and 7 additional hours of homemaker services weekly. On February 5, 2016, Sunshine sent a letter to Petitioner denying her request for the additional personal care services as not being medically necessary. Also on February 5, 2016, Sunshine sent a separate letter to the Petitioner advising her that the request for additional homemaker services was partially approved

– an additional 4 hours weekly were approved, rather than the 7 additional hours requested by the Petitioner.

6. Petitioner's daughter stated her mother should be approved for the additional hours because she needs total assistance throughout the day with all her activities of daily living. The daughter also stated she has her own health problems such as [redacted] and [redacted] which prevent her from lifting, pushing, or pulling more than 5 pounds. She stated she is able to assist her mother with things such as meal preparation and laundry. The daughter is not employed outside the home.

7. The Respondent's witness, Dr. Gilchrist, stated that he would be willing to approve the additional personal care and homemaker hours requested by the Petitioner, but in that case, the respite hours would have to be terminated due to the increase of the other services. Otherwise, the combination of the currently approved home health hours and respite care should be sufficient to meet the Petitioner's needs.

8. The Petitioner's daughter stated she did not want the respite hours to be reduced and wants the respite hours to be maintained along with an increase in the other service hours.

CONCLUSIONS OF LAW

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

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

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

11. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the Petitioner since the issue involved a request for an increase in services. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

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

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

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

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

15. Fla. Stat. § 409.98 lists the services which must be covered by Long-Term Care plans. Respite care, personal care assistance, and homemaker services are

among the services available from Long-Term Care plans and are addressed in the AHCA contract.

16. The Petitioner currently receives Homemaker services, which are defined in the contract as:

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

17. The Petitioner also currently receives Personal Care services, which are defined in the contract as follows:

> A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

18. The Petitioner also currently receives Respite Care services, which are defined in the contract as follows:

> Services provided to enrollees unable to care for themselves furnished on a short-term basis due to the absence or need for relief of persons normally providing the care. Respite care does not substitute for the care usually provided by a registered nurse, a licensed practical nurse or a therapist. Respite care is provided in the home/place of residence, Medicaid licensed hospital, nursing facility or assisted living facility.

19. The AHCA contract also provides that a Plan "may place appropriate limits on a service on the basis of such criteria as medical necessity, as defined by the

Agency, or for utilization control, consistent with the terms of this Contract, provided the services furnished can be reasonably expected to achieve their purpose."

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

21. The Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012, and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

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

22. After considering the evidence and testimony presented, the hearing officer concludes that the Petitioner has not demonstrated that her personal care and homemaker services should be increased under the LTC Program. The Petitioner

clearly needs assistance with all her activities of daily living (ADLs). However, she already receives assistance from the home health aide twice per day who helps her with bathing and other needs. She receives 7 hours weekly of homemaker service which assists with chores such as housekeeping and laundry. She also receives 8 hours weekly of respite care to provide relief to her caregiver (i.e., her daughter).

23. Although there was some discussion on the record about Sunshine's willingness to increase the home health hours if the respite service is terminated, the Petitioner's daughter indicated she did not want to accept such an arrangement. The hearing officer cannot make any conclusions based on that discussion since it was in the nature of a potential compromise or settlement among the parties. However, the parties are free to engage in such discussions or negotiations on their own at any time.

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 ___16___ day of ___Mav___________, 2016,

in Tallahassee, Florida.

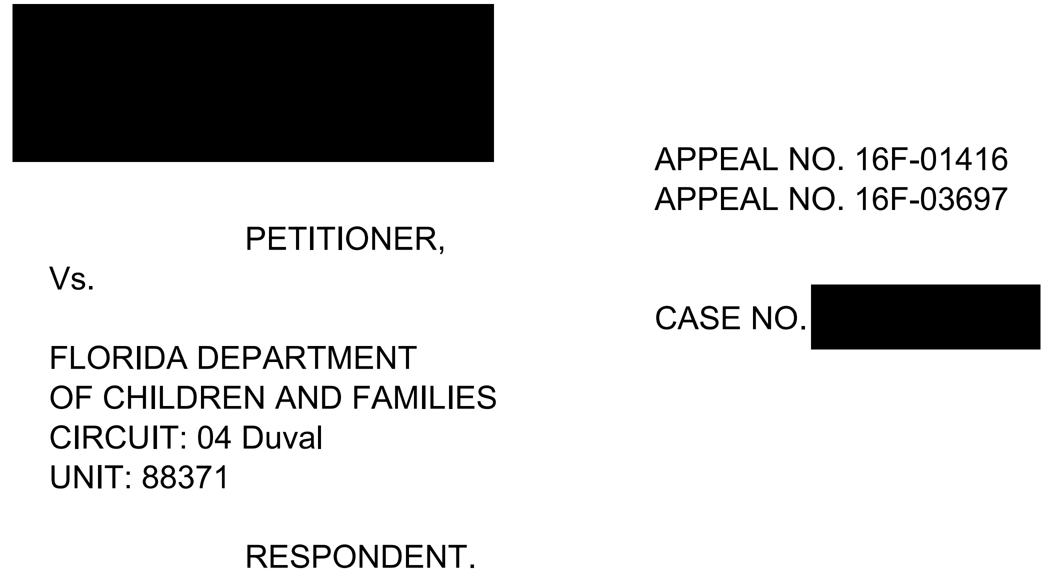
____
Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To [redacted] PETITIONER
RHEA GRAY, AREA 11, AHCA FIELD OFFICE MANAGER

May 17, 2016

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 16F-01416
APPEAL NO. 16F-03697

PETITIONER,

Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 04 Duval
UNIT: 88371

RESPONDENT.

_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on April 7, 2016 at 2:49 p.m.

APPEARANCES

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

For the Respondent: Kenneth Wilson, Economic Self-Sufficiency Specialist II for the Department of Children and Families.

ISSUE

The petitioner is appealing the Department’s action on February 1, 2016 to continue his enrollment in the Medically Needy (MN) program with a monthly share of cost (SOC) in the amount of $1112.

The petitioner is also appealing the Department's action on February 1, 2016 to deny his application for the Qualifying Individual 1 (QI1) program due to exceeding the income limit.

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

FINDINGS OF FACT

1. On January 25, 2016, the petitioner (age 42) completed an interim contact form to continue his enrollment in the MN program. The petitioner receives $1417 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 $1417. The total gross income was subtracted by the unearned income disregard in the amount of $20 to result in $1397 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 $1217. The SOC was further reduced by the $104.90 Medicare premium for a remaining share of cost in the amount of $1112.

3. The total income included in the QI1 budget for the petitioner as an individual was $1417. The $20 unearned income disregard was subtracted from the total gross income which resulted in a countable income of $1397.

4. The Department determined that the petitioner was ineligible for the QI1 program as the income exceeded the QI1 income standard for an individual of $1325.

5. The petitioner does not dispute the income included in the Department's calculations. The petitioner argues that he has multiple health issues, including heart disease. The petitioner contends his medical bills are accumulating to the amount of $100000 to $175000. The petitioner needs Medicaid and help paying his Medicare premium; he is receiving Medicare Parts A and B. He is not receiving any institutional care services (ICP), hospice services, or community based waiver services at this time.

6. The petitioner believes he is entitled to Medicaid due to his numerous health conditions and can understand not being eligible if he only had one medical condition. The petitioner argues that he worked hard for this country to keep it safe and needs help to get medical treatment. The petitioner inquired if he could be considered a "couple" in order to qualify for the SLMB program.

7. The Department explained that the Medicaid and QI1 programs are income based and that gross income is used in its calculations. The Department further explained that the petitioner's income exceeded the income limits to be eligible for both programs. The Department explained that since the petitioner is unmarried, he is considered to be an individual; therefore the income standards for an individual was considered in his case.

CONCLUSIONS OF LAW

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

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

The petitioner's continued enrollment in the Medically Needy Program will be addressed first:

10. Fla. Admin. Code § 65A-1.701, Definitions, states in part:

> (20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services.

11. 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.

The denial of the QI1 will now be addressed:

12. Fla. Admin. Code § 65A-1.713 SSI-Related Medicaid Income Eligibility Criteria states:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
> (b) For QMB, income must be less than or equal to the federal poverty level after application of exclusions specified in subsection 65A-1.713(2),

F.A.C.
(g) For SLMB, income must be greater than 100 percent of the federal poverty level but equal to or less than 120 percent of the federal poverty level.
(j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. QI1 is eligible only for payment of the Part B Medicare premium through Medicaid.

13. 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. 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.

14. The Department's Program Policy Manual, CFOP 165-22, Appendix A-9, sets forth the income standards for an individual effective January 2016 as $981 for the QMB program, $1177 for the SLMB program, and $1325 for the QI 1 program. The income standards are a percentage of the Federal Poverty Level as explained above.

15. The above authority sets the income standard for an individual applying for the QI1 program at $1325 effective January 2016.

16. The petitioner's countable income was $1397, which exceeds the income limit for an individual in the QI1 Program, which has the highest income limit of the MSP

programs. Therefore, the undersigned concludes that the Department correctly denied QI1 program benefits.

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 __May__________, 2016,

in Tallahassee, Florida.

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

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

May 20, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01420

PETITIONER,
Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 Palm Beach
UNIT: 88701

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on April 19, 2016 at 3:05 p.m. i

APPEARANCES

For the Petitioner:

For the Respondent: Gus Artau, operation consultant manager.

STATEMENT OF ISSUE

The petitioner is 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. In accordance with Fla. Admin. Code R. 65-2.060 (1), the petitioner carries 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 one exhibit which was entered into evidence and marked as Petitioner's Composite Exhibit 1.

FINDINGS OF FACT

1. On December 28, 2015, the petitioner submitted a recertification application for SSI-Related Medicaid benefits. He is the only household member. The petitioner receives Social Security Disability Income (SSDI) of $1,167. The Department determined he was eligible he was for the Medically Needy Program with a share of cost.

2. To determine the petitioner's SSI-Related Medicaid benefits, the respondent used the petitioner's gross income of $1,167 and subtracted a $20 unearned disregard resulting to the petitioner's countable income of $1,147. The respondent compared it to the income limit for one person which is $864 and found the petitioner's countable income 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.

3. The respondent performed the following budget calculations when it determined the petitioner's estimated SOC. It determined the petitioner's monthly gross income was $1,167. A $20 unearned income disregard was subtracted resulting to $1,147 as the countable income. The Medically Needy Income Limit of $180 for household size of one was subtracted resulting to $967 as the petitioner's SOC.

4. On February 24, 2016, the petitioner requested a hearing to challenge the Department's action to enroll him in the Medically Needy Program. The petitioner does not receive Medicare Part A or Medicare Part B.

5. The petitioner does not dispute the gross income included in the Department's calculations. The petitioner argued that his income has not changed. He does not understand how suddenly he is over the over the income limit for full Medicaid. The petitioner argues that he cannot purchase medication with the money he is getting from his disability.

CONCLUSIONS OF LAW

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

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

8. The petitioner has been determined disabled by Social Security. His Medicaid eligibility was determined under the SSI-Related Medicaid Program.

9. Fla. Admin. Code at R. 65A-1.711 (1) SSI-Related Medicaid Non Financial Eligibility Criteria, states, "For MEDS-AD Demonstration Waiver, the individual must be age 65 or older, or disabled as defined in 20 C.F.R. §416.905…"

10. Income budgeting for MEDS-AD is set forth in Fla. Admin. Code R. 65A-1.713. It states:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
> (a) For MEDS-AD Demonstration Waiver, income cannot exceed 88 percent of the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C. (2) Included and Excluded Income. For all SSI-related coverage groups the department follows the SSI policy specified in 20 C.F.R. 416.1100, et seq.,…
> (4) Income Budgeting Methodologies. To determine eligibility SSI budgeting methodologies are applied except where expressly prohibited by 42 U.S.C. §1396, or another less restrictive option is elected by the state under 42 U.S.C. §1396(2000 Ed., Sup. IV)...

11. 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…"

12. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, Appendix A-9, identifies 88 % of the federal poverty level for SSI-Related Medicaid under the MEDS-AD Program at $864 effective July 2015. The petitioner's total countable income of $1,147 (after $20 disregard) exceeds the income standard for full MEDS-AD as listed above. The respondent's action to deny full Medicaid Program benefits for the petitioner was within the rules and regulation of the Program. The petitioner is not eligible for full coverage Medicaid.

13. A review of the rules and regulations did not find any exception to meeting the income limits for the Program.

14. 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.

15. The above authority explains the Medically Needy Program is a coverage group for aged, blind or disabled individuals who do not qualify for full Medicaid due to their level of income.

16. 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."

17. 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."

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

> (1)(h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses…
> (4)(c) Medically Needy. The amount by which the individual's countable income exceeds the Medically Needy income level, called the "share of cost", shall be considered available for payment of medical care and services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical cost…

19. Fla. Admin. Code R. 65A-1.716 (2), Income and Resource Criteria, states, "Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows: Size 1 Level $180."

20. The Policy Manual at passage 2440.0102, Medically Needy Income Limits (MSSI) states:

> When the assistance group has met the technical eligibility criteria and the asset limits, it is enrolled. There is no income limit for enrollment. The assistance group is income eligible (entitled to Medicaid) once income is less than or equal to the Medically Needy Income Level (MNIL) or medical bills equal the amount by which his income exceeds the MNIL. Once medical bills are equal to this surplus income, referred to as share of cost, the assistance group is eligible.
> The eligibility specialist must determine eligibility for Medically Needy any time the assistance group's income exceeds the income limits for another full Medicaid Program.

21. A review of the rules did not find any exceptions to the income limits. The undersigned reviewed the respondent's budget calculations and the petitioner's reported income using the rules cited above and did not find a more favorable outcome other than the SOC assigned by the respondent. Eligibility for full Medicaid is not found.

22. The undersigned concludes the respondent's action to deny full Medicaid benefits and to enroll the petitioner in the Medically Needy Program with the estimated SOC of $967 is within the rules of the Program.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The

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

DONE and ORDERED this ___20_ day of ___May___________, 2016,

in Tallahassee, Florida.

Christiana Gopaul-Narine
Hearing Officer
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1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

May 24, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01430

PETITIONER,

Vs.

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

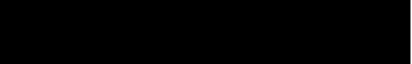
RESPONDENT.

_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above referenced matter on April 25, 2016 at 8:33 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 the Agency's reduction of Petitioner's Speech Therapy from four units three times per week (3 hours) to two times per week (2 hours), for the certification period February 2, 2016 to July 30, 2016. Because the matter at issue involves a reduction in services, Respondent carries the burden of proof.

PRELIMINARY STATEMENT

Dr. Rakesh Mittal, physician consultant for eQHealth Solutions, appeared as a witness for the Respondent. Respondent submitted three sets of documents which were entered into evidence and marked Respondent Exhibits 1 to 3.

Petitioner continues to receive Speech therapy at four units three times per week (3 hours) pending the outcome of this appeal.

FINDINGS OF FACT

1. Petitioner is a 20 year-old recipient of the Medicaid program with a birth date of June 1995. When he turns 21 years old in June, he will no longer be eligible for Speech Therapy services.

2. Petitioner is diagnosed with

3. On February 2, 2016, Petitioner's provider submitted a request to continue receiving four units (1 hour) of Speech Therapy services three times per week for a total of three hours weekly for the certification period.

4. EQHealth Solutions has been authorized to perform Prior Authorization of Speech Therapy services for the Agency.

5. On February 8, 2016, EQHealth made its initial determination and sent a "Notice of Outcome-Partial Denial" to Petitioner approving two hours per week of Speech Therapy services, thus reducing his Speech Therapy services by one hour per week.

The basis for the partial denial is that the services are not medically necessary as defined in 59G-1.010, Florida Administrative Code (F.A.C.).

6. Notice of the partial denial was also sent to the Petitioner's provider and indicated the following principle reason for the decision:

> Submitted information does not support the medical necessity for requested frequency and/or duration. Therapy services are approved for partial length of service requested, based on the documentation provided.

The clinical rationale for the decision was noted as:

> The patient is a 20 year old with autism who may benefit from continued speech therapy addressing intelligibility and syntax. The request is excessive based on the severity of delay, goals submitted and the progress made over many years of therapy. Four units two times per week 2/2/16 thru 7/30/16 is sufficient therapy at this developmental age.

7. On February 11, 2016, a request for reconsideration was received by eQHealth. On February 19, 2016 eQHealth sent A "Notice of Reconsideration Determination" to the Petitioner which upheld the initial decision.

8. on February 19, 2016, the "Notice of Reconsideration Determination" sent to petitioner's provider indicated the following medical basis for the decision:

> The information submitted for reconsideration provided no evidence to support the reversal of the previous decision. The original decision is upheld.

9. The Petitioner submitted a timely request for a fair hearing on February 24, 2016.

10. Respondent's physician consultant reviewed the Speech Therapist's evaluation and plan of care report for the Petitioner. The January 21, 2016 report shows Petitioner met 3 of his 6 short term goals and met the remaining goals with 60% accuracy. The

physician consultant also highlighted comments made under the clinical findings section of the report:

> Progress has been noted in overall vocabulary and has shown improvement in his goals.
>
> His syntax skills continue to show improvement which has made him a more confident communicator.
>
> Even though [Petitioner's] scores have not increased, he has shown significant progress with social skills. He continues to seek communication with familiar and unfamiliar persons in a variety of environments.

11. The physician consultant stated based on the Petitioner's progress and the length of time he has received Speech Therapy, eQHealth determined that two hours of Speech Therapy per week were medically necessary and that three hours of Speech Therapy per week were excessive.

12. On page 11 of Respondent's Exhibit 2, the approval of the two (2) hours per week recommended for Speech Therapy services is followed by the statement:

> If the recipient's condition changes such that an increase of services is warranted during the certification period, the provider may submit a modification request.

13. Petitioner's Speech Therapist explained Petitioner's progress was because he has been receiving therapy three hours per week. The therapist stated he needed five hours of speech therapy per week. Petitioner's witnesses all felt the reduction in speech therapy service hours made no sense to them since he is making progress.

14. The Petitioner's mother noted the age equivalent level of her son's scores in the Comprehensive Assessment of Spoken Language (CASL). The CASL is a comprehensive language test comprised of 15 core and supplementary subtests for

children and young adults between the ages 3 through 21. Five Core Subtests were administered to the Petitioner: Synonyms, Grammaticality Judgment, Nonliteral Language, Meaning from Context, and Pragmatic Judgment. His age equivalent results for these subtests range from 7 to 9 years of age. He was administered these subtests in July 2015 and January 2016. A comparison of his scores shows he made no progress in three of the subtests (Nonliteral Language, Meaning from Context, and Pragmatic Judgment) and made slight improvements in the remaining two.

15. Petitioner's Speech Therapist explained the Petitioner has new short term goals to meet before the services end in June and reducing the service hours were going to be detrimental to him reaching those goals. The new short term goals and purpose are listed in the speech therapist's Letter of Medical Necessity dated 2/11/2016 (see Respondent Exhibit 2, page 50-51.) Petitioner will …

1. Write a 5-sentence narrative about self using correct syntax and complex sentence structure, independently, with 100% accuracy. Purpose: To aid in job applications, interviews, social encounters.

2. Answer questions about self (daily routine, activities, upcoming events) using grammatically correct sentences, independently with 80% accuracy. Purpose: To increase conversational skills, comprehension skills, and expressive language skills.

3. Label meanings of words and use new words in appropriate context (sentence, story) with given verbal prompts, 10/10 opportunities. Purpose: To increase vocabulary and understanding of words so that he can function in the community (grocery shopping, ordering at restaurants, request objects, etc.)

4. Follow unfamiliar 3 step directions independently with 80% accuracy. Purpose: To increase problem solving skills, follow directions when given tasks at a job, bus schedule, or making snacks.)

5. Increase intelligibility in connected speech by increasing his mean length of utterance spontaneously, when answering questions, independently 10/10 opportunities. Purpose: To increase his intelligibility so that others can understand him, especially when he is away from his mother, on the phone, and out in the community to keep him safe.

6. Initiate a conversation (with therapist, mom, grandma), of 4-5 conversational turns, using appropriate eye contact and body language, when given minimal reminders, during each treatment session. Purpose: To increase his social skills so that he can function in the community, at social gatherings, workplace, restaurants, etc.

7. Use strategies to calm self and decrease angry self talk when given visual prompts with 100% accuracy. Purpose: To help [Petitioner] effectively calm self so that he is not a danger to himself or others.

In her report, the speech therapist stated reducing the therapy service hours to two hours per week would not be sufficient in order to target the above skills and prepare him for the adult world. She repeated this opinion during the hearing.

CONCLUSIONS OF LAW

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

17. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code § 65-2.056.

18. 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).

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 59G-1.010 states in part:

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

21. Because the Petitioner is under twenty-one-years-old, the requirements of Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT) must be considered. Florida Statute § 409.905, Mandatory Medicaid services, provides that Medicaid services for children must include:

> (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic

> screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

22. In reviewing the appeal for compliance with EPSDT requirements, speech therapy services are part of Florida's Medicaid state plan of services. The agency is providing these services to the Petitioner for the certification period under appeal, and is therefore, in compliance with this EPSDT requirement. The remaining matter to consider is compliance with the EPSDT definition of medical necessity, which includes the amount and duration of the services.

23. The Therapy Services Coverage and Limitations Handbook (Handbook), promulgated August 2013, on page 1-2, provides the following purpose of therapy services program:

> The purpose of the therapy services program is to provide medically necessary physical therapy (PT), occupational therapy (OT), respiratory therapy (RT) and speech-language pathology (SLP) services to recipients under the age of 21. The therapy services program also provides limited services to recipients age 21 and older specifically SLP services pertaining to the provision of augmentative and alternative communication systems and PT and OT services pertaining to wheelchair evaluations and fittings.

24. The Handbook, on page 1-4 sets forth a description of the speech-language pathology services:

> Services include the evaluation and treatment of disorders of verbal and written language, articulation, voice, fluency, phonology, mastication, deglutition, cognition, communication (including the pragmatics of verbal communication), auditory processing, visual processing, memory,

> comprehension and interactive communication as well as the use of instrumentation, techniques, and strategies to remediate, maintain communication functioning, acquire a skill set, restore a skill set, and enhance the recipient's communication needs, when appropriate. Services also include the evaluation and treatment of oral pharyngeal and laryngeal sensorimotor competencies.

25. The physician consultant explained that the Petitioner made progress during the last certification period, meeting three of his short term goals and achieving 60% on the remaining three short term goals. As a result, he determined that two hours per week of speech therapy were medically necessary and not three hours per week.

26. Notwithstanding the Petitioner's success in meeting his short term goals for the past certification period, the results of the Comprehensive Assessment of Spoken Language (CASL) highlights the Petitioner's overall lack of progress. The Petitioner's speech therapist has set new short term goals that requires the Petitioner receive at least three hours of therapy per week if he is to meet these goals before his speech therapy ends in June 2016. The goals are to assist the Petitioner in meeting the challenges he will face as a 21 year old.

27. Respondent did not address the CASL results but noted the significant progress the speech therapist annotated in her report. Petitioner's witnesses argued he made the significant progress because he was receiving speech therapy three times per week (three hours).

28. After considering the evidence, EPSDT requirements, and the appropriate authorities set forth in the findings above, the hearing officer concludes the Respondent has not met its burden of proof. Petitioner's witnesses provided sufficient and

compelling evidence he needs to continue receiving three hours of speech therapy services for the remaining time he is eligible.

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

DONE and ORDERED this ___24___ day of ___May___________, 2016,

in Tallahassee, Florida.

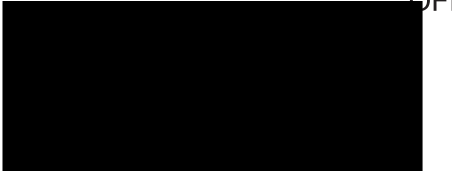
____
Warren Hunter
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

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

May 27, 2016

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 16F-01460
APPEAL NO. 16F-01461
APPEAL NO. 16F-01462
APPEAL NO. 16F-01463

PETITIONER,
Vs.

CASE NO.

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

RESPONDENT.
________________________________/

ORDER OF DISMISSAL

Pursuant to notice, the undersigned convened two administrative hearings by phone in the above-referenced matter on March 24, 2016 at 1:01 p.m.; and on May 26, 2016 at 1:11 p.m. One continuance was granted for the petitioner ("petitioner") was present and testified. Respondent was represented by Fred Snedeker with the Office of Public Benefits Integrity Program, Benefit Recovery Unit (hereafter "PBI", "Respondent" or "Agency"). Mr. Snedeker testified. Respondent submitted one exhibit, which was accepted into evidence and marked as Respondent's Exhibit "1".

Prior to the May 26, 2016 hearing, the respondent voided the petitioner's Food Assistance (FA) and three Medicaid (MMC, MMP, and MN) overpayment claims down to $0. Petitioner has a $0 balance on the four overpayment claims; has $0 liability on the claims; and has no other overpayments claims with the respondent. Petitioner

agreed with the Department's action to void her four overpayment claims and was satisfied with this resolution. Petitioner verbally withdrew her appeals while on the record as there were no more issues under appeal to be resolved. The undersigned accepts petitioner's verbal withdrawal and DISMISSES the appeals as withdrawn.

DONE and ORDERED this 27 ay of May, 2016, in Tallahassee, Florida.

Mary Jane Stafford

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

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

May 10, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01490

PETITIONER,
Vs.

CASE NO.

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

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on April 5, 2016 at approximately 2:00 p.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 February 26, 2016 denying Medicaid eligibility for the retro months of February through April 2015. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

A packet of information was submitted by the Department and was entered into evidence as Respondent's Exhibits "1" through "15".

FINDINGS OF FACT

1. The petitioner, a 64 year old male with [redacted] due to right [redacted] was determined disabled by the Division of Disability Determinations per vocational rule 201.04 effective May 1, 2015.

2. Petitioner was admitted to Fawcett Memorial Hospital February 16, 2015 with a [redacted]

3. Petitioner applied for Medicaid benefits April 1, 2015.

4. Medical records and a request for a disability determination, including retro-months back to February 2015, were submitted to the Division of Disability Determination (DDD) on August 21, 2015.

5. DDD responded favorably on September 22, 2015 effective May 1, 2015, not approving the requested retro-months of February through April 2015.

6. On February 8, 2016, a FAX request (Form 2931) was sent to DDD requesting information about the retro months. On February 9, 2016, a reply stating "No Disability Information Available" was received from DDD. Therefore, the Department submitted a Disability Determination request and Transmittal along with medical records to DDD requesting retroactive Medicaid for February through April 2015. The DDD packet was returned stating, "This is not the proper way to request a DDD witness be present for a

hearing. Not the proper way to request retro either. DDD is not called as a witness for hearings for retro only. DDD allowed case in 9/2015."

7. A Notice of Case Action (NOCA) was mailed on February 26, 2016 denying Medicaid for February through April 2015.

8. DDD never considered eligibility for the petitioner for the requested retro months of February through April 2015. DDD was asked to have a representative at this proceeding and refused.

CONCLUSIONS OF LAW

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

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

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

> If the individual has not received a disability decision from SSA, a blindness/disability application must be submitted to the Division of Disability Determinations (DDD) for individuals under age 65 who are requesting Community Medicaid under community MEDS-AD, Medically Needy, and Emergency Medicaid for Alien Programs.
> State disability determinations for disability-related Medicaid applications must be done for all applicants with pending Title II or Title XVI claims unless SSA has denied their disability within the past year. If SSA has denied disability within the past year and the decision is under appeal with SSA, do not consider the case as pending. Use the decision SSA has already rendered. The SSA denial stands while the case is pending appeal.

12. The above authority explains that a disability application must be sent to the DDD to be reviewed for applicants who are under the age of 65, who are requesting Community Medicaid under Community MEDS-AD, Medically Needy, and Emergency Medicaid for Alien programs. DDD affirmed the petitioner a disabled individual.

13. The record clearly demonstrates that the petitioner meets disability criteria. The remaining issue is the onset date of his eligibility. The petitioner argues the onset date should be February 1, 2015. The respondent is bound by the onset date established by DDD.

14. The petitioner filed a Medicaid application April 1, 2015. This application protects the retro period of January through March 2015 which DDD did not consider in its disability determination.

15. Fla. Admin. Code 65-2.066, Final Orders, explains: "(6) In the Final Order the Hearings Officer shall authorize corrective action retroactively to the date the incorrect action was taken." Given all the evidence and the controlling legal authorities, the undersigned concludes that the onset date of the petitioner's disability is February 1, 2015.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted. The Department is directed to approve Medicaid coverage from February 1, 2015 through April 30, 2015 and to issue appropriate notices.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this __10__ day of __May__________, 2016,

in Tallahassee, Florida.

Gregory Watson

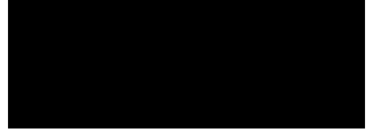
Gregory Watson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

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

May 31, 2016

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 16F-01508

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 April 8, 2016 at 11:30 a.m.

APPEARANCES

For the Petitioner:

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

STATEMENT OF ISSUE

At issue is whether the Respondent's denial of the Petitioner's request for dental services (removal of lower mandible) was correct. The Petitioner has the burden of proving his case by a preponderance of the evidence.

PRELIMINARY STATEMENT

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

Appearing as witnesses for the Respondent were Dr. Merlin Osoria, Medical Director, and Diana Anda, Grievance and Appeals Manager, from Simply Healthcare, which is Petitioner's managed health care plan. Also present as witnesses for the Respondent were Jackeline Salcedo, Complaints and Grievance Specialist, and Dr. Susan Hudson, Dental Consultant, from DentaQuest, which is an organization that reviews requests for dental services on behalf of Simply Healthcare.

Respondent submitted several documents as evidence for the hearing, which were marked as follows: Exhibit 1 – Statement of Matters and Authorization Determination; Exhibit 2 – Denial Notice; Exhibit 3 – Dental Consultant Review Form. After the hearing concluded, the record was left open for Simply Healthcare to submit a copy of the plan provisions concerning dental benefits. This was subsequently received and marked as Exhibit 4.

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

FINDINGS OF FACT

1. The Petitioner is a seventy-one (71) 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 Simply Healthcare.

2. On or about February 19, 2016, the Petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from Simply Healthcare (through

DentaQuest) to perform a removal of the lower mandible. Simply Healthcare and DentaQuest denied this request on February 22, 2016. The reason for the denial was that this service is not a covered benefit under the Simply Healthcare plan.

3. Petitioner testified that he needs the removal of his lower mandible so that dentures will fit in his mouth. He also stated he cannot chew food because he has no teeth in his upper jaw and he also has an infection. All the dental crowns in his upper mandible were previously removed and he states that procedure was approved by the plan.

4. The Respondent’s witness, Ms. Anda from DentaQuest, testified that the removal of the lower mandible is not a covered service under Simply Healthcare’s 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.

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CONCLUSIONS OF LAW

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

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

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

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

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

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

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

12. The Petitioner’s request for removal of the lower mandible was denied as being a non-covered service, not because of any medical necessity considerations.

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 Simply Healthcare, may provide more generous benefits but cannot be more restrictive than the Medicaid guidelines contained in the Dental Handbook. The plan provisions submitted by Simply Healthcare state that the plan will cover evaluations, x-rays, extractions, abscess drainage, dentures, dental cleanings, and preventive exams. The service requested by the Petitioner is not one of the covered services.

15. After considering the evidence and testimony presented, the undersigned concludes that the Petitioner has not demonstrated that the requested service should have been approved by Simply Healthcare. Removal of the mandible is a non-covered service for adults under the Medicaid guidelines referenced above and under the Simply Healthcare dental plan provisions. Therefore, the hearing officer cannot make a determination that this service 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 31 day of May, 2016, in Tallahassee, Florida.

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

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

May 12, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01528
16F-02228
16F-02229

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.

_______________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on March 23, 2016 at 10:00 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the petitioner:

For the respondent: Sylma Dekony, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action to deny his application for Food Assistance Program (FAP) benefits and the Medicare Savings Program (MSP). Petitioner is also appealing the current amount of his Medically Needy (MN) Share of Cost (SOC). The petitioner carries the burden of proof by a preponderance of the evidence for the FAP and MSP issues. During the hearing, the undersigned reserved

the right to assign the burden of proof for the MN SOC in the Final Order. After further review, the burden of proof for the MN SOC issue is assigned to the Department.

PRELIMINARY STATEMENT

On January 28, 2016, the Department sent the petitioner a Notice of Case Action (NOCA) informing him that his and his wife's application for FAP and QI1 benefits (MSP) was denied as "your household's income is too high to qualify for this program." Said notice also notified the petitioner that his and his wife's MN SOC would end on February 29, 2016. The petitioner timely appealed these actions on February 3, 2016; however, the MN hearing request was not received by the Office of Appeal Hearings until March 1, 2016 and the FAP and MSP hearing requests were not received until March 24, 2016.

The petitioner presented 12 pages of evidence during the hearing for the undersigned to consider, which were entered into the record as Petitioner's Composite Exhibit 1. The Department presented a total of 49 pages of evidence for the undersigned to consider during the hearing, which were entered into the record as Respondent's Composite Exhibit 1. The record was left open until April 1, 2016 for the petitioner to submit additional information to the Department and for the Department to then evaluate, submit additional evidence and confirmation of any changes that resulted from the petitioner's additional evidence. The petitioner submitted an additional 24 pages of evidence, which were entered into the record as Petitioner's Composite Exhibit 2. The Department submitted an additional 77 pages of evidence, which were entered into the record as Respondent's Composite Exhibit 2. The record was closed on April 1, 2016.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner and his wife were enrolled in the MN program with a SOC of $2,340.

2. On January 14, 2016, the petitioner submitted an application for additional benefits of FAP and MSP. The petitioner reported on the application that he and his wife receive Social Security Disability Income (SSDI), earned income from [redacted] and that his wife receives an annuity payment monthly.

3. The respondent determined the petitioner and his wife were over the asset and income limits for all programs. On January 27, 2016, the respondent denied the petitioner and his wife's FAP and MSP benefits application and closed their MN benefits.

4. On March 1, 2016, the petitioner submitted another application for FAP, SSI-Related Medicaid and MSP benefits. On March 2, 2016, the petitioner sent a copy of his bank statement to the Department and on March 17, 2016, his wife's bank statement was sent. On March 20, 2016, the respondent denied the petitioner's application for FAP and MSP benefits stating they were over income and enrolled the petitioner and his wife in the MN program with a SOC of $4,108.

5. The petitioner receives SSDI of $1,021.90 per month. He sent the following paystubs to the Department from [redacted] February 11, 2016 $314.65; February 18, 2016 $282.10, February 25, 2016 $75.95 and March 3, 2016 $127.16. The Department converted his weekly earned income to a monthly average by adding all these gross amounts together, dividing by four and then multiplying by a

conversion factor of 4.3 to arrive at $859.87 monthly earned income. The petitioner agreed to the income listed above.

6. The petitioner's wife receives SSDI of $872.90 per month. The petitioner also provided her following paystubs from [redacted] February 11, 2016 $294; February 18, 2016 $168; February 25, 2016 $168 and March 3, 2016 $168. The Department converted her weekly earned income to a monthly average by adding all these gross amounts together, dividing by four and then multiplying by a conversion factor of 4.3 to arrive at $857.85 monthly earned income. She also receives a monthly annuity of $1,920. This annuity was not included in the previous certification period. The petitioner agreed to his wife's income listed above.

7. The Department determined the petitioner's FAP eligibility as follows:

$3,813.00 Total unearned income
+$1,717.72 Total earned income
$5,530.72 Total income

$5,530.72 Total income
-$ 343.54 Earned income deduction (20% of $1,717.72)
-$ 899.80 Excess medical deduction ($934.80 total medical expenses - $35 disregard)
-$ 155.00 Standard deduction
$4,132.38 Adjusted income

$920.00 Shelter costs
+$345.00 Standard utility allowance (SUA)
$1,265.00 Total shelter cost
-$2,066.19 Shelter standard (50% of the adjusted net income of $4,132.38)
$ 0.00 Excess shelter deduction

$4,132.38 Adjusted income
-$ 0.00 Excess shelter deduction
$4,132.38 FAP Adjusted income

The Monthly Net Income Limit for a household size of two is $1,328.00, the petitioner's FAP adjusted income ($4,132.38) exceeds the net income limit; therefore, the Department found the petitioner and his wife to be over income for the FAP program and denied their application.

8. The Department calculated the petitioner and his wife's countable income for the MSP programs as follows:

$3,813.00 Total unearned income
- $ 20.00 Unearned income disregard
$3,793.00 Countable unearned income

$1,597.88 Total earned income (For Medicaid purposes, the weekly earned income is multiplied by 4 instead of 4.3)
- $ 65.00 Earned income disregard
- $ 766.44 1/2 remaining disregard
$ 766.44 Countable earned income

$3,793.00 Countable unearned income
+$ 766.44 Countable earned income
$4,559.44 Total countable income

The Department determined the petitioner and his wife were ineligible for QI1 benefits as their combined countable income of $4,559.44 was over the income limit of $1,803 for a couple.

9. The Department calculated the petitioner and his wife's MN SOC as follows:

$3,813.00 Total unearned income
- $ 20.00 Unearned income disregard
$3,793.00 Countable unearned income

$1,597.88 Total earned income (For Medicaid purposes, the weekly earned income is multiplied by 4 instead of 4.3)
- $ 65.00 Earned income disregard)
- $ 766.44 1/2 remaining disregard)
$ 766.44 Countable earned income

$3,793.00	Countable unearned income
+$ 766.44	Countable earned income
$4,559.44	Total countable income

Total countable income:	$4,559.44
-Medically Needy Income Limit (MNIL)	$ 241.00
-Medical Insurance Premium	$ 209.80
Remaining SOC	$4,108.00

The petitioner's wife's annuity was not previously counted in the MN SOC. The Department included a deduction in the above budget for the medical insurance premium the petitioner is currently paying out of pocket.

10. The petitioner argued that the first $14,000 of his and his wife's income should be excluded when determining their eligibility for all programs due to the Achieving a Better Life Experience (ABLE) Act of 2014. The Department asserted ABLE Accounts are tax advantaged savings accounts for individuals with disabilities which are not yet in effect in Florida. It further stated that there are no policies or procedures in place for this program as it has not been implemented yet.

CONCLUSIONS OF LAW

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

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

13. The petitioner argued that the first $14,000 of his and his wife's income (each) should not be included in the determination of their eligibility for public benefits

eligibility due to the ABLE Act of 2014. The Department argued that the ABLE Act of 2014 has not yet been implemented in Florida.

14. The Achieving a Better Life Experience Act of 2014 § 101, 26 U.S.C. 529A (1986), (ABLE Act of 2014) states in part:

> The purposes of this title are as follows:
> (1) To encourage and assist individuals and families in saving private funds for the purpose of supporting individuals with disabilities to maintain health, independence, and quality of life…

15. Section 1009.986, Fla. Stat., Florida ABLE program, states in part:

> (1) LEGISLATIVE INTENT.—It is the intent of the Legislature to establish a qualified ABLE program in this state which will encourage and assist the saving of private funds in tax-exempt accounts in order to pay for the qualified disability expenses of eligible individuals with disabilities. The Legislature intends that the qualified ABLE program be implemented in a manner that is consistent with federal law authorizing the program and that maximizes program efficiency and effectiveness…
> (3) DIRECT-SUPPORT ORGANIZATION; FLORIDA ABLE, INC.—
> (a) The Florida Prepaid College Board shall establish a direct-support organization to be known as "Florida ABLE, Inc.,"
> (4) FLORIDA ABLE PROGRAM.—(a) On or before July 1, 2016, Florida ABLE, Inc., shall establish and administer the Florida ABLE program.

16. The undersigned concludes at this time, the State of Florida has established the qualified ABLE program (See House Bill 642 (2015)). Although the bill was approved by the Governor on May 21, 2015, the ABLE accounts administered through the Florida Prepaid College Board have not been offered for application yet. Pursuant to the above authorities, the purpose of a qualified ABLE program is to encourage and assist the saving of private funds in tax-exempt accounts in order to pay for the qualified disability expenses of eligible individuals with disabilities. The undersigned did not find any law or authority that

directs the Department to exclude these funds when it determines eligibility for public assistance benefits. Further, the petitioner and his wife have private bank accounts at Suntrust. No evidence was provided to show that their accounts are ABLE accounts administered through the Florida Prepaid College Board.

17. Based on the above-cited authorities, the undersigned concludes that, absent to any contrary evidence, the petitioner and his wife's income are to be counted, in full, for the determination of public assistance eligibility. The undersigned could find no law or regulation that supported the petitioner's argument that the first $14,000 of his and his wife's income should be excluded from the determination of their public assistance eligibility. The Department was correct not to exclude $14,000 of the petitioner and his wife's income when it determined their eligibility for FAP, MSP and MN benefits.

IN REGARDS TO THE FAP DENIAL:

18. The Code of Federal Regulations appearing in 7 C.F.R. § 273.9, income and deductions states in part:

> (a) Income eligibility standards. Participation in the Program shall be limited to those households whose incomes are determined to be a substantial limiting factor in permitting them to obtain a more nutritious diet…
> (b) Definition of income…
> (1) Earned income shall include: (i) All wages and salaries of an employee.
> (2) Unearned income shall include, but not be limited to: …
> (ii) Annuities; pensions; retirement, veteran's, or disability benefits; worker's or unemployment compensation including any amounts deducted to repay claims for intentional program violations… old age, survivors, or social security benefits…
> (d) Income deductions. Deductions shall be allowed only for the following household expenses:
> (1) Standard deduction

(2) Earned income deduction. Twenty percent of gross earned income
(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…
(6) Shelter costs-
(ii) Excess shelter deduction. Monthly shelter expenses in excess of 50 percent of the household's income after all other deductions in paragraphs (d)(1) through (d)(5) of this section have been allowed (ii) Excess shelter deduction. Monthly shelter expenses in excess of 50 percent of the household's income after all other deductions in paragraphs (d)(1) through (d)(5) of this section have been allowed. If the household does not contain an elderly or disabled member, as defined in § 271.2 of this chapter, the shelter deduction cannot exceed the maximum shelter deduction limit established for the area…
(A) Continuing charges for the shelter occupied by the household, including rent,
(iii) Standard utility allowances…

19. The above-cited legal authority states earned income, social security benefits, and annuities are included in the budget used to calculate FAP benefits. The petitioner reported recurring out of pocket medical expenses of $934.80 per month. The Department subtracted a $35 medical deduction from these medical expenses and included an excess medical deduction of $899.80. The Department included a standard deduction of $155 per month. The Department also gave the petitioner an earned income deduction of $343.54 (20% of the total gross earned income). The petitioner's $920 per month rent and $345 for the standard utility allowance were also included in the FAP budget. There was no excess shelter deduction included as the total shelter/utility costs of $1,265 were less than the shelter standard (50% of the adjusted income of $4,132.38) of $2,066.19. The petitioner was not found to be eligible for any other deductions.

20. The Code of Federal Regulations appearing in 7 C.F.R. § 273.10, determining household eligibility and benefit levels states in part:

> …
> (e)Calculating the net income and benefit levels—(1) 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 § 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...
> (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.

21. The Department's Program Policy Manual at Appendix A-1 shows that effective October 1, 2015, the standard deduction for a two-person household is $155. It further shows that the maximum FAP benefit is $357 for a household of two. The standard utility allowance is $345 per month for a household that incurs a heating and cooling expense. The Gross Income Limit for a household of two is $2,655 and the Net Income Limit for a household of two is $1,328.

22. The above authorities explain that households which contain an elderly or disabled member must meet net monthly income eligibility standards. As petitioner and his wife are disabled, petitioner's household is subject to the net income limit. The petitioner's adjusted income is $4,132.38. The net income limit for a household size of 2 is $1,328. As the petitioner's net income is over the net income limit for his household size, the Department denied his application for FAP benefits.

23. After carefully considering the testimony and evidence presented, along with the pertinent rules and regulations stated above, the undersigned cannot find a more favorable outcome for the petitioner. The undersigned concludes that the Department was correct to deny petitioner's FAP application as his FAP adjusted income (after all deductions) exceeds the net income limit for a household of two.

IN REGARDS TO THE MSP DENIAL:

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

> …
> (12) Limits of Coverage
> (a) Qualified Medicare Beneficiary (QMB). Under QMB coverage, individuals are entitled only to Medicare cost-sharing benefits, including payment of Medicare premiums.
> (b) Special Low-Income Medicare Beneficiary (SLMB). Under SLMB coverage, individuals are entitled only to payment of the Part B Medicare premium…
> …
> (d) Part B Medicare Only Beneficiary (QI1). Under QI1 coverage, individuals are only entitled to payment of their Medicare part B premium. (This is coverage for individuals who would be eligible for QMB or SLMB coverage except their income exceeds time limits for those programs.)

25. Fla. Admin. Code R. 65A-1.713(1) further addresses the SSI-Related Medicaid Income Eligibility Criteria as follows:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
> …
> (b) For QMB, income must be less than or equal to the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.
> …
> (g) For SLMB, income must be greater than 100 percent of the federal poverty level but equal to or less than 120 percent of the federal poverty level.
> …
> (j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. QI1 is eligible only for payment of the Part B Medicare premium through Medicaid.

26. The Code of Federal Regulations appearing in 20 C.F.R. § 416.1124, Unearned income we do not count, states in 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. The $20 exclusion does not apply to a benefit based on need that is totally or partially funded by the Federal government or by a nongovernmental agency. However, assistance which is based on need and funded wholly by a State or one of its political subdivisions is excluded totally from income as described in § 416.1124(c)(2). If you have less than $20 of unearned income in a month and you have earned income in that month, we will use the rest of the $20 exclusion to reduce the amount of your countable earned income;

27. The SSI-Related Programs – Financial Eligibility Standards show the QI1 income limit for a couple is $1,803.00, the Special Low Income Medicare Beneficiary (SLMB) income limit for a couple is $1,602, and the Qualified Medicare Beneficiary (QMB) income limit for a couple is $1,335. The petitioner's total countable income is

$4,559.44, which exceeds the income limits to be eligible for all the MSP programs.

28. After careful review of the controlling legal authorities and evidence, the undersigned concludes that the Department correctly followed rule in denying the petitioner and his wife's application for the MSP benefits.

IN REGARDS TO THE AMOUNT OF THE CURRENT MEDICALLY NEEDY SOC:

29. Fla. Admin. Code R. 65A-1.710, SSI-Related Medicaid Coverage Groups, states in part:

> …
> (5) Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. §§ 1396a and 1396d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance due to their level of income or resources. The program does not cover nursing facility care, intermediate care for the developmentally disabled services, or other long-term care services.

30. Fla. Admin. Code R. 65A-1.713 defines the income limits for SSI - Related Medicaid programs:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
> (a) For MEDS-AD Demonstration Waiver, income cannot exceed 88 percent of the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.
> …
> (h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses.

31. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 2640.0500, Share of Cost (MSSI) sets forth:

> The eligibility specialist must determine eligibility for Medically Needy any time the assistance group's assets and/or income exceeds the appropriate

> categorical asset/income limits. The eligibility specialist determines whether the assistance group's assets are within the Medically Needy asset limits and whether the assistance group members meet the technical factors. If the Medically Needy asset limit is met and the assistance group meets all technical factors, the eligibility specialist determines the amount of countable income and computes a budget using the MNIL which is the same for both family and SSI-Related Medicaid coverage groups (refer to Appendix A-7).
> If income is equal to or less than the MNIL, there is no share of cost and the individual is eligible. Medicaid is authorized for individuals who are eligible without a share of cost.
> If income is greater than the MNIL, share of cost is determined for appropriate members. Appropriate members are enrolled but cannot be eligible until the share of cost is met.

32. The Code of Federal Regulations 20 C.F.R. § 416.1124 defines unearned income that is not counted in SSI – Related Medicaid programs:

> …
> (C)(12) The first $20 of any unearned income in a month other than income in the form of in-kind support and maintenance received in the household of another (see §416.1131) and income based on need. Income based on need is a benefit that uses financial need as measured by your income as a factor to determine your eligibility.

33. Federal Regulations 20 C.F.R. § 416.1112, Earned income we do not count, states in relevant part:

> (a) General. While we must know the source and amount of all of your earned income…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 income in the month…
> (c) Other earned income we do not count. We do not count as earned income—
> …
> (5) $65 of earned income in a month;
> …
> (7) One-half of remaining earned income in a month;

34. 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.
> …
> (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 for OAA, AFDC, AB, APTD, or AABD.
> (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.** [emphasis added]
> (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;** [emphasis added]

35. Fla. Admin. Code R. 65A-1.713 sets forth the Income Budgeting Methodologies for the Medically Needy Program:

> …
> (C) Medically Needy. The amount by which the individual's countable income excees 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.

36. The SSI-Related Programs – Financial Eligibility Standards show the Medically Needy Income Level (MNIL) for a couple is $241.00.

37. The Deparment determined that the petitioner incurrs $934.80 in out of pocket medical expenses. However, it did not include these medical expenses in the

calculation of the SOC. The respondent agreed to review the petitioner's case to determine if these recurring medical expenses could be deducted from the SOC; however, no additional information was submitted to indicate this review was completed. According to the above cited authorities, any medical expenses incurred by the eligible individual must be deducted from the countable income to determine the SOC. Therefore, the undersigned concludes that the petitioner's $934.80 recurring medical expenses must be deducted from his and his wife's SOC calculation. By the undersigned's calculation, the SOC should then be $3,173 ($4,108 - $934.80).

38. The authorities cited set forth the rules for enrollment and budgeting methodologies for the Medically Needy Program. As the petitioner's total countable income of $4,559.44 exceeds the income limit for full Medicaid ($1,175.00), the undersigned finds the respondent correctly evaluated the petitioner and his wife for the Medically Needy Program. However, it failed to include the recurring out of pocket medical expenses in the calculation of the SOC amount. The undersigned concludes that the petitioner and his wife's SOC amount for January 2016 and ongoing is $3,173 per month, after all allowable deductions.

39. After careful review of the evidence and controlling legal authorities, the undersigned concludes the respondent incorrectly calculated the petitioner and his wife's SOC amount by not deducting their recurring medical expenses. The Department is ordered to deduct the petitioner and his wife's $934.80 recurring medical expenses from their coutable income and reduce their SOC to $3,173.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are denied in part and granted in part as follows:

The appeals concerning the Department's action to deny petitioner FAP and MSP benefits are DENIED and the Department's actions are affirmed.

The appeal concerning the petitioner and his wife's SOC amount is GRANTED and the Department is ORDERED to correct their SOC amount to $3,173 effective January 1, 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 12 day of May, 2016,

in Tallahassee, Florida.

Brandy Ricklefs

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

May 16, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01567
16F-01568
16F-01569

PETITIONER,

Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 Dade
UNIT: 88651

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on April 26, 2016 at 10:02 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner:

For the Respondent: Lourdes Menendez,
Public Benefits Integrity Investigator

STATEMENT OF ISSUE

At issue is the respondent's action to deny Temporary Cash Assistance (TCA), Food Assistance Program (FAP) benefits and Medicaid for the petitioner's minor children. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner.

PRELIMINARY STATEMENT

Jesus Sotuyo, Public Benefits Integrity Investigator, appeared for the respondent.

The petitioner submitted no exhibits. The respondent submitted 62 pages of evidence, which were marked and entered as Respondent's Exhibits "1" through "17". The record was held open until April 29, 2016 to submit additional evidence including the department's policy on the requirement of social security numbers and birth certificates. The above mentioned evidence was received on April 27, 2016. The evidence was marked and entered as Respondent's Exhibit "18". The record was closed the same day.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner was receiving $144 in FAP benefits for himself only.

2. On January 22, 2016, the petitioner submitted an application requested additional benefits of TCA, FAP, and Medicaid for his alleged 2 minor children ages six and eleven.

3. The petitioner is currently receiving $733 in Supplemental Security Income (SSI) benefits through the Social Security Administration with a Medicaid entitlement. The petitioner has a shelter expense of $300 that includes utilities. He also has a telephone expense of $60 per month.

4. On February 16, 2016, the respondent sent a Notice of Case Action (NOCA) to the petitioner requesting a face to face interview scheduled for February 26, 2016 at 10:00 a.m. and requested the following information to be provided no later than 10 days from his interview date:

MUST PROVIDE IMMUNIZATION RECORDS, SOCIAL SECURITY CARDS, BIRTH CERTIFICATE, [redacted], PROOF OF SCHOOL ATTENDANCE, AND [redacted] DAYCARE ENROLLMENT".

5. On February 24, 2016, the respondent sent a NOCA to the petitioner rescheduling the face to face interview for February 29, 2016 at 10:00 a.m.

6. On February 26, 2016, the petitioner contacted the department and stated he would not be keeping the scheduled appointment.

7. The petitioner did not keep the rescheduled appointment on February 29, 2016 and also failed to provide the information requested.

8. On March 1, 2016, the respondent sent a NOCA to the petitioner informing him: "We have reviewed your eligibility and found that your Food Assistance benefits would remain the same."

9. The petitioner timely requested the hearing.

10. The respondent explained that the petitioner's request for additional benefits could not be approved without verification of the children's social security numbers, birth certificates, and the children's school records. The respondent also states the social security numbers provided by the petitioner are incorrect and potentially belong to someone else.

11. The petitioner did not dispute the respondent's statement concerning the social security numbers not belonging to the children. He states he is unsure of the correct numbers for the children. He only "knows it starts with 766". He also states he is not listed on the birth certificate and is unable to get a copy of the birth certificates. The

petitioner further states the children are attending private school but he is unsure of the name of the school.

12. The petitioner argues that he is unable to take the children to the doctor since he is not been approved for Medicaid.

13. The petitioner has a current application pending with the respondent, listing both children. The 6 year old is listed with an alternate social security number on the current application.

CONCLUSIONS OF LAW

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

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

Medicaid benefits will be addressed first:

16. Fla. Admin. Code R. 65A-1.302 Social Security Numbers, states in the pertinent part:

> (1) To be eligible for public assistance, the individual must either provide the social security number (SSN) when known for each person whose needs are included in the assistance group or SFU or, apply for a SSN for each individual who either does not have a number assigned or whose number is unknown…
> (2) If the SSN is unknown or has never been obtained, the individual must apply for a SSN through the local Department office or Social Security Administration (SSA) office…
> (3) If the individual (or his representative) fails to provide or apply for a SSN on his own behalf or on the behalf of the child(ren) without good

> cause, the needs of the individual or child, whichever is applicable, must be excluded from the assistance group.

17. The above cited authority sets forth the requirement to provide the social security number (SSN) for individuals applying for assistance. If the SSN is unknown, they must apply for a SSN in order to be included in the assistance group. The petitioner acknowledges that he is unaware of the SSN's of the children and has not applied for a one.

18. Federal Regulations at 7 C.F.R. § 435.406 Citizenship and alienage, states:

> (a) The agency must provide Medicaid to otherwise eligible residents of the United States who are—
> (1) Citizens: (i) Under a declaration required by section 1137(d) of the Act that the individual is a citizen or national of the United States; and
> (ii) The individual has provided satisfactory documentary evidence of citizenship or national status, as described in §435.407…

19. Federal Regulations at 7 C.F.R. § 435.407 Types of acceptable documentary evidence of citizenship states in the pertinent part:

> …(a) Primary evidence of citizenship and identity. The following evidence must be accepted as satisfactory documentary evidence of both identity and citizenship:
> (1) A U.S. passport…
> (b) Secondary evidence of citizenship. If primary evidence from the list in paragraph (a) of this section is unavailable, an applicant or beneficiary should provide satisfactory documentary evidence of citizenship from the list specified in this section to establish citizenship and satisfactory documentary evidence from paragraph (e) of this section to establish identity, in accordance with the rules specified in this section.
> **(1) A U.S. public birth certificate showing birth in one of the 50 States** (*emphasis added*), the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (after November 4, 1986 (NMI local time))…
> The birth record document may be issued by the State, Commonwealth, Territory, or local jurisdiction. It must have been recorded before the person was 5 years of age. A delayed birth record document that is

> recorded at or after 5 years of age is considered fourth level evidence of citizenship…
> (c) Third level evidence of citizenship. Third level evidence of U.S. citizenship is documentary evidence of satisfactory reliability that is used when both primary and secondary evidence is unavailable. Third level evidence may be used only when the applicant or beneficiary alleges being born in the U.S. A second document from paragraph (e) of this section to establish identity must also be presented:..
> (4) Early school record showing a U.S. place of birth. The school record must show the name of the child, the date of admission to the school, the date of birth, a U.S. place of birth, and the name(s) and place(s) of birth of the applicant's parents.
> (d) Fourth level evidence of citizenship. Fourth level evidence of citizenship is documentary evidence of the lowest reliability. Fourth level evidence should only be used in the rarest of circumstances. This level of evidence is used only when primary, secondary and third level evidence is unavailable…
> (4) Medical (clinic, doctor, or hospital) record created at least 5 years before the initial application date that indicates a U.S. place of birth. (For children under 16 the document must have been created near the time of birth or 5 years before the date of application.)…
> (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…

20. The above cited regulations explain that citizenship and identity must be verified and lists documents used in verification of citizenship and identity. In accordance with the authority, the respondent requested copies of the birth certificates and school records of the children in order to establish identity and citizenship. The petitioner failed to provide the requested information.

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

> (1) Technical eligibility criteria of living in the home of a specified relative, age, residence, citizenship and deprivation apply to coverage groups as follows.
> (2) Coverage groups must meet the deprivation criterion only to the extent that children and parents or caretaker relatives meet payment standard income criteria [Refer to subsection 65A-1.716(2), F.A.C.].
> (3) The child must be living with a specified relative as defined in paragraph 65A-1.705(7)(a), F.A.C., unless specified that the child may be living with a non-relative.
> (4) Age criteria are as specified in Rule 65A-1.703, F.A.C.
> (5) The individual must be a resident of Florida as provided by s. 1902(a) and (b) of the Social Security Act (2007), incorporated by reference. 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.
> (6) The individual must be a citizen of the United States or a qualified alien as defined in 8 USC s. 1641(b) (2000 Ed., Sup. V), incorporated by reference…

22. In accordance with the above cited authorities, the respondent is required to verify citizenship, age, and relationship/living arrangement in order to determine Medicaid eligibility for the children. As the petitioner failed to provide the verification requested to establish citizenship, age, and relationship/living arrangement for the children, the undersigned concludes the petitioner's application for Medicaid was denied correctly.

FAP benefits will now be addressed:

23. Federal Regulations at 7 C.F.R. §273.2 Office operations and application processing, states in the pertinent part:

> …(f) Verification. Verification is the use of documentation or a contact with a third party to confirm the accuracy of statements or information. The State agency must give households at least 10 days to provide required verification. Paragraph (i)(4) of this section contains verification procedures for expedited service cases.

> (1) Mandatory verification. State agencies shall verify the following information prior to certification for households initially applying:…
> (v) Social security numbers. **The State agency shall verify the social security number(s) (SSN)** reported by the household by submitting them to the Social Security Administration (SSA) for verification according to procedures established by SSA…
> The State agency shall accept as verified an SSN which has been verified by another program participating in the IEVS described in §272.8. If an individual is unable to provide an SSN or does not have an SSN, the State agency shall require the individual to submit Form SS-5, Application for a Social Security Number, to the SSA in accordance with procedures in §273.6. A completed SSA Form 2853 shall be considered proof of application for an SSN for a newborn infant.
> (vi) Residency. The residency requirements of §273.3 shall be verified except in unusual cases (such as homeless households, some migrant farmworker households, or households newly arrived in a project area) where verification of residency cannot reasonably be accomplished. Verification of residency should be accomplished to the extent possible in conjunction with the verification of other information such as, but not limited to, rent and mortgage payments, utility expenses, and identity. If verification cannot be accomplished in conjunction with the verification of other information, then the State agency shall use a collateral contact or other readily available documentary evidence. Documents used to verify other factors of eligibility should normally suffice to verify residency as well. Any documents or collateral contact which reasonably establish the applicant's residency must be accepted and no requirement for a specific type of verification may be imposed. No durational residency requirement shall be established.

24. Federal Regulations at 7 C.F.R. §273.6 Social security numbers, states:

> (a) Requirements for participation. The State agency shall require that a household participating or applying for participation in the Food Stamp Program provide the State agency with the social security number (SSN) of each household member or apply for one before certification. If individuals have more than one number, all numbers shall be required. The State agency shall explain to applicants and participants that refusal or failure without good cause to provide an SSN will result in disqualification of the individual for whom an SSN is not obtained…
> (c) Failure to comply. If the State agency determines that a household member has refused or failed without good cause to provide or apply for an SSN, then that individual shall be ineligible to participate in the Food Stamp Program. The disqualification applies to the individual for whom the SSN is not provided and not to the entire household.

25. The above cited authorities explain the respondent must verify the assistance group member's SSN and residency, if questionable. The petitioner did not provide the requested information to verify the SSN's of the children and did not submit any good cause reason in not obtaining the SSN; therefore, the undersigned concludes that the respondent was correct in denying the petitioner's request for additional FAP benefits.

TCA will now be addressed:

26. Federal Regulations at 45.C.F.R. §205.52 Furnishing of social security numbers states:

> (a) As a condition of eligibility, each applicant for or recipient of aid will be required:
> (1) To furnish to the State or local agency a social security account number, hereinafter referred to as the SSN (or numbers, if more than one has been issued); and
> (2) If he cannot furnish a SSN (either because such SSN has not been issued or is not known), to apply for such number through procedures adopted by the State or local agency with the Social Security Administration.

27. The above cited regulation explains that a SSN issued to each applicant or recipient is required in order to determine eligibility. The petitioner submitted SSN's that potentially do not belong to the minor children. The department was unable to determine eligibility as these are not the SSN's issued to the minor children.

28. Fla. Admin. Code R. 65A-1.205 Eligibility Determination Process, addresses the verification process in part and states:

> (1)(a) The Department must determine an applicant's eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter. It is the applicant's responsibility to keep appointments with the eligibility specialist and furnish information, documentation and verification needed to establish eligibility…
> (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… 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...
> (4) **If an applicant or recipient does not keep an appointment without arranging another time with the eligibility specialist; or does not sign and date the applications described in subsection (1); or does not submit required documentation or verification the Department will deny benefits as it cannot establish eligibility.** (*emphasis added)*

29. Federal regulations at 7 C.F.R. § 273.9 addresses who is responsible for obtaining verification and states in part:

> (f)(5)(i) The household has primary responsibility for providing documentary evidence to support statements on the application and to resolve any questionable information. The State agency must assist the household in obtaining this verification provided the household is cooperating with the State agency as specified under paragraph (d)(1) of this section. Households may supply documentary evidence in person, through the mail, by facsimile or other electronic device, or through an authorized representative. The State agency must not require the household to present verification in person at the food stamp office. The State agency must accept any reasonable documentary evidence provided by the household and must be primarily concerned with how adequately the verification proves the statements on the application.

30. The above cited authorities explain that, as an applicant for benefits, the petitioner has the ultimate responsibility to keep appointments with the department and provide the verifications necessary for the respondent to make an eligibility determination. The respondent sent written notices on February 16, 2016 and February 26, 2016 requesting verification to establish the identity, social security numbers, and citizenship of the two minor children. The petitioner failed to keep the appointments set and further

failed to provide the information requested to determine eligibility. The petitioner did not request and extension with the respondent to obtain the verification.

31. In review of all testimony and evidence, the petitioner was provided the opportunity to provide the verification required to determine eligibility for the children and he failed to do so. Therefore, the respondent was correct in denying the petitioner's request for additional benefits.

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 __16___ day of __May______________, 2016,

in Tallahassee, Florida.

Pamela B. Vance

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

May 25, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01576

PETITIONER,

Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 Lake
UNIT: 88002

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 10:45 a.m. on March 30, 2016.

APPEARANCES

For the Petitioner:

For the Respondent: Stanley Jones, ACCESS
Economic Self-Sufficiency Specialist

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny the petitioner Medicaid Qualifying Individual 1 (QI1) benefits is proper. The respondent carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

By notice dated March 1, 2016, the respondent notified the petitioner QI1 was approved for December 2015 and denied for February 2016 through April 2016, due to income. Petitioner timely requested a hearing to challenge the QI1 denial.

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 March 30, 2016, for the respondent to submit an additional exhibit. The exhibit was received timely and entered as Respondent Exhibit “5”. The record was closed on March 30, 2016.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner received QI1 benefits. Also prior to the action under appeal, petitioner’s husband did not receive income from the Social Security Administration (SSA). QI1 for the petitioner is the only issue.

2. On January 26, 2016, the Department received petitioner’s Food Assistance (FA) application for her and her husband. The application indicates petitioner receives $415 from Social Security and her husband started receiving $1,497 Social Security in May 2015.

3. Also on January 26, 2016, the Department approved the petitioner and her husband FA benefits.

4. On February 29, 2016, the petitioner called the Department’s Customer Call Center (CCC) to inquire about her QI1 benefits. The CCC informed the petitioner that her January 26, 2016 application was only for FA. The CCC reused petitioner’s January 26, 2016 application for Medicaid QI1 benefits.

5. The following is the Department's calculation of the petitioner's QI1 eligibility:

$ 415	petitioner's SSDI
+$1,497	petitioner's husband's SSDI
$1,912	total household income
-$ 20	unearned income disregard
$1,892	total countable income

6. The QI1 income limit for a couple is $1,793. Petitioner's $1,892 household income exceeds $1,793.

7. On March 1, 2016, the Department mailed petitioner a Notice of Case Action, notifying QI1 was approved for December 2015 and denied for February 2016 through April 2016, due to income.

8. Petitioner stated that she cannot afford to pay her Medicare premium. And it is "unfair" that she is no longer eligible for Medicaid QI1.

9. After the hearing, the respondent's representative submitted income verification from the SSA for the petitioner and her husband. The verification confirms the petitioner receives $415 SSDI. However, petitioner's husband receives $1,498 SSDI not $1497. The additional $1.00 would also exceed the $1,793 QI1 income limit for a couple.

CONCLUSIONS OF LAW

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

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

12. Fla. Admin. Code R. 65A-1.702 Special Provisions explains the Buy-In Programs and in part states:

> (12) Limits of Coverage.
> (a) Qualified Medicare Beneficiary (QMB). Under QMB coverage, individuals are entitled only to Medicare cost-sharing benefits, including payment of Medicare premiums.
> (b) Special Low-Income Medicare Beneficiary (SLMB). Under SLMB coverage, individuals are entitled only to payment of the Part B Medicare premium. If eligible, AHCA shall pay the premium for up to three months retroactive to the month of application…
> (d) Part B Medicare Only Beneficiary (QI1). Under QI1 coverage, individuals are only entitled to payment of their Medicare Part B premium. (This is coverage for individuals who would be eligible for QMB or SLMB coverage except their income exceeds limits for those programs.)…

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

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows…
> (b) For QMB, income must be less than or equal to the federal poverty level…
> (g) For SLMB, income must be greater than 100 percent of the federal poverty level but equal to or less than 120 percent of the federal poverty level…
> (j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. QI1 is eligible only for payment of the Part B Medicare premium through Medicaid…

14. The Department's Program Policy Manual, CFOP 165-22, Appendix A-9 (April 2015), identifies the following couple's Buy-In income standards:

QMB	$1,328
SLMB	$1,593
QI1	$1,793

15. Federal regulation at 20 C.F.R. § 416.1121 defines different types of unearned income as follows:

> Some types of unearned income are—
> (a) Annuities, pensions, and other periodic payments. This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits…

16. In accordance with the above authority, the Department included petitioner's $415 SSDI and her husband's $1,497 SSDI, to arrive at $1,912 combined household income.

17. Federal regulation at 20 C.F.R. § 416.1124(c) (12) establishes a $20 disregard for "the first $20 of any unearned income in a month". The Department deducted $20 from petitioner's $1,912 household income to arrive at $1,892 countable income.

18. The evidence establishes that petitioner's household income exceeds the income standard for all three Buy-In Programs.

19. In careful review of the cited authorities and evidence, the undersigned concludes the respondent met its burden of proof. Petitioner is not eligible for Medicaid QI1 due to exceeding the QI1 income limit.

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 ___25___ day of ___May___________, 2016,

in Tallahassee, Florida.

Priscilla Peterson

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

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

Jun 01, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01589

PETITIONER,

Vs.

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

RESPONDENT.

_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on April 27, 2016 at approximately 3:30 p.m.

APPEARANCES

For Petitioner:

For Respondent: Cindy Henline
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 12.5 additional hours per week of Companion Care was correct. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

Petitioner's son represented her. He may sometimes be referred to as "Petitioner's representative." Cindy Henline 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
- Juan Rodas – Compliance Officer - UnitedHealthcare

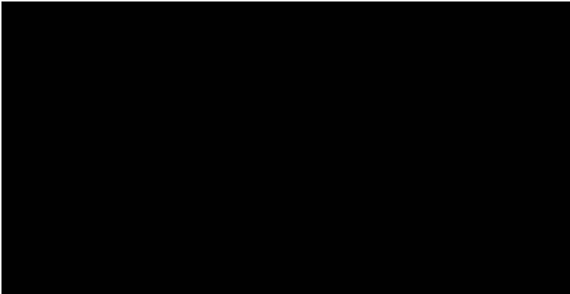
Petitioner moved Exhibits 1 and 2 into evidence. Respondent's Exhibits 1 – 12 were entered into evidence. The undersigned took administrative notice of the following:

- Florida Statutes Sections 409.913, 409.963, 409.965, 409.978, 409.979, 409.98, 408.984.
- Florida Administrative Code Rule 59G-1.010.

FINDINGS OF FACT

1. Petitioner is a 61-year-old female. Petitioner receives both Medicare and Medicaid. She is enrolled with UnitedHealthcare ("United") as her both her Managed Medical Assistance ("MMA") plan and her Long Term Care ("LTC") plan.

2. Petitioner's medical history includes:



3. Petitioner requires total assistance with her Activities of Daily Living ("ADLs") and Instrumental Activities of Daily Living ("IADLs"). She lives with her 29-year-old son.

Her 18-year-old daughter used to live with her, but has moved away to attend college out-of-state, leaving her son as her primary caregiver.

4. On January 12, 2016, Petitioner's Case Manager, [redacted] 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, [redacted] recommended a range of 31-50 minutes per day, five (5) days per week to be covered by United, and 31-50 minutes per day to be provided by her son two (2) days per week. Dr. Karver approved 30 minutes per day to be provided by United. (Respondent's Exhibit 9).

5. The sum total of the minimum amount of time for each recommended service to be provided by United, based upon the range provided by [redacted] is 1,577 minutes per week, which is 27.28 hours per week. This calculation assumes Petitioner's son will provide 839 minutes of care (14 hours per week).

6. The sum total of the maximum amount of recommended time is 3,315 minutes per week, which is 38.58 hours per week. Dr. Karver approved 2,012 minutes per week, which is 33.53 hours per week. Dr. Karver stated she then added hours to provide 40 hours of services, based upon her medical judgment.

7. On January 14, 2016, United issued a Notice of Action, Respondent's Exhibit 3, denying the request for the additional 12.5 hours per week of Companion Care. The Notice stated, in pertinent part:

> You have asked for 52.5 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. 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 sources.
>
> The total number of hours approved is 40 hours a week.

8. Petitioner's son testified he cares for his mother on nights and weekends. He stated he frequently travels for work and leaves the house between 5:00 a.m. and 5:30 a.m. He said he typically gets home between 5:30 p.m. and 6:30 pm., but sometimes does not arrive until 7:00 p.m. He said there are two (2) other family members who live 15 – 20 minutes away, but they are rarely available.

9. Petitioner's son said Petitioner is unable to dial 911. Dr. Karver offered to provide a Personal Emergency Response System (PERS). She also offered Adult Day Care as an option, or to distribute the 40 hours differently in order to meet Petitioner's needs. She said the care provided worked fine when Petitioner's daughter also lived with her, but United cannot provide someone to watch her just in case something happens. She said home health services are designed to supplement family care, not replace it.

10. Petitioner's son said they tried Adult Day Care, but that she did not enjoy it and would prefer to stay at home. Dr. Karver also suggested a nursing home because she is in an unsafe situation. He said it is part of Latin culture for him to care for her and not put her in a nursing home. He also said his mother previously worked as a nurse at both a hospital and nursing home, and that he did not like the quality of nursing homes.

CONCLUSIONS OF LAW

11. 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.

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

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

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

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

16. 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…."

17. 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.

18. 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.

19. 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.

20. 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.

21. [redacted] provided a wide range of recommended time, anywhere between 27.28 hours per week and 38.58 hours per week. Dr. Karver initially approved 34 hours based upon the LTC assessment, but chose to increase Petitioner's hours to 40 hours per week due to her own medical judgment. The 40 hours per week is just over the maximum recommendation of [redacted]

22. It is undisputed that Petitioner requires total assistance with all of her ADLs and IADLs. 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 chose to exceed the number of hours above the LTC assessment calculation due to her clinical judgment that the additional hours are medically necessary. She also provided several alternatives to increasing the Companion Care, which Petitioner's son rejected.

24. It is highly commendable that Petitioner's son wants to honor his mother and his Latin culture by taking care of her in the home. But Medicaid can only provide medically necessary services. The additional hours are desirable, but not medically necessary.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

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

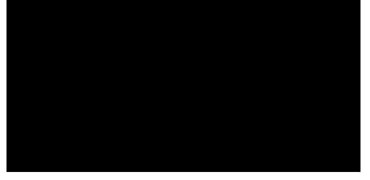
Rick Zimmer
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

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

Jun 06, 2016

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 16F-01591

PETITIONER,

Vs.

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

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 19, 2016 at approximately 9:00 a.m.

APPEARANCES

Petitioner:

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

STATEMENT OF ISSUE

At issue is whether or not Respondent's action denying Petitioner's request for three (3) cans of Chocolate Boost nutritional supplement per day was correct. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

Petitioner represented himself.

with appeared as a witness for Petitioner. Petitioner moved Exhibit 1 into evidence.

Stephanie Lang, R.N. Specialist, appeared both as a witness and representative for Respondent, the Agency for Health Care Administration (hereinafter "AHCA" or the "Agency"). Respondent presented the following witnesses:

- Dr. Merlin Osorio – Medical Director – Clear Health Alliance
- Diana Anda – Grievance and Appeals Supervisor – Clear Health Alliance

Tracy Jeter-Cummings, Program Administrator with Clear Health Alliance ("Clear Health") observed the hearing. Respondent moved Exhibits 1 – 4 into evidence. The undersigned held the record open for Respondent to provide additional evidence. Respondent submitted additional evidence, entered as Respondent's Exhibits 5 – 8.

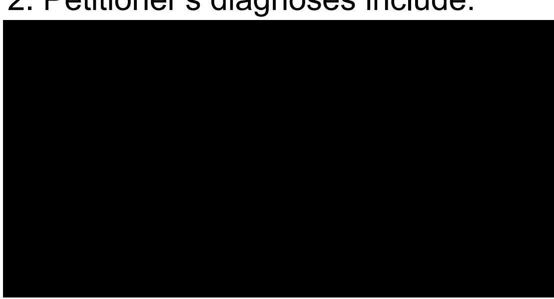
Administrative notice was taken of the following:

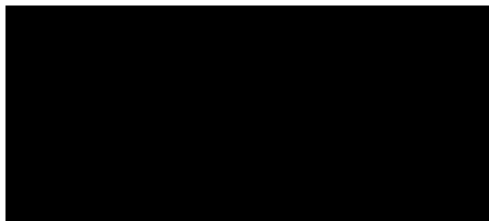
- Florida Statutes: § 409.905, § 409.910, § 409.962, § 409.963, § 409.964, § 409.965, and § 409.973.
- Florida Administrative Code: R.59G-1.001, R.59G-1.010 and R.59G-4.070.

FINDINGS OF FACT

1. Petitioner is a 53-year-old male. At all times relevant to this proceeding, he was eligible to receive Medicaid services.

2. Petitioner's diagnoses include:





3. Petitioner's height is 72 inches and his weight is 132 pounds. This results in a BMI of 17.9. A normal BMI ranges from 18.5 – 24.9, therefore Petitioner is underweight. Dr. Osorio said Clear Health will cover nutritional supplements when an individual's BMI is 18.5 or less.

4. Petitioner became enrolled in Clear Health's Managed Medical Assistance (MMA) plan on August 1, 2014. Petitioner was enrolled with Clear Health until the end of March 2016. Ms. Anda testified he was retroactively disenrolled effective January 1, 2016. Petitioner and [redacted] stated that Ms. Anda's testimony was the first time they had ever heard about the disenrollment. According to the supplemental evidence submitted by AHCA, the notice that Petitioner was retroactively disenrolled was not sent to him until May 16, 2016. (Respondent's Exhibit 7). Ms. Anda said Clear Health has been paying for claims submitted in 2016.

5. Ms. Lang testified the reason for the disenrollment is that Petitioner has a Medicare Special Needs Plan as his primary insurance. Individuals with this plan are not eligible to enroll in Medicaid MMA plans. These individuals default into the Medicaid State Plan.

6. Petitioner is on the [redacted] is his Case Manager.

7. Petitioner received Boost from his prior MMA plans, but has been denied by Clear Health every time he has requested it. Petitioner has been receiving Boost

nutritional supplement drinks through the [redacted] However, [redacted] said the [redacted] is no longer able to provide the Boost because they are the payor of last resort and they must be requested through regular Medicaid. She said Medicare plan will only cover Boost if it is administered through a tube. She said he has not received Boost since his last shipment on February 28, 2016.

8. Petitioner said the medications that he takes for [redacted] gives him a poor appetite. Petitioner said he drinks a Boost for breakfast with a piece of toast because his morning medication has to be taken with food. Then he drinks a Boost for lunch and another one for dinner. He can swallow and absorb regular food, he just does not have enough of an appetite to be able to eat.

9. On February 9, 2016, Petitioner visited his physician for an Infectious Disease Follow Up. The notes from the visit, contained in Respondent's Exhibit 2, include Petitioner's medical conditions and low BMI, among other information. The notes state Petitioner should have another follow up visit in three (3) months as well as:

- Intervention and counseling on cessation of tobacco use
- Gain weight: Discussion of diet
- Education and counseling Refer to www.floridamedicalclinic.com/services/ for smoking cessation information
- Education and counseling Abnormal BMI. Refer to www.floridamedicalclinic.com/services/ for weight gain information.

10. Petitioner's physician wrote a prescription for a 90-day supply of Chocolate Boost to be consumed three (3) times per day. A Medication Prior Authorization Form ("Form") was faxed to Clear Health the same day. The Form indicates the cans of Boost are to be consumed orally.

11. On February 11, 2016, Clear Health issued a Notice of Action, Respondent's Exhibit 3, stating, in pertinent part:

> **Clear Health Alliance** has reviewed your request for ENSURE, which we received on 02-02-2016. After our review, this service has been:
>
> **Denied** as of 02-22-2016
>
> ….
>
> **The facts that we used to make our decision are**: 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.

12. According to Clear Health, the denial was based on CPT B4150 – enteral formula. (Respondent's Exhibit 1). According to Respondent's Exhibit 4, CPT B4150 is for formulas administered through an enteral feeding tube. CPT B4150 SC is for formula administered orally. Both the prescription and the Medicaid Prior Authorization Form indicate the Boost are to be consumed orally, three (3) times per day.

13. Boost is indicated as a general dietary supplement. (Respondent's Exhibit 4). Dr. Osorio said there is no formal requirement for a recipient to receive nutritional counseling prior to receiving a dietary supplement, but he said Petitioner should exhaust his other options first before receiving the Boost. He said a nutritional assessment for a high calorie diet, as well as medications that stimulate appetite should be tried. When asked if those options are less costly alternatives to Boost, Dr. Osorio did not know about the medications, but said it would be less costly to do the nutritional assessment first. Petitioner and [redacted] said his Case Manager with Clear Health has never told him he needed to try either alternative.

CONCLUSIONS OF LAW

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

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

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

17. Section 409.973, Fla. Stat. addresses the minimum benefits provided under Medicaid managed care plans:

> (1) MINIMUM BENEFITS.—Managed care plans shall cover, at a minimum, the following services:
> …
> (p) Medical supplies, equipment, prostheses, and orthoses...
> (x) Prescription drugs.

18. “Medical supplies” are defined as “medical or surgical items that are consumable, expendable, disposable or non-durable and that are used for the treatment or diagnosis of a patient’s specific illness, injury, or condition. Also see ‘Supplies and appliances’.” Fla. Admin. Code R. 59G-1.010(163).

19. “Supplies and appliances” means “items necessary for use by a patient during the course of an illness or injury.” Fla. Admin. Code R. 59G-1.010(277).

20. “Prescription” is defined as “any order for drugs, medical supplies, equipment, appliances, devices, or treatments written or transmitted by any means of communication by a licensed practitioner….” Fla. Admin. Code. 59G-1.010(223).

21. Based upon the definitions in the Florida Administrative Code, Boost is a consumable medical supply, which is a minimum benefit under Medicaid managed care plans.

22. The July 2010 Durable Medical Equipment/Medical Supply Services Coverage and Limitations Handbook ("DME Handbook") is promulgated into law by Chapter 59G of the Florida Administrative Code.

23. Page 1-2 of the DME Handbook states: "Medical supplies are defined as medically necessary medical or surgical items that are consumable, expendable, disposable, or non-durable and appropriate for use in the recipient's home." The DME Handbook requires any medical supplies provided to the Medicaid recipient to be medically necessary.

24. The definition of medically necessary is found in Fla. Admin. Code R. 59G-1.010 which states:

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

goods, or services medically necessary or a medical necessity or a covered service.

25. Clear Health claims the Boost is not medically necessary at this time because Petitioner needs to try other alternatives first. However, his Case Manager never told him he should do so. He has been disenrolled from Clear Health, and only found out about that fact at the hearing.

26. The Medication Prior Authorization Form submitted to Clear Health and the prescription indicated the Boost should be used in conjunction with a nutritional assessment. Trying to determine a high calorie diet that Petitioner can consume with his low appetite, as well as consuming the Boost, are not mutually exclusive. He can also try appetite stimulating medications at the same time.

27. The undersigned concludes Clear Health has failed him in terms of counseling him on options other than Boost. While this is not technically a termination of the Boost since it was being provided by the PAC Waiver and not Medicaid, it is similar in substance. The burden of proof is on Petitioner, and he has met it. His low BMI, combined with Clear Health's failure to educate him on other options, renders the Boost medically necessary at the time the action was taken.

28. It appears that Petitioner is now on Medicaid State Plan, so it is between AHCA and Clear Health as to which entity should pay for the Boost. However, as the named Respondent and single-state agency, AHCA is ultimately responsible for making sure Petitioner receives the Boost.

29. Petitioner is encouraged to pursue the nutritional assessment and appetite stimulating medications in addition to the Boost. Both Petitioner's physician and Dr. Osorio recommended nutritional counseling as part of his overall treatment plan. He

is not gaining weight on Boost, only maintaining it. Pursuing the broad approach recommended, Petitioner may ultimately gain some weight.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Petitioner's appeal is GRANTED. Respondent is directed to provide three (3) cans of Boost per day, consistent with his prescription.

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 June, 2016,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
Don Fuller, Area 5, AHCA Field Office Manager
[redacted]

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

FILED

May 31, 2016

Office of Appeal Hearings
Dept. of Children and Families

APPEAL NO. 16F-01595

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-referenced matter on April 18, 2016 at approximately 10:30 a.m.

APPEARANCES

For the Petitioner:

For the 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 extraction of all four (4) wisdom teeth with I.V. sedation. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

Petitioner's mother represented her. She presented one (1) witness,

who is a neighbor and friend. Petitioner moved Exhibits 1 – 8 into evidence.

Petitioner submitted additional proposed evidence to the Office of Appeal Hearings on May 12, 2016. Since the record in this proceeding had closed at that time, the evidence will not be considered.

Lisa Sanchez, Medical/Health Care Program Analyst represented Respondent, the Agency for Health Care Administration ("AHCA" or "Agency"). Respondent presented the following witnesses:

- Carlene Brock – Quality Operations Nurse, Amerigroup
- Dr. Frank Manteiga – Dental Director – DentaQuest
- Jackelyn Salcedo – Complaints & Grievances Specialist - DentaQuest

Respondent moved Exhibits 1 – 13 into evidence at the hearing.

FINDINGS OF FACT

1. Petitioner is a 13-year-old female. Petitioner is enrolled with Amerigroup as her Managed Medical Assistance (MMA) plan. DentaQuest is Amerigroup's Dental vendor.

2. Petitioner recently had her braces removed. Her orthodontist said she needs to have her wisdom teeth extracted or it will ruin the orthodontic work. She was then referred to a pediatric dentist, who stated she needs to have her wisdom teeth extracted. Both the orthodontist and pediatric dentist took x-rays of Petitioner's teeth. The pediatric dentist said she has problems with her adult teeth so she needed to find a new dentist.

3. Amerigroup suggested [redacted] because they have a general dentist and an oral surgeon in the same practice. Both the general dentist and the oral surgeon said she needs to have her wisdom teeth extracted.

4. Petitioner's mother stated she has returned three (3) times because of her daughter's pain and blisters in her mouth. She testified her daughter had taken eight (8) acetaminophen on the date of the hearing for help with the pain. Petitioner is currently using a second bottle of Peridex mouthwash. Dr. Manteiga said Peridex is specifically for periodontal disease.

5. On February 15, 2016, Petitioner's oral surgeon submitted a request to have Petitioner's wisdom teeth extracted. The oral surgeon's note stated: "[Petitioner] was seen for a consult for extractions of her wisdom teeth. During my exam I found that these teeth showed signs of impaction. IV sedation will be performed due to how complex these are and due to her dental phobia and anxiety. PT IN PAIN." (Petitioner's Exhibit 2) (emphasis in original).

6. On February 16, 2016, Amerigroup issued a Notice of Action, Petitioner's Exhibit 3, denying the extraction of the wisdom teeth and general anesthesia. Dr. Manteiga said the anesthesia is automatically denied if the procedure is denied. Regarding the denial of the extractions, the Notice stated, for all four (4) teeth:

> The information your dentist sent shows your tooth does not need to be removed. Your tooth has no sign of infection and your dentist has not told us that you are in pain. Please follow up with your dentist.

7. DentaQuest and Amerigroup overlooked the clear statement in the oral surgeon's note where he stated Petitioner is in pain.

8. On February 29, 2016, Petitioner's mother filed a Member Grievance with Amerigroup, requesting an internal appeal of the denial.

9. DentaQuest re-reviewed the request for the extractions. The Dental Consultant who performed the review upheld the denial, stating:

> Appeal received. Denial upheld. We received and reviewed all submitted documentation (radiographs, ADA form, narrative, notes, etc.) for our final determination. To qualify for extraction of impacted wisdom teeth, there must be pathology or, on a per tooth basis, provider must furnish a narrative that describes pain that is more than norm eruption pain – for example: a description of duration, intensity, medications, or other factors that are more than normal eruption pain – the description of such factors is necessary to demonstrated need. Provider may resubmit with a tooth specific narrative. (Respondent's Exhibit 8).

10. On March 2, 2016, DentaQuest issued an Authorization Determination advising the denial was upheld.

11. On March 3, 2016, Petitioner's mother filed a State Complaint with the Agency. The request was reviewed by a Board Certified Oral & Maxillofacial Surgeon with a third party, MCMC. MCMC recommended that the denial should be upheld, stating the rationale as:

> The requested dental services are not medically necessary. The case is a request to review the medical necessity and Plan Policy provisions for coverage of proposed odontectomies of third molars in an adolescent patient. There is no clinical narrative or clinical exam or history to document or substantiate any need for the proposed surgery other than for preventive/prophylactic purposes. There is a panoramic radiograph which shows 4 impacted wisdom teeth without associated pathology. There is no history provided to show prior episodes of infection, pain, decay, need for antibiotics, periodontal disease or pocket depths, nor any other demonstrable pathology at this time. As such, medical necessity has not been demonstrated. Plan policy states that medical necessity must be demonstrated, and that "The prophylactic removal of asymptomatic wisdom teeth (third molars)…is not a covered service." As such, based upon the submitted information, the requested services are not medically necessary and removal in this case clinically is to be strictly prophylactic.
>
> Observation, no treatment, are both considered alternative treatment options.
> (Respondent's Exhibit 10).

12. On March 3, 2016, Amerigroup issued a letter advising the denial remains upheld.

13. On April 13, 2016, Petitioner's general dentist wrote a prescription for Doxycycline 100mg to treat her gum infection. Petitioner also scheduled a consultation with a periodontist set for May 10, 2016, which is subsequent to the hearing. Therefore, the undersigned is unaware of the results of the consultation.

14. Dr. Manteiga stated it could be something other than her wisdom teeth causing the pain. He said the roots of the wisdom teeth are not completely formed and they appear to be coming in straight, therefore the pain could be due to normal eruption. He testified the blisters in Petitioner's mouth are not consistent with a problem with wisdom teeth. He stated a condition called pericoronitis would be in the clinical narrative if the infection was due to her wisdom teeth.

15. Dr. Manteiga stated it is standard practice to prescribe an antibiotic if there is any infection. He said the Peridex is designed to reduce inflammation so that a periodontist can make a better evaluation and diagnosis. He said he thinks the braces caused periodontitis, and that sometimes gums grow over braces. He said she needs to be evaluated by a periodontist (which, at the time of hearing was scheduled for May 10, 2016) because he strongly believes the pain is being caused by gum disease. He said the periodontist might do a deep cleaning or even surgery.

16. Ms. Brock stated if the documentation from the periodontist indicates that the problem is due to the wisdom teeth instead of gum disease, Petitioner can submit a new request for extraction of the wisdom teeth.

CONCLUSIONS OF LAW

17. By agreement between AHCA and the Department of Children and Families ("DCF"), the Office of Appeal Hearings has jurisdiction to conduct this hearing pursuant to Section 120.80, Fla. Stat.

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

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

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

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

22. The Florida Medicaid Dental Services Covered and Limitations Handbook, November 2011, is promulgated into rule by Chapter 59G of the Florida Administrative Code.

23. Page 2-13 of the Dental Handbook describes oral surgery services as:

> Oral surgery services include extractions well as surgical and adjunctive treatment of diseases, injuries, deformities, and defects of the oral and maxillofacial regions.

24. Page 2-14 of the Dental Handbook defines a "Surgical Extraction" as:

> A surgical extraction is the removal of any erupted or unerupted tooth by the open method that includes the retraction of a mucoperiosteal flap and the removal of alveolar bone in order to extract or section a tooth.

25. The Dental Handbook requires that all services provided be medically necessary.

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

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

27. Since the Petitioner is under 21 years of age, a broader definition of medical necessity applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPDST) requirements. Section 409.905, 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.

28. Under the above statute, the Agency offers dental services as an EPSDT service to Medicaid-eligible recipients less than 21 years of age.

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

> (1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.
> (2) A state Medicaid plan must include "reasonable standards … for determining eligibility for and the extent of medical assistance" … and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.
> (3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."
> (4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."
> (5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to provide medically unnecessary, albeit desirable, EPSDT services. However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."

> (6) A state “may place appropriate limits on a service based on such criteria as medical necessity.” In so doing, a state “can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis” and my present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)).

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

31. Dr. Manteiga gave credible testimony that Petitioner’s wisdom teeth do not need to be extracted at this time. He testified that he strongly believed Petitioner’s pain is due to gum disease and not her wisdom teeth.

32. Amerigroup had Petitioner’s case reviewed three (3) times. Twice by DentaQuest and once by MCMC. All reviewers were in agreement that removal of the wisdom teeth is not necessary.

33. Petitioner’s mother’s concern for her daughter’s pain is completely understandable, and the issue needs to be addressed and corrected. At the time of the hearing, Petitioner was scheduled to meet with a periodontist. The periodontist should be able to make a definitive conclusion as to whether the pain is being caused by gum disease or the wisdom teeth (or both).

34. The undersigned has reviewed all pertinent rules and regulations, including EPSDT requirements. Petitioner has not met her burden to show, by the greater weight of the evidence, that the extraction of the wisdom teeth is medically necessary at this time.

35. Petitioner and her mother are encouraged to consult with the periodontist and participate in any recommended treatment. If the periodontist is able to correct the problem, then all is well. If the treatment does not correct the problem, or if the periodontist determines the wisdom teeth are causing the pain, Petitioner can submit a new request for extraction of the wisdom teeth at that time.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this __31__ day of __May________, 2016,

in Tallahassee, Florida.

Rick Zimmer

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

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

May 24, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01700

PETITIONER,
Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 13 Hillsborough
UNIT: AHCA

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on April 13, 2016 at 3:06 p.m.

APPEARANCES

For the Petitioner:

For the Respondent: Stephanie Lang, RN Specialist/Fair Hearing Coordinator
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is whether the Agency properly denied Petitioner's request for prescription medications Petitioner held the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

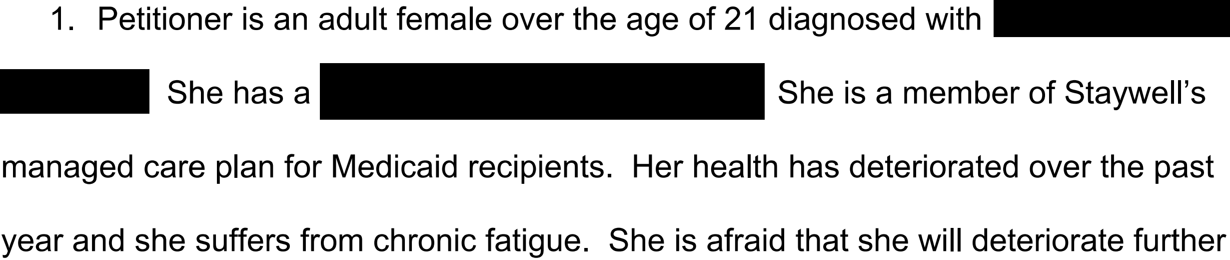
The Agency for Healthcare Administration (AHCA or Agency) is responsible for administering Florida's Medicaid Program. AHCA contracts with managed care plans to provide services, including pharmacy services, to Medicaid recipients in Florida. The managed care plans provide prior authorization reviews for requested services.

Petitioner was present and she brought her neighbor/friend [redacted] as her representative and witness. Respondent's witnesses were Stephanie Shupe (Regulatory Research Coordinator), Erica Hatchman (Manager of Pharmacy Appeals) and Lauren Barnes (Manager of Pharmacy Operations), all with Staywell Health Plan.

Petitioner did not submit any documentary evidence into the record. Respondent submitted nineteen exhibits marked and entered as Respondent's Exhibits 1 through 19. The hearing officer took administrative notice of Sections 409.910, 409.962 through 409.965, 409.973, and 409.91195 of the Florida Statutes (2016), Florida Administrative Code Rules 59G-1.001, 1.010, 4.255, 4.250, and the Medicaid Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook (July 2014).

FINDINGS OF FACT

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



1. Petitioner is an adult female over the age of 21 diagnosed with [redacted] She has a [redacted] She is a member of Staywell's managed care plan for Medicaid recipients. Her health has deteriorated over the past year and she suffers from chronic fatigue. She is afraid that she will deteriorate further

without the medication. She has two children and wants to be around and healthy for them.

2. Petitioner's treating doctor submitted a preauthorization request to the Agency for a combined therapy of [redacted] on or about January 26, 2016. The doctor provided clinical notes and lab results to support the preauthorization request.

3. The Agency, through its agent (the plan), reviewed the submitted documentation and denied the request. The denial notice dated January 27, 2016 stated the member must have evidence of [redacted] in order to be approved for [redacted] The plan issued a separate denial notice for the [redacted] which was denied because the sovaldi was denied (and ribavirin cannot be taken alone). In response to the denials, Petitioner's physician requested an appeal through the plan on February 15, 2016.

4. Petitioner's physician indicated in her letter to the plan (dated January 29, 2016) that this medication therapy can more effectively treat early stage disease than later stages. The physician included an article from a medical group to support this argument.

5. The plan reviewed the clinical documentation and the physician's letter. Its medical reviewer determined that Petitioner does not have [redacted] and denied the appeal. The plan sent a notice explaining this which was dated February 17, 2016.

6. Petitioner requested a fair hearing on March 8, 2016 to challenge the denial. She does not want to wait until her disease progresses before she can receive treatment, as it is harder to treat at later stages and seems ineffective to wait.

7. The Agency denied the preauthorization request for [redacted] because Petitioner's condition must meet certain criteria to be approved for that particular drug. [redacted] was denied because Petitioner didn't meet the criteria for [redacted] and one cannot be approved without the other. Based on the plan's review of Petitioner's medical records, her condition does not meet the prior authorization criteria for [redacted] because she does not have at least [redacted] The plan reviewed the medical records against the Agency's prior authorization criteria for the drug. Petitioner's medical records do not show that she meets the criteria for the drug.

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 65-2.060(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.”

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.

16. 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(16), Florida Statutes 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.

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 for [redacted] and [redacted] The Medicaid drug criteria for [redacted] require at least [redacted] [redacted] for approval. Petitioner's records show her hepatic fibrosis is not that

advanced, so she does not meet the established criteria for the drugs. There are no exceptions to the guidelines for special cases not included in the criteria. Petitioner is entitled to all the benefits, support, and care the State of Florida may furnish to a person in her circumstances, except when eligibility is limited by law, such as here.

20. Petitioner had the burden of proof in this case. Petitioner did not meet her burden of proof to show that she meets the criteria to receive this medication. She is encouraged to work with her physician and the Agency to find a medication that will meet her needs and can be approved.

21. After careful review of the evidence submitted and the relevant laws set forth above, the undersigned finds the Agency's action in this matter was correct.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Petitioner's appeal is hereby DENIED and Agency's action is AFFIRMED.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this ___24__ day of ___May___________, 2016,

in Tallahassee, Florida.

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

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

Jun 01, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01702

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 April 20, 2016, at 9:02 a.m.

APPEARANCES

For the Petitioner:

For the Respondent: Mary Triplett, supervisor

STATEMENT OF ISSUE

At issue is the denial of Emergency Medicaid for Alien (EMA) benefits. In accordance with Fla. Admin. Code R. 65-2.060 (1), the petitioner carries the burden of proof by a preponderance of evidence in this appeal.

PRELIMINARY STATEMENT

At the hearing, the petitioner presented one exhibit which was accepted 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 held open until the close of business on May 20, 2016 for clarification on residency. The evidence was received, accepted into evidence and marked as Respondent's Composite Exhibit 2.

Present as translators for the Notice of Case Action and a letter from the petitioner's mother, [redacted] patient advocate Conifer Health Solution/St Mary's Hospital. The respondent has no objections.

FINDINGS OF FACT

1. On January 9, 2016, the petitioner (age 16) and her mother entered the United States of America from Columbia on a visitor's visa (B2). Their date of entry was determined by the petitioner's mother's written statement which stated they entered on January 9, 2016 (Petitioner's Composite Exhibit 1). They had previously visited Florida on December 1, 2012.

2. On January 25, 2016, the petitioner was admitted to [redacted]

3. On January 28, 2016, the petitioner's mother signed the Attestation of Intent to Remain in Florida.

4. On February 1, 2016, the petitioner passed away. She incurred medical bills for the duration of her treatment from January 25, 2016 through February 1, 2016.

5. On February 8, 2016, the petitioner's representative submitted an application on behalf of the petitioner requesting Emergency Medical Assistance for Aliens (EMA) benefits.

6. On February 10, 2016, a Notice of Case Action was sent to the hospital/ petitioner's representative. The notice requested the representative to complete and

sign the affidavit for designated representative form. On same day, a second Notice of Case Action was sent requesting gross income, proof of INS status, proof of identification, assets and proof that she applied for Social Security Disability. A due date of February 22, 2016 was given.

7. On February 12, 2016, the petitioner's representative provided identification, a statement of Attestation of Intent to Remain in Florida signed on January 28, 2016 by the petitioner's mother, an affidavit for designated representative form, a letter dated February 5, 2016, signed by the petitioner's mother stating they came in United States on vacation on January 9, 2016, a medical referral form and supporting bills.

8. On March 3, 2016, the Department denied the petitioner's Medicaid application and issued a Notice of Case Action. The reason given for the denial was that none of the members meet the requirement for the program.

9. At the hearing, the Department stated the reason for the denial was that the petitioner had an active visitor's visa (B2) and was considered to be a visitor.

10. On March 3, 2016, the petitioner's representative requested a hearing to challenge the Department's action to deny the petitioner EMA Medicaid benefits.

11. At the hearing, the petitioner's representative informed the undersigned the petitioner's mother left Florida sometime in February 2016, shortly after her daughter was cremated. He asserted the petitioner and her mother intended to live in Florida up until the time of her death.

CONCLUSIONS OF LAW

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

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

14. The Department's Program Policy Manual (Policy Manual), CFOP 165-22 at passage 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 her behalf. This included providing the representative with a written request for verification. The petitioner's mother selected the Conifer's patient advocate as her designated representative by completing form CF-ES-2505.

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.

17. The Policy Manual at passage 0230.0105 addresses Emergency Medicaid for Noncitizens (MFAM). It states:

> This program provides emergency Medicaid coverage for noncitizens who would otherwise be eligible for Medicaid except for their noncitizen status. They must meet all technical requirements except for citizenship, child support enforcement cooperation, and welfare enumeration.
> To be eligible for emergency Medicaid benefits, the noncitizen must meet the income requirements for whichever Medicaid coverage group the noncitizen is determined to be eligible.
> Medicaid coverage is for the duration of the emergency medical situation only, as certified by a health professional. This includes emergency labor and delivery.

18. The above states that to be eligible for Emergency Medicaid for Noncitizens all technical factors must be met except citizenship therefore the petitioner must meet residency as a technical factor.

19. The Policy Manual at passage 1430.0300, addresses Residency (MFAM) as follows:

> Residency exists when the intent of the individual is to remain in the state. Residency is not dependent upon the duration of the stay. **Residency does not exist when the stay is for a temporary purpose such as a vacation and there is intent to return to a residence in another state.**
> An individual must satisfy one of the following residence requirements:
> 1. must reside in the State of Florida with the intent to remain, (individuals statement as to their intent to remain is acceptable) or
> 2. must be living in the State of Florida for employment purposes without intent to remain and meets the following conditions:
> a. the individual or caretaker relative is not receiving assistance from another state, and
> b. the individual or caretaker relative came to Florida with a job commitment or is actively seeking employment during the stay in the state…(emphasis added)

20. The above states that residency does not exist when the stay is for a temporary purpose such **as a vacation** and there is intent to return to a residence in another state. The petitioner's mother provided a written statement that she came to the United States on vacation; therefore, based on her statement she does not meet the residency requirements. Her letter did not indicate any intent to remain in Florida. She signed an Attestation of Intent to Remain in Florida; however, she returned to Columbia in February.

21. The Policy Transmittal No. : C-05-02-0001 dated February 3, 2015, provides Clarification on Residency Policy for EMA and states:

> Emergency Medicaid for Aliens (EMA) is available for non-citizens that do not qualify for Medicaid due to citizenship status, but meet all other eligibility criteria. Visitors or students in the U.S. do not usually meet the residency requirement.
> **However, there are cases in which an individual originally entered the U.S. under a visa (non-immigrant) and later applied for permanent residency and expresses an intent to remain in Florida. In these cases, the individual and their children under the age of 21, would meet the residency requirement.** This would have to be verified through VIS-CPS (formerly SAVE) or USCIS documentation. (emphasis added)

22. The above transmittal states that visitors or students in the U.S. do not usually meet the residency requirement; however, if they later applied for permanent residency and express an intent to remain in Florida, the residency requirement is met. There is no indication the petitioner's mother applied for permanent residency. She did sign a form indicating she intended to remain here; however, she did not.

23. The Policy Manual at passage 1430.0117 Noncitizens not Eligible for Assistance (MFAM) states:

> The following individuals are not eligible for Medicaid on the factor of citizenship status:
> 1. foreign government representatives on official business and their families and servants,
> 2. visitors for business or pleasure, including exchange visitors,
> 3. crewmen on shore leave,
> 4. noncitizens in travel status while traveling directly through the U.S.,
> 5. treaty traders and investors and their families,
> 6. foreign students,
> 7. international organization representatives and individuals and their families and servants,
> 8. temporary workers including agricultural contract workers, or
> 9. members of foreign press, radio, film, or other information media and their families.
>
> **Verification of these statuses is usually the I-94, Arrival-Departure Record, annotated with the letters "A" through "V" except “T” (A-2, B-1, etc.).** (emphasis added)

24. The petitioner’s representative argued the petitioner’s mother expressed an intent to remain in Florida by signing an Attestation of Intent to Remain in Florida at the time of the petitioner’s hospital stay. The representative argued that even though the petitioner’s mother returned to her country after her daughter’s death, there was an intent to remain in Florida prior to her daughter’s death.

25. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the signed Attestation of Intent to Remain in Florida cannot be relied on as intent to reside in Florida. The petitioner’s mother returned to Colombia and no one provided any evidence that she applied for permanent residency. The findings further show the petitioner and her mother visited Florida on December 1, 2012 and did not remain. According to the authority cited above, a person here on a visitor’s visa with a B2 code is not eligible for EMA benefits. The Department’s action 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 01 day of June, 2016, in Tallahassee, Florida.

Christiana Gopaul Narine

Christiana Gopaul-Narine
Hearing Officer
Building 5, Room 255
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Tallahassee, FL 32399-0700
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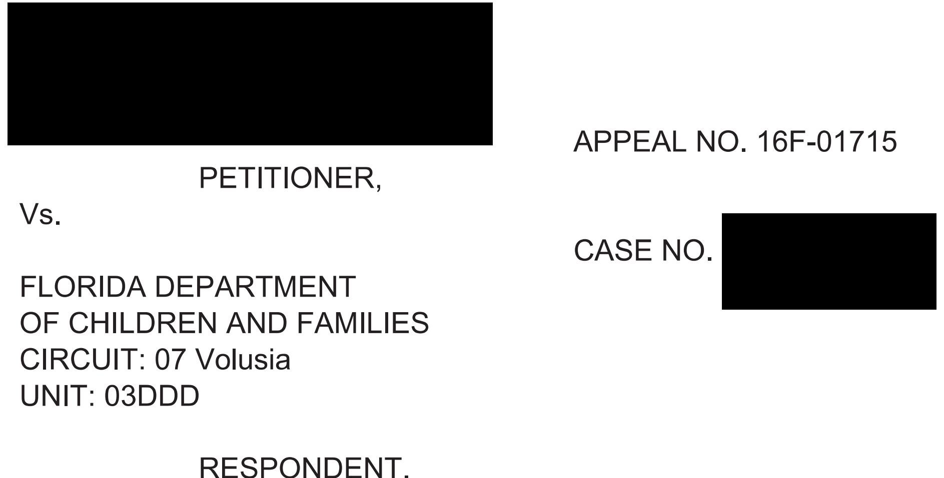
Copies Furnished To [redacted] Petitioner
Office of Economic Self Sufficiency

May 27, 2016

Office of Appeal Hearings
Dept. of Children and Families

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



PETITIONER,

Vs.

APPEAL NO. 16F-01715

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 07 Volusia
UNIT: 03DDD

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on April 20, 2016 at 11:35 a.m.

APPEARANCES

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

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

ISSUE

The petitioner is appealing the Department's action to deny his SSI-Related Medicaid application on March 2, 2016 as he did not meet the disability requirement.

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

PRELIMINARY STATEMENT

Appearing as an observer was Ursula Lett-Robinson, hearing officer with the Office of Appeal Hearings for DCF.

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

The record was held open until 5:00 p.m. on April 25, 2016 to allow time for the petitioner to submit evidence. Evidence was submitted and entered as the Petitioner's Exhibit 1.

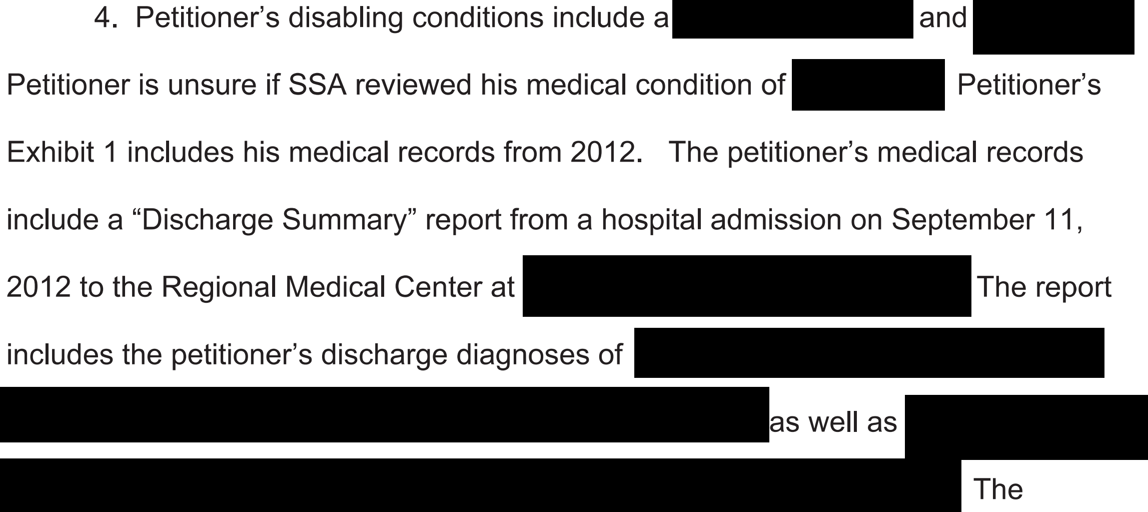
The record was closed as on April 25, 2015 at 5:00 p.m.

FINDINGS OF FACT

1. On February 18, 2016, the petitioner (age 48) applied for SSI-Related Medicaid with the Department as a disabled adult.

2. On March 2, 2016, the Department mailed a Notice of Case Action to inform petitioner that his application for SSI-Related Medicaid was denied due to not meeting the disability requirement. He previously applied for and was denied disability benefits by the Social Security Administration (SSA).

3. Petitioner applied for Social Security disability on January 31, 2014 and was denied on June 4, 2014 with a denial code of "N31", which the Department defined as "Non-pay-Capacity for substantial gainful activity-customary past work, no visual impairment." The petitioner filed an appeal on October 5, 2014. The petitioner explained that he had a hearing for his SSA denial in December 2015 and that his appeal is still pending; he has not yet received a decision on his pending appeal.



4. Petitioner's disabling conditions include a and Petitioner is unsure if SSA reviewed his medical condition of Petitioner's Exhibit 1 includes his medical records from 2012. The petitioner's medical records include a "Discharge Summary" report from a hospital admission on September 11, 2012 to the Regional Medical Center at The report includes the petitioner's discharge diagnoses of as well as The Petitioner's Exhibit 1 also includes the SSA Supplemental Security Income (SSI) Notice of Disapproved Claim (Notice) dated June 4, 2014. The Notice states, "We are writing about your claim for Supplemental Security Income (SSI) payments. Based on a review of your health problems you do not qualify for payments on this claim. This is because you are not disabled or blind under our rules."

5. The Notice includes the "Explanation of Determination" which lists the evidence used in the determination. The evidence used in making the disability determination includes a report dated April 11, 2014 from the Department; a report from dated April 9, 2014; and a report from West Care dated April 12, 2014. The Notice further states, "You state that you are disabled and unable to work because of

6. The petitioner argues that his condition has worsened the middle of last year and that he is almost 100 percent bedridden. The petitioner contends that he cannot stand up for more than a couple of minutes. The petitioner does not report any new

medical conditions. The petitioner argues that he needs a

7. The Department's position is that since the petitioner's SSA denial is still under appeal, the SSA denial stands. The Department explained that if the petitioner's condition has worsened or if he has any new medical conditions, he may complete a new application with the SSA since his denial is still under appeal.

CONCLUSIONS OF LAW

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

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

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

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

11. The findings show petitioner is 48 years old. In this case, before Medicaid eligibility can be determined, petitioner must meet the federal definition of disabled.

12. Additionally, 42 C.F.R. § 435.541 **Determination of Disability**, states:

> (a) *Determinations made by SSA.* The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...
> (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.911 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under 435.909.
> (b) *Effect of SSA determinations.*
> (1)…
> (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, alleges a new period of disability which meets the durational requirement of the Act, **and** has not applied to SSA for a determination with respect to these allegations– …
> (A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or...**(emphasis added)**

13. The Department's ACCESS Florida Program Policy Manual, 165-22, section

1440.1205 Exceptions to State Determination of Disability (MSSI, SFP), states:

> The state does not make a disability determination under the following conditions:
> 1. When an individual only applies to SSA (no application is filed with DCF and no SSI denial or ex parte is involved).
> 2. When an individual receives Title II disability or SSI benefits based on their own disability (not dependent or early retirement benefits).
> 3. When an earlier favorable federal or state determination of blindness/disability is still in effect and no unfavorable decision has been rendered by SSA.
> 4. When an individual is no longer eligible for SSI solely due to institutionalization.
> 5. When the applicant is appealing an earlier decision from SSA and claims no new disabling condition (condition not previously considered by SSA).

14. The above authorities indicate that the Department must make an independent determination of disability if the individual has applied for Medicaid after 12 months have passed since the SSA has made a disability determination. An exception to this is if the individual has a worsening medical condition or a disabling condition different from what was considered by SSA in making its determination and there has not been an application for disability with the SSA regarding these conditions. In this case, the petitioner applied for Medicaid after 12 months passed since the SSA denial. The findings show that the petitioner has reported his disabling conditions of hernia and hydrocele to the SSA. The petitioner is unsure if the SSA reviewed his medical condition of [redacted] The findings show that the SSA reviewed the petitioner's conditions of hernia, hydrocele and substance abuse. The findings also show that the petitioner's medical records from September 2012 include his diagnosis of [redacted] the SSA disability determination included a review of his medical records from April 2014. Therefore, the undersigned cannot conclude that the SSA disability

determination did not include a review of the petitioner's medical condition of hepatitis C. The above authorities also explain that if the SSA denial is under appeal and the individual is not claiming any new medical conditions not previously reviewed by the SSA, the Department does not make a disability determination. Petitioner's SSA denial is currently under appeal.

15. The undersigned concludes that the petitioner did not meet his burden of proof to show that the Department's action was incorrect. The undersigned concludes that the Department was correct to adopt the SSA disability denial, which is now under appeal. Until petitioner meets the federal disability criteria (while under age 65) his eligibility for Medicaid cannot be determined.

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 ___27___ ay of ___May___________, 2016,

in Tallahassee, Florida.

Paula Ali

Paula Ali
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

Jun 01, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01729

PETITIONER,
Vs.

CASE NO.

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

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on April 11, 2016 at 9:45 a.m.

APPEARANCES

For the petitioner:

For the respondent: Sylma Dekony, ACCESS Senior Specialist

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny the petitioner's application for Adult-Related Medicaid benefits. Petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner submitted an on-line application on January 29, 2016 to apply for Adult-Related Medicaid benefits. There was no notice sent to the petitioner to inform her that she was denied for these benefits. Instead, the respondent mailed a Notice of

Case Action to the petitioner on March 1, 2016, notifying her that the Medically Needy application dated January 29, 2016 was denied based on the contention that she did not complete a phone interview necessary to determine eligibility and the value of her assets was too high for this program. At the outset of the hearing, the respondent explained the system only generated the Medically Needy Program notice for the household and also the denial code regarding the asset limit was incorrect.

On March 3, 2016, the petitioner timely requested a hearing to challenge the denial of her Adult-Related Medicaid application.

Petitioner did not submit any exhibits. Respondent submitted four exhibits, entered as Respondent Exhibits "1" through "4". The record was held open until close of business on April 18, 2016 for submission of additional evidence from the respondent. On April 11, 2016, additional evidence was received and entered as Respondent Exhibit "5". The record closed on April 18, 2016.

FINDINGS OF FACT

1. The petitioner (58) applied for Medicaid Assistance on January 29, 2016 for herself. Petitioner reported on her application that she is disabled. Petitioner is not age 65 or older and does not have any minor children.

2. Petitioner claimed she applied for disability with Social Security Administration on January 29, 2016.

3. On February 9, 2016 (11 days after the date of the application), the respondent mailed the petitioner a pending notice giving her a deadline of February 11, 2016 to contact the office to complete a phone interview and provide the following:

[redacted]

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 to have a phone interview with you to determine your eligibility or to continue your benefits.
Please call (407) 317 - 7070 on or before February 11, 2016 between the hours of 9:00 A.M and 11:00 A.M for your phone interview.

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

Please read the disability pamphlet
Please complete and sign the Authorization To Disclose Information Form

5Call for your interview at 407-317-7070 on the date above. It is important that when you call for your interview that you have available the name, address, and phone number of your medical providers (doctors and hospitals) if asked. Sign & date the Authorization to Disclose (ES 2514). The Financial Information Release (ES 2613) mailed with this notice must be signed by you and your spouse if married, your designated representative, or POA/Legal Guardian. A copy of the POA or guardianship document is needed, as verification. Note: You must apply for benefits with the SSA and provide proof of application before Medicaid can be approved and diligently pursue to conclusion any benefit you may be entitled to receive. Please return signed forms to ACCESS PO Box 1770, Ocala, FL 34478/ Last 3 months statement showing ALL transactions & current balance for ALL accounts owned including including: Citizens bank (saving) & Wells Fargo (IRA/Checking)

4. On March 1, 2016, the respondent mailed a Notice of Case Action denying the petitioner's application for the Medically Needy Program. However, the petitioner was seeking Adult-Related Medicaid benefits. The respondent explained the petitioner did not complete a telephone interview and did not provide the requested information.

5. The Division of Disability Determination (DDD) is responsible for making a State disability determination on behalf of the respondent when an applicant applies for Medicaid on the basis of disability. Petitioner's application was not referred to DDD.

6. Petitioner explained she received the pending notice on February 12, 2016. She attempted to call the number on the notice; however; she was unable to reach anyone or leave a long message as the voicemail was full. Petitioner did not understand why she was given such short notification to contact the Department.

7. The respondent explained that on February 12, 2016, the processor received a voicemail on her answering machine from someone by the name of [redacted] however; the individual did not leave any contact information for the call to be returned.

8. The respondent explained the reason the pending notice was issued late was due to a backlog in the processing unit. Petitioner's case was reassigned to another processor on February 8, 2016; the processor mailed the pending notice to the petitioner on February 9, 2016 and scheduled the interview for February 11, 2016. According to the Department's policy, the respondent must schedule an interview within three working days. The respondent issued the pending notice on February 9, 2016, eleven days after the date of the application. The Department's running record comments do not indicate the respondent contacted the petitioner to complete the interview.

9. On March 10, 2016, the respondent completed a supervisory review with the petitioner; the petitioner explained she received the pending notice after the date of the scheduled interview and that she attempted to contact the number on the notice but was unsuccessful in reaching anyone to complete the interview. The respondent explained an interview could not be completed until a new application is submitted by the petitioner.

CONCLUSIONS OF LAW

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

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

12. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 0640.0104, Expedited Service for Disability-Related Medicaid (MSSI, SFP) states:

> Screen applications for disability related Medicaid to see if an expedited interview is necessary. Provide eligible AGs expedited services regardless of whether or not they are requested.
> Individuals or families are entitled to expedited services if an AG member is:
> 1. under age 65 and claiming a disability; and
> 2. not currently receiving SSI or SSDI benefits from the Social Security Administration (SSA),…
> Provide the individual a copy of the Screening for Expedited Medicaid Appointments form. Inform the individual that the Department uses all recorded information to determine eligibility for an expedited interview.
> Provide individuals eligible for expedited services with a notice of the time and date of the scheduled interview.
> **Schedule an interview for an expedited applicant within three working days; conduct an interview and complete the disability packet within seven calendar days of the date of application**. If the application is dropped off or mailed, contact the household by phone to tell them of the scheduled appointment, and mail a follow-up appointment notice. **If unable to reach the applicant by phone, schedule the appointment five to seven calendar days from the application date.** (emphasis added)
> Provide individuals with a brochure titled Notice of Disability Information and Request Form. The brochure includes a list of the information the individual will need to bring to the interview to complete the disability forms used by the Division of Disability Determinations to determine whether the applicant is disabled. The date of the scheduled interview is the verification due date for these households. The notice/brochure will also advise the individual that failure to show for the interview or to bring the requested information to the interview may delay application processing.

13. The Policy Manual at passage 0640.0400, APPLICATION TIME STANDARDS (MSSI, SFP) explains:

> The time standard begins upon receipt of a signed application.

Process applications as soon as possible after the assistance group (AG) completes all eligibility requirements. If the household completes all requirements and provides all information, process the application by the 30th day after the application date. **Process applications and determine eligibility or ineligibility within 90 calendar days after the date of the application for individuals who claim a disability.** (emphasis added)
Disability/Blindness Decision:
1. Conduct an interview and complete a disability/blindness packet within seven calendar days from the application date.
2. Request a disability/blindness decision within two calendar days of receipt of appropriate information.
3. Submit the packet no more than nine calendar days following the date of application.

14. Fla. Admin. Code R. 65A-1.205 Eligibility Determination Process.

(1)(b) Time standards for processing applications vary by public assistance program in accordance with 7 C.F.R. § 273.2(g), 45 C.F.R. § 206.10(a) (3) (i) and 42 C.F.R. § 435.911. For Food Assistance and Cash Assistance Programs, time standards begin the date following the date the application was filed and end on the date the Department makes benefits available or mails a notice concerning eligibility. For the Medicaid Program, the time standard ends on the date the Department mails an eligibility notice. The Department must process and determine eligibility within the following time frames:

Program:	Application Processing Time Standards
Medical Assistance and State Funded Programs for individuals who apply on the basis of disability	90 days

The Department uses information provided on the Screening for Expedited Medicaid Appointments form, CF-ES 2930, 04/2007, incorporated by reference, to expedite processing of Medicaid disability-related applications.
(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.

15. Based on the policies and authority cited above, the petitioner's application for disability related Medicaid should have been screened for an expedited interview. Respondent admitted to causing a delay in the application process as it did not mail the pending notice to the petitioner until eleven days after the date of the application. The respondent did not attempt to contact the petitioner for the interview when it caused the delay in the application process. Petitioner testified she attempted to contact the respondent on February 12, 2016 but was unable to leave an extensive voice message. According to the respondent, on February 12, 2016, someone by the name of [redacted] left a message on the processor's voice mail. The undersigned finds the petitioner's testimony to be credible. Therefore, the respondent needs to address the application thoroughly and as quickly as possible.

16. The undersigned concludes that a State disability determination should have been completed. However, a favorable disability determination by DDD cannot be guaranteed. Delay by the respondent does not create automatic eligibility as the State must follow the Social Security disability standards in accordance with federal regulations found at 42 C.F.R. § 435.540: "Definition of disability. (a) Definition. The agency must use the same definition of disability as used under Supplemental Security Income (SSI)…" While a final determination of disability cannot be guaranteed because of federal regulations, the respondent's processing delay needs to be remedied.

17. After considering the evidence, testimony and the appropriate authorities cited above, the undersigned concludes the respondent erred in denying the petitioner's Adult-Related Medicaid application without completing an expedited interview and

referring it to DDD for a disability determination. Therefore, the undersigned hereby remands this matter back to the Department to obtain the necessary information and forward all the required documentation to DDD to complete a disability determination. The respondent is to preserve and honor the petitioner's application dated January 29, 2016 and complete the eligibility determination process for the petitioner's Medicaid benefits. The respondent is to issue a written Notice of Case Action (NOCA) to the petitioner as soon as possible, including her appeal rights, upon completion of the Adult-Related Medicaid eligibility determination.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted and remanded back to the Department to take correction action as specified in the Conclusions of Law.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 01 day of June, 2016,

in Tallahassee, Florida.

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

Jun 06, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01739

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.

__________________________________/

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on April 27, 2016, at 10:45 a.m.

APPEARANCES

For the petitioner:

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

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the respondent incorrectly denied her request for a Sabina II hoyer lift?

PRELIMINARY STATEMENT

(“petitioner”), the petitioner, appeared on her own behalf.

Suzanne Chillari, Medical – Health Care Program Analyst with the Agency for Health Care Administration (“AHCA” or “Agency”), appeared on behalf of the Agency for Health Care Administration. The following individuals appeared as witnesses on behalf of the Agency for Health Care Administration: Christian Laos, Senior Compliance Analyst with United Healthcare; Sloan Karver, M.D., Long-Term Care Medical Director for United Healthcare; and Juan Rodas, Compliance Officer at United Healthcare.

The petitioner introduced Exhibits “1” through “6”, inclusive, at the hearing, all of which were accepted into evidence and marked accordingly. The respondent introduced Exhibits “1” through “7”, inclusive, at the hearing, which were accepted into evidence and marked accordingly. The hearing record in this matter was left open until the close of business on May 4, 2016 for the respondent to provide the relevant law in this case. When the information was not supplied, the hearing officer entered an Order requesting the information a second time. When the information was received from the respondent, it was accepted into evidence and marked as respondent’s Composite Exhibit “8”.

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 46-year-old female.

2. Petitioner was eligible to receive Medicaid benefits at all times relevant to these proceedings.

3. Petitioner is enrolled in the United Healthcare Community Plan. United Healthcare is a managed care organization ("MCO") contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in the State of Florida.

4. Petitioner's effective date of enrollment in United Healthcare Community Plan was October 1, 2015.

5. On or about February 18, 2016, the petitioner's provider submitted a prior authorization request to United Healthcare Community Plan for a Sabina II hoyer lift.

6. A hoyer lift is an assistive device that allows a patient to be transferred between a bed and a chair or other similar resting place using hydraulic power. Sling lifts are used for patients whose mobility is limited.

7. The Sabina II hoyer lift is a specific brand of hoyer lift.

8. In a Notice of Action dated February 23, 2016, United Healthcare Community Plan notified the petitioner it was denying her request for a Sabina II hoyer lift.

9. The Notice of Action explains, in part: "You asked for a special lift. You are able to get this through Medicare. The health plan will not cover this at this time. The health plan will cover any Medicare copayment for this service."

10. The Notice of Action goes on to state: "The facts that we used to make our decision are: Service is able to be provided under Medicare. Medicaid is the payer of last resort. Reference: FS 409.910(1)."

11. Petitioner is diagnosed with [redacted] [redacted] is a progressive [redacted] characterized by [redacted]

12. The petitioner requires a lift device to transfer safely. A lift device is medically necessary for the petitioner.

13. The petitioner does not currently have a lift device.

14. The petitioner's Medicare coverage is with a managed care organization other than United Healthcare.

15. The petitioner testified she contacted her Medicare MCO and was told by a representative at that office that Medicare will not pay for a Sabina II hoyer lift.

16. The petitioner does not have a Notice of Case Action or other document from her Medicare MCO evidencing that Medicare will not pay for a lift device.

17. The Long-Term Care Medical Director testifying for the respondent stated Medicare will pay for a lift device if it is determined to be medically necessary. She also explained Medicare will likely not pay for a brand-specific lift device such as the Sabina II. The Long-Term Care Medical Director did not dispute the medical necessity of the lift.

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 conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to § 120.80, Fla. Stat.

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

20. Goods and services requested under the Florida Medicaid Program must be shown to be medically necessary in order to be approved.

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

22. The petitioner in the present case is requesting a new service. Therefore, in accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof is assigned to the petitioner.

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

24. Section 409.905, Fla. Stat. addresses mandatory Medicaid services under the State Medicaid Plan and explains as follows:

> Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law…
> (4) HOME HEALTH CARE SERVICES.--The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home…
> (a) The agency shall require prior authorization of home health services….
> (c) The agency may not pay for home health services unless the services are medically necessary …

25. The Florida Medicaid Home Health Services Coverage and Limitations Handbook (October 2014) is incorporated by reference and promulgated into Rule by 59G-4.130, Florida Administrative Code.

26. The Florida Medicaid Home Health Services Coverage and Limitations Handbook, on Page 2-27, states as follows:

> Home health agencies that provide DME must comply with the policies and procedures contained in this handbook and in the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook.

27. 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. The Handbook, on Page 1-27, states:

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.
>
> Medicaid HMOs a` `1`re also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

28. Page 1-28 of the Florida Medicaid Provider General Handbook provides a list of HMO covered services. These services include durable medical equipment.

29. Page 1-30 of the Florida Medicaid Provider General Handbook states: “An HMO’s services cannot be more restrictive than those provided under Medicaid fee-for-service.”

30. In order for durable medical equipment and supplies to be approved, the equipment and supplies must not only be medically necessary but must also meet all requirements set forth in the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook.

31. Although the terms medically necessary and medical necessity are often used interchangeably and may be used in a variety of contexts, their definition for

Florida Medicaid purposes is contained in the Florida Administrative Code. Fla. Admin. Code R. 59G-1.010 states:

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

32. 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.

33. 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.

34. The Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook (July 2010) ("DME Handbook") is promulgated into rule by Fla. Admin. Code R. 59G-4.070.

35. The DME Handbook describes the covered services, limitations, and exclusions associated with the acquisition and reimbursement of durable medical equipment and medical supplies obtained through the Medicaid program.

36. The DME Handbook sets forth the definition of durable medical equipment on Page 1-2. "Durable medical equipment (DME) is defined as medically-necessary equipment that can withstand repeated use, serves a medical purpose, and is appropriate for use in the recipient's home as determined by the Agency for Health Care Administration (AHCA)."

37. The DME Handbook provides the definition of a patient lift on Page 2-73, where it states as follows: :A patient lift is a portable device used to lift and transfer a recipient between a bed, a chair, wheelchair, or toilet with minimal personal assistance."

38. The DME Handbook, also on Page 2-73, explains:

> Medicaid may reimburse for portable patient lifts for recipients ***under 21 years of age*** [Emphasis added], for use in the recipient's home, when the assistance of more than one person is necessary to move the recipient from bed to chair or chair to toilet, etc.

39. Medicare.gov, the official United States Government site for Medicare, at www.medicare.gov/coverage/patient-lifts.html, states "Medicare Part B (Medical Insurance) covers patient lifts as durable medical equipment (DME) that your doctor prescribes for use in your home." It further explains "Medicare will only cover your DME if your doctors and DME suppliers are enrolled in Medicare. Doctors and suppliers have to meet strict standards to enroll and stay enrolled in Medicare. If your doctors or suppliers aren't enrolled, Medicare won't pay the claims submitted by them."

40. AHCA Contract No. FP###, Attachment II, Effective 7/15/15, Page 87 of 217, the contract between the Agency for Health Care Administration and United Healthcare, at Paragraph (d), explains the following:

> The Managed Care Plan shall comply with all current Florida Medicaid Handbooks (Handbooks) as noticed in the Florida Administrative Register (FAR), or incorporated by reference in rules relating to the provision of services, except where the provisions of the Contract or the applicable federal waivers alter the requirements set forth in the Handbooks and Medicaid fee schedules.

41. The Florida Medicaid Provider General Handbook on Page 1-12 discusses a recipient's responsibility for exhausting third party liability sources. It explains:

> Medicaid is the payer of last resort. If a recipient has other insurance coverage through a third party source, such as Medicare, TRICARE, insurance plans, AARP plans, or automobile coverage, the provider must bill the primary insurer prior to billing Medicaid.

42. AHCA Contract FP025, Attachment II – Core, Section VIII.D.1.ii discusses a managed care plan's responsibility for copayments and deductibles. It details:

> The Managed Care Plan is responsible for Medicare coinsurance and deductibles for covered services. The Managed Care Plan shall reimburse providers or enrollees for Medicare deductibles and co-insurance payments made by the providers or enrollees, according to Medicaid guidelines referenced in the Florida Medicaid Provider General Handbook.

43. After a careful evaluation of the facts in this case along with the authorities set forth above, the hearing officer concludes the petitioner has not met her burden of proof to show that the respondent incorrectly denied her request for a Sabina II hoyer lift. Medicaid will only reimburse for a patient lift if the recipient is under 21 years of age.

44. The hearing officer is in agreement with the testimony of both parties at the hearing that a hoyer lift is medically necessary for the petitioner. The hearing officer encourages the respondent and the petitioner's Medicaid MCO to communicate with the petitioner and the petitioner's Medicare MCO to facilitate the acquisition of this piece of equipment for the petitioner.

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 06 day of June, 2016,

in Tallahassee, Florida.

Peter J. Tsamis

Peter J. Tsamis
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished To: [redacted] Petitioner
Dietra Cole, Area 8, AHCA Field Office Manager

Jun 01, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01765

PETITIONER,

Vs.

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 April 26, 2016 at 10:01 a.m.

APPEARANCES

For the Petitioner:

For the Respondent: Dotlin Williamson, supervisor.

STATEMENT OF ISSUE

The petitioner is 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. In accordance with Fla. Admin. Code R. 65-2.060 (1), the petitioner carries 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 did not present any exhibits.

FINDINGS OF FACT

1. On February 29, 2016, the petitioner submitted a recertification application for SSI-Related Medicaid benefits. He is the only household member. The petitioner receives Social Security Disability Income (SSDI) of $ 1,761. The Department determined he was ineligible for full Medicaid but he was eligible for the Medically Needy Program with a share of cost.

2. To determine the petitioner's SSI-Related Medicaid benefits, the respondent used the petitioner's gross income of $1,761 and subtracted a $20 unearned disregard resulting to the petitioner's countable income of $1,741. The respondent compared it to the income limit for one person which was $872 and found the petitioner's countable income 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.

3. The respondent performed the following budget calculations when it determined the petitioner's estimated SOC. It determined the petitioner's monthly gross income was $1,761. A $20 unearned income disregard was subtracted resulting to $1,741 as the countable income. The Medically Needy Income Limit of $180 for household size of one was subtracted resulting to $1,561 as the petitioner's SOC.

4. On March 8, 2016, the petitioner requested a hearing to challenge the Department's action to enroll him in the Medically Needy Program. The petitioner does not receive Medicare Part A or Medicare Part B.

5. The petitioner does not dispute the gross income included in the Department's calculations. The petitioner argued that his income has not changed. He does not understand how suddenly he is over the income limit for full Medicaid. He argues that he cannot purchase medication with the money he is getting from his disability. He also argues that the doctors want him to pay upfront before seeing him.

6. The Department explained that the petitioner was approved for full Medicaid because no income was counted in the Medicaid budget, now that the Department updated his case with his SSDI, he is over the income for full Medicaid.

CONCLUSIONS OF LAW

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

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

9. The petitioner has been determined disabled by Social Security. His Medicaid eligibility was determined under the SSI-Related Medicaid Program.

10. Fla. Admin. Code at R. 65A-1.711 (1) SSI-Related Medicaid Non-Financial Eligibility Criteria, states, "For MEDS-AD Demonstration Waiver, the individual must be age 65 or older, or disabled as defined in 20 C.F.R. §416.905…"

11. Income budgeting for MEDS-AD is set forth in Fla. Admin. Code R. 65A-1.713. It states:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
> (a) For MEDS-AD Demonstration Waiver, income cannot exceed 88 percent of the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C. (2) Included and Excluded Income. For all SSI-related coverage groups the department follows the SSI policy specified in 20 C.F.R. 416.1100, et seq.,…
> (4) Income Budgeting Methodologies. To determine eligibility SSI budgeting methodologies are applied except where expressly prohibited by 42 U.S.C. §1396, or another less restrictive option is elected by the state under 42 U.S.C. §1396(2000 Ed., Sup. IV)...

12. Federal Regulations at 20 C.F.R. § 416.1124 (c) (12), Unearned Income we do not count, states in part, "The first $20 of any unearned income in a month…"

13. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, Appendix A-9, identifies 88 % of the federal poverty level for SSI-Related Medicaid under the MEDS-AD Program at $872 effective April 2016. The petitioner's countable income exceeds the income standard for full MEDS-AD as listed above. The respondent's action to deny full Medicaid Program benefits for the petitioner was within the rules and regulation of the Program. The petitioner is not eligible for full coverage Medicaid.

14. A review of the rules and regulations did not find any exception to meeting the income limits for the Program.

15. Fla. Admin. Code R. 65A-1.710, SSI-Related Medicaid coverage Groups, states in part:

> (5) Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. §§ 1396a and 1396d, for aged, blind or disabled individuals (or

> couples) who do not qualify for categorical assistance due to their level of income or resources.

16. The above authority explains the Medically Needy Program is a coverage group for aged, blind or disabled individuals who do not qualify for full Medicaid due to their level of income.

17. Fla. Admin. Code R. 65A-1.702 (13) Determining Share of Cost (SOC). "The SOC is determined by deducting the Medically Needy Income Level from the individual's or family's income."

18. Fla. Admin. Code R. 65A-1.701 (30) states, "Share of Cost (SOC): SOC represents the amount of recognized medical expenses that a Medically Needy enrolled individual or family must incur each month before becoming eligible to receive Medicaid benefits for medical expenses incurred during the remainder of the month."

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

> (1)(h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses…
> (4)(c) Medically Needy. The amount by which the individual's countable income exceeds the Medically Needy income level, called the "share of cost", shall be considered available for payment of medical care and services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical cost…

20. Fla. Admin. Code R. 65A-1.716 (2), Income and Resource Criteria, states, "Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows: Size 1 Level $180."

21. The Policy Manual at passage 2440.0102, Medically Needy Income Limits (MSSI) states:

> When the assistance group has met the technical eligibility criteria and the asset limits, it is enrolled. There is no income limit for enrollment. The assistance group is income eligible (entitled to Medicaid) once income is less than or equal to the Medically Needy Income Level (MNIL) or medical bills equal the amount by which his income exceeds the MNIL. Once medical bills are equal to this surplus income, referred to as share of cost, the assistance group is eligible.
> The eligibility specialist must determine eligibility for Medically Needy any time the assistance group's income exceeds the income limits for another full Medicaid Program.

22. A review of the rules did not find any exceptions to the income limits. The undersigned reviewed the respondent's budget calculations and the petitioner's reported income using the rules cited above and did not find a more favorable outcome other than the SOC assigned by the respondent. Eligibility for full Medicaid is not found.

23. The undersigned concludes the respondent's action to deny full Medicaid benefits and to enroll the petitioner in the Medically Needy Program with the estimated SOC of $1,561 is within the rules of the Program.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The

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

Jun 01, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NOs. 16F-01772
& 16F-01773

PETITIONER,

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 14 Bay
UNIT: AHCA

RESPONDENT.
__________________________________/

FINAL ORDER OF DISMISSAL

THIS CAUSE is before Patricia C. Antonucci, following hearing to determine jurisdiction over Petitioner's appeals. Said hearing convened via teleconference on April 26, 2016 at approximately 4:03 p.m. EST/3:03 p.m. CST. Petitioner was represented by his mother, [redacted] Respondent, the Agency for Health Care Administration (AHCA) was represented by Cindy Henline, Medical/Health Care Program Analyst, who presented two witnesses from Petitioner's health plan, Staywell/WellCare ("Staywell"): Alexandria Hicks and Robert Walker, both Regulatory Research Coordinators. All parties and witnesses were duly sworn.

At issue was a decision by Respondent to deny payment of claims for medical procedures including an evaluation/office visit, an MRI, an EEG, and an injection. On the record, Staywell testified that Petitioner's provider/physician had provided these services and then billed Staywell for same.

Although Staywell denied payment and/or required more information before remitting payment to the provider, they explained that the provider could not retroactively bill Petitioner for services rendered. Petitioner's mother confirmed that all services had been provided and that she had not received any bills.

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 <u>claim for services is denied</u> or is not acted upon with reasonable promptness.
> (2) Any recipient who requests it because he or she <u>believes the agency has taken an action erroneously</u>.
> …
>
> § 431.201 Definitions.
> <u>Action means a termination, suspension, or reduction of</u> Medicaid eligibility or <u>covered services</u>. …
> (emphasis added)

Indeed, the instant appeals are based upon a dispute in billing between the Agency/Staywell and the provider. Except in very limited circumstances (*see* page 1-6 to 1-7 of the Florida Medicaid Provider General Handbook, promulgated by Florida Statutes 409.908 and Florida Administrative Code Chapter 59G-5.020(1)), a Medicaid recipient cannot be billed directly for services he has already received.

As such, there is no termination, suspension, or reduction of Medicaid-covered services at issue in these appeals. As the undersigned has no jurisdiction to hear cases related to provider billing, there is no relief which the undersigned has authority to provide.

WHEREFORE, the Petitioner's appeals are hereby DISMISSED, in accordance with this Final Order of Dismissal.

NOTICE OF APPEAL RIGHTS

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

DONE and ORDERED this 01 day of June, 2016,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
Marshall Wallace, Area 2, AHCA Field Office Manager

Jun 01, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01776

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 April 12, 2016 at 11:30 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 tooth extraction was correct. The Petitioner has the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

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

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

Respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Exhibits: Exhibit 1 – case summary and member eligibility information; Exhibit 2 – claim form; Exhibit 3 – X-ray Exhibit 4 – Authorization Determination; and Exhibit 5 – Notice of Action.

Also present for the hearing was a

FINDINGS OF FACT

1. The Petitioner is a seventeen (17) year-old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. She receives services under the plan from Humana, which utilizes DentaQuest for review and approval of dental services.

2. On or about February 3, 2016, the Petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from DentaQuest to perform extractions of 4 wisdom teeth (Teeth 1, 16, 17, and 32). DentaQuest partially denied

this request on February 4, 2016 – approving one extraction and denying three extractions.

3. The denial notice stated the three extractions were denied as not being medically necessary. This denial notice also stated the following regarding the reason for the denial:

> We cannot approve this request to remove your teeth because the information that your dentist sent shows that your teeth are not bad enough to be removed and show no sign of infection or pain. We have told your dentist this also. Please talk to your dentist about your choices to treat your teeth.

4. Petitioner's mother testified her daughter needs the extractions because she is in pain and the dentist told her the wisdom teeth will interfere with other teeth if they are not removed.

5. The Respondent's expert witness, Dr. Mantega, stated that the extraction of tooth 17 and tooth 32 have also now been approved by DentaQuest. With respect to tooth 16, he stated the extraction was denied because the tooth does not show any sign of infection.

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

.

CONCLUSIONS OF LAW

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

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

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

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

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

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

> "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide;
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
> . . .
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

13. The service at issue, tooth extraction, is a covered service for individuals under age twenty-one (21) in the Florida Medicaid Program. DentaQuest approved extractions of three teeth (1, 17, and 32) but has denied the extraction of tooth 16 due to medical necessity considerations.

14. Petitioner's mother believes the extraction should be approved because her daughter is in pain and the dentist told her it must be removed to prevent interference with other teeth.

15. Respondent's witness stated that the denial of the extraction for tooth 16 was appropriate because that tooth does not show any signs of infection or other reason to justify its extraction at this time.

16. After considering the evidence presented and relevant authorities set forth above, the undersigned concludes the Petitioner has not demonstrated that the denial of the request for extraction of tooth 16 was incorrect. Petitioner has not established that the request for this service is medically necessary as defined by Fla. Admin. Code R. 59G-1.010(166). Although Petitioner's dentist requested the extraction, this does not establish it is medically necessary. Respondent's witness testimony supports the denial of the requested service.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 01 day of June, 2016,

in Tallahassee, Florida.

Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
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Copies Furnished To: [redacted] PETITIONER
RHEA GRAY, AREA 11, AHCA FIELD OFFICE MANAGER

May 06, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01781

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 07 Volusia
UNIT: AHCA

RESPONDENT.

_________________________________/

FINAL ORDER

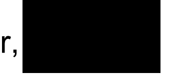
Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on May 4, 2016 at 3:13 p.m.

APPEARANCES

For the Petitioner:

For the Respondent: Sheila Broderick, registered nurse specialist

STATEMENT OF ISSUE

At issue is the respondent's decision denying a Medicaid provider,  reimbursement for medical services rendered to the petitioner February 14, 2016 – February 15, 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. United Healthcare (United) is the contracted health care organization in the instant case.

By notice dated February 25, 2016, United informed the petitioner that it denied Halifax Hospital's request for medical services rendered to her February 14, 2016 – February 15, 2016.

The petitioner requested a hearing on March 8, 2016 to challenge the denial decision.

[redacted] was present as a witness for the petitioner. The petitioner submitted documentary evidence which was admitted into the record as Petitioner's Composite Exhibit 1.

The respondent presented two witnesses from United: Susan Frishman, senior compliance analyst and Juan Rodas, compliance officer. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

FINDINGS OF FACT

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

1. The petitioner is a Florida Medicaid recipient. The petitioner is enrolled with United HMO.

2. The petitioner was transported to [redacted] on February 12, 2016 due to temporary unconsciousness. The petitioner was remained in the emergency room for observation for 24 hours, through February 13, 2016. The petitioner was admitted into the hospital for additional testing on February 14, 2016. The petitioner was diagnosed with [redacted] The petitioner was discharged from the hospital on February 15, 2016

3. All Medicaid goods and services must be medically necessary. Some services require prior or post service authorization which is completed by the Agency, the HMO or another designee. [redacted] submitted a service authorization request to United on February 15, 2016.

4. United approved the emergency room charges for February 12, 2016 – February 13, 2016. United determined there was insufficient medical records to support the continued inpatient stay February 14, 2016 – February 15, 2016 and denied the provider's authorization request for those days.

5. The petitioner received a bill from the cardiologist who treated her at [redacted] Providers who accept Medicaid must accept Medicaid's reimbursement rate and cannot seek reimbursement from the Medicaid recipient. The petitioner is not responsible for the bill. United has resolved the issue with the provider, the petitioner does not have an outstanding balance with the cardiologist or [redacted]

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:

- 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

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 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 06 day of May, 2016, in Tallahassee, Florida.

Leslie Green

Leslie Green
Hearing Officer
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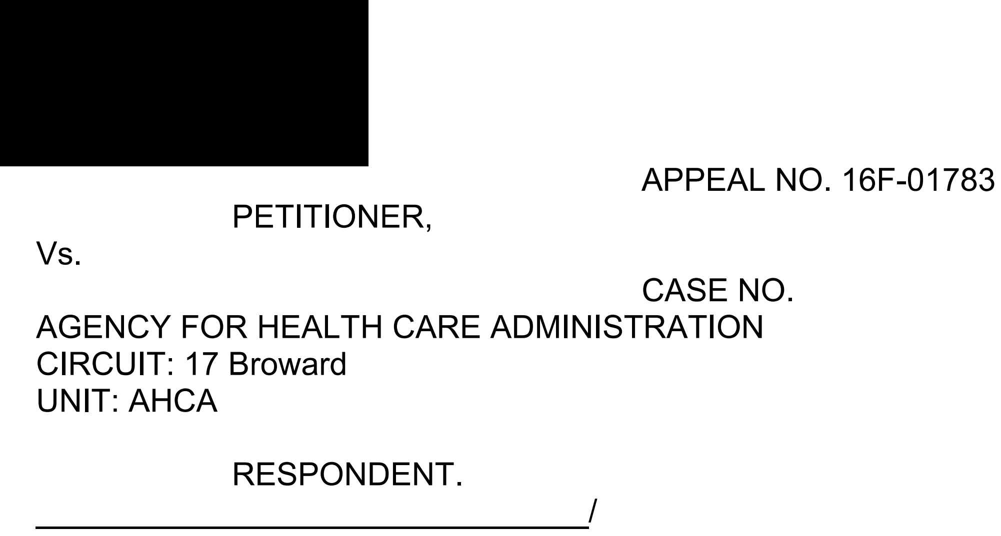
Copies Furnished To [redacted] Petitioner
Debbie Stokes, Area 4, AHCA Field Office Manager

Jun 28, 2016

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 16F-01783

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.

_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on May 10, 2016, at 10:30 a.m.

APPEARANCES

For the Petitioner:

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

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the respondent incorrectly denied his request for 17 of the 21 hours of psychological testing he requested?

PRELIMINARY STATEMENT

the petitioner's mother, appeared on behalf of the petitioner, ("petitioner"), who was not present. may sometimes hereinafter be referred to as the petitioner's "representative".

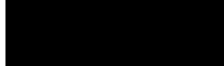
Linda Latson, R.N., Registered Nurse Specialist and Fair Hearing Coordinator for the Agency for Health Care Administration ("AHCA" or "Agency"), appeared on behalf of the Agency for Health Care Administration. The following individuals appeared as witnesses on behalf of the Agency: Toby Pina, L.C.S.W., Clinical Director of the Child Welfare Specialty Plan and Healthy Kids at Cenpatico; Ann Whitehouse, Psy.D., Clinical Psychologist Reviewer for Cenpatico; Narendra Patel, M.D., J.D., Medical Director of Cenpatico, and Paula Daley, Appeals and Grievance Coordinator for Sunshine Health. Kizzy Alleyne, Paralegal at Sunshine Health, was present solely for observation.

The respondent introduced Exhibits "1" through "6", inclusive, at the hearing, all of which were accepted into evidence and marked accordingly. The hearing record in this matter was left open until the close of business on March 17, 2016 in order for both parties to submit additional information. Once the petitioner's information was received, it was accepted into evidence and marked as petitioner's Exhibits "1" and "2", inclusive. Once the respondent's information was received, it, too, was accepted into evidence and marked as respondent's Exhibit "7", inclusive. The hearing record was then closed.

The information to be provided by the respondent after the hearing included both the second Notice of Action sent by Cenpatico to the petitioner along with the applicable law in this case. Although the respondent submitted the Notice of Action, the only law provided by the respondent was Florida Administrative Code Rule 59G-1.010.

FINDINGS OF FACT

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

1. The petitioner is an 11-year-old male. His date of birth is 

2. Petitioner was eligible to receive Medicaid benefits at all times relevant to these proceedings.

3. The petitioner is enrolled in Sunshine Health. Sunshine Health is a health maintenance organization ("HMO") contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in Florida.

4. Sunshine Health has contracted Cenpatico[1] to provide behavioral health services to Sunshine Health members.

5. On or about March 1, 2016, the petitioner's psychologist submitted an Outpatient Psychological Testing Authorization Request Form to Cenpatico for approval of 21 hours of psychological testing for the petitioner for dates of service March 1, 2016 through June 1, 2016.

6. The Outpatient Psychological Testing Authorization Request Form states, in part:

[1] Cenpatico recently underwent a name change. The new organization name is Envolve People Care.

7. Cenpatico forwarded the petitioner's request to Ann Whitehouse, Psy.D. to review the request for medical necessity on March 4, 2016. Dr. Whitehouse is a licensed clinical psychologist and clinical reviewer for Cenpatico.

8. The referral form from the petitioner's physician to the psychologist lists the following diagnoses

9. Sunshine Health and Cenpatico mailed a Notice of Action dated March 4, 2016 to the petitioner advising him Cenpatico approved four hours of psychological testing for dates of service March 1, 2016 through June 1, 2016 and denied the remaining 17 hours.

10. The Notice of Action states, in part:

> The time requested by [Petitioner's] provider exceeds standard administration time for the tests selected and testing for educational purposes is not considered medically necessary. Four (4) units are approved. This decision was made based on InterQual 2015 Behavioral Health Criteria, Child Psychological Testing Decision Support Guidelines. This review was performed by Narendra Patel, MD, who is a licensed psychiatrist.

11. Cenpatico completed an internal review of its decision to deny 17 of the requested 21 hours on March 31, 2016. It mailed an additional Notice of Action to the petitioner on April 1, 2016 informing him of its decision to uphold the denial.

12. The April 1, 2016 Notice of Action from Cenpatico and Sunshine Health states, in part:

> We have looked at your appeal for psychological testing.
> Our decision, as of 3/31/16, is to:
> Uphold the original decision and deny seventeen (17) hours of psychological testing for 3/1/16 through 6/1/16. Based on the clinical information provided, [Petitioner] does not meet the criteria for this level of

care. There is no documentation that shows the tests requested are needed to determine a diagnosis or to continue further treatment. It appears any questions related to [Petitioner]'s diagnosis or treatment can be answered with an outpatient psychiatric consultation, outpatient therapy, or medication. It has been determined that this request is not approved.

13. The decision to uphold the denial was made by a board certified licensed psychiatrist. The decision was based on InterQual 2015 Behavioral Health Criteria, Child Psychological Testing Decision Support Guidelines.

14. The petitioner was born in a homeless shelter and abandoned by his biological mother. He and his two-year-old sister at the time were adopted by the petitioner's representative in this case when the petitioner was three-months-old.

15. The petitioner's mother has a Ph.D. in Psychology. However, she specializes in counseling and not testing and diagnoses. Her knowledge of testing and diagnoses is limited to what she learned when she was in school.

16. It became apparent to the petitioner's mother when the petitioner was still at a very young age that he had developmental delays. The petitioner's mother sought services for her son and the petitioner began receiving speech therapy when he was one-year-old. He was placed into the integrated pace program through the school board when he was three-years-old.

17. The petitioner is graduating elementary school and will be starting middle school.

18. Despite receiving special services and accommodations at school, the petitioner is not performing at his present grade level.

19. The petitioner has previously undergone psychological testing at school.

20. The petitioner's mother testified that, despite the psychological testing the petitioner received at school, he has not been diagnosed with a specific disability. She stated that a school psychologist may only administer tests – he or she may not make a formal diagnosis.

21. It is the position of the petitioner's mother that a formal diagnosis is required so the petitioner can receive the appropriate services and accommodations he needs in order to optimize his potential and quality of life.

22. The Cenpatico Medical Director testified that the petitioner's plan will only cover psychological testing performed for treatment purposes. He testified that the plan will not cover the cost of psychological testing for educational purposes.

23. The Cenpatico Medical Director and Clinical Psychologist Reviewer both testified that psychological testing for educational purposes falls within the scope and purview of the school board.

24. The petitioner's mother could not specify for exactly which tests the 21 hours of psychological testing were requested.

25. The petitioner's mother explained in her testimony that she is unsure of whether the full 21 hours of psychological testing is necessary – that she is relying on the judgment and expertise of the licensed psychologist who requested the services.

26. The Cenpatico Clinical Psychologist Reviewer testified at the hearing that the 21 hours of psychological testing requested is "absolutely excessive", and that a full battery of tests would only require six hours.

27. The petitioner has never had a psychiatric evaluation.

28. A psychiatric evaluation does not require prior authorization.

29. A comprehensive psychiatric evaluation may result in the diagnosis of the petitioner’s specific disability.

30. The petitioner’s mother is hesitant about the petitioner having a psychiatric evaluation because she is afraid it will result in the prescribing of medication.

31. The petitioner does not always do well on medication over the long-term.

32. A psychiatric evaluation will not necessarily result in the prescription of medication for the petitioner.

33. The petitioner has an individualized Education Program (“IEP”). An IEP is a written statement of the educational program designed to meet a child’s individual needs. Every child who receives special education services must have an IEP. An IEP is completed by the school board.

34. The petitioner receives special services through the school board. These services include occupational therapy.

35. The psychological testing requested by the petitioner is for educational purposes, not therapeutic purposes.

CONCLUSIONS OF LAW

36. 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.

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

38. All goods and services requested under the Florida Medicaid Program must be shown to be medically necessary in order to be approved.

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

40. 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.

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

42. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Chapter 59G-5.020. In accordance with the above Statute, the Handbook states on page 1-27

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.
>
> Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

43. Pages 1-28 and 1-29 of the Florida Medicaid Provider General Handbook provide a list of HMO covered services. Although these services include mental health targeted case management and children’s programs that promote increased utilization

of prevention and early intervention services for at-risk children in the target population, they do not specifically include child psychological testing.

44. Page 1-30 of the Florida Medicaid Provider General Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

45. The Florida Medicaid Provider General Handbook, on Page 1-12, states:

> Medicaid is the payer of last resort. If a recipient has other insurance coverage through a third party source, such as Medicare, TRICARE, insurance plans, AARP plans, or automobile coverage, the provider must bill the primary insurer prior to billing Medicaid.

46. Although the terms medically necessary and medical necessity are often used interchangeably and may be used in a variety of contexts, their definition for Florida Medicaid purposes is contained in the Florida Administrative Code. Fla. Admin. Code R. 59G-1.010 states:

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

47. Since petitioner is under 21, a broader definition of medically necessary applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPDST) requirements. Section 409.905, Fla. Stat., Mandatory Medicaid Services defines Medicaid services for children to include:

> (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

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

> [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.
>
> (2) A state Medicaid plan must include "reasonable standards … for determining eligibility for and the extent of medical assistance" … and

such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.

(3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."

(4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."

(5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. **The state is not required to provide medically unnecessary, albeit desirable, EPSDT services.** However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."

(6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and my present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)) (emphasis added).

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

50. 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.

51. 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.

52. The InterQual criteria are generally accepted, highly regarded evidence-based utilization review criteria used by the health services industry. They are set forth in respondent's Exhibit "4".

53. Note 4 of the InterQual criteria states as follows:

> Apart from the use of rating scales and checklists, the clinical utility of psychological testing has not been established for patients younger than 13 years of age. Formal psychological testing is not indicated for routine screening or assessment of behavioral health disorders. Research also does not support the use of projective or objective personality testing as a primary method of establishing or ruling out DSM-based psychiatric diagnoses.

54. After carefully reviewing the testimony and evidence in this matter, the hearing officer concludes the petitioner has not met his burden of proof to demonstrate the respondent incorrectly denied his request for an additional 17 hours of psychological

testing for the following reasons. First, the testing requested is for educational purposes and not therapeutic purposes. As indicated above, Medicaid is the payer of last resort. Psychological testing for educational purposes falls within the scope and purview of the school board. The petitioner presently has an IEP and is receiving specialized services through the school board. Second, the petitioner's representative was unable to explain exactly for what tests the time will be used, nor was she able to definitively express why 21 hours of testing is necessary. The respondent's specialist testified that 21 hours of psychological testing is "absolutely excessive" and not necessary. Third, the InterQual criteria relied on by the respondent explains that "Formal psychological testing is not indicated for routine screening or assessment of behavioral health disorders". As stated by the respondent's witness at the hearing, the petitioner may undergo a psychiatric evaluation to assist in ascertaining his disability. Such an assessment does not require prior authorization.

55. It is apparent from the mother's testimony and demeanor at the hearing that she is a loving and nurturing parent who is advocating for the petitioner. However, the information proffered at the hearing and afterwards does not support a conclusion that an additional 17 hours of psychological testing is medically necessary.

56. The parties are urged to continue working together to assist the petitioner in securing whatever additional testing is necessary from the proper source, whether it be psychiatric testing through the health plan or more testing through the school board.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 28 day of June, 2016,

in Tallahassee, Florida.

Peter J. Tsamis

Peter J. Tsamis
Hearing Officer
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1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

May 04, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01785
16F-02678

PETITIONER,
Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 01 Escambia
UNIT: 88630

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on April 13, 2016 at 9:36 a.m.

APPEARANCES

For the Petitioner:

For the Respondent: Steve Kent, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of February 5, 2016 reducing his Food Assistance benefits to $96 and increasing his Adult Related Medically Needy Share of Cost to $626. The respondent carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner submitted evidence prior to the hearing, which was entered as Petitioner Exhibit 1. The Department submitted evidence prior to the hearing, which was entered as Respondent Exhibit 1.

The hearing was reconvened on April 21, 2016 to discuss the petitioner's Adult Related Medically Needy share of cost increase, as the Department was unaware of the petitioner's request for a hearing on the Adult Related Medically Needy issue prior to the April 13, 2016 hearing. The Department submitted additional evidence on April 13, 2016, which was entered as Respondent Exhibit 2.

FINDINGS OF FACT

1. The petitioner recertified for Food Assistance and Adult Related Medically Needy benefits in December 2015.

2. The Department received an electronic update from Social Security on February 3, 2016 reporting the petitioner's Social Security increasing from $773 to $826 effective March 2016.

3. The Department updated the petitioner's case with the new income information on February 4, 2016.

4. The Department issued a Notice of Case Action on February 5, 2016. The notice informed the petitioner his Food Assistance benefits would decrease from $120 to $96 effective March 2016, and his Adult Related Medically Needy Share of Cost would increase from $573 to $826 effective March 1, 2016.

5. The petitioner confirmed in hearing his Social Security benefit did increase from $773 to 826 effective March 2016.

6. The petitioner confirmed he does have Medicare.

7. The Department confirmed the state is paying the Medicare Part B premium for the petitioner.

8. The petitioner confirmed his land payment obligation runs between $330 and $340. The petitioner stated the $336 the Department was including in the calculations seemed accurate.

9. The petitioner incurs an electric bill and heats and cools his home with electricity.

10. The petitioner is concerned that his electric bill has increased and that was not considered when his benefits were calculated.

11. The Department explained Food Assistance policy allows the use of a Standard Utility Allowance of $345 each month. This is to cover all utilities when an individual incurs a heating and cooling expense, such as the petitioner's electric bill.

12. The Department explained the Food Assistance budget calculations as follows: The Department deducted the Standard Deduction for a one-member household of $155 from the petitioner's gross income of $826 to reach an adjusted income of $671 ($826 - $155 = $671).

13. The Department considered 50 percent of the petitioner's adjusted income of $671 as the petitioner's Shelter Standard ($671 x 50% = $335.50). The Department totaled the petitioner's land payment of $336 and the Standard Utility Allowance of $345 to reach a shelter/utility total expense of $681 ($336 + $345 = $681). The Department subtracted the petitioner's shelter standard from the shelter/utility total expense to reach an excess shelter deduction of $345.50 ($681 - $335.50 = $345.50). The excess

shelter deduction was subtracted from the adjusted income to reach a net adjusted income of $325.50 ($671 - $345.50 = $325.50).

14. The Department multiplied the net adjusted income of $325.50 by 30 percent to reach the benefit reduction amount of $98 ($325.50 x 30% = $98). The maximum monthly allotment for a one-person household is $194. The Department subtracted the benefit reduction amount from the maximum monthly allotment to reach a Food Assistance allotment of $96 beginning March 2016 ($194 - $98 = $96).

15. The Department explained for Medically Needy there are only two deductions allowed to determine the share of cost. The first deduction allowed is a standard $20 disregard. The second deduction is the Medically Needy Income Limit (MNIL). In the petitioner's case, the household size of one allows an MNIL of $180.

16. The petitioner believes the change in his benefits to be disproportionate between his Food Assistance and Adult Related Medically Needy. He believes his benefits should come approximately half from each program.

17. The Department explained the benefit determination for each program is completed independent of other program eligibility determination. Each program has a separate set of rules for determining the eligibility and benefit amount.

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 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.

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

Food Assistance

20. Title 7 “Agriculture”, Subtitle B “Regulations of the Department of Agriculture (continued)”, Chapter II, “Food and Nutrition Service”, Subchapter C “Food Stamp and Food Distribution Program sets forth all federal regulations for the program. Part 273 “Certification of Eligible Households” describes the rules to be applied in the eligibility determination process for SNAP (Supplemental Nutrition Assistance Program), known in Florida as the FAP (Food Assistance Program).

21. 7 C.F.R. § 273.9 “Income and Deductions” states in relevant part:

> (a) Income eligibility standards. Participation in the Program shall be limited to those households whose incomes are determined to be a substantial limiting factor in permitting them to obtain a more nutritious diet. Households which contain an elderly or disabled member shall meet the net income eligiblity standards for the Food Stamp Program. *[sic]*
> ...
> (1) The gross income eligibility standards for the Food Stamp Program shall be as follows:
> (i) The income eligibility standards for the 48 contiguous States and the District of Columbia, Guam and the Virgin Islands shall be 130 percent of the Federal income poverty levels for the 48 contiguous States and the District of Columbia.
> ...
> (2) The net income eligibility standards for the Food Stamp Program shall be as follows:
> (i) The income eligibility standards for the 48 contiguous States and the District of Columbia, Guam and the Virgin Islands shall be the Federal income poverty levels for the 48 contiguous States and the District of Columbia.
> ...
> (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;

22. The findings show the petitioner currently receives $826 in Social Security benefits effective March 1, 2016. In accordance with the above controlling authorities, the undersigned concludes the Department correctly included the petitioner's gross income in his Food Assistance benefit calculations beginning March 2016.

23. 7 C.F.R § 273.9 (d) "Income deductions" states in relevant part:

Deductions shall be allowed only for the following household expenses:

(1) Standard deduction—(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. For household sizes greater than six, the standard deduction shall be equal to the standard deduction for a six-person household.
...
(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.

(B) Property taxes, State and local assessments, and insurance on the structure itself, but not separate costs for insuring furniture or personal belongings.
(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, including, but not limited to, basic service fees, wire maintenance fees, subscriber line charges, relay center surcharges, 911 fees, and taxes; and fees charged by the utility provider for initial installation of the utility. One-time deposits cannot be included.
...
(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);

24. 7 C.F.R. § 273.10 “Determining household eligibility and benefit levels”

states in relevant part:

(e) Calculating net income and benefit levels—(1) Net monthly income. (i) To determine a household's net monthly income, the State agency shall:

(A) Add the gross monthly income earned by all household members and the total monthly unearned income of all household members, minus income exclusions, to determine the household's total gross income. 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.
...
(H) Total the allowable shelter expenses to determine shelter costs, unless a deduction has been subtracted in accordance with paragraph (e)(1)(i)(G) of this section. Subtract from total shelter costs 50 percent of the household's monthly income after all the above deductions have been subtracted. The remaining amount, if any, is the excess shelter cost. If there is no excess shelter cost, the net monthly income has been determined. If there is excess shelter cost, compute the shelter deduction according to paragraph (e)(1)(i)(I) of this section.

(I) Subtract the excess shelter cost up to the maximum amount allowed for the area (unless the household is entitled to the full amount of its excess shelter expenses) from the household's monthly income after all other applicable deductions. Households not subject to a capped shelter expense shall have the full amount exceeding 50 percent of their net income subtracted. The household's net monthly income has been determined.

(ii) In calculating net monthly income, the State agency shall use one of the following two procedures:

(A) Round down each income and allotment calculation that ends in 1 through 49 cents and round up each calculation that ends in 50 through 99 cents; or

(B) Apply the rounding procedure that is currently in effect for the State's Temporary Assistance for Needy Families (TANF) program. If the State TANF program includes the cents in income calculations, the State agency may use the same procedures for food stamp income calculations. Whichever procedure is used, the State agency may elect to include the cents associated with each individual shelter cost in the computation of the shelter deduction and round the final shelter deduction amount. Likewise, the State agency may elect to include the cents associated with each individual medical cost in the computation of the medical deduction and round the final medical deduction amount.

(2) Eligibility and benefits. (i)(A) Households which contain an elderly or disabled member as defined in §271.2, shall have their net income, as calculated in paragraph (e)(1) of this section (except for households considered destitute in accordance with paragraph (e)(3) of this section), compared to the monthly income eligibility standards defined in §273.9(a)(2) for the appropriate household size to determine eligibility for the month.
...
(ii)(A) Except as provided in paragraphs (a)(1), (e)(2)(iii) and (e)(2)(vi) of this section, the household's monthly allotment shall be equal to the maximum food stamp allotment for the household's size reduced by 30 percent of the household's net monthly income as calculated in paragraph (e)(1) of this section. If 30 percent of the household's net income ends in cents, the State agency shall round in one of the following ways:
(1) The State agency shall round the 30 percent of net income up to the nearest higher dollar; or
(2) The State agency shall not round the 30 percent of net income at all. Instead, after subtracting the 30 percent of net income from the

appropriate Thrifty Food Plan, the State agency shall round the allotment down to the nearest lower dollar.
(B) If the calculation of benefits in accordance with paragraph (e)(2)(ii)(A) of this section for an initial month would yield an allotment of less than $10 for the household, no benefits shall be issued to the household for the initial month.
(C) Except during an initial month, all eligible one- and two-person households shall receive minimum monthly allotments equal to the minimum benefit and all eligible households with three or more members which are entitled to $1, $3, and $5 allotments shall receive allotments, of $2, $4, and $6, respectively, to correspond with current coupon book determinations.

25. 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 standards: The Monthly 100% Net Income Limit for a household of one is $981. The Standard Deduction for a one to three member household is $155. The Standard Utility Allowance (SUA) is $345 for all households. The Maximum Benefit for a one-person household is $194 effective October 1, 2014.

26. The undersigned reviewed the Food Assistance benefit calculations in accordance with the above controlling authorities. The petitioner's Social Security income of $826 is the only income included. The standard deduction of $155 is deducted from the income of $826 leaving an adjusted income of $671 ($826 - $155 = $671). The adjusted income of $671 multiplied by 50 percent equals the shelter standard of $335.50 for this instant case ($671 x 50% = $335.50). The petitioner has the ability to heat and cool his home and is responsible for utility expenses in her home. The undersigned concludes the petitioner is entitled to the Standard Utility Allowance (SUA) of $345. The land payment of $336 and the SUA of $345 added together equals a total shelter cost of $681 ($336 + $345 = $681). The total shelter cost less the shelter

standard of $335.50 leaves an excess shelter expense of $345.50 ($681 - $335.50 = $345.50). The adjusted income of $671 less the excess shelter expense of $345.50 leaves the adjusted net income of $325.50 ($671 - $345.50 = $325.50). The adjusted net income multiplied by 30 percent equals the benefit reduction amount of $98 ($325.50 x 30% = $98). The maximum benefit for a one-person household of $194 less the benefit reduction amount of $98 leaves a monthly benefit amount of $96. The undersigned concludes the Department correctly calculated the petitioner's benefits based on the verified change in income.

ADULT RELATED MEDICAID

27. Fla. Admin. Code § 65A-1.709 "SSI-Related Medicaid Coverage" states, "SSI-Related Medicaid provides medical assistance to eligible individuals who are aged, blind or disabled in accordance with Titles XVI and XIX of the Social Security Act and Chapter 409, F.S."

28. 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.

29. The above authority explains that MEDS-AD Demonstration Waiver is limited to individuals who are not receiving Medicare. This is the full Medicaid coverage program for aged or disabled individuals. The petitioner receives Medicare and no evidence was presented to show that he is receiving institutional care services, hospice services or home and community based services. The undersigned concludes the

petitioner does not qualify for full coverage Medicaid, as he is a Medicare recipient and not receiving one of the specified categories of assistance. Therefore, the Adult Related Medically Needy program for aged or disabled individuals is the correct program for the petitioner. The undersigned further concludes the Department is correct to adjust the share of cost when there is a change in the amount of income received.

30. Fla. Admin. Code R. 65A-1.710 “SSI-Related Medicaid Coverage Groups” states in relevant part:

> (5) Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. §§ 1396a and 1396d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance due to their level of income or resources. The program does not cover nursing facility care, intermediate care for the developmentally disabled services, or other long-term care services.

31. The above authority explains that the Medically Needy Program is for individuals who do not qualify for full (or categorical assistance) Medicaid due to their level of income. The undersigned concludes when an individual does not qualify for full Medicaid due to receiving Medicare, the Medically Needy program is also the appropriate coverage group.

32. 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:
> ...
> (h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses.
> ...

(2) Included and Excluded Income. For all SSI-related coverage groups the department follows the SSI policy specified in 20 C.F.R. 416.1100 (2007) (incorporated by reference) et seq.,
...
(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.
...
(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.

33. Federal Regulations at 20 C.F.R. § 416.1121 "Types of unearned income" states in relevant part: "(a) Annuities, pensions, and other periodic payments. This

unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veterans benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits."

34. 20 C.F.R. § 416.1124 "Unearned income we do not count" (c)(12) states in part:

> 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.

35. Fla. Admin. Code R. 65A-1.716 "Income and Resource Criteria" states in relevant part, "(2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows: Family Size 1 Monthly Income Level of $180."

36. According to the above authorities, the Medically Needy share of cost is calculated by subtracting the $20 unearned disregard and the MNIL of $180 for an individual from the petitioner's gross income of $826 to reach a $626 beginning March 2016. The share of cost is not reduced by the petitioner's Medicare premium as the state is paying the premium. The undersigned concludes the Department correctly calculated the petitioner's benefits based on the verified change in income.

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 04 day of May, 2016,

in Tallahassee, Florida.

Melissa Roedel

Melissa Roedel
Hearing Officer
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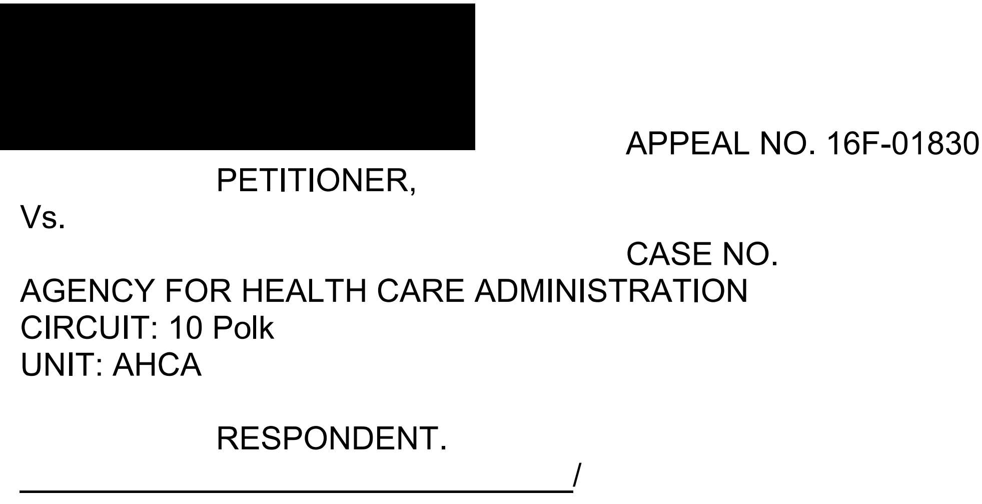
Copies Furnished T[redacted]etitioner
Office of Economic Self Sufficiency

Jun 08, 2016

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 16F-01830

PETITIONER,

Vs.

CASE NO.

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

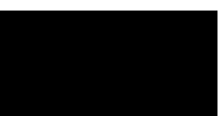
RESPONDENT.

_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing telephonically on May 10, 2016, at 2:40 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 respondent prove by a preponderance of the evidence that it correctly reduced the petitioner's incontinent liners from 720 units per month to 200 units per month?

PRELIMINARY STATEMENT

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

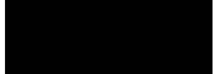
Stephanie Lang, R.N., Registered Nurse Specialist and Fair Hearing Coordinator for the Agency for Health Care Administration ("AHCA" or "Agency"), appeared on behalf of the Agency for Health Care Administration. The following individuals appeared as witnesses on behalf of the Agency: Sommer Brooks, Contract Manager for Coventry Healthcare of Florida ("Coventry"); Mellody Gordon, Manager of Utilization Management at Coventry; and Darwin Caraballo, M.D., Long-Term Care Medical Director at Coventry. Coventry Healthcare of Florida is now Aetna.

The respondent introduced Exhibits "1" through "5", inclusive, at the hearing, all of which were accepted into evidence and marked accordingly. The hearing record in this matter was left open until the close of business on May 13, 2016 for the respondent to provide additional information. Once received, the documents were accepted into evidence and marked as respondent's Composite Exhibit "6". The hearing record was then closed.

The hearing officer took administrative notice of the following: Sections 409.910; 409.962; 409.963; 409.964; 409.965; 409.973 and 409.98, F.S. The hearing officer also took administrative notice of the following Florida Administrative Code Rules: 59G-1.001; 59G-1.010; and 59G-4.070, as well as the Florida Medicaid DME and Medical Supply Services Coverage and Limitations Handbook, and 42 C.F.R. Section 441.745.

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 74-year-old female. She resides in 

2. The petitioner was eligible to receive Medicaid benefits at all times relevant to these proceedings.

3. The petitioner participates in the Long-Term Care Program. An objective of the Long-Term Care Program is to prevent institutionalization.

4. The petitioner was enrolled in Coventry Healthcare of Florida. Coventry was a health maintenance organization ("HMO") contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in Florida. Coventry Healthcare of Florida is now Aetna.

5. The effective date of petitioner's enrollment with Coventry was February 1, 2014.

6. The petitioner was previously approved to receive 720 individual units of incontinent liners per month.

7. On or about February 3, 2016, the petitioner's provider submitted a prior authorization request to Coventry for five boxes of incontinent liners per month. Each box contains nine packages and within each package is contained 16 liners. This equals 720 individual liners per month.

8. In a Notice of Action dated March 1, 2016, Coventry notified the petitioner that her request for incontinent liners was partially denied. The Notice states, in part: "We made our decision because … maximum allowed is 200/units/month per FL Medicaid AHCA Fee schedule guidelines. Approve only up to 200/month."

9. The petitioner requested a fair hearing and this proceeding ensued.

10. The petitioner lives alone.

11. The petitioner is confined to a wheelchair during the day. At night, she sleeps in a sleep chair.

12. The petitioner cannot ambulate or transfer independently.

13. The petitioner is incontinent.

14. The petitioner is prescribed a diuretic. As a result, she expels a large volume of urine.

15. The petitioner does not have the physical capacity to put on underwear or adult diapers.

16. The petitioner sits directly on the incontinent liners she places on her wheelchair or sleep chair without wearing underwear or adult diapers. Underneath the incontinent liners is a thin under-pad which is also provided by Coventry. The under-pad may be thought of as a chair pad.

17. Incontinent liners are thin. The petitioner has to attach two incontinent liners together using the elastic backing on the liners in order to cover the entire seating area of her wheelchair.

18. The petitioner has gained a great deal of weight since becoming confined to a wheelchair.

19. The petitioner cannot move easily as the result of having [redacted]

20. When the petitioner needs to change her incontinent liners, she holds on to something to hoist herself off her wheelchair or sleep chair. She then slips the liners underneath her. The petitioner cannot stand independently.

21. Adult diapers are more absorbent than incontinent liners and would be a more suitable alternative to using two incontinent liners at a time.

22. Using adult diapers is not an option for the petitioner because she cannot stand independently and she has no one to assist her with putting on and removing the diapers.

23. Due to the frequency of urination, the petitioner uses 20 to 24 incontinent liners per day.

24. 24 incontinent liners per day multiplied by 30 days per month equals 720 incontinent liners.

25. The petitioner’s seating area needs to remain dry in order to minimize the risk of skin breakdown and pressure sores.

26. It is the position of Coventry that, in accordance with Florida Medicaid guidelines, it can only approve a maximum of 200 incontinent liners per month.

27. Coventry proffered no testimony or evidence at the hearing to show why 720 incontinent liners per month are no longer medically necessary for the petitioner.

CONCLUSIONS OF LAW

28. 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.

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

30. All goods and services requested under the Florida Medicaid Program must be shown to be medically necessary in order to be approved.

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

32. The respondent in the present case is proposing to terminate, reduce, or change the petitioner's services. Therefore, in accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof is assigned to the respondent.

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

34. The Florida Medicaid program is authorized by Fla. Stat. ch 409 and Fla. Admin. Code R. 59G.

35. Section 409.905, Fla. Stat. addresses mandatory Medicaid services under the State Medicaid Plan:

> Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law…
> (4) HOME HEALTH CARE SERVICES.--The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home…
> (a) The agency shall require prior authorization of home health services….
> (c) The agency may not pay for home health services unless the services are medically necessary …

36. The Florida Medicaid Home Health Services Coverage and Limitations Handbook October 2014 is incorporated by reference and promulgated into Rule by Chapter 59G-4.130, Florida Administrative Code.

37 The Florida Medicaid Home Health Services Coverage and Limitations Handbook, on Page 2-27, states as follows:

> Home health agencies that provide DME must comply with the policies and procedures contained in this handbook and in the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook.

38. Section 409.912, Fla. Stat. states, in relevant parts:

> **Cost-effective purchasing of health care**.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care …

39. 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. In accordance with the above Statute, the Handbook states on page 1-27:

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.
>
> Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

40. Pages 1-28 of the Florida Medicaid Provider General Handbook provide a list of HMO covered services. These services include medical supplies.

41. Page 1-30 of the Florida Medicaid Provider General Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

42. In order for durable medical equipment and supplies to be approved, the equipment and supplies must not only be medically necessary but must also meet all requirements set forth in the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook.

43. Although the terms medically necessary and medical necessity are often used interchangeably and may be used in a variety of contexts, their definition for Florida Medicaid purposes is contained in the Florida Administrative Code. Fla. Admin. Code R. 59G-1.010 states:

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods or services furnished or ordered must:
>
> (a) Meet the following conditions:
>
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
>
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
>
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
>
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
>
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
>
> (b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

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

44. 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.

45. 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.

46. The Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook (July 2010) (“DME Handbook”) is promulgated into rule by Fla. Admin. Code R. 59G-4.070. The Handbook describes the covered services, limitations, and exclusions associated with the acquisition and

reimbursement of durable medical equipment and medical supplies obtained through the Medicaid program.

47. The DME Handbook, on Pages 2-48 and 2-49, sets forth the medical necessity, age, and documentation requirements for receiving disposable incontinence briefs, diapers, protective underwear, pull-ons, liners, shields, guards, pads, and undergarments, along with the associated limitations for receiving such supplies. The DME Handbook limits the receipt of these medical supplies to recipients four to 20 years of age and up to a combined total of 200 individual units per month.

48. Page 1-27 of the Florida Medicaid Provider General Handbook states:

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

49. In addition to providing mandatory covered services, Coventry also provides certain expanded benefits to Long-Term Care participants. Among these expanded benefits is consumable medical supplies to recipients over 21, such as incontinence liners and disposable diapers.

50. AHCA Contract No. FP022, Attachment II, Exhibit II-B, Effective 11/01/15, the Long-Term Care Contract between the Agency for Health Care Administration and Coventry, on Page 14 of 90, explains as follows:

> Medical Equipment and Supplies --- Medical equipment and supplies, specified in the plan of care, include: (a) devices, controls or appliances that enable the enrollee to increase the ability to perform activities of daily living; (b) devices, controls or appliances that enable the enrollee to perceive, control or communicate the environment in which he or she lives; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment that is necessary to address enrollee functional limitations;

> **(e) necessary medical supplies not available under the State Plan including consumable medical supplies such as adult disposable diapers. This service includes the durable medical equipment benefits available under the state plan service as well as expanded medical equipment and supplies coverage under this waiver.** [Emphasis added] All items shall meet applicable standards of manufacture, design and installation. This service also includes repair of such items as well as replacement parts.

51. The Long-Term Care Contract between the Agency for Health Care Administration and Coventry does not limit the receipt of consumable medical supplies to recipients between four and 20 years of age, nor does it limit the amount of individual units to 200 per month.

52. In the present case, the respondent proffered no testimony or evidence to support a conclusion that 720 individual incontinence liners are no longer medically necessary for the petitioner. It relied solely on the limitation for such supplies contained in the DME Handbook for recipients ages 4 through 20. There is no similar limitation in the Long-Term Care Contract between the Agency for Health Care Administration and Coventry. There is also no evidence the petitioner's medical condition has improved and that she longer needs the previously approved amount.

53 The respondent has not met its burden of proof to demonstrate that the previously approved amount of incontinence liners is no longer medically necessary and a lower amount is warranted.

54. In rendering this decision, the undersigned hearing officer considered all of the testimony and documentary evidence presented during the hearing process and reviewed all conditions of "medical necessity" set forth in the Florida Administrative Code and the rules governing the Florida Medicaid program.

DECISION

The Petitioner's appeal is hereby GRANTED. The respondent is instructed to continue providing the petitioner with 720 individual incontinence liners per month.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 08 day of June, 2016, in Tallahassee, Florida.

Peter J. Tsamis

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

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

Jun 23, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01833

PETITIONER,
Vs.

CASE NO.

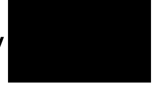
FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 Palm Beach
UNIT: 88322

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, a telephonic administrative hearing was convened before the undersigned hearing officer on May 3, 2016 at 9:11 a.m.

APPEARANCES

For the Petitioner: The petitioner was present and was represented by 

For the Respondent: Mary Triplett, Supervisor for the Department of Children and Families (DCF).

ISSUE

The petitioner is appealing the Department's action on March 11, 2016 to deny Medicaid on the basis that she did not meet the disability criteria.

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

PRELIMINARY STATEMENT

Appearing as a witness for the respondent was Lauren Coe, Program Operations Administrator for the Division of Disability Determination (DDD).

The petitioner was on the call but disconnected during the hearing; she did not call back for the remainder of the hearing.

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

The record was held open until 5:00 p.m. on May 3, 2016 to allow the petitioner to submit additional evidence. Evidence was received and entered as the Petitioner's Exhibit 2. The record was closed as of 5:00 p.m. on May 3, 2016.

FINDINGS OF FACT

1. On December 15, 2015, the petitioner (date of birth [redacted]) completed an application for SSI-Related Medicaid. The petitioner is single and does not have any minor children living in the home with her. The petitioner did not file an application with the Social Security Administration (SSA) and has not been determined disabled.

2. The petitioner is currently unemployed. The petitioner's level of education is unknown. The petitioner's representative believes the petitioner did not have a steady job when she was working; he believes she last worked a few years ago. It was unknown which type of work the petitioner previously performed. It is unknown how much weight the petitioner can lift. There are no visual impairments, no sensitivity to cold or heat. There are no mental, speech, or hearing impairments. The petitioner's

representative contends that the petitioner's family has informed him that the petitioner is confined to her bed; she is not ambulatory.

3. The petitioner was admitted into the [redacted] on November 10, 2015; she had [redacted] on November 30, 2015. The Respondent's Exhibit 2 page 32 through 33, includes the petitioner's progress notes. The progress notes include the diagnoses of : [redacted]

4. The petitioner's representative contends the petitioner was admitted into the hospital a second time in February 10, 2016 in New Jersey; he believes her condition has worsened. The petitioner's representative is unsure of the petitioner's prognosis.

5. The petitioner's representative lists her medical conditions as a heart condition, [redacted] The petitioner has a history of substance abuse. The petitioner explains that she cannot get out of bed and cannot hold a job. The petitioner asserts she has moved to New Jersey to live with her parents and can provide more medical records from where she is now

receiving medical treatment. The petitioner's representative provided more of the petitioner's medical records, post-hearing.

6. The Department explained that the petitioner is under the age of 65 and has not been deemed disabled by the SSA; she did not meet any of the other eligibility requirements to become eligible for Medicaid. Therefore, her SSI-Related Medicaid application was submitted to the DDD.

7. The DDD representative, [redacted] explained that the petitioner's application for SSI-Related Medicaid was submitted to the DDD. The DDD representative contends that it reviewed the petitioner's medical records but was not able to make a determination of disability based on the records alone. The DDD contends that it was unable to get in contact with the petitioner to conduct an interview in order to obtain medical information necessary to complete the Residual Functional Capacity (RFC) assessment. The DDD representative contends that the five-step sequential evaluation process did not begin as no one was able to make contact with the petitioner. The DDD's position is that the petitioner's application was denied due to insufficient medical evidence to show that the petitioner is disabled. The DDD required functioning information and a follow-up of the surgery that took place in order to make a determination of disability in the petitioner's case.

CONCLUSIONS OF LAW

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

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

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

10. Fla. Admin Code R. 65A-1.710 et seq., set forth the rules of eligibility for Elderly and Disabled Individuals Who Have Income of Less Than the Federal Poverty Level. For an individual less than 65 years of age to receive benefits, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. The regulations state, in part:

> "The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment which makes you unable to do your previous work or any other substantial gainful activity which exists in the national economy. If your severe impairment(s) does not meet or medically equal a listing in appendix 1 to subpart P of part 404 of this chapter, we will assess your residual functional capacity as provided in §§416.920(e) and 416.945. (See §416.920(g)(2) and 416.962 for an exception to this rule.) We will use this residual functional capacity assessment to determine if you can do your past relevant work. If we find that you cannot do your past relevant work, we will use the same residual functional capacity assessment and your vocational factors of age, education, and work experience to determine if you can do other work. (See §416.920(h) for an exception to this rule.)

11. The Federal Regulation at 20 C.F.R. §416.920, Evaluation of disability of adults, in general, states:

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

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

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

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

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

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

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

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

(v) At the fifth and last step, we consider our assessment of your residual functional capacity and your age, education, and work experience to see if you can make an adjustment to other work. If you can make an

> adjustment to other work, we will find that you are not disabled. If you cannot make an adjustment to other work, we will find that you are disabled. (See paragraph (g) of this section and § 416.960(c).)

12. The findings show that petitioner has multiple medical conditions, including [redacted] The petitioner is currently unemployed. Step one of the disability evaluation is if the applicant is working, and it is substantial gainful activity, the applicant is not disabled. Substantial gainful activity (SGA) is defined in 20 C.F.R. § 416.974 and the current dollar amount is defined in Social Security's 2016 Red Book A Summary Guide To Employment Supports For Persons With Disabilities Under The Social Security Disability Insurance And Supplemental Security Income Programs and states, "If your impairment is anything other than blindness, earnings averaging over $1130 a month (for the year 2016) generally demonstrate SGA." The petitioner is not working at this time; therefore she is not earning the threshold amount. The petitioner passes step one of the 5 steps to determine a disability.

13. Step two is whether or not an individual has a severe impairment. The regulation at 20 C.F.R. § 416.909, How long the impairment must last, states, "Unless your impairment is expected to result in death, it must have lasted or must be expected to last for a continuous period of at least 12 months. We call this the duration requirement." The findings show that petitioner has a severe impairment. However, the petitioner's prognosis is not known at the time. To meet step two of the disability determination, the individual's impairment must have lasted or be expected to last for a continuous period of at least 12 months. Therefore, the undersigned concludes petitioner does not meet the duration requirement at step two of the disability

evaluation. There is no evidence that petitioner has applied for Social Security disability benefits and been granted a disability determination. Therefore, the undersigned concludes petitioner is not eligible for Medicaid as she is not determined to be disabled based on the facts of this record.

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 23 day of June, 2016,

in Tallahassee, Florida.

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

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

Jun 14, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01855
16F-03837

PETITIONER,

Vs.

CASE NO.

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 May 19, 2016, at 9:00 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner:

For the Respondent: Mary Triplett, DCF supervisor.

ISSUE

At issue is the respondent’s action to deny payment of the Medicare Part B Premium under the “Qualified Individuals 1 (QI 1)” Medicaid Program, or any other applicable program, due to excess income.

Also at issue is whether the respondent issued the correct Food Assistance Program (FAP) benefit level to the petitioner based on the household income and expenses. The petitioner carries the burden of proof by the preponderance of evidence on both issues.

PRELIMINARY STATEMENT

By notice dated February 5, 2016, the Department notified the petitioner that his Qualifying Individual 1 (QI 1) was denied due to excess income. On March 10, 2016, petitioner timely requested a hearing to challenge the Department's action.

During the hearing, the petitioner indicated he wanted to challenge his FAP benefits level.

The petitioner did not provide any evidence for the undersigned to consider. The respondent submitted evidence which was labeled Respondent's Exhibits 1 through 3. The record was left open through June 1, 2016 for both parties to submit additional information. Petitioner's evidence was timely received and marked as Petitioner's Composite Exhibit 1. The respondent's additional evidence was timely received and was labeled Respondent's Exhibits 4 through 9. The record closed on June 1, 2016.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner has been receiving FAP and Qualified Individual 1 (QI 1) Medicare Savings Program (MSP) or Buy-in Program from the Department. He last received MSP in December 2015.

2. QI 1 is one of three benefits available to eligible applicants to have their Medicare Part B premiums paid for under the state Medicare Buy-In Program. The Medicare Buy-

In Program includes QMB, SLMB and QI 1, each with a different income limit. To be eligible for these benefits, the applicants have to meet certain income guidelines. For one individual, the highest income limit is $1,325 at the time of application.

3. The petitioner is disabled. He is not subject to a net income test or a shelter cap and is allowed excess medical expenses. His gross monthly Social Security disability (SSD) income is $1,475 effective January 2016. His regular payment is $1,354 after a $121.80 deduction for Medicare Part B premiums. In February 2016, petitioner's SSD benefits were reduced by $243.60 (two months of Part B premiums), followed by a $25 overpayment withholding, resulting in $1,207.20 in net payment.

4. On February 3, 2016, the Department received an application from the petitioner requesting Food Assistance and Medicare Savings Program (MSP) benefits. On that application, the petitioner reported the following monthly expenses: $775 for rent, $90 for electricity and $200 for telephone, $20 for prescription drugs, $50 for medical supplies and $50 for gas. The petitioner does not currently have any out-of- pocket recurring medical expenses.

5. The Department processed the application, denied the petitioner for the Medicare Buy-In Programs, due to excess income. On February 5. 2016, the Department sent a notice to the petitioner informing him of the action, *see* Respondent's Exhibits 1 -3.

6. The Department used the individual income limit standard in the Medicare Buy In determination for the petitioner. Since his income of $1,475, minus the $20 unearned income disregard, was more than $1,325, he was not eligible for QI-1.

7. The Department's representative explained that gross income must be used in all eligibility determinations according to its policy. Petitioner did not dispute the facts

presented by the respondent. He argued that his SSD benefits has not increased from last year, therefore his QI-1 should remain the same. Additionally, petitioner contends that even with his loss of MSP, his SSD is short by $93.90 for which he could not account. Petitioner is seeking MSP effective January 2016.

8. Petitioner was approved for $16 in Food Assistance. The expenses originally used to determine the eligibility effective March 2016 included the monthly rent of $775, the standard utility allowance (SUA) of $345 and $104.90 (Medicare Part B premium). After review, the petitioner the Medicare Part B premium was increased to $121.80.

9. Originally, the Food Assistance budget for March 2016 shows petitioner was allowed a $155 standard deduction, followed by an $69.90 ($104.80 -$35) excess medical expenses from his gross household income to arrive at the $1,250.10 adjusted income, 50% of which becomes shelter standard ($625.05). With shelter/utility costs $1,120 ($775 shelter and $345 for SUA), petitioner was allowed $494.95 excess shelter deduction, resulting in $755.15 Food Stamp Net Adjusted Income.

10. A 30% benefit reduction occurred in the amount of $227 ($755.15 X 30%), resulting in a negative balance when subtracted from $194, the maximum allotment. The respondent assigned the $16 minimum level of benefits to the petitioner. Respondent determined petitioner was eligible to receive the $16 minimum monthly FAP allotment because the household income is less than the 200% monthly gross income limit of $1,962 for a household size of one.

11. Petitioner did not dispute the facts presented by the respondent. He explained that he had two premiums taken from his Social Security check in February 2016 and did not have enough money left to buy food. During the hearing, petitioner explained

that his Part B premium is $121.80. The respondent advised the petitioner to submit all verification to the Department for consideration.

12. On May 19, 2016, petitioner submitted an SSA award letter and a bank statement verifying his income and his medical expenses (Part B premiums) for consideration (Petitioner's Composite Exhibit 1).

13. On May 25, 2016, the undersigned received additional evidence from the respondent showing that petitioner's case had been updated. The Food Assistance budget for July 2016 shows petitioner's household gross income was reduced by a $155 standard deduction and a $86.80 excess medical expenses to arrive at the $1,233.20 adjusted income, 50% of which becomes shelter standard ($616.60). With shelter/utility costs $1,120, petitioner was allowed $503.40 excess shelter deduction, resulting in the Food Stamp Net Adjusted Income downwards adjusted to $729.80.

14. A 30% benefit reduction occurred in the amount of $219 ($729.80 X 30%), resulting in a negative balance when subtracted from $194, the maximum allotment. The respondent assigned the $16 minimum level of benefits to the petitioner*, see*. Respondent's Exhibit 8. Petitioner's FAP benefits amount did not change.

CONCLUSIONS OF LAW

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

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

<u>QI 1 Medicare Savings Program (MSP) issue:</u>

17. Federal Regulations at 20 C.F.R. § 416.1123, How we count unearned income, states in part:

> (b) *Amount considered as income.* We may include more or less of your unearned income than you actually receive…(2) We also include more than you actually receive if amounts are withheld from unearned income because of a garnishment, or to pay a debt or other legal obligaton, [*sic*] or to make any other payment such as payment of your Medicare premiums.

18. The above regulation explains that the gross amount is considered as income for Medicaid eligibility. The Department must follow this guideline.

19. Federal Regulations at 20 C.F.R. § 416.1124, Unearned income we do not count, states in part:

> (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 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).

20. The above regulations explain that only a $20 general exclusion in applied in the SSI-Related Medicaid Program.

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

> (12) Limits of Coverage.
> (a) Qualified Medicare Beneficiary (QMB). Under QMB coverage, individuals are entitled only to Medicare cost-sharing benefits, including payment of Medicare premiums.
> (b) Special Low-Income Medicare Beneficiary (SLMB). Under SLMB coverage, individuals are entitled only to payment of the Part B Medicare premium…
> (d) Part B Medicare Only Beneficiary (QI1). Under QI1 coverage, individuals are only entitled to payment of their Medicare Part B premium.

> (This is coverage for individuals who would be eligible for QMB or SLMB coverage except their income exceeds limits for those programs.)

22. Fla. Admin. Code R. 65A-1.713(1) further addresses the "SSI-Related Medicaid Income Eligibility Criteria" stating:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
> …
> (j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. QI1 is eligible only for payment of the Part B Medicare premium through Medicaid.

23. Federal Regulations at 20 C.F.R. § 416.121 "Types of Unearned Income" states in relevant part: "(a) Annuities, pensions, and other periodic payments. This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veteran's benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits."

24. The Department's Program Policy Manual, CFOP 165-22, (The Policy Manual), Appendix A-9 defines the income limit for Medicare Buy-In Programs. Effective April 2016 the income standards for an individual are: QMB - $990, SLMB - $1,188, and QI1 - $1,337. In accordance with Fla. Admin Code R. 65A-1.713, QI1 has the highest income standard of all the Buy-In Programs.

25. The Department must follow these guidelines. In this instant case, the petitioner's QI 1 was denied based on his total gross unearned income. The maximum income level for an individual to be eligible for the Buy-in Program is $1,325 before April 2016 and $1,337 effective April 2016. The petitioner's total gross income is $1,475.

The Department deducted $20 from $1,475 to arrive at $1,455 as total countable income. This amount exceeds the established income limits.

26. After careful review of the cited authorities and the evidence, the undersigned concludes the Department correctly followed rule in denying the petitioners QI-1 Medicaid benefits due to the petitioner's income exceeding the income limit for the Buy-In Program. The undersigned reviewed the rules, but did not find any exception to this formula, therefore could not find that petitioner was eligible for the QI-1 Program. The petitioner has failed to meet his burden that he is eligible for any of the Department's MSP Programs. With regard to the discrepancy in SSD payments, petitioner is encouraged to contact the Social Security Administration directly to address that.

FAP Benefits Level:

27. Federal regulation C.F.R. § 273.9 addresses income/allowable deductions budgeting in the FAP in part and states as follows:

> (a) Income eligibility standards. Participation in the Program shall be limited to those households whose incomes are determined to be a substantial limiting factor in permitting them to obtain a more nutritious diet.
> (b) Definition of income…
> (2) Unearned income shall include, but not be limited to: …
> (ii) Annuities; pensions; retirement, veteran's, or disability benefits; worker's or unemployment compensation including any amounts deducted to repay claims for intentional program violations as provided in §272.12; old-age, survivors, or social security benefits…
> (d) *Income deductions.* Deductions shall be allowed only for the following household expenses:
> (1) *Standard deduction*—
> (2) Earned income deduction.
> (3) Excess medical deduction. That portion of medical expenses in excess of $35 per month, excluding special diets, incurred by any household member who is elderly or disabled as defined in §271.2. Spouses or other persons receiving benefits as a dependent of the SSI or disability and blindness recipient are not eligible to receive this deduction but persons

> receiving emergency SSI benefits based on presumptive eligibility are eligible for this deduction…
> (4) Dependent care.
> (5) Optional child support deduction.
> (6) Shelter costs—
> (ii) Excess shelter deduction. Monthly shelter expenses in excess of 50 percent of the household's income after all other deductions in paragraphs (d)(1) through (d)(5) of this section have been allowed(ii) Excess shelter deduction. Monthly shelter expenses in excess of 50 percent of the household's income after all other deductions in paragraphs (d)(1) through (d)(5) of this section have been allowed. If the household does not contain an elderly or disabled member, as defined in § 271.2 of this chapter, the shelter deduction cannot exceed the maximum shelter deduction limit established for the area…
> (A) Continuing charges for the shelter occupied by the household, including rent,
> (iii) Standard utility allowances…
> (A) With FNS approval, a State agency may develop the following standard utility allowances (standards) to be used in place of actual costs in determining a household's excess shelter deduction.

28. The respondent must follow these federal budgeting guidelines when determining eligibility. The FAP budgeting process involves deducting some standard deductions as well as some of the recipients' actual expenses. If the recipient is aged or disabled, medical expenses not covered by insurance and owed by the recipient over $35 per month could be deducted. Rent or mortgage is an allowable deduction as well as a standard deduction for utilities. There is no evidence that the petitioner was eligible for any additional deductions. It also directs the Department to include Social Security benefits as income that must be included in the eligibility determination.

29. Federal Regulations 7 C.F.R. § 273.10(e) addresses income and 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.
(B) Multiply the total gross monthly earned income by 20 percent and subtract that amount from the total gross income; or multiply the total gross monthly earned income by 80 percent and add that to the total monthly unearned income, minus income exclusions.
(C) Subtract the standard deduction.
(D) If the household is entitled to an excess medical deduction as provided in Sec. 273.9(d)(3), determine if total medical expenses exceed $35. If so, subtract that portion which exceeds $35.
(E) Subtract allowable monthly dependent care expenses, if any, up to a maximum amount as specified under Sec. 273.9(d)(4) for each dependent.
(F) Subtract allowable monthly child support payments in with Sec. 273.9(d)(7).
(G) Subtract the homeless shelter deduction, if any, up to the maximum of $143.
(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.
(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.

30. The FAP standards for gross income, net income, and deductions appear in the Policy Manual at Appendix A-1. Effective October 1, 2015, the 200% FPL for a one-person assistance group is $1,962, the standard deduction is $155, the Standard Utility

Allowance is $345 and the maximum FAP allotment is $194. Additionally, it indicates that minimum monthly allotment for a household of one as $16.

31. The Policy Manual at passage 2610.0103.01 addresses Budgets and Tests and states:

> Assistance groups must meet the gross income standards to be eligible for food stamps with the following exceptions:
> 2. standard filing units (SFUs) that are broad-based categorically eligible must meet the 200% gross income limits.

32. The petitioner is a BBCE household and needs only to have gross income at or less than 200% of the FPL to be eligible for FAP.

33. The Policy Manual at 2610.0106.02 addresses Minimum Benefit (FS) for recurring months and states that eligible households made up to two persons are eligible for eight percent of the maximum FAP benefit for a one-person assistance group.

34. The above cited explains that assistance groups that consists of one or two household members are eligible for the minimum monthly FAP benefit allotment if the household meets all the regular eligibility requirements. The maximum FAP benefit amount for one is $194. Petitioner was approved $16 (8% x $194) effective March 2016, because his household income is less than $1,962. The undersigned reviewed the Department's most recent budget calculation and found no mathematical errors. The undersigned concludes that the respondent's action is correct.

35. After considering the evidence, testimony, and the appropriate authorities cited above, the hearing officer concludes that the respondent's action to approve $16 effective March 2016 is correct. The hearing officer cannot conclude that the petitioner

is eligible for any additional benefits based on the income and expenses presented and the above-cited rules. The petitioner has failed to meet his burden that he is eligible for any additional FAP benefits.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are denied. The Department's actions are upheld.

NOTICE OF RIGHT TO APPEAL

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

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

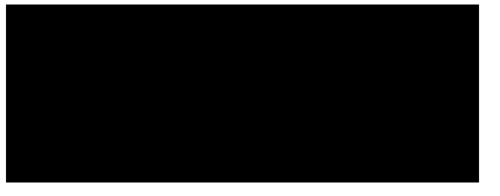
Roosevelt Reveil
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

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

Jun 03, 2016

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 16F-01863

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 April 15, 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 dental/orthodontic services (braces) was correct. The Petitioner has the burden of proving his case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The Petitioner submitted documents as evidence for the hearing which were marked as Petitioner Exhibit 1.

Appearing as witnesses for the Respondent were Dr. Susan Hudson, Dental Consultant, and Jackeline Salcedo, Complaint and Grievance Specialist, from DentaQuest, which is the Petitioner's dental services organization. Also present as a witness for the Respondent was Carlene Brock, Quality Operations Nurse from Amerigroup, which is Petitioner's managed health care plan.

Respondent submitted the following documents as evidence for the hearing, which were marked as Respondent composite Exhibit 1: case summary, authorization request, orthodontic evaluation form, dental records, denial notices, and criteria.

Also present for the hearing was a

FINDINGS OF FACT

1. The Petitioner is a sixteen (16) year-old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. He receives services under the plan from Amerigroup, which utilizes DentaQuest for review and approval of dental services.

2. On or about February 26, 2016, the Petitioner's treating dentist or orthodontist (hereafter referred to as "the provider"), requested prior authorization for orthodontic treatment (braces). DentaQuest, on behalf of Amerigroup, denied this request on

February 29, 2016. Amerigroup had previously approved an orthodontic evaluation visit to determine the need for braces.

3. The denial notice stated the request for braces was denied since it was not medically necessary. This denial notice also stated the following regarding the reason for the denial:

> To qualify for braces you need to get 26 points on a test. The test gives points for crowded, missing, and rotated teeth as well as spacing. Our Dental Director scored your teeth. You do not qualify for braces. We have told your dentist. Please talk to your dentist. You reached a score of: 12 points.

4. Petitioner's grandfather stated his grandson is in pain because he has a tooth which is coming out in a horizontal direction instead of a vertical direction, which is damaging the adjacent teeth. He also stated the dentist doesn't want to do surgery to correct the problem and is recommending the braces to straighten out the teeth. He also stated the well-being of his grandson should be the primary concern rather than a point system to evaluate the need for braces.

5. The Respondent's expert witness, Dr. Hudson, testified that the denial of the Petitioner's request for the braces was appropriate because an individual must have a score of 26 or higher on the evaluation form which is used to assess the need for braces, and the Petitioner's score on that form was 12 based on DentaQuest's review. The Petitioner's dentist reached a score of 3 on the evaluation form. Dr. Hudson also stated other procedures, such as oral surgery, can treat the impacted tooth and that an impacted tooth does not qualify someone to receive braces.

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

.

CONCLUSIONS OF LAW

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

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

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

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

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

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

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

13. Braces are a covered service for individuals under age twenty-one (21) in the Florida Medicaid Program. The Dental Handbook, on page 2-15, states the following in reference to orthodontic services:

> Orthodontic procedures may be reimbursed for Medicaid recipients under age 21.
>
> Prior authorization is required for all orthodontic services. Orthodontic services are limited to those recipients with the most handicapping malocclusion. A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the patient by causing impaired mastication, dysfunction of the temporomandibular articulation, susceptibility to periodontal disease, susceptibility of dental caries, and impaired speech due to malpositions of the teeth.

14. The Dental Handbook also describes an evaluation form used to assess the need for orthodontic treatment. This form is referred to as "The Medicaid Orthodontic Initial

Assessment Form (IAF)" and the form calculates a numerical score based on the individual patient's conditions. The Dental Handbook, on page 2-18, describes the scores as follows:

> A score of 26 or greater may indicate that treatment of the recipient's condition could qualify for Medicaid reimbursement, and the orthodontic provider should submit a prior authorization request to Medicaid for consideration of orthodontic services. A score of 26 or greater on the IAF is not a guarantee of approval. It is used by the provider to determine whether diagnostic records should or should not be sent to the orthodontic consultant.
>
> A score of less than 26 indicates that treatment of the recipient's condition may not qualify for Medicaid reimbursement, and the request for prior authorization may be denied.
> This does not say that such cases do not represent some degree of malocclusion, but simply that the severity of the malocclusion does not qualify for coverage under the Florida Medicaid Orthodontic Program.
>
> When the IAF score is less than 26, but the strategical positioning of the malocclusion constitutes a serious impediment or threat to normal growth, development and function of the jaws or dentition, the provider must submit a completed prior authorization, IAF, diagnostic photographs, panoramic x-ray and study models to the Medicaid orthodontic consultant for determination of medical necessity.

15. Petitioner's grandfather believes the braces should be approved for his grandson because he is in pain and his dentist recommended the braces instead of surgery to correct the problem.

16. Respondent's witness stated that the braces were denied since the Petitioner's score on the evaluation form was less than 26 (his score was 12). She also stated there are other treatment options which can be explored to correct the Petitioner's problem with his impacted tooth.

17. After considering the evidence presented and relevant authorities set forth above, the undersigned concludes the Petitioner has not demonstrated that the denial of the request for the braces was incorrect. Petitioner has not established that the request for this service is medically necessary as defined by Fla. Admin. Code R. 59G-1.010(166). Although Petitioner's orthodontist requested the braces, this does not establish it is medically necessary. Respondent's witness testimony and the Handbook provisions addressing orthodontic treatment support the denial of the requested service. The Petitioner should explore other treatment options with his provider.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this __03__ day of __June________, 2016, in Tallahassee, Florida.

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

Copies Furnished To [redacted] PETITIONER
RHEA GRAY, AREA 11, AHCA FIELD OFFICE MANAGER

Jun 01, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-01869

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 April 15, 2016 at 10:00 a.m.

APPEARANCES

For the Petitioner:

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

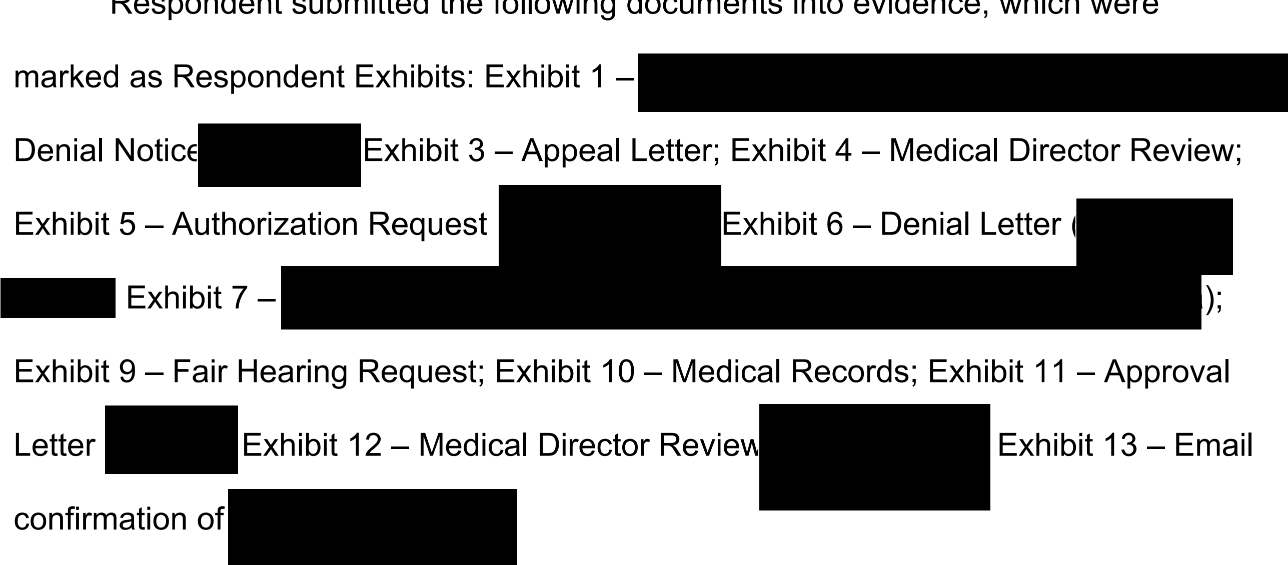
STATEMENT OF ISSUE

At issue is whether the Respondent's denial of the Petitioner's request for the prescription medications and the Petitioner's request for an was correct. Petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

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

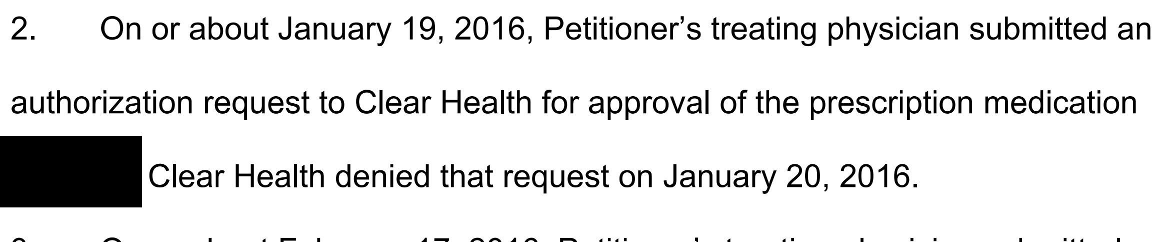
Appearing as witnesses for the Respondent were Dr. Jeanette Rios, Medical Director, Diana Anda, Grievance and Appeals Manager, and Francis Quinones, Clinical Pharmacist, for Clear Health Alliance, which is the Petitioners' managed health care plan.



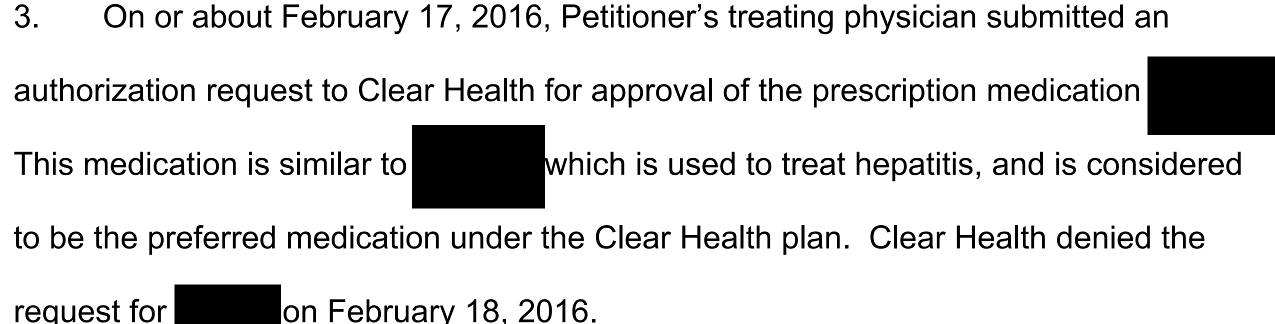
Respondent submitted the following documents into evidence, which were marked as Respondent Exhibits: Exhibit 1 – Denial Notic Exhibit 3 – Appeal Letter; Exhibit 4 – Medical Director Review; Exhibit 5 – Authorization Request Exhibit 6 – Denial Letter (Exhibit 7 –); Exhibit 9 – Fair Hearing Request; Exhibit 10 – Medical Records; Exhibit 11 – Approval Letter Exhibit 12 – Medical Director Review Exhibit 13 – Email confirmation of

FINDINGS OF FACT

1. The Petitioner is a fifty-eight (58) year old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. She receives services under the plan from Clear Health Alliance.



2. On or about January 19, 2016, Petitioner's treating physician submitted an authorization request to Clear Health for approval of the prescription medication Clear Health denied that request on January 20, 2016.

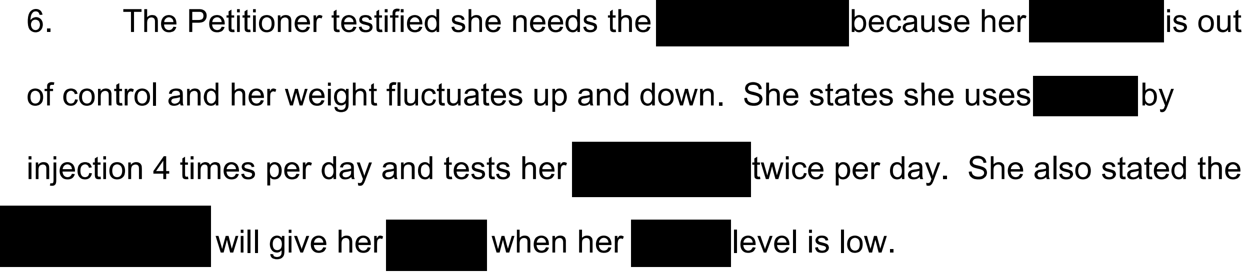


3. On or about February 17, 2016, Petitioner's treating physician submitted an authorization request to Clear Health for approval of the prescription medication This medication is similar to which is used to treat hepatitis, and is considered to be the preferred medication under the Clear Health plan. Clear Health denied the request for on February 18, 2016.

4. On March 28, 2016, after reviewing additional medical records and other information, Clear Health approved the request fo for a 12 week course of treatment.

5. On or about February 3, 2016, Petitioner's treating physician submitted an authorization request to Clear Health for approval of an . Clear Health denied that request on February 10, 2016. The denial notice stated the following:

> Your request for was not approved. There is no evidence of frequent self-adjustments of for the past 6 months on clinical information submitted for review.



6. The Petitioner testified she needs the because her is out of control and her weight fluctuates up and down. She states she uses by injection 4 times per day and tests her twice per day. She also stated the will give her when her level is low.

7. The Respondent's witness, Dr. Rios, stated the criteria for approval of an require that the patient need frequent self-adjustment of dosage and, in

this case, the Petitioner is on fixed [redacted] doses. In addition, the patient should require frequent glucose monitoring of at least 4 times daily, and the Petitioner stated she tests her blood sugar only twice daily. Finally, Dr. Rios stated the Petitioner has not exhibited significant fluctuations in her glucose levels.

8. Services under the Medicaid State Plan in Florida are provided in accordance with the Respondent's Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July, 2012, and the Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook ("DME Handbook"), effective July, 2010.

CONCLUSIONS OF LAW

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

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

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

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

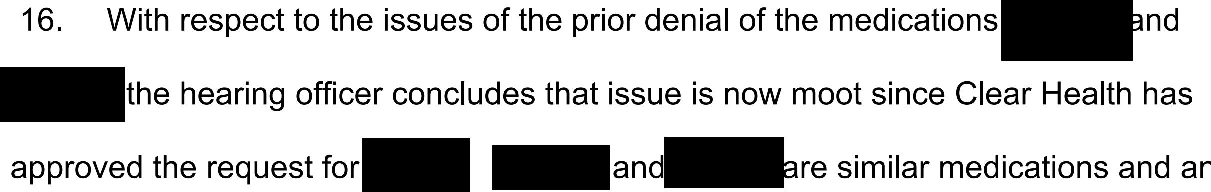
13. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered

by the Respondent. The Medicaid Handbook and the DME Handbook are incorporated by reference in Chapter 59G-4, Florida Administrative Code.

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

15. 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.



16. With respect to the issues of the prior denial of the medications and the hearing officer concludes that issue is now moot since Clear Health has approved the request for and are similar medications and an

individual would not be furnished with both medications. is the preferred medication under the Clear Health plan and it was approved rather than

17. Regarding the denial of the Respondent's witness outlined the criteria for approval of this medical device and the Petitioner has not met the criteria. Specifically, she is on fixed doses of and does not need self-adjustment of the dosage, she does not require frequent glucose monitoring (at least 4 times daily), and she has not exhibited significant fluctuations in her glucose levels.

18. After considering all the documentary evidence and witness testimony presented, the undersigned concludes Clear Health Alliance correctly denied Petitioner's request for the insulin pump.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is DENIED as to the and dismissed as to the medication requests since that issue is now moot due to Clear Health's approval of the

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the Petitioner disagrees with this decision, the Petitioner may seek a judicial review. To begin the judicial review, the Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The Petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The

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

DONE and ORDERED this __01__ day of ___June________, 2016,

in Tallahassee, Florida.

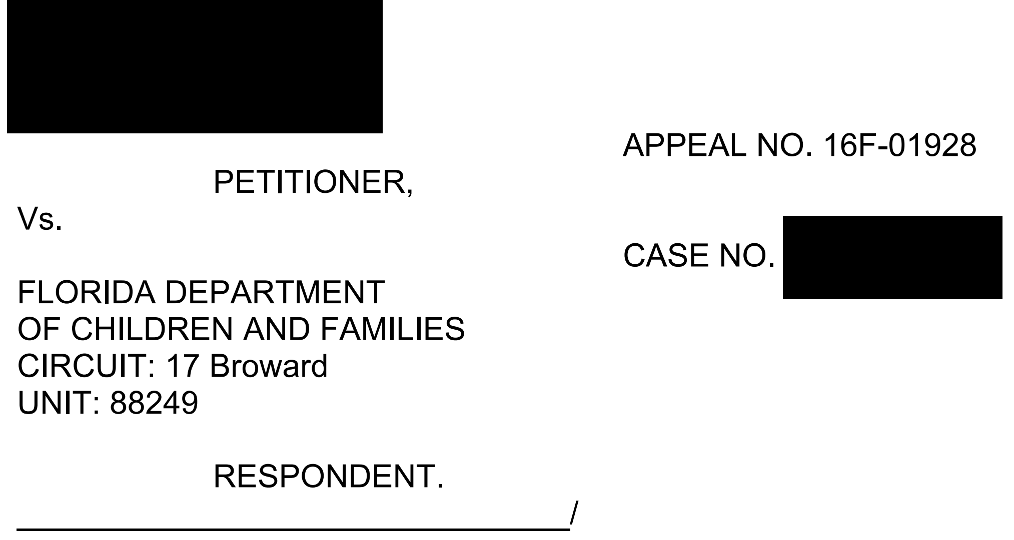
Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To [redacted] PETITIONER
RHEA GRAY, AHCA AREA 11, FIELD OFFICE MANAGER

Jun 08, 2016

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 16F-01928

PETITIONER,

Vs.

CASE NO.

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 May 19, 2016, at 1:15 p.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner:

For the Respondent: Mary Triplett, economic self-sufficiency supervisor.

STATEMENT OF ISSUE

At issue is whether the respondent's action denying petitioner's Medicaid benefits through the Department's SSI-Related Medicaid Program on the basis that she does not meet the disability criteria is correct. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

By a Notice of Case Action dated February 23, 2016, the respondent informed the petitioner that her SSI-Related Medicaid Program benefits were being denied because she did not meet the disability requirement of the Program. On March 14, 2016, the petitioner timely requested a hearing to challenge the respondent's action.

During the hearing, the petitioner submitted an exhibit, which was accepted into evidence and marked as Petitioner's Composite Exhibit 1. The respondent submitted five exhibits, which were marked as Respondent's Exhibits "1" through "5" respectively.

The record was left open through May 26, 2016 for the petitioner to submit additional information. The information was timely received, entered into evidence and marked as Petitioner's Composite Exhibit 2. The record was closed on May 26, 2016.

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. On March 4, 2012, the petitioner experienced shortness of breath and went to the hospital. She was diagnosed with [redacted] and underwent triple bypass surgery on March 8, 2012. After the surgery, the petitioner applied for Medicaid with the Department and was approved.

2. In March 18, 2013, the petitioner applied for Supplemental Security Income (SSI) with the Social Security Administration (SSA) alleging her disability began March 4, 2012. SSA considered the following conditions: [redacted]

March 26, 2013, and upon reconsideration on June 19, 2013", *see* Petitioner's Composite Exhibit 2.

On June 19, 2013, the petitioner filed a Request for Reconsideration for Social Security benefits. The hearing was held on January 9, 2015, during which time the petitioner testified. On February 10, 2015, an Administrative Law Judge (ALJ) issued a ruling upholding the June 19, 2013 decision.

4. On February 25, 2015, the petitioner requested an appeal with the Office of Disability Adjudication and Review (ODAR) challenging the SSA's decision. On April 20, 2016, a Notice of Appeals Council Action was sent to the petitioner from SSA informing the petitioner, "We found no reason under rules to review the Administrative Law Judge's decision. Therefore we have denied your request for review", *see* Petitioner's Composite Exhibit 2.

5. The petitioner ([redacted]) is 64. She does not meet the aged criteria for SSI-Related Medicaid benefits. She has no minor children and does meet the technical requirement for the Family-Related Medicaid category. The petitioner did not allege blindness. Disability must be established to determine Medicaid eligibility.

6. Petitioner is not currently employed. She last worked in 2010 sorting mail for the United States Postal Service for about four years. Between 2006 and 2007, petitioner worked in the fitting room at [redacted] store, doing regular maintenance. Before then, she worked for over 22 years as a gas station attendant, pumping gas, making payroll, etc. She is receiving SS benefits in the United States and pension benefits from United Kingdom.

7. The Department of Children and Families (Department or DCF) determines eligibility for SSI-Related Medicaid programs. To be eligible, an individual must be blind, disabled, or 65 years or older. The Division of Disability Determinations (DDD) conducts disability reviews regarding Medicaid eligibility for individuals applying for disability benefits under the state Medically Needy Program. Once a disability review is completed, the claim is returned to DCF for a final determination of eligibility and effectuation of any benefits due.

8. On January 27, 2016, the petitioner applied for Medicaid benefits through the Department's SSI-Related Medicaid Program to continue her benefits. Information obtained from the petitioner was forwarded to DDD for review on February 16, 2016.

9. DDD received petitioner's disability package from the Department for a disability review. The DDD has access to Social Security information. Case notes from DDD Transmittal indicate petitioner's medical conditions to be [REDACTED] and [REDACTED] DDD determined these medical were already known and considered by SSA and will be addressed in the course of her appeal before an administrative law judge (ALJ).

10. On February 22, 2016, DDD denied the petitioner's claim of disability by adopting the February 2015 SSA denial citing, "(N 31)-customary past work, no visual impairment." DDD did not make an independent determination, as it considered petitioner's medical conditions to be the "same/related allegations".

11. On February 23, 2016, the Department mailed the petitioner a Notice of Case Action denying her application for SSI-Related Medicaid due to not meeting the disability criteria, *see* Respondent's Exhibits 1 through 5.

12. The respondent explained that it denied the petitioner's SSI-Related Medicaid application because SSA has determined that she was not disabled and DDD has adopted the decision. The respondent explained that SSA decision is binding and must be accepted by the Department as final. The respondent explained that once DDD determined that the petitioner is no longer disabled, the Department has to terminate the Medicaid as she no longer meets the technical requirement for the SSI-Related Medicaid Program for people under age 65.

13. The petitioner did not dispute the facts presented; however, she asserted that she has shortness of breath and is easily fatigued. She explained that her condition started since 2012 and has not changed. Petitioner believes with her medical conditions the same, she should be found disabled and be eligible for Medicaid benefits. She did not claim any new conditions. She does not understand why her Medicaid has been terminated. The petitioner has been receiving SSI-Related Medicaid benefits from the Department since 20112 until she was terminated in March 2016.

CONCLUSIONS OF LAW

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

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

16. Fla. Admin. Code R 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. Individuals

less than 65 years of age 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 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.

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

> § 435.540 Definition of disability.
> (a) Definition. The agency must use the same definition of disability as used under SSI...

18. Federal Regulations at 42 C.F.R. § 435.541 "Determination of Disability," states:

> (a) *Determinations made by SSA.* The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.
> (1) If the agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act, the agency may not make a determination of disability when the only application is filed with SSA.
> (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.911 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under §435.909.
> (b) *Effect of SSA determinations.* (1) Except in the circumstances specified in paragraph (c)(3) of this section—
> (i) An SSA disability determination is binding on an agency until the determination is changed by SSA.
> (ii) If the SSA determination is changed, the new determination is also binding on the agency.
> (2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.

(c) *Determinations made by the Medicaid agency.* The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:
(1) The individual applies for Medicaid as a non-cash recipient and has not applied to SSA for SSI cash benefits, whether or not a State has a section 1634 agreement with SSA; or an individual applies for Medicaid and has applied to SSA for SSI benefits and is found ineligible for SSI for a reason other than disability.
(2) The individual applies both to SSA for SSI and to the State Medicaid agency for Medicaid, the State agency has a section 1634 agreement with SSA, and SSA has not made an SSI disability determination within 90 days from the date of the individual's application for Medicaid.
(3) The individual applies to SSA for SSI and to the State Medicaid agency for Medicaid, the State does not have a section 1634 agreement with SSA, and either the State uses more restrictive criteria than SSI for determining Medicaid eligibility under its section 1902(f) option or, in the case of a State that uses SSI criteria, SSA has not made an SSI disability determination in time for the State to comply with the Medicaid time limit for making a prompt determination on an individual's application for Medicaid.
(4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA, and—
(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or
(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.
(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—
(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or
(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

19. The Department's Program Policy Manual (The Policy Manual) CFOP 165-22 at passage 1440.1204 "Blindness/Disability Determinations (MSSI, SFP)" states:

…If SSA has denied disability within the past year and the decision is under appeal with SSA, do not consider the case as pending. Use the

> decision SSA has already rendered. The SSA denial stands while the case is pending appeal.
> When the individual files an application within 12 months after the last unfavorable disability determination by SSA and provides evidence of a new condition not previously considered by SSA, the state must conduct an independent disability determination. Request a copy of the SSA denial letter. The SSA denial letter contains an explanation of all the conditions considered and the reason for denial.

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

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

21. According to the above-cited authorities, an SSA decision made within 12 months of the Medicaid application that is under appeal is controlling and binding on the

State Agency unless the applicant reports a disabling condition not previously reviewed by SSA. Additionally, they direct worsening and deteriorating of conditions to the SSA. In this instant case, SSA has determined that the petitioner's condition was not severe enough to prevent her from performing customary past work. On February 22, 2016, DDD adopted the SSA decision and alerted the Department that the petitioner was not disabled.

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

23. The hearing officer explored all other Medicaid groups. The only other Medicaid group was Family-Related Medicaid Program benefits. The petitioner has no minor children residing with her. The Family-Related Medicaid Program benefit rules are set forth in the Fla. Admin. Code R. 65A-1.705, Family-Related Medicaid General Eligibility Criteria. The rules set forth that to be eligible for that Medicaid Program, a dependent child must be living in the home. The petitioner does not meet the criteria for Family-Related Medicaid Program benefits. It is concluded, the respondent's action to deny the petitioner's application for Medicaid Program benefits was within the rules of the Program.

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 08 day of June, 2016,

in Tallahassee, Florida.

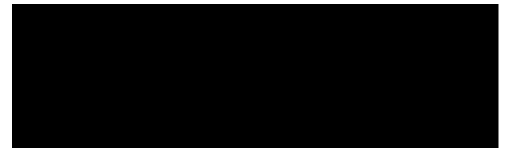
Roosevelt Reveil
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

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

Jun 09, 2016

Office of Appeal Hearings
Dept. of Children and Families

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



PETITIONER,

vs.

APPEAL NO. 16F-01963

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 03 Columbia
UNIT: AHCA

and

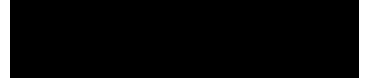
WellCare of Florida, Inc. d/b/a StayWell Health Plan,

RESPONDENTS.
________________________________/

FINAL ORDER

Pursuant to notice, Hearing Officer Patricia C. Antonucci convened hearing in the above-captioned matter on May 11, 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 or “the Agency”), through its contracted health plan, StayWell/WellCare (“StayWell”) to deny Petitioner’s request for [redacted] a prescription medication.

Petitioner bears the burden of proving, by a preponderance of the evidence, that said denial is improper.

PRELIMINARY STATEMENT

The Agency for Health Care Administration is responsible for administering Florida's Medicaid Program. AHCA contracts with managed care plans to provide services, including pharmacy services, to Medicaid recipients residing in the State of Florida. The managed care plans, in turn, provide prior authorization reviews for all requested goods and services.

Prior to hearing, StayWell filed a request to be added as a party to this appeal. StayWell was thereafter copied on all correspondence regarding this matter; however, the undersigned neglected to formally grant StayWell's request at hearing on May 11, 2016.

Per federal regulations, StayWell is a proper party to this case. 42 C.F.R. § 438.408(f)(2) informs, "[t]he parties to the State fair hearing include the MCO or PIHP as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate." In accordance with this regulation, the undersigned hereby joins StayWell as a co-Respondent.

At hearing, the Petitioner was present, and acted as her own representative. Respondent was represented by Selwyn Gossett, Medical/Health Care Program Analyst, on behalf of AHCA. Respondent also presented two witnesses from StayWell: Stephanie Shupe, Regulatory Research Coordinator, and Lauren Barnes, Manager of Pharmacy Operations. Petitioner's Composite Exhibit 1, and Respondent's Exhibits 1 through 9, inclusive, were admitted into evidence.

FINDINGS OF FACT

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

1. Petitioner is an adult female, who is diagnosed with [redacted] Petitioner was initially diagnosed in 1996, and feels that she is getting progressively worse with time. At all times relevant to this proceeding, Petitioner has been eligible for and receiving Medicaid services, through StayWell/WellCare.

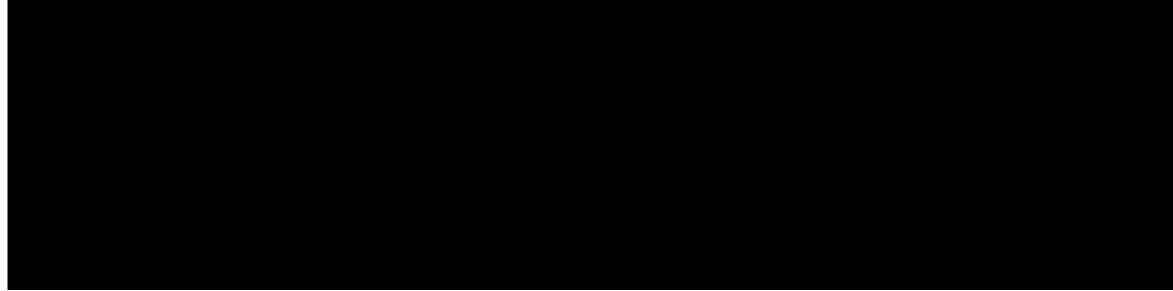
2. On or about February 19, 2016, Petitioner's treating doctor submitted to StayWell a preauthorization request for [redacted] noting on the facsimile cover page: '[redacted]'

3. The doctor did not provide any supporting documentation along with this request, and did not respond to StayWell's attempts to coordinate supplemental receipt of same.

4. StayWell reviewed the request for [redacted] in conjunction with AHCA-based [redacted] as well as WellCare's own policy and procedure guidelines.

5. Via Notice of Action dated February 22, 2016, StayWell informed Petitioner of its decision to deny her request, stating, in pertinent part:

[redacted]



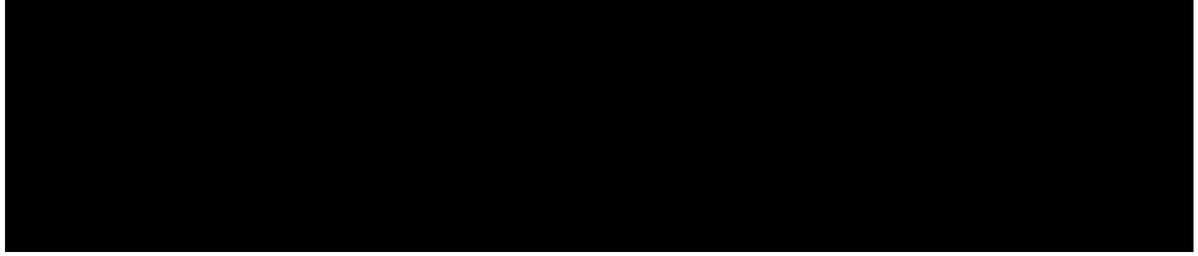
6. On or about March 11, 2016, Petitioner requested a fair hearing to challenge this denial.

7. At hearing, Petitioner explained that she requested because she is feeling progressively worse and staying in bed more often. She wants to be healthy enough to visit and interact with her children and grandchildren. Petitioner stated that her ex-husband, who has both Medicaid and Medicare, was approved to receive even though his was not as bad as Petitioner's. She does not understand why she does qualify for the prescription, as she has seen its "miracle drug" effect on her ex-husband, whose starting enzyme levels were lower than hers. Petitioner is unable to take other medications, but feels that might work well for her.

8. Petitioner further explained that her provider's office is very difficult to work with, and that the doctor's staff have been impatient and rude when responding to Petitioner's requests for assistance with the prior authorization process. The Petitioner has encountered great frustration in trying to coordinate with her provider to get StayWell the documentation it needs. As the Petitioner also suffers from and the stress of trying to prepare a thorough request has aggravated her health concerns. She is worried that further delay and/or denial of

will result in the need for more blood tests, which she undergoes as needed, but does not enjoy. The Petitioner feels that she is all alone in this process, and is struggling to advocate for herself, so as to meet her health care needs.

9. Respondent explained that its initial decision to deny was based on the provider's failure to submit any clinical documentation, whatsoever, for review. After examining all of the documentation that Petitioner, herself, submitted as evidence for hearing, StayWell noted that many of the criteria for prior authorization were, indeed, fulfilled; however, StayWell determined that denial was still proper, as Petitioner and/or her provider had yet to document:



10. StayWell noted that it in preparation for hearing, it also reviewed the most current version of AHCA's criteria, and concluded that Petitioner did not meet the requirements contained, therein.

11. Because the Petitioner did not fulfill all of the guidelines, StayWell determined that was not medically necessary to meet Petitioner's needs; however, StayWell testified that if Petitioner is able to obtain additional documentation to fulfill all criteria *or* if her provider submits a statement explaining why Petitioner should be exempt from the criteria, StayWell will consider the request, anew.

12. StayWell also agreed to assign Petitioner a case manager, who will assist Petitioner with navigating the requirements of prior authorization, and can help facilitate

coordination between Petitioner's doctors/providers and StayWell. The plan also noted that it would provide Petitioner with a list of participating providers, in the event she wishes to see a different [redacted] In addition, StayWell offered to assist the Petitioner in following up on any grievances against her current provider's office.

CONCLUSIONS OF LAW

13. The Department of Children and Families Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 120.80, Florida Statutes.

14. The Florida Medicaid program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. It is administered by AHCA.

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

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

17. Section 409.912, Florida Statutes, provides that AHCA shall purchase goods and services for Medicaid recipients in the most cost-effective manner possible, consistent with the delivery of quality medical care. To this end, the Agency has contracted with managed care organizations to provide medical coverage to enrolled recipients. In the instant case, Petitioner's managed care plan is StayWell.

18. The July 2012 Florida Medicaid Provider General Handbook ("Provider

Handbook") is incorporated by reference into Fla. Admin. Code R. 59G-5.020. 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.

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

20. All Medicaid covered services must be "medically necessary" as defined by law. 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.

21. In order to aid determination of the medical necessity of specific goods and services, the Agency has formulated certain guidelines, which govern its reviews. These guidelines are "consistent with generally accepted professional medical standards… and [are] not experimental or investigational."

22. As StayWell's own guidelines cannot be more restrictive than those that govern fee-for-service Medicaid, review of AHCA's guidelines is appropriate.

23. With regard to prescription drugs, Sections 409.912(8)(a)(14) through 409.912(16), Florida Statutes, are instructive. Pursuant to Fla. Stat. § 409.912(8)(a)(14), "the agency may require prior authorization for Medicaid-covered prescribed drugs." Per Fla. Stat. § 409.91195, the Agency establishes and maintains a prior authorization review process, formulating prior authorization guidelines via committee.

24. The July 2014 Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook ("Prescribed Drug Handbook") is promulgated into law by Fla. Admin. Code R. 59G-4.250. Said Prescribed Drug Handbook echoes the information contained within the Florida Statutes.

25. In accordance with its authority to establish criteria for prior authorization, AHCA has formulated specific criteria for the approval of [redacted] At the time of StayWell's review, the Medicaid drug criteria for [redacted] required (in part) at least [redacted] for approval.

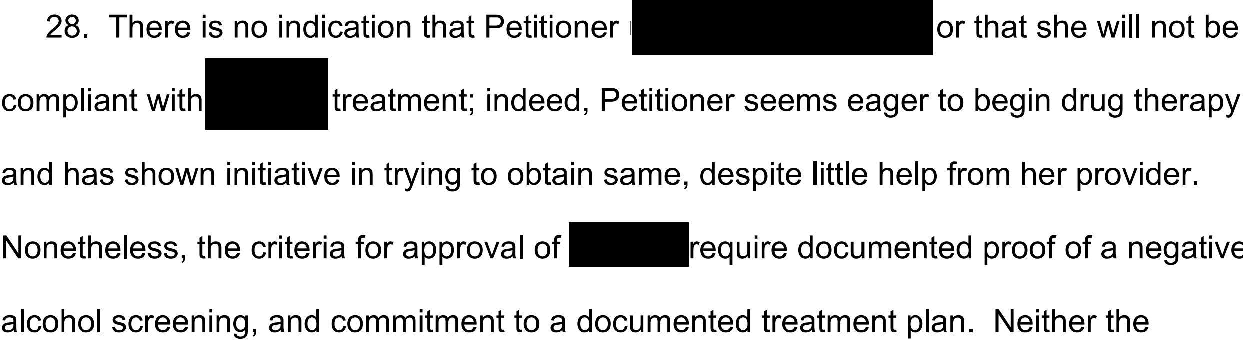
26. As there is no indication what stage of [redacted] Petitioner exhibits, the undersigned concludes that StayWell's denial "…was correct at the time the decision was made." Fla. Admin. Code R 65-2.056(3).

27. As this hearing is *de novo*, the undersigned must also review StayWell's decision in combination with AHCA criteria, as they exist, today. Said criteria were most recently updated on June 1, 2016.[1] While the undersigned notes that there is no longer any specification with regard to the stage of hepatic fibrosis, the following, currently unmet criteria remain:

- "Patient has abstained from the use of… alcohol for a minimum of one month as evidenced by negative urine or blood confirmation tests collected within the past 30 days, prior to initiation of therapy (results must be submitted with request)… OR Patient is receiving substance or alcohol abuse counseling services or seeing an addiction specialist as an adjunct to HCV treatment and it is documented in the medical records;"

AND

- "Patient commits to the documented planned course of treatment including anticipated blood tests and visits, during and after treatment."



28. There is no indication that Petitioner [redacted] or that she will not be compliant with [redacted] treatment; indeed, Petitioner seems eager to begin drug therapy, and has shown initiative in trying to obtain same, despite little help from her provider. Nonetheless, the criteria for approval of [redacted] require documented proof of a negative alcohol screening, and commitment to a documented treatment plan. Neither the

[1] Prescription drug criteria for Harvoni may be found on AHCA's website, at: http://ahca.myflorida.com/Medicaid/Prescribed_Drug/drug_criteria_pdf/Harvoni_Criteria.pdf (last accessed June 2, 2016).

results of alcohol testing nor a physician's treatment plan have been submitted for review.

29. Absent evidence that all of the [redacted] criteria have been fulfilled, *or* documentation that Petitioner should be exempt from meeting same, the undersigned is unable to determine that Respondent's denial is improper.

30. Petitioner's case is sympathetic, and the undersigned notes the frustration Petitioner has encountered in trying to meet her health care needs. Her dedication to her own self-advocacy is admirable. Petitioner is strongly encouraged to work with her providers, her new case manager, and StayWell, and to continue seeking treatment options. Should Petitioner wish to submit a new request for [redacted] she is free to do so at any time. If her request is denied, she will be notified in writing, and will retain the right to appeal that, specific denial.

DECISION

Based upon the foregoing, Respondent's denial is AFFIRMED, and 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 _09_ day of ___June_______, 2016,

in Tallahassee, Florida.

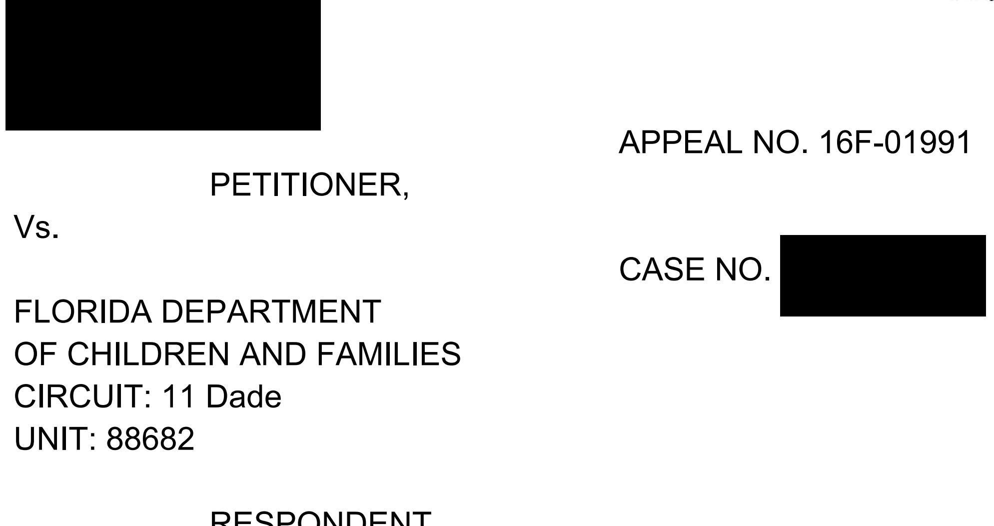
Patricia C. Antonucci
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: appeal.hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Debbie Stokes, Area 4, AHCA Field Office Manager
Stephanie Shupe, StayWell/WellCare

May 31, 2016

Office of Appeal Hearings
Dept. of Children and Families

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



PETITIONER,

Vs.

APPEAL NO. 16F-01991

CASE NO.

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

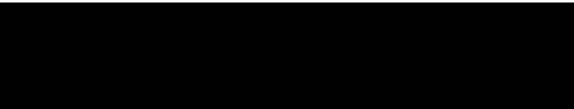
RESPONDENT.
________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on April 25, 2016 at 3:17 p.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: Yanet Herrera, pro se

For the Respondent: 

STATEMENT OF ISSUE

At issue is the respondent's action to terminate full Medicaid for petitioner's son and enroll him in the Medically Needy (MN) program with an $8,365 Share of Cost (SOC) at recertification. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner.

PRELIMINARY STATEMENT

The petitioner submitted 20 pages of evidence, which was entered and marked as Petitioner's Composite Exhibit "1". The respondent submitted 58 pages of evidence, which was entered and marked as Respondent's Composite Exhibit "1". The record was held open until April 25, 2016 to submit additional evidence including department policy related to Medically Needy Budgeting and the income alert mentioned by the respondent. On April 25, 2016 the respondent submitted the policy requested, petitioner's application for Medicaid dated March 9, 2016, and an updated Medically Needy Budget. Both were marked and entered as Respondent's Exhibits "2" through "4".

On April 28, 2016, the undersigned determined additional information was required from the respondent. An Interim Order was sent to the respondent requesting the Notice of Case Action (NOCA) dated on or around March 8, 2016 to be submitted within 10 days. The respondent submitted the NOCA sent to the petitioner as requested on March 10, 2016. An additional NOCA dated March 14, 2016 was also submitted. Both were marked and entered into evidence as Respondent's Exhibit "5" and "6". The record was closed the same day.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner's son was receiving full Medicaid beginning in 2014.

2. On February 2, 2016, the petitioner submitted a recertification application for Medicaid for her 10-year-old son [redacted]

3. The petitioner's household includes the petitioner, her husband, and 2 minor sons. The petitioner and her husband intend to file taxes.

4. The petitioner's husband works for the [redacted] and is paid bi-weekly; he works 80 hours per pay period, earning [redacted] per hour with additional overtime of 10-20 hours each pay period, earning [redacted] per overtime hour.

5. On February 8, 2016, the respondent sent a Notice of Case Action (NOCA) requesting proof of the household income: "Proof of all gross income corresponding to the last 4 weeks. Use the form 'Verification of employment / Loss of Income' or you can send your last four pay stubs". The verification was due February 18, 2016.

6. The petitioner did not provide the verification of income requested.

7. On March 8, 2016, the respondent sent a NOCA informing the petitioner that her son's full Medicaid would be terminated effective March 31, 2016 and he would be enrolled in the MN program with a SOC effective April 1, 2016.

8. On March 9, 2016, an additional application was submitted listing the petitioner's husband's SWICA verified income at $8,950.37 per month.

9. The respondent then determined the petitioner's SOC by subtracted the Medically Needy Income Limit (MNIL) for a household of four of $585 from the SWICA verified income.

10. On March 14, 2016 the respondent sent the petitioner a NOCA informing the petitioner her the SOC would increase to $8,365 effective April 1, 2016.

11. The petitioner timely requested the hearing.

12. The petitioner argues that her son is need of over 40 hours per week in therapies to live and the therapies are too expensive for them to pay. She also asserts that she was

told by her son's doctor that due to her son's condition, he would be eligible for the full Medicaid and household income was not a factor.

CONCLUSIONS OF LAW

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

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

Full Medicaid benefits will be now be addressed:

15. Federal regulation 42 C.F.R. § 435.602 Financial responsibility of relatives and other individuals states in the pertinent part:

> (a) Basic requirements. Subject to the provisions of paragraphs (b) and (c) of this section, in determining financial responsibility of relatives and other persons for individuals under Medicaid, the agency must apply the following requirements and methodologies:
> (1) Except for a spouse of an individual or a parent for a child who is under age 21 or blind or disabled, the agency must not consider income and resources of any relative as available to an individual.
> (2) In relation to individuals under age 21 (as described in section 1905(a)(i) of the Act), the financial responsibility requirements and methodologies that apply include **considering the income and resources of parents or spouses whose income and resources would be considered if the individual under age 21** were dependent under the State's approved AFDC plan, whether or not they are actually contributed, except as specified under paragraphs (c) and (d) of this section. These requirements and methodologies must be applied in accordance with the provisions of the State's approved AFDC plan. (*emphasis added*)

16. The above authority sets forth that children under the age of 21 must have the income and resources of their parents included in determining eligibility. The

petitioner's husband's income must be included when determining eligibility for the minor child in the home.

17. 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.

18. In accordance with the above cited authority and The Policy Manual, the respondent correctly determined the petitioner's eligibility with a household size of four, including the petitioner, her husband, and their two mutual children.

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

> (1) General rule. Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household.
> (2) Income of children and tax dependents. (i) The MAGI-based income of an individual who is included in the household of his or her natural, adopted or step parent and is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined, is not included in household income whether or not the individual files a tax return.
> (ii) The MAGI-based income of a tax dependent described in paragraph (f)(2)(i) of this section who is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined is not included in the household income of the taxpayer whether or not such tax dependent files a tax return.

(3) In the case of individuals described in paragraph (f)(2)(i) of this section, household income may, at State option, also include actually available cash support, exceeding nominal amounts, provided by the person claiming such individual as a tax dependent.
(4) Effective January 1, 2014, in determining the eligibility of an individual using MAGI-based income, a state must subtract an amount equivalent to 5 percentage points of the Federal poverty level for the applicable family size only to determine the eligibility of an individual for medical assistance under the eligibility group with the highest income standard using MAGI-based methodologies in the applicable Title of the Act, but not to determine eligibility for a particular eligibility group.

20. 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).

21. The Policy Manual, Appendix A-7, effective April, 2016, lists the Family-Related Medicaid income limits for a household of four for children over age six and under age 19 as follows. It does not provide a standard disregard for this group:

$2,694 income standard

$ 585 MNIL
$ 101 MAGI

22. 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 $8,950.37. Step 2: There are were no deductions provided. Step 3: There is no standard disregard provided for children six through 18. Step 4: The balance of $8,950.37 is greater than the income limit of $2,694 for a child six through 18 in a household of four. Step 5: The income of $8,950.37 less the MAGI disregard of $101 is $8,849.37. The amount is greater than the income limit of $2,694. The undersigned concludes that the petitioner's son is ineligible for Medicaid. The undersigned further concludes Medically Needy (MN) eligibility must be explored.

Enrollment in Medically Needy and Share of Cost amount will now be addressed:

23. 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.

24. Fla. Admin. Code 65A-1.701 "Definitions" defines share of cost (SOC) as, "Share of Cost (SOC): SOC represents the amount of recognized medical expenses that a Medically Needy enrolled individual or family must incur each month before becoming eligible to receive Medicaid benefits for medical expenses incurred during the remainder of the month".

25. 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.

26. Effective April, 2016, The Policy Manual at Appendix A-7 lists the MNIL for children age six through 18 in a household of 4 as $585.

27. In accordance with above cited authority and The Policy Manual, the respondent determined the petitioner’s countable household income to be $8,950.37. The MNIL of $585 was subtracted from the income to determine the petitioner’s SOC of $8,365.

28. Based on the testimony, evidence, and a review of the respondent’s budget calculations, the undersigned has concluded that the respondent used the best available information to terminate full Medicaid benefits and enroll the petitioner’s son in the Medically Needy Program with an estimated SOC of $8,365. As the petitioner did not return the requested income verification, eligibility was determined on the best available information at the time.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied. Eligibility for full Medicaid benefits is not found. Enrollment in the Medically Needy Program is correct.

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 May, 2016,

in Tallahassee, Florida.

Pamela B. Vance

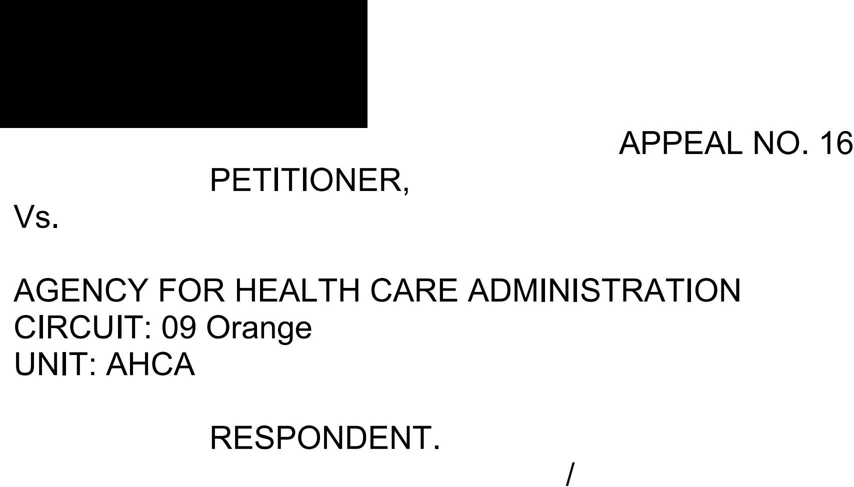
Pamela B. Vance
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

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

Jun 13, 2016

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 16F-01997

PETITIONER,

Vs.

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

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on May 18, 2016 at approximately 10:30 a.m.

APPEARANCES

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 denial of Petitioner's request for an additional 13 hours per week of home health services was correct. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

Petitioner represented herself 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 moved Exhibits 1 and 2 into evidence. Respondent’s Exhibits 1 – 8 were entered into evidence.

FINDINGS OF FACT

1. Petitioner is a 46-year-old female. Petitioner receives both Medicare and Medicaid. She is enrolled with UnitedHealthcare (“United”) as her both her Managed Medical Assistance (“MMA”) plan and her Long Term Care (“LTC”) plan.

2. Petitioner has [redacted] Her condition renders her blind and her lower extremities paralyzed. She requires total assistance with all of her Activities of Daily Living (“ADLs”). She cannot be left home alone because her blindness and paralysis would prevent her from calling for help in an emergency. Dr. Karver stated she did not want Petitioner left alone.

3. Petitioner lives with her 66-year-old mother, who is her primary caregiver. Her mother is semi-retired. She works outside of the home on Tuesdays, Wednesdays, and Thursdays, leaving at 9:00 a.m. and returning at 6:00 p.m.

4. Petitioner’s 79-year-old grandmother currently assists her on Wednesdays, but has been advised by her physician that she is unable to continue doing so. Petitioner also receives services on Thursdays through a grant program, but the services will terminate on June 18, 2016.

5. Petitioner receives 27 hours per week of home health services. She requested an additional 13 hours per week, for a total of 40 hours per week. On January 22, 2016, United issued a Notice of Action, Respondent's Exhibit 3, denying the request. The Notice stated, in pertinent part:

> You have asked for 40 hours of care at home a week.
>
> You are getting 27 hours of care a week.
>
> Your care plan for help is based on how much help you need. Needs in Florida Medicaid are defined by the law. For a service to be needed it must treat a problem. It must also be common practice. It must also be just for you. It must also not be in excess of your needs. It must also be safe. It must also be the least costly treatment in the state that meets your needs. It must also not be for the convenience of you or another person. The fact that a doctor orders a 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 27 hours per week.

6. Petitioner uses Granny Nannies as her home health provider. A caregiver comes every night from 7:30 p.m. – 8:30 p.m. in order to bathe her. This utilizes 10.5 hours per week, leaving 16.5 hours remaining.

7. Petitioner needs assistance for nine (9) hours per day, three (3) days per week when her mother is unavailable. This is a total of 27 hours per week.

8. Dr. Karver said Petitioner should consider working with her case manager to try to rearrange the usage of the approved hours in order to meet her needs. Petitioner said

she has tried that option, but has been unable to come up with a workable solution. Dr. Karver suggested Adult Day Care ("ADC") as an option, and said that studies show it can be beneficial for someone to attend ADC. Petitioner said she would be more comfortable in her home environment.

CONCLUSIONS OF LAW

9. 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.

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

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

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

13. 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.

14. 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…."

15. 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.

16. 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.

17. 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.

18. 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.

19. Petitioner’s mother is away from the home for 27 hours per week. United has approved 27 hours per week of home health services. The shortfall is coming from

Petitioner utilizing 10.5 hours per week for her daily bath at a time when her mother is home.

20. The solution to the problem seems to be for Petitioner to utilize the 10.5 hours per week for her daily bath at a time between 9:00 a.m. and 6:00 p.m., while her mother is away. This would result in using exactly the 27 hours per week of services that have been approved. Further, it would eliminate the need for Petitioner's grandmother to assist her, which she is no longer able to do.

21. The undersigned concludes Petitioner has not met her burden of proof to show the additional 13 hours are medically necessary.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 13 day of June, 2016,

in Tallahassee, Florida.

Rick Zimmer

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

Copies Furnished To [redacted] Petitioner
Judy Jacobs, Area 7, AHCA Field Office

Jun 13, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-02004

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 May 16, 2016 at 10:04 a.m.

APPEARANCES

For the Petitioner: Pro Se

For the Respondent: Fatima Leyva,
Senior Human Services Program Specialist,
Agency for Health Care Administration

STATEMENT OF ISSUE

The Petitioner is appealing the Agency for Health Care Administration's (AHCA) decision, through DentaQuest, to deny the Petitioner's request for dental procedure D2740-crown porcelain/ceramic substrate for tooth 24 and 25. Because the issue under appeal involves a request for services, Petitioner bears the burden of proof.

PRELIMINARY STATEMENT

Appearing as Respondent's witness from Humana Healthcare (Humana) was Mindy Aikman, Grievance and Appeals Specialist. Appearing as Respondent's witnesses from DentaQuest were: Dr. Susan Hudson, Dental Consultant and Jackelyn Salcedo, Complaints and Grievance Specialist. Respondent's exhibit 1 was entered into evidence.

Upon convening the hearing, Petitioner advised she has been approved to have a crown repair for tooth 25. The approval of a crown for tooth 24 remained at issue.

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 63 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. The Petitioner's dentist sent an initial request for prior authorization for dental procedure D2740-procelain crown/ceramic substrate for tooth 24 and 25, which was received on February 9, 2016.
4. DentaQuest made its determination on February 11, 2016 denying the procedure for both teeth. Notice was sent to the provider providing the denial reason:

> There is no evidence of decay or missing crown to support the need for replacement.

5. Petitioner stated she was happy with the recent approval for crown replacement of tooth 25, but wanted approval for tooth 24 so both teeth would look the same.

6. The Dental Consultant witness explained that there was no medical necessity for tooth 24 to have a crown and the procedure would only be for cosmetic purposes.

CONCLUSIONS OF LAW

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

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

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

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

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

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

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

of the delivery of the care, goods, or services.

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

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

(a) Meet the following conditions:

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

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

14. Petitioner wants a crown for tooth 24 so that it looks the same as tooth 25.

15. Respondent explained tooth 24 does not have any medical need for a crown and the procedure would be cosmetic.

16. Petitioner has failed to meet her burden of proof to establish medical necessity for tooth 24 to have a crown. The above authorities make clear that Medicaid services must be consistent with symptoms or confirmed diagnosis and must not be furnished in a manner primarily intended for the recipient’s convenience.

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 13 day of June, 2016,

in Tallahassee, Florida.

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

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

Jun 30, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-02005

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 April 22, 2016 at 8:30 a.m. and on May 18, 2016 at 10:00 a.m.

APPEARANCES

For the Petitioner:

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

STATEMENT OF ISSUE

At issue is whether the respondent's action to partially deny the petitioner's request for Speech Therapy (ST) service hours for the certification period March 6,

2016 through July 29, 2016, was correct. Respondent bears the burden of proof in this matter.

PRELIMINARY STATEMENT

The hearing in this matter initially commenced on April 22, 2016 and was rescheduled for May 18, 2016 to allow the petitioner additional time to submit supporting documentation.

Appearing as a witness for the petitioner was [redacted] the petitioner's Medicaid Waiver support coordinator. The petitioner submitted a report from her speech therapist and her school Individual Education Plan (IEP) as evidence for the hearing, which were marked as Petitioner composite Exhibit 1.

Appearing as a witness for the respondent was Rakesh Mittal. M.D., Physician-Consultant with eQHealth Solutions, Inc. Respondent submitted the following documents as evidence for the hearing, which were marked as Respondent composite Exhibit 1: Statement of Matters, Outpatient Review History, Denial Notices, and Speech Therapy reports.

FINDINGS OF FACT

1. The petitioner's ST service provider, [redacted] (hereafter referred to as "the provider"), requested the following ST service hours for the certification period at issue: 12 units (3 hours) weekly. Each unit is the equivalent of fifteen (15) minutes.

2. eQHealth Solutions, Inc. is the Quality Improvement organization (QIO) contracted by the respondent to perform prior authorization reviews for therapy services. The provider submitted the service request through an internet based system. The submission included, in part, information about the petitioner's medical conditions; her functional limitations; and other pertinent information related to the household.

3. eQHealth Solutions' personnel had no direct contact with the petitioner, her family, or her physicians. All pertinent information was submitted by the provider directly to eQHealth Solutions.

4. The medical information submitted by the provider contained, in part, the following information in regard to the petitioner:

5. The petitioner has been receiving speech therapy services since at least 2011 for three (3) hours weekly.

6. A Plan of Care was also submitted by the provider. The document was signed by a physician and outlined the type of assistance to be provided by the ST provider. The long-term goals include the following:

- Improving expressive language skills
- Improving receptive language skills
- Improving pragmatic skills

7. A physician at eQHealth Solutions, who is board-certified in pediatrics, reviewed the submitted information and partially denied the requested ST services, approving 4 units (1 hour) weekly rather than the requested 12 units (3 hours) weekly. The

rationale for the decision was: "The request is excessive based on the severity of delay with articulation and intelligibility skills being normal. Four units one time per week is sufficient therapy at this developmental age." A notice of this determination was sent to all parties on March 4, 2016.

8. The above notice stated that a reconsideration review of this determination by eQHealth could be requested, and additional information could be provided with the request for reconsideration. A reconsideration review was not requested in this case.

9. The petitioner thereafter requested a fair hearing and this proceeding followed.

10. The respondent administratively approved the requested therapy hours (3 hours weekly) during the pendency of the hearing process.

11. The respondent's witness, Dr. Mittal, testified that the reduction of the petitioner's speech therapy service to 1 hour weekly was appropriate because she has been receiving therapy for 3 hours weekly since 2011, her articulation skills were within normal limits, and her speech was intelligible. He also commented that the petitioner has made progress in some areas of her speech therapy, but has made no progress in other areas.

12. The petitioner's mother believes the speech therapy should be continued at the current level of 3 hours weekly because her daughter needs to be prepared for adult life and learn new vocabulary. She stated her daughter can understand what other people say, but cannot express herself.

13. The petitioner's Medicaid Waiver support coordinator stated that the petitioner will be transitioning to the Medicaid Waiver program when she becomes 21 years of age in a few months and she is seeking to maintain the same services she is currently

receiving from the Medicaid program. She also stated the petitioner needs to learn to express her wants and needs and an ordinary person cannot understand her.

14. ST service for children (i.e., individuals under age 21) is a covered service under the Medicaid State Plan in Florida. These services are provided in accordance with the respondent's Therapy Services Coverage and Limitations Handbook ("Therapy Handbook"), effective August, 2013.

CONCLUSIONS OF LAW

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

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

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

18. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the respondent since the petitioner had been previously approved for 12 units (3 hours) weekly of speech therapy service and the Respondent is seeking to reduce this service to 4 units (1 hour) weekly. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

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

20. The petitioner has requested ST services. As the petitioner is under 21 years of age, the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements apply to the evaluation of the petitioner's eligibility for or amount of this service.

21. The Centers for Medicare and Medicaid Services, State Medicaid Manual makes available to all State Medicaid agencies informational and procedural material needed by the States to administer the Medicaid program. It is the method by which the Health Care Financing Administration (HCFA) issues mandatory, advisory, and optional Medicaid policies and procedures to the Medicaid State agencies.

22. The State Medicaid Manual in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services section states in part:

> 5010. Overview
> A. Early and Periodic Screening, Diagnostic and Treatment Benefit.--Early and periodic screening, diagnostic and treatment services (EPSDT) is a required service under the Medicaid program for categorically needy individuals under age 21…
>
> 5110. Basic Requirements
>
> OBRA 89 amended §§1902(a)(43) and 1905(a)(4)(B) and created §1905(r) of the Social Security Act (the Act) which set forth the basic requirements for the program. Under the EPSDT benefit, you[1] must provide for screening, vision, hearing and dental services at intervals which meet reasonable standards of medical and dental practice established after consultation with recognized medical and dental organizations involved in child health care. You must also provide for medically necessary screening, vision, hearing and dental services regardless of whether such services coincide with your established periodicity schedules for these services. Additionally, the Act requires that any service which you are permitted to cover under Medicaid that is necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be provided to EPSDT participants regardless of whether the service or item is otherwise included in your Medicaid plan.

[1] "You" in this manual context refers to the state Medicaid agency.

23. The service the petitioner has requested (ST services) is one of the services provided by the state to treat or ameliorate an individual's conditions under the State plan. Chapter 409.905, Fla. Stat., states, in part:

> Any service under this section shall be provided only when medically necessary …

24. The issue to be decided is the medical necessity of the service or amount of service. The State Medicaid Manual provides for limitations on services as follows:

> 5110. Basic Requirements…
> …Services under EPSDT must be sufficient in amount, duration, or scope to reasonably achieve their purpose. The amount, duration, or scope of EPSDT services to recipients may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. Appropriate limits may be placed on EPSDT services based on medical necessity.
>
> 5122. EPSDT Service Requirements
> F. Limitation of Services.--The services available in subsection E are not limited to those included in your State plan.
> Under subsection E, the services must be "necessary . . . to correct or ameliorate defects and physical or mental illnesses or conditions . . ." and the defects, illnesses and conditions must have been discovered or shown to have increased in severity by the screening services. You make the determination as to whether the service is necessary. You are not required to provide any items or services which you determine are not safe and effective or which are considered experimental.
>
> 5124. Diagnosis and Treatment
> B. Treatment.--
> 1. General. - You must make available health care, treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services. Treatment services may be limited as described in §5122 F.

25. Once a service has been identified as requested under EPSDT, the Medicaid program determines the amount or necessity for that service based on the State of Florida's published definition of medical necessity. The Fla. Admin. Code R. 59G-1.010 defines medical necessity:

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

26. Based upon the information submitted by the petitioner's provider, eQHealth Solutions completed a prior authorization review to determine medical necessity for the requested ST services.

27. In the petitioner's case, the respondent has determined that 4 units (1 hour) weekly of ST service is medically necessary, rather than the 12 units (3 hours) weekly requested by the petitioner. The petitioner was previously approved for 12 units of speech therapy weekly.

28. Fla. Stat. § 409.913 governs the oversight of the integrity of the Florida Medicaid Program. Section (1)(d) sets forth the “medical necessity or medically necessary” standards, and states in pertinent part as follows:

> “Medical necessity” or “medically necessary” means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice*….*
>
> Section (1)(d) goes on to further state:
>
> …For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

29. Section (1)(d) highlights that the Agency makes the final decision regarding whether or not a requested service is medically necessary. As stated above, this proceeding is a de novo proceeding for the purpose of the Agency reaching its final decision. The final decision making authority for this proceeding has been delegated to the hearing officer in Fla. Admin. Code R. 65-2.066.

30. ST services, also referred to as speech-language pathology services, are described on page 1-4 of the Therapy Handbook as follows:

> Speech-language pathology services involve the evaluation and treatment of speech-language disorders.
>
> Services include the evaluation and treatment of disorders of verbal and written language, articulation, voice, fluency, phonology, mastication, deglutition, cognition, communication (including the pragmatics of verbal communication), auditory processing, visual processing, memory, comprehension and interactive communication as well as the use of instrumentation, techniques, and strategies to remediate, maintain communication functioning, acquire a skill set, restore a skill set, and

> enhance the recipient's communication needs, when appropriate. Services also include the evaluation and treatment of oral pharyngeal and laryngeal sensorimotor compete*ncies.*

31. The Therapy Handbook on page 2-2 sets forth the requirements for ST services, as follows:

> Medicaid reimburses for services that are determined medically necessary and do not duplicate another provider's service.

32. The petitioner's physician ordered a ST service frequency greater than that approved by eQHealth Solutions. Rule 59G-1.010(166) (c), however, specifically states a prescription does not automatically mean the requirements of medical necessity have been satisfied.

33. The respondent's witness, Dr. Mittal, stated he believes the services should be reduced at this time since the petitioner has been receiving speech therapy for 3 hours weekly since 2011, her articulation skills were within normal limits, and her speech was intelligible.

34. The petitioner's witnesses stated she needs to learn to express herself and an ordinary person cannot understand her.

35. After considering all the documentary evidence and witness testimony presented, the undersigned concludes the respondent has not met its burden of proof in demonstrating it was correct in reducing the requested speech therapy services for the certification period at issue. One of the main factors cited in the rationale to reduce the therapy services is that the speech therapy report indicated that articulation skills were within normal limits and the speech was intelligible. However, the same therapy report

also indicates the petitioner has severe deficits in both expressive and receptive language skills. In addition, both the petitioner's mother and her support coordinator testified at the hearing that the petitioner has difficulty expressing herself and an ordinary person cannot understand her. Accordingly, the services should not be reduced at this time.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is GRANTED, and the petitioner shall continue receiving 12 units (3 hours) of speech therapy services weekly for the current certification period.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 30 day of June, 2016,

in Tallahassee, Florida.

Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700

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

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

Jun 06, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-02006

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 April 22, 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 action to deny Petitioner's request for an increase in Speech Therapy (ST) service hours was correct. Petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

Appearing as a witness for the Petitioner was [redacted] [redacted] the Petitioner's speech therapy provider. The Petitioner did not submit any documents as evidence for the hearing.

Appearing as witnesses for the Respondent were Betty Mayo, Nursing Director, Alexander Fabano, Contract Manager, and Patrice Miller, from Children's Medical Services (CMS). Also present as witnesses for the Respondent were Catherine Ruiz, Grievance and Appeals Manager, and Dr. Olunwa Ikpeazu, Medical Director, from South Florida Community Care Network, which is the Petitioner's managed care health plan.

Respondent submitted the following documents as evidence for the hearing, which were marked Respondent composite Exhibit 1 – authorization request, denial notice, and speech therapy plan of care/evaluation.

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

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 Network (CCN). Her medical diagnosis includes [redacted] [redacted]

2. The Petitioner's ST service provider, [redacted] (hereafter referred to as "the provider"), requested the following ST service hours: 12 units (3 hours) weekly or 3 sessions per week of 1 hour per session. Each unit is the equivalent of fifteen (15) minutes.

3. The Petitioner has been receiving 2 hours weekly of speech therapy services for approximately the past 2 years. Before that, she received 3 hours of services weekly.

4. A Plan of Care was also submitted by the provider. The document was signed by a physician and outlined the type of assistance to be provided by the ST provider. The long-term goals include the following:

- Improving expressive language skills
- Improving play/socialization skills
- Improving receptive language skills
- Improving swallowing function

5. On February 18, 2016 the Petitioner's health plan, CCN, partially denied the request for speech therapy services – approving 2 hours weekly rather than the requested 3 hours weekly. The denial notice stated the following:

> Based on clinical documentation reviewed, medical necessity could not be established for the level of therapy requested at this time. We will approve 2x week x 60 minutes = 8 units per week.

6. The Petitioner thereafter requested a fair hearing and this proceeding followed.

7. The Petitioner's witness, [redacted] stated that the Petitioner has been making more than just minimal progress in her speech therapy. She also stated the Petitioner was fed through a G-tube until about 5 years ago and also had a tracheotomy

which was removed in 2010. Because of this, she only recently began eating solid foods and needs help with her swallowing function. She also had three open heart surgeries, the most recent of which was performed approximately 1 year ago. [redacted] also stated only a speech therapist can provide therapy in the area of swallowing function.

8. The Petitioner's mother stated her daughter eats well, swallows well, and eats mostly pureed foods.

9. The Respondent's witness, Dr. Ikpeazu, stated the plan denied the request for increased speech therapy services for the following reasons: the evaluation states the patient can consume regular meals with moderate assistance, the patient's outlook is "guarded" according to the evaluation, the main therapy goal is feeding and swallowing, and increasing services would not make much difference based on the age of the patient.

10. ST service for children is a covered service under the Medicaid State Plan in Florida. These services are provided in accordance with the respondent's Therapy Services Coverage and Limitations Handbook ("Therapy Handbook"), effective August, 2013.

CONCLUSIONS OF LAW

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 § 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 Petitioner since the Petitioner had been previously approved for 2 hours weekly of speech therapy service and she is seeking an increase to 3 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, 7th Ed.).

15. 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.

16. The petitioner has requested ST services. As the petitioner is under 21 years of age, the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements apply to the evaluation of the petitioner's eligibility for or amount of this service.

17. 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.

18. 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.

19. The service the petitioner has requested (ST services) is one of the services provided by the state to treat or ameliorate an individual's conditions under the State plan. Chapter 409.905, Fla. Stat., states, in part:

> Any service under this section shall be provided only when medically necessary …

20. 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.

[1] "You" in this manual context refers to the state Medicaid agency.

> 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.

21. 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.

22. Based upon the information submitted by the Petitioner’s provider, CCN completed a prior authorization review to determine medical necessity for the requested ST services.

23. In the Petitioner’s case, the Respondent has determined that 8 units (2 hours) weekly of ST service is medically necessary, rather than the 12 units (3 hours) weekly requested by the Petitioner. The Petitioner was previously approved for 2 hours of speech therapy weekly.

24. 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. ST services, also referred to as speech-language pathology services, are described on page 1-4 of the Therapy Handbook as follows:

> Speech-language pathology services involve the evaluation and treatment of speech-language disorders.
>
> Services include the evaluation and treatment of disorders of verbal and written language, articulation, voice, fluency, phonology, mastication, deglutition, cognition, communication (including the pragmatics of verbal communication), auditory processing, visual processing, memory, comprehension and interactive communication as well as the use of instrumentation, techniques, and strategies to remediate, maintain communication functioning, acquire a skill set, restore a skill set, and enhance the recipient's communication needs, when appropriate. Services also include the evaluation and treatment of oral pharyngeal and laryngeal sensorimotor competencies.

27. The Therapy Handbook on page 2-2 sets forth the requirements for ST services, as follows:

> Medicaid reimburses for services that are determined medically necessary and do not duplicate another provider's service.

28. The Petitioner's physician ordered a ST service frequency greater than that approved by CCN. Rule 59G-1.010(166) (c), however, specifically states a prescription does not automatically mean the requirements of medical necessity have been satisfied.

29. The Respondent's witness stated that increasing services would not make much difference given the Petitioner's age and current status.

30. The Petitioner's therapy provider stated the Petitioner needs increased speech therapy to help her with swallowing solid foods. Petitioner's mother stated her daughter can eat well, swallow well, and mainly eats pureed foods.

31. After considering all the documentary evidence and witness testimony presented, the undersigned concludes the Petitioner has not demonstrated that speech therapy services should be increased at this time. She has been receiving speech therapy at a level of 2 hours weekly for approximately the past 2 years and has been making some progress in the area of swallowing. The therapy plan of care states she can eat small pieces of regular food with moderate assistance. There is no indication that she will be unable to continue with her progress in therapy while receiving 2 hours weekly of speech therapy 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 06 day of June, 2016,

in Tallahassee, Florida.

Rafael Centurion
Hearing Officer
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1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished To [redacted] PETITIONER
RHEA GRAY, AHCA AREA 11, FIELD OFFICE MANAGER

Jun 02, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-02037

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 an administrative hearing telephonically in the above-referenced matter on May 25, 2016 at 1:13 p.m.

APPEARANCES

For the Petitioner:

For the Respondent: Mary Triplett, supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action denying her application for SSI-Related Medicaid. The petitioner carries the burden of proof by a preponderance of the 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 March 8, 2016, the Department informed the petitioner that her application for SSI-Related Medicaid was denied. The notice reads in pertinent part: "You…do not meet the disability requirement."

The petitioner timely requested a hearing to challenge the denial decision on March 15, 2016.

The petitioner was present and testified. The petitioner did not submit documentary evidence.

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.

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 39) filed an application for SSI-Related Medicaid with the Department on January 11, 2016.

2. The petitioner is single, she 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 had not applied for disability with SSA at the time of the hearing. Applying for other benefits an applicant may be eligible to receive is a condition of eligibility for Medicaid. The Department stated that it did not pursue this matter with the petitioner because the issue was rendered moot when she was found to be ineligible for other reasons.

4. The petitioner asserts that she is disabled due to multiple mental health issues: The petitioner experiences hallucinations; she can be aggressive when she is having an episode; she has frequent thoughts of suicide and has attempted suicide numerous times; she cannot hold down a job long term; she does not get on well with others and has difficulty establishing and maintaining relationships. The petitioner takes three psychiatric medications:

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 January 12, 2016.

6. DDD completes a five-step sequential analysis to determine if an applicant is disabled: 1) The individual cannot be engaging in substantial gainful activity (working and earning income that meets or exceeds set limits); 2) the alleged impairment must

be severe and intended to last 12 continuous months; 3) impairment(s) meets a disability listing set forth in federal regulations; 4) individual incapable of returning to previous work; 5) individual incapable of performing any work in the national economy.

7. DDD reviewed two diagnoses in the instant case: foot fracture (a physical impairment) and mood disorder (mental impairment which includes all the petitioner's psychiatric diagnoses). DDD determined that the petitioner did not meet the disability criterion because with her education (high school graduate and two years of college), work history (20 years unskilled manual labor jobs), and residual functional capacity (capable of physical work which requires sedentary to light exertion and mental functioning not severe enough to prevent her from working), she is capable of performing other work in the national economy such as silver wrapper, wash room operator, and eyeglass frame polisher. DDD explains its decision in the Case Analysis section of the petitioner's Disability Report:

PHYSICAL

ADLs
The claimant last worked in October or November 2015 as a server at a restaurant. Claimant is able to conduct her own personal care such as bathing and dressing. It causes great discomfort in right shoulder to lift

her arm. She is able to cook, clean and do laundry limitedly. It takes her longer to do things when using her walker. She is able to do her own shopping using the electric cart. She does not drive. She has three cats that she cares for. She can walk approximately twenty to forty feet without stopping. She would then need to rest approximately five to ten minutes before continuing. She does use a walker and a wheelchair. She can lift and carry a gallon of milk and a full laundry basket with her left arm; she has difficulty lifting anything with her right arm. In a typical day, she wakes up, does her personal care, goes to AA or NA meetings, tries to cook, watches TV, reads and volunteers at church. She is taking over the counter medications for her conditions. She last saw a doctor on 1/26/16. She is taking her medications as prescribed. She last saw her mental health doctor on 1/15/16. She is taking her mental health medications as prescribed. The medication does help. She has experienced some weight gain from the medications. She can manage her own money when she has money. Claimant is willing to attend a CE is needed.

MENTAL
A mental PRTF by [REDACTED] dated 2/29/16 found the claimant's mental condition required a RFC assessment and the co-existing non-mental impairments required referral to another medical specialty. The claimant's allegations of [REDACTED] and [REDACTED] abuse are medically determinable impairments that evidence does not establish the presence of the "C" criteria. ADLs and persistence/pace are adequate within her physical tolerance. Some limitations in quality of relating and persistence/pace due to residual mood symptoms. See PRTF. A MRFC [mental residual functional capacity) by [REDACTED] [REDACTED] dated 2/29/16 found "Summary: Claimant can understand, retain, and carry out simple instructions. Claimant can consistently and usually perform routine tasks on a sustained basis, with minimal (normal) supervision, and can cooperate effectively with public and co-workers in completing simple tasks and transactions. Claimant can adjust to the mental demands of most new task settings. Functional restrictions beyond levels assessed above are not attributable to claimant's mental illness as reflected in the objective medical evidence file."

SUMMARY
Light RFC. She would be able to perform light work such as a silver wrapper (318.687-018), washroom operator (529.665-014) or polisher, eyeglass frames (713.684-038).

DECISION
N32 Denial. Voc. Rule 202.21

8. Lauren Coe, DDD program operations administrator, noted that the DDD examiner erred in continuing the analysis of the petitioner's physical impairments to Step 5. The petitioner's physical injuries, multiple fractures of face and lower extremities, were not expected to last 12 months and therefore were not considered severe. The physical impairment should have been denied at Step 2. Per Ms. Coe, only the mental impairment analysis should have been continued to Step 5. However, because the error was in the claimant's favor and it did not change the ultimate conclusion, DDD did not issue an amended denial decision and let the matter stand.

9. The Department issued a denial notice to the petitioner on March 8, 2016.

10. The petitioner argued that her Medicaid application should have been approved because the severity of her mental health issues seriously impact her level of functioning and have prevented her from being able to hold down a job for more than a few months all of her adult life. The petitioner does not believe that her physical impairments (multiple body and face fractures) are disabling. She believes she will recover fully from her physical injuries and is not appealing the physical impairment denial decision. She is appealing the mental impairment denial decision only.

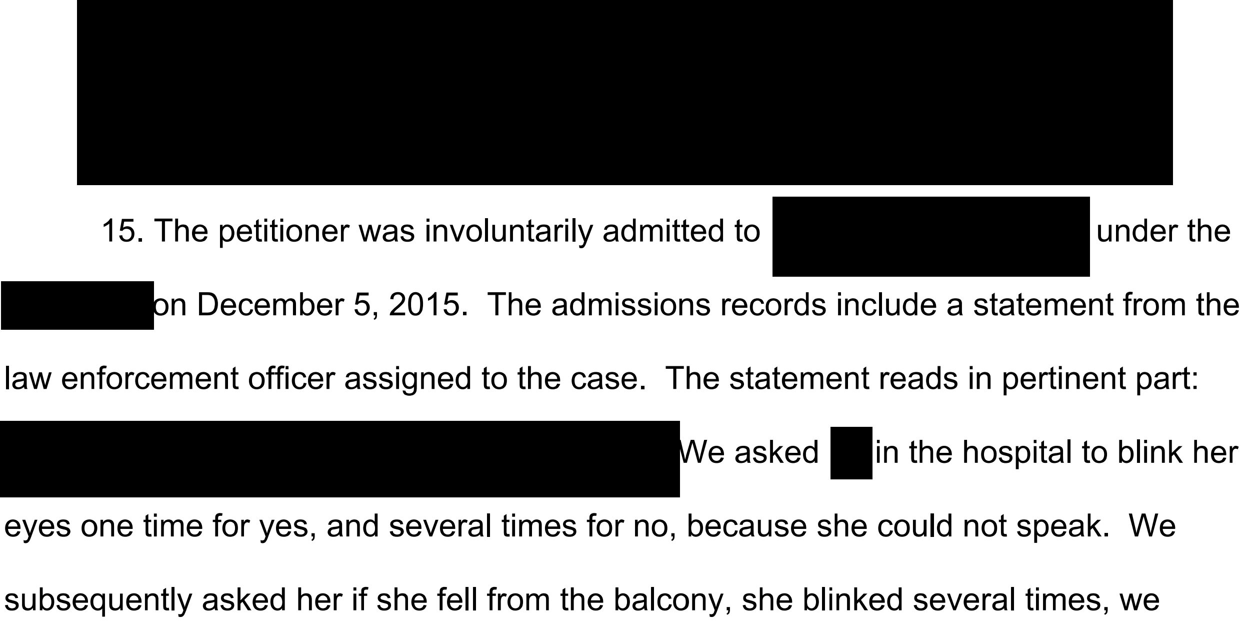
11. The petitioner began exhibiting maladaptive behaviors in elementary school. She was diagnosed with an [redacted] at age 20. Since the initial diagnosis, she has also been diagnosed with [redacted]

12. The petitioner completed high school and two years of college. She has had difficulty working long term because of maladaptive behaviors. She does not get along

well with people. She has worked a series of short term unskilled manual labor jobs (restaurant food server, maid, truck loader, wood refinisher) all of her adult life.

13. The petitioner has attempted suicide approximately 10 times, the first attempt occurring in her early twenties. She has been involuntary hospitalized under the Baker Act approximately 20 times.

14. The petitioner's most recent suicide attempt occurred on December 5, 2015. The petitioner jumped off the balcony of her third floor apartment, breaking numerous bones in her lower extremities and face. The records of the first responders, the local fire rescue service that attended the petitioner, reads in pertinent part:



15. The petitioner was involuntarily admitted to [redacted] under the [redacted] on December 5, 2015. The admissions records include a statement from the law enforcement officer assigned to the case. The statement reads in pertinent part: [redacted] We asked [redacted] in the hospital to blink her eyes one time for yes, and several times for no, because she could not speak. We subsequently asked her if she fell from the balcony, she blinked several times, we asked her if she jumped and she blinked one time."

16. [redacted] admissions records dated December 5, 2015 describe the incident as "Intentional self-harm by jumping from a high place…"

17. The petitioner's Discharge Summary from [redacted] is dated January 15, 2016 and address her mental health issues as follows:

[redacted]

18. Prior to the [redacted] hospitalization, the petitioner was involuntarily admitted to [redacted] under the Baker Act due to acute psychosis on October 14, 2014. [redacted] clinical notes read:

[redacted]

…

[redacted]

19. Prior to the October 2014 admission, the petitioner was also [redacted] under the [redacted] he year before, on September 26, 2013. SCMHC clinical notes read:

[redacted]

ADMISSION DIAGNOSES:
Axis 1:
Axis 2:
Axis 3
Axis 4

20. Lauren Coe with DDD acknowledged that the petitioner's mental health issues are serious; however, Ms. Coe argued that the petitioner's acute behaviors are due to Ms. Coe argued further that when the petitioner abstains from substances and follows her mental health treatment, the acute behaviors improve significantly and she is capable of working.

21. The petitioner argued that her mental health issues are the cause of her acute behaviors. The petitioner acknowledged an addiction to alcohol for which she has been in recovery for over a decade. The petitioner argued that she only uses cocaine and marijuana occasionally and those substances are not at the root cause of her behaviors. She takes those substances because her prescription psychiatric medications have no effect on her moods at all. The petitioner asserted that her acute behaviors predate the use of non-prescription substances. The petitioner argued that she requires medical insurance so she cannot get the proper treatment.

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 the same Florida Statutes.

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

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

25. 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. §416.905.

26. 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.

27. Federal Regulations at 20 C.F.R. § 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.)
> (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 § 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).

28. 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. She last worked in late 2015. The petitioner meets step one criterion.

29. 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 petitioner has multiple mental health diagnoses, has attempted suicide several times, and has been involuntary hospitalized under the Baker Act numerous times. The undersigned concludes that the petitioner’s mental health issues/affective disorders are severe.

30. 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 sections 12.03 Schizophrenic, paranoid and other psychotic disorders. To meet the disability criterion under this listing an applicant must present with:

> Characterized by the onset of psychotic features with deterioration from a previous level of functioning.
>
> The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.
>
> A. Medically documented persistence, either continuous or intermittent, of one or more of the following:
>
> 1. Delusions or hallucinations; or
>
> 2. Catatonic or other grossly disorganized behavior; or
>
> 3. Incoherence, loosening of associations, illogical thinking, or poverty of content of speech if associated with one of the following:
>
> a. Blunt affect; or
>
> b. Flat affect; or
>
> c. Inappropriate affect; or
>
> 4. Emotional withdrawal and/or isolation;
>
> AND
>
> B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Marked difficulties in maintaining concentration, persistence, or pace; or

4. Repeated episodes of decompensation, each of extended duration;

OR

C. Medically documented history of a chronic schizophrenic, paranoid, or other psychotic 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.

31. The petitioner's 2013 - 2015 clinical records from SCMHC and [redacted] of more than 2 years that has caused a more than minimal limitation on the petitioner's ability to do basic work. She has never been able to hold down a job for more than a few months at a time. She has serious difficulty functioning socially, maintaining relationships. The clinical records and other evidence prove repeated episodes of decompensation (a temporary worsening of symptoms); numerous involuntary hospitalizations; and intermittent hallucinations. The Department's assertion that the petitioner's acute behaviors are due to substance abuse was taken into consideration. However, the

undersigned concludes that petitioner's extensive psychiatric history dating back nearly 20 years predates her use of other substances and proves that her mental health issues are the root cause her acute behaviors.

32. Based on the record, the undersigned concludes that the petitioner's schizoaffective disorder meets or equals listing 12.03 in the federal regulation. Therefore, the petitioner is to be considered disabled. The petitioner met her burden of proof in this matter.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is **GRANTED** and remanded to the Department for further development. The petitioner is considered to have met the disability requirement. The Department is ordered to determine the petitioner's eligibility for SSI-Related Medicaid based on all other factors, including, but not limited to, applying for other benefits she may be eligible to receive.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 02 day of June, 2016,

in Tallahassee, Florida.

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

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

Jun 03, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-02043

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 April 18, 2016 at 8:30 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 bariatric surgery was correct. The Petitioner bears the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The Petitioner submitted medical records as evidence for the hearing, which were marked as Petitioner Exhibit 1.

The 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.

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 March 9, 2016, 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 March 14, 2016 based on medical necessity criteria.

3. The Petitioner has been diagnosed with She states she is in constant pain and uses a wheelchair for mobility. 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. He stated this was not established in the Petitioner's case. He also stated the Petitioner is a poor candidate for weight-loss surgery due to her prior heart surgery and because many of her health problems are caused by

5. The Petitioner stated she believes her request for the bariatric surgery should be approved because of her medical conditions. She also stated she sleeps sitting up because otherwise she would not be able to breathe. She stated she has tried many diets but has not been able to lose weight. She also stated she cannot exercise because she cannot walk more than 10 minutes at a time.

6. Services under the Medicaid State Plan in Florida are provided in accordance with the Respondent's Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July, 2012.

CONCLUSIONS OF LAW

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

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

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

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

11. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the Respondent. The Medicaid Handbook referred to above is incorporated by reference in Fla. Admin. Code R. 59G-4.001.

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

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

13. Although the Petitioner testified she has tried to follow many different diets, 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 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 records contain some diet recommendations but there is a lack of information and follow-up to indicate what foods were being consumed and what progress was being achieved by the Petitioner. 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 __03__ day of __June__, 2016,

in Tallahassee, Florida.

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

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

Jun 14, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-02046

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.
________________________________/

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on May 16, 2016, at 1:30 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 respondent incorrectly denied his request for the prescription medication

PRELIMINARY STATEMENT

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

Stephanie Lang, R.N., Registered Nurse Specialist and Fair Hearing Coordinator for the Agency for Health Care Administration ("AHCA" or "Agency"), appeared on behalf of the Agency for Health Care Administration. The following individuals appeared as witnesses on behalf of the Agency: Stephanie Shupe, Regulatory Research Coordinator with Staywell; and Lauren Barnes, Pharm.D., Pharmacist and Manager of Pharmacy Operations at Staywell.

The respondent introduced Exhibits "1" through "22", inclusive, at the hearing. At the respondent's request, the hearing officer took administrative notice of the following: Sections 409.910, 409.962, 409.963, 409.964, 409.965, 409.973, 409.912, and 409.91195, F.S.; Chapters 59G-1.001, 59G-1.010, and 59G-4.250, F.A.C.; and the Florida Medicaid Prescribed Drug Services Coverage, Limitations, and Reimbursement Handbook.

FINDINGS OF FACT

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

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

2. Petitioner was eligible to receive Medicaid services at all times relevant to this proceeding.

3. The petitioner is an enrolled member of Staywell. Staywell is a health maintenance organization ("HMO") contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in Florida.

4. The petitioner's effective date of enrollment with Staywell is November 1, 2015.

5. On October 27, 2015, December 31, 2015, and January 29, 2016, the petitioner's medical provider submitted prior authorization requests to Staywell for the prescription drug

6. is a drug approved for the treatment of and has been shown to not only treat but also cure the disease.

7. In each of the above instances, Staywell issued a Notice of Action denying the prior authorization request submitted by the petitioner's medical provider.

8. On or about January 8, 2016, the petitioner's medical provider submitted an appeal to Staywell requesting an internal reconsideration of the plan's denial of the petitioner's December 31, 2015 prior authorization request for

9. On January 13, 2016, Staywell issued a final determination letter to the petitioner advising her that Staywell was upholding its decision to deny her request for submitted on December 31, 2015.

10. The petitioner has

11. is an appropriate treatment for

12. Staywell follows the Agency for Health Care Administration Preferred Drug List ("PDL").

13. The Preferred Drug List is a listing of prescription products recommended by the Pharmaceutical and Therapeutics Committee for consideration by the Agency as efficacious, safe, and cost effective choices when prescribing for Medicaid patients.

14. Medications not on the Preferred Drug List require prior authorization.

15. Prior authorization of a drug not on the Preferred Drug List requires the trial and failure of any more cost-effective alternatives for the treatment of the patient's condition which do appear on the list.

16.

17. is on the Preferred Drug List.

18. The petitioner's medical provider did not provide any documentation to the Agency showing the petitioner tried and that treatment with was not successful.

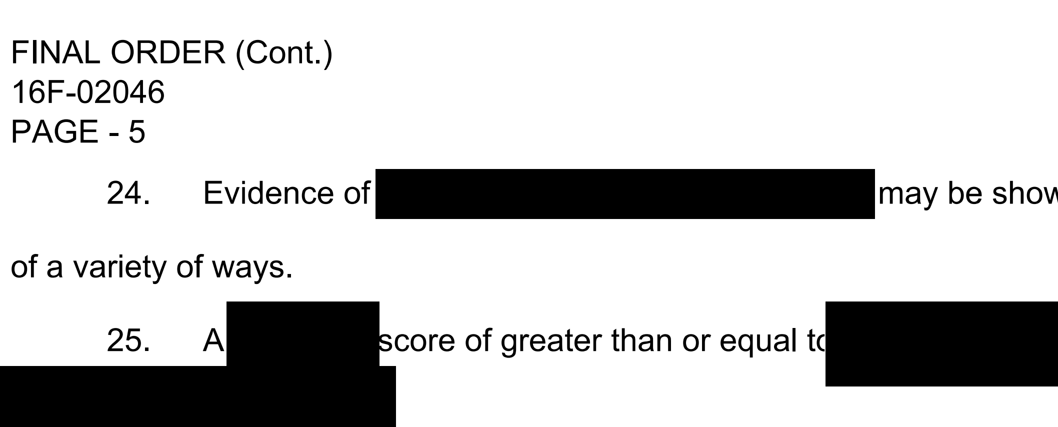
19. The Agency for Health Care Administration has specific requirements for the approval of

20. Staywell follows the Agency for Health Care Administration criterion for the approval of

21. The first criterion for the approval of is that the patient must meet or exceed a certain viral load. The petitioner's viral load meets this requirement.

22. The second criterion is that the patient have a certain genotype. In this case, the petitioner has genotype 1 which meets this requirement.

23. The third criterion is the patient must have

24. Evidence of  may be shown in any one of a variety of ways.

25. A score of greater than or equal to

26. The petitioner has a

27. Another requirement for the approval of is that the patient has abstained from the use of illicit drugs and alcohol for a minimum of one month as evidenced by negative urine or blood confirmation tests collected within the past 30 days.

28. Although some of the petitioner's blood and alcohol urine drug screens were greater than 30 days old at the time the petitioner's medical provider submitted the prior authorization requests for there is no evidence to indicate the petitioner is abusing alcohol or using illicit drugs.

CONCLUSIONS OF LAW

29. 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.

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

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

32. 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.

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

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

35. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Rule 59G-5.020. In accordance with the above Statute, the Handbook states on page 1-27

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.
>
> Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

36. Page 1-22 of the Florida Medicaid Provider General Handbook provides a list of Medicaid covered services. These services include prescribed drug services.

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

38. Page 1-30 of the Florida Medicaid Provider General Handbook states: “An HMO’s services cannot be more restrictive than those provided under Medicaid fee-for-service.”

39. In the present case, the criteria used by Staywell to assess the petitioner's eligibility for Harvoni are identical to those of the Agency for Health Care Administration.

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

> 14. The agency may require prior authorization for Medicaid-covered prescribed drugs. The agency may prior-authorize the use of a product:
>
> a. For an indication not approved in labeling;
> b. To comply with certain clinical guidelines; or
> c. If the product has the potential for overuse, misuse, or abuse.
>
> The agency may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug….

41. 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.

42. The Florida Medicaid Prescribed Drug Services Coverage, Limitations, and Reimbursement Handbook discusses non-PDL drugs on Page 2-4. It states:

> 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.

43. The Florida Medicaid Prescribed Drug Services Coverage, Limitations, and Reimbursement Handbook discusses prior authorization for non-PDL drugs on Page 2-5. It explains, in part:

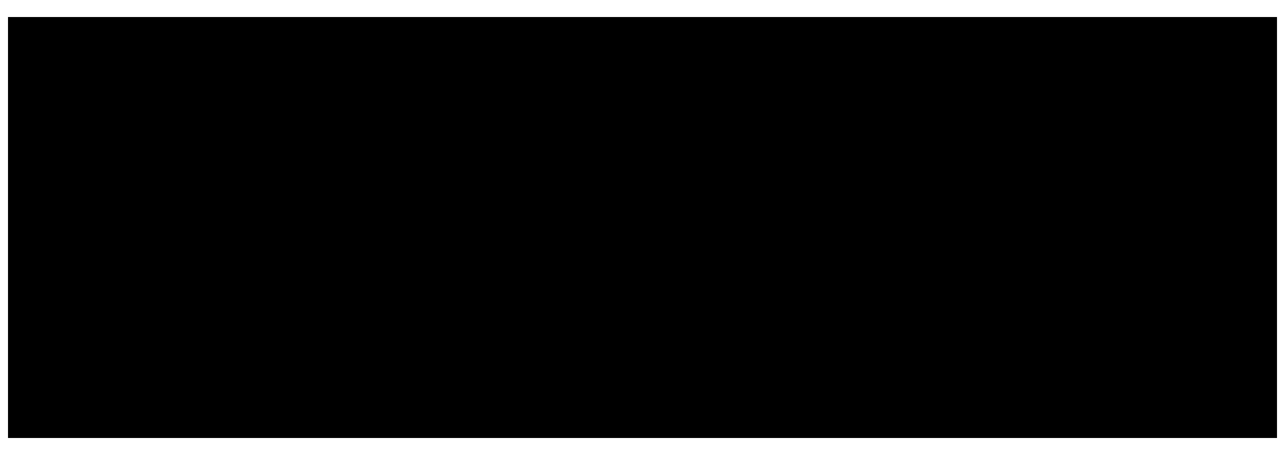
> Approval of reimbursement for alternative medications that are not listed on the Preferred Drug List shall be considered if listed products have been tried without success within the previous twelve months. The step-therapy prior authorization may require the prescriber to use medications in a similar drug class or that are indicated for a similar medical indication unless contraindicated in the Food and Drug Administration labeling….

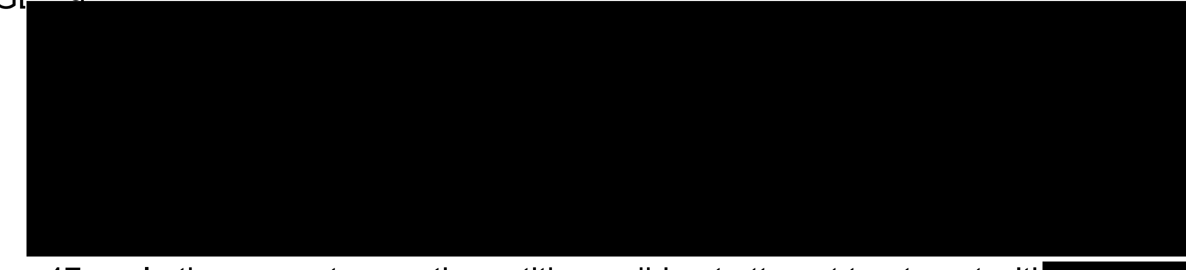
44. Both the Agency and Staywell require a patient to undergo treatment with [redacted] before they will approve [redacted]

45. 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.

46. The Agency for Health Care Administration Prior Authorization Criteria for





47. In the present case, the petitioner did not attempt treatment with which is a preliminary requirement of both the Agency and Staywell before they will consider approving Therefore, the respondent correctly denied her request for Harvoni.

48. Pursuant to the above, the petitioner has not met her burden of proof to demonstrate the Agency incorrectly denied her request for

49. This document does not purport to state the petitioner does not require the requested medication. It only goes so far as to state the Agency correctly denied the petitioner's request pursuant to the law in place for the pre-authorization of this drug. It is hoped the respondent and Staywell will continue working with the petitioner and her medical provider to determine if this medication can be properly approved.

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 14 day of June, 2016,

in Tallahassee, Florida.

Peter J. Tsamis

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

Copies Furnished To: [redacted] Petitioner
Don Fuller, Area 5, AHCA Field Office Manager
Stephanie Shupe

Jun 07, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-02058

PETITIONER,

Vs.

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

RESPONDENT.
________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on May 2, 2016 at 11:30 a.m. in Florida.

APPEARANCES

For the Petitioner:

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

STATEMENT OF ISSUE

At issue is whether the Respondent's action to partially deny Physical Therapy (PT) service hours that were requested for the Petitioner for the certification period February 29, 2016 through August 26, 2016, was correct. The Respondent bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

Appearing as witnesses for the Petitioner were his parents The Petitioner submitted physician letters, medical records, and a letter from his physical therapist as evidence for the hearing, which were marked as Petitioner's Exhibit 1.

Appearing as a witness for the Respondent was Rakesh Mittal, M.D., Physician-Consultant with eQHealth Solutions, Inc. Respondent's composite Exhibit 1 was entered into evidence, consisting documents such as a statement of matters, outpatient review history, denial notices, and therapy evaluation/plan of care.

All parties appeared in person for the hearing except for Dr. Mittal, who appeared telephonically.

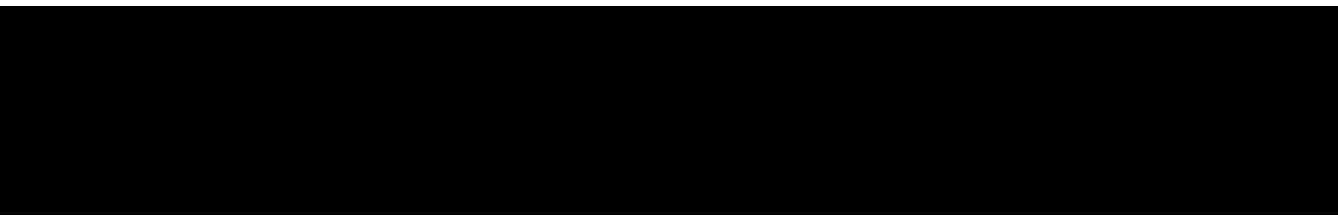
FINDINGS OF FACT

1. The Petitioner's PT service provider, (hereafter referred to as "the provider"), requested the following PT service hours for the certification period at issue: 4 units (1 hour), two times per week, or a total of 2 hours weekly.

2. eQHealth Solutions, Inc. is the Quality Improvement Organization (QIO) contracted by the Respondent to perform prior authorization reviews for therapy services. The provider submitted the service request through an internet based system. The submission included, in part, information about the Petitioner's medical conditions; his functional limitations; and other pertinent information related to the household.

3. eQHealth Solutions' personnel had no direct contact with the Petitioner, his family, or his physicians. All pertinent information was submitted by the provider directly to eQ Health.

4. The medical information submitted by the provider contained, in part, the following information in regard to the Petitioner:



5. The Petitioner was approved for 2 hours weekly of physical therapy services in the prior certification period. He also currently receives 3 hours weekly of occupational therapy services.

6. A Plan of Care was also submitted by the provider. The document was signed by a physician and outlined the type of assistance to be provided by the PT provider. The duties include, in part:

- Sensory stimulation
- Strengthening and stretching exercises
- Transitional activities
- Range-of-Motion exercises
- Balance activities
- Postural control exercises
- Caregiver education

7. A physician at eQHealth Solutions, who is board-certified in pediatrics, reviewed the submitted information, partially denied the requested PT services, and instead approved 4 units (1 hour) of physical therapy once per week. This physician-reviewer wrote, in part: "The request is excessive based on the severity of the delay, goals

submitted and the minimal progress made over many years." A notice of this determination was sent to all parties on March 4, 2016.

8. The above notice stated that a reconsideration review of this determination by eQHealth could be requested, and additional information could be provided with the request for reconsideration. A reconsideration review was requested by the Petitioner's provider.

9. A second physician at eQ Health Solutions reviewed the submitted information and upheld the initial decision to partially deny the service by approving only 1 hour per week rather than 2 hours per week. A notice of this reconsideration decision was sent to all parties on March 9, 2016.

10. The Petitioner thereafter requested a fair hearing and this proceeding followed. The Respondent administratively approved the requested service hours (2 hours weekly) pending the outcome of the fair hearing process since these hours had been approved in the prior certification period.

11. The Respondent's witness, Dr. Mittal, testified that the partial denial of the Petitioner's request for PT services was appropriate because the information submitted by the physical therapy provider indicated the Petitioner had made very little progress in meeting his therapy goals and had shown little improvement since he still requires total assistance with his ADLs. He also stated the caregivers (i.e., the parents) can supplement the therapy through a home exercise program.

12. The Petitioner's father testified that the therapy should be continued at its currently level of 2 hours weekly due to his son's serious medical conditions and because the parents cannot assist with the therapy at home. He stated that on a

previous occasion, a trained therapist dislocated his son's hip while performing therapy, and the parents are concerned they may injure their son if they make similar attempts.

13. PT service for children is a covered service under the Medicaid State Plan in Florida. These services are provided in accordance with the Respondent's Therapy Services Coverage and Limitations Handbook ("Therapy Handbook"), effective August, 2013.

CONCLUSIONS OF LAW

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

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

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

17. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the Respondent since the Petitioner had been previously approved for the PT services at issue, and the Respondent is seeking to reduce these services for the current certification period. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

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

19. The Petitioner has requested PT services. As the Petitioner is under 21 years of age, the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements apply to the evaluation of the Petitioner's eligibility for or amount of this service.

20. The Centers for Medicare and Medicaid Services, State Medicaid Manual makes available to all State Medicaid agencies informational and procedural material needed by the States to administer the Medicaid program. It is the method by which the Health Care Financing Administration (HCFA) issues mandatory, advisory, and optional Medicaid policies and procedures to the Medicaid State agencies.

21. The State Medicaid Manual in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services section states in part:

> *5010. Overview*
> *A. Early and Periodic Screening, Diagnostic and Treatment Benefit.-- Early and periodic screening, diagnostic and treatment services (EPSDT) is a required service under the Medicaid program for categorically needy individuals under age 21…*
>
> *5110. Basic Requirements*
>
> *OBRA 89 amended §§1902(a)(43) and 1905(a)(4)(B) and created §1905(r) of the Social Security Act (the Act) which set forth the basic requirements for the program. Under the EPSDT benefit, you[1] must 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.*

[1] "You" in this manual context refers to the state Medicaid agency.

22. The service the Petitioner has requested (PT services) is one of the services provided by the state to treat or ameliorate an individual's conditions under the State plan. Chapter 409.905, Fla. Stat., states, in part:

> *Any service under this section shall be provided only when medically necessary …*

23. The issue to be decided is the medical necessity of the service or amount of service. The State Medicaid Manual provides for limitations on services as follows:

> *5110. Basic Requirements…*
> *…Services under EPSDT must be sufficient in amount, duration, or scope to reasonably achieve their purpose. The amount, duration, or scope of EPSDT services to recipients may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. Appropriate limits may be placed on EPSDT services based on medical necessity.*
>
> *5122. EPSDT Service Requirements*
> *F. Limitation of Services.--The services available in subsection E are not limited to those included in your State plan.*
> *Under subsection E, the services must be "necessary . . . to correct or ameliorate defects and physical or mental illnesses or conditions . . ." and the defects, illnesses and conditions must have been discovered or shown to have increased in severity by the screening services. You make the determination as to whether the service is necessary. You are not required to provide any items or services which you determine are not safe and effective or which are considered experimental.*
>
> *5124. Diagnosis and Treatment*
> *B. Treatment.--*
> *1. General. - You must make available health care, treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services. Treatment services may be limited as described in §5122 F.*

24. Once a service has been identified as requested under EPSDT, the Medicaid program determines the amount or necessity for that service based on the State of Florida's published definition of medical necessity. The Fla. Admin. Code R. 59G-1.010 defines medical necessity:

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

25. Based upon the information submitted by the Petitioner's provider, eQHealth Solutions completed a prior authorization review to determine medical necessity for the requested PT services.

26. In the Petitioner's case, the Respondent has determined that some PT service is medically necessary, but approved only 1 hour of PT service weekly rather than the requested 2 hours weekly.

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. PT services are described on page 1-3 of the Therapy Handbook as follows:

> *Physical therapy is a specifically prescribed program to develop, maintain, improve or restore neuro-muscular or sensory-motor function, relieve pain, acquire a skill set, restore a skill set, or control postural deviations to attain maximum performance.*
> *Physical therapy services include evaluation and treatment of range-of-motion, muscle strength, functional abilities and the use of adaptive and therapeutic equipment. Examples are rehabilitation through exercise, massage, the use of equipment and habilitation through therapeutic activities.*

30. The Therapy Handbook on page 2-2 sets forth the requirements for PT 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 a PT service frequency greater than that approved by eQHealth Solutions. Rule 59G-1.010(166) (c), however, specifically states a prescription does not automatically mean the requirements of medical necessity have been satisfied.

32. The Respondent's witness, Dr. Mittal, stated that he believed only 1 hour weekly of physical therapy service was medically necessary for the Petitioner at this time due to the minimal progress and little improvement made during his years of therapy.

33. The Petitioner's father stated that he believed his son should continue receiving 2 hours weekly of physical therapy.

34. 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 partially denying the requested physical therapy services for the certification period at issue. Although the Petitioner has been making slow progress in his therapy goals, the therapy evaluation indicates the treatments have been effective in increasing or improving range of motion, head/trunk control, and postural strength and alignment. He has met only 30%, 20%, and 50%, respectively, of his 3 short-term goals. However, he was able to meet 80% of his long-term goal (right hip flexion). Accordingly, the Petitioner's physical therapy services should not be reduced at this time.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is GRANTED, and the Petitioner shall continue receiving 2 hours weekly of physical therapy services (4 units, 2 times per week) for the current certification period.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 07 day of June, 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 T[redacted] PETITIONER
RHEA GRAY, AHCA AREA 11, FIELD OFFICE MANAGER

Jun 29, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-02110

PETITIONER,
Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pasco
UNIT: 883DT

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on May 24, 2016 at 2:05 p.m. All parties appeared telephonically from different locations.

APPEARANCES

For the petitioner

For the respondent: Signe Jacobson, Economic Self Sufficiency Supervisor

STATEMENT OF ISSUE

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

PRELIMINARY STATEMENT

On March 10, 2016, the Department sent the petitioner a Notice of Case Action (NOCA) informing him that his application dated March 7, 2016 for Medicaid was denied

because "you or a member(s) of your household do not meet the disability requirement." The petitioner timely appealed this action on March 18, 2016.

The petitioner presented a total of 736 pages of evidence for the undersigned to consider, which was entered into the record as Petitioner's Composite Exhibits 1 through 4. The Department presented a total of 36 pages of evidence for the undersigned to consider, which was entered into the record as Respondent's Composite Exhibit 1. The record was held open until close of business on June 7, 2016 for the petitioner to submit a copy of the Social Security Administration (SSA) denial letter and any objections to the Department's evidence. The petitioner did not send the SSA denial letter or any written objections in reference to the Department's evidence. The record was closed on June 7, 2016.

FINDINGS OF FACT

1. On March 7, 2016, the petitioner applied for Medicaid for himself. He is 40 years old and lives with his girlfriend who is not applying for benefits. The petitioner claimed to be disabled. The Department did not send a Disability Determination and Transmittal form to the Division of Disability Determination (DDD) to make a disability determination.

2. The petitioner filed a disability application with the SSA on December 3, 2014, which was denied on August 25, 2015. The petitioner appealed this denial on October 15, 2015 and it is currently pending for a hearing with an Administrative Law Judge (ALJ).

3. DDD did not conduct an independent review. The Department 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.

5. On March 10, 2016, the Department sent the petitioner a NOCA informing him that he was ineligible for Medicaid.

6. The petitioner's representative reported his disabling conditions to be:

His representative reported that all of the above conditions have worsened and that he has two new conditions which are shoulder pain and seizures. The petitioner's representative testified that the onset date for the worsening of all conditions and the two new conditions is January 30, 2016.

7. The SSA denial letter gives a detailed explanation for its denial, but as the petitioner did not provide it, the undersigned cannot make a finding on what conditions were considered by its agency.

8. The petitioner's representative testified during the hearing that the petitioner has an attorney and that all of the new and worsening conditions have been reported to the SSA.

CONCLUSIONS OF LAW

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

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

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

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

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

> (a) *Determinations made by SSA*. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.
> (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under § 435.909.
> (b) *Effect of SSA determinations*.
> (1) Except in the circumstances specified in paragraph (c)(3) of this section-
> (i) **An SSA disability determination is binding on an agency until the determination is changed by SSA**. [emphasis added]
> (ii) If the SSA determination is changed, the new determination is also binding on the agency.
> (2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of

ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.
(c) *Determinations made by the Medicaid agency*. The agency must make a determination of disability in accordance with the requirements of this section if any of following circumstances exist…
(4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and-
(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or
(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.
(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—
(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or
(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

13. The above federal regulation explains that the respondent may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.912 on the same issues presented in the Medicaid application. The respondent is bound by the federal agency's decision unless there is evidence of a new disabling condition not reviewed by SSA. The petitioner's representative confirmed that all of the petitioner's medical conditions have been reported to the SSA. SSA denied the petitioner's disability claim on August 25, 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 August 25, 2015 and denying the petitioner's Medicaid disability application.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

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

Brandy Ricklefs

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@myflfamilies.com

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

Jun 08, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-02129

PETITIONER,
Vs.

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

And

MOLINA HEALTHCARE OF FLORIDA, INC.

RESPONDENTS.
_______________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on May 2, 2016 at 10:00 a.m. in Florida.

APPEARANCES

For the Petitioner:

For the Respondent AHCA: 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 a was correct. Petitioners bear the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

Appearing was a witness for the Petitioner was his nursing assistant. The Petitioner submitted a letter from his physician as evidence for the hearing, which was marked as Petitioner Exhibit 1.

Appearing telephonically as witnesses for the Respondent were Alice Quiros, A.V.P. of Government Contracts, Carlos Galvez, Government Contracts Specialist, and Dr. Valerie Maguire, Medical Director, for Molina Healthcare, which is the Petitioners' managed health care plan. Molina Healthcare was included as an additional Respondent in this proceeding pursuant to its request to be added as a party.

Respondent submitted the following documents into evidence: Exhibit 1 – Fair Hearing Summary and Authorization Request; Exhibit 2 – DME Handbook provision; Exhibit 3 – Florida Medicaid DME Fee Schedule; and Exhibit 4 – Denial Notice.

Also present telephonically for the hearing was a Spanish language interpreter,

Interpreter Number from

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. He receives services under the plan from Molina Healthcare.

2. On or about February 9, 2016, Petitioners' treating physician submitted an authorization request to Molina Healthcare for approval of a

3. On or about February 18, 2016, Molina Healthcare denied the pre-authorization request for the The denial notice stated the following:

> … it has been determined that the service requested is not reimbursable under the Florida Medicaid Program. Therefore, the service is considered a "non-covered benefit."

4. The Petitioner testified he believes the should be approved because it was recommended by his urologist and urinary catheters don't fit him. He states he has had many urinary infections and scarring from the infections. He also states he has difficulty urinating and needs to be changed 3-4 times daily due to these problems.

5. The Petitioner's nursing assistant also stated the Petitioner has difficulty urinating and needs to be changed often due to that problem.

6. The Respondent's witness, Mr. Galvez, stated the request for the was denied because the item is not covered under Florida Medicaid guidelines since it is not listed in the Medicaid fee schedule.

7. Services under the Medicaid State Plan in Florida are provided in accordance with the Respondent's Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July, 2012, and the Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook ("DME Handbook"), effective July, 2010.

CONCLUSIONS OF LAW

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

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

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

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

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

13. The DME Handbook lists various types of medical equipment which are covered by the Florida Medicaid Program. The DME Handbook also states the following on page 2-3:

> Many durable medical equipment (DME) items and services are limited to recipients under 21 years of age.
>
> To determine whether a service is available to all recipients or limited to recipients under age 21 years of age, refer to the DME and Medical Supply Services Provider Fee Schedules and the service specific requirements described in this handbook.

14. The [redacted] requested by the Petitioner is not listed as a covered benefit or service in either the DME Handbook or the accompanying fee schedules.

15. Managed care plans, such as Molina Healthcare, are required to comply with the various Medicaid Handbooks and regulations.

16. After considering all the documentary evidence and witness testimony presented, the undersigned concludes Molina Healthcare correctly denied Petitioner's request for the [redacted] This conclusion is based on the fact the requested prosthetic device is not listed on the Medicaid fee schedules, rather than whether or not the device is medically necessary.

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 08 day of June, 2016,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] PETITIONER
RHEA GRAY, AHCA AREA 11, FIELD OFFICE MANAGER
MOLINA HEALTHCARE

May 12, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-02134

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 April 26, 2016 at 11:30 a.m.

APPEARANCES

For the Petitioner:

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

STATEMENT OF ISSUE

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

PRELIMINARY STATEMENT

The Petitioner submitted a letter and a letter from her doctor as evidence for the hearing, which were marked as Petitioner Exhibit 1.

Appearing as witnesses for the Respondent were Dr. Neil Williams, Dental Consultant, and Jackeline Salcedo, Grievance Specialist, from DentaQuest, which is the Petitioner's dental services review organization. Also present as a witness for the Respondent was Stacy Larsen, Clinical Analyst from Humana, which is Petitioner's managed health care plan.

Respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Exhibits: Exhibit 1 – Member Information; Exhibit 2 – Claim Form; Exhibit 3 – X-rays; Exhibit 4 – Authorization Determination; Exhibit 5 – Notice of Action; Exhibit 6 – Criteria for Dental Crowns; Exhibit 7 – Dental Director Review Form; and Exhibit 8 – Updated Authorization Determination.

FINDINGS OF FACT

1. The Petitioner is a sixty-four (64) year old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. She receives services under the plan from Humana, which utilizes DentaQuest for review and approval of dental services.

2. On or about January 14, 2016, the Petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from DentaQuest to perform a dental

crown procedure on one of the Petitioner's teeth (tooth 30). DentaQuest denied this request on January 19, 2016.

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

> This service is part of a partial denture treatment plan. For this service to be approved, the partial denture must have also been approved. We have denied the partial denture. We have told your dentist this also. Please talk to your dentist about your choices to treat your teeth.

4. Petitioner testified that she needs the dental crown because she does not want an extraction of the tooth in question since an extraction would require more anesthesia and she is allergic to anesthesia.

5. Respondent's expert witness, Dr. Williams, testified that Petitioner's dentist requested a partial denture in late 2015 and this was denied at that time because it was decided that a full denture would be more appropriate due to decay in other teeth. The dental crown has been denied at this time because services on individual teeth are not considered appropriate when there is a need for full dentures.

6. With regard to the prior denial of the partial denture and the need for full dentures, the Petitioner stated this had been requested by a different dentist than the dentist requesting the crown. She also stated her other teeth are fine and she only needs the dental crown on tooth 30.

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

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CONCLUSIONS OF LAW

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

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

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

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

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

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

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

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

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

15. The Florida Medicaid Program provides limited dental services for adults. The Dental Handbook describes the covered services for adults as follows:

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

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

17. Petitioner stated she needs the dental crown because she does not want an extraction due to being allergic to anesthesia. She maintains that her other teeth are fine and she does not understand why her prior dentist had made a request for partial dentures.

18. Respondent's witness stated that, based on the prior request concerning partial dentures, a decision had been made that the Petitioner needs full dentures due to the condition of her other teeth. Because of this, the Respondent's position is that it would not be appropriate to perform work on individual teeth in that area.

19. After considering the evidence and testimony presented, the undersigned concludes the Petitioner has not demonstrated that the Respondent should have approved the request for the dental crown. Due to uncertainty and conflicting testimony concerning the prior request for the partial dentures, the hearing officer cannot make a determination that the Petitioner has established medical necessity for the dental crown.

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 __12__ day of __May________, 2016,

in Tallahassee, Florida.

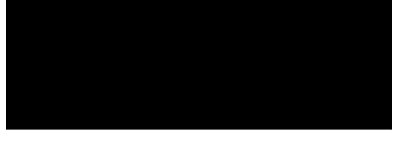
Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To [redacted] PETITIONER
RHEA GRAY, AREA 11, AHCA FIELD OFFICE MANAGER

Jun 20, 2016

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 16F-02174

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 May 19, 2016 at approximately 10:30 a.m.

APPEARANCES

Petitioner:

For Respondent: Diane Soderlind
Registered Nurse Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is whether or not Respondent's denial of Petitioner's request for lower partial dentures and two (2) fillings was correct. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

The following individuals were present as witnesses for Respondent:

- Michelle Riegler – Compliance Officer – Magellan Complete Care
- Dr. Daniel Dorrego – Dental Consultant – DentaQuest

- Jackelyn Salcedo – Complaints & Grievances Specialist - DentaQuest
- Omeshia Smith – Complaints & Grievances Specialist - DentaQuest

Petitioner gave oral testimony, but did not move any exhibits into evidence.

Respondent moved Exhibits 1 through 9 into evidence at the hearing.

Administrative notice was taken of the following:

- Florida Medicaid Dental Services Coverage and Limitations Handbook, November 2011[1].
- Florida Statutes §§ 409.963, 409.965, 409.971, 409.972, & 409.973.
- Florida Administrative Code Rule 59G-1.010.

FINDINGS OF FACT

1. Petitioner is a 54-year-old male. Petitioner is enrolled with Magellan Complete Care ("Magellan") as his Managed Medical Assistance (MMA) plan. DentaQuest is Magellan's dental vendor.

2. On March 14, 2016, Petitioner's dentist submitted a prior authorization request for deep cleanings of all four (4) quadrants of Petitioner's teeth, surgical extraction of tooth # 1, an upper partial denture, a lower partial denture, and surface fillings for teeth numbers 16 and 30.

3. On March 16, 2016, Magellan issued a Notice of Action, Respondent's Exhibit 7, denying Petitioner's request for the lower partial denture and the two (2) fillings. The Notice stated, in pertinent part:

> - [Regarding the lower partial denture]. Our dentist looked at the information your dentist sent, and says you are not missing enough teeth to affect your chewing function. We have also told your dentist. Please talk to your dentist.
> - [Regarding the filling on tooth # 16]. This is not a covered benefit.
> - [Regarding the fillings on tooth # 30]. This is not a covered benefit.

---

[1] The November 2011 Florida Medicaid Dental Services Coverage and Limitations Handbook has since been updated as of May 3, 2016. The relevant provisions of the Dental Handbook are unchanged.

4. On March 17, 2016, Magellan issued an Approval Notice approving the deep cleanings, extraction of tooth # 1, and the upper partial denture. (Respondent's Exhibit 6).

5. Dr. Dorrego testified the upper partial denture was approved because Petitioner was missing a front tooth, and that his treatment plan included extraction of another front tooth. He said missing a front tooth is an automatic qualifier for upper partial dentures because they are considered necessary socially.

6. Dr. Dorrego said by having the upper partial denture in Petitioner's mouth, the result will be Petitioner having 10 teeth in occlusion. He said occlusion means having any combination of natural and artificial teeth that touch to where the individual can chew and speak properly. He said there must be fewer than eight (8) teeth in occlusion to qualify for dentures.

7. Magellan's contract with the Agency for Health Care Administration ("AHCA" or "Agency") requires them to provide "medically-necessary, emergency dental procedures to alleviate pain or infection to enrollees age twenty-one (21) and older." (Respondent's Exhibit 2). The contract also requires Magellan to "comply with provisions of the Medicaid Dental Services Coverage and Limitations Handbook" ["Dental Handbook"]. Magellan's coverage limitations and exclusions cannot be more stringent than those in the Dental Handbook.

CONCLUSIONS OF LAW

8. By agreement between AHCA and the Department of Children and Families ("DCF"), the Office of Appeal Hearings has jurisdiction to conduct this hearing pursuant to Section 120.80, Fla. Stat.

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

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

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

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

13. The Dental Handbook is promulgated into law by Chapter 59G of the Florida Administrative Code.

14. Page 2-3 of the Dental Handbook states, in pertinent part:

> Medicaid will reimburse for medically-necessary emergency dental procedures to alleviate pain and or infection for eligible adult Medicaid recipients 21 years of age or older. Emergency dental care shall be limited to emergency problem-focused evaluations, necessary radiographs to make a diagnosis, extraction, and incision and drainage of abscess.

15. Page 2-33 of the Dental Handbook says that Medicaid will not reimburse for "Partial dentures where there are at least eight posterior teeth in occlusion."

16. Page 2-33 of the Dental Handbook also provides, regarding Restorative Service: "Restorations may be reimbursed for eligible recipients under age 21…."

17. The plain language of the Dental Handbook excludes partial dentures for individuals with eight (8) or more posterior teeth in occlusion. Petitioner has 10 posterior teeth in occlusion.

18. The Dental Handbook also states that restoration of teeth is limited to Medicaid recipients under 21. Petitioner is over 21, therefore the fillings are not a covered benefit.

19. Petitioner is encouraged to work with his dentist regarding his condition. In the event his condition worsens to where he would require lower dentures, he can submit a new request at that time.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 20 day of June, 2016,

in Tallahassee, Florida.

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

Copies Furnished To [redacted], Petitioner
Judy Jacobs, Area 7, AHCA Field Office

Jun 03, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-02175

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 16 MONROE
UNIT: AHCA

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on April 29, 2016 at 3:00 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 a MRI scan was correct. The Petitioner bears the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

Petitioner was present for the hearing and was represented by her Case Manager. Appearing as a witness for the Petitioner was [redacted] a nurse at the Petitioner's care center facility.

The Petitioner submitted a letter from her physician as evidence for the hearing, which was marked as Petitioner Exhibit 1.

Appearing as witnesses for the Respondent were Michelle Riegler, Compliance Officer, and Dr. Phillip Benjakul, Physician-Advisor from Magellan Complete Care, which is the Petitioner's managed health care plan.

Respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Exhibits: Exhibit 1 – Case Summary and Clinical Guidelines; Exhibit 2 – Authorization Process; Exhibit 3 – Provider Documents; Exhibit 4 – Provider Submission 2/2/16; Exhibit 5 – Provider Submission 2/3/16; Exhibit 6 – Notice Requesting Clinical Information; Exhibit 7 – Magellan Request for Extension; Exhibit 8 – Magellan Request for Peer to Peer Review; Exhibit 9 – Notice of Action Letters; and Exhibit 10 – Post-Determination Notice.

The documents submitted by the Respondent contained some medical records pertaining to another individual not involved in this proceeding. These records were removed from the Respondent's packet and the Petitioner's representative indicated he would contact AHCA to report a possible breach of that individual's HIPAA privacy rights.

FINDINGS OF FACT

1. The Petitioner is a fifty-seven (57) year-old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. She receives services under the plan from Magellan Complete Care.

2. On or about January 27, 2016, the Petitioner's treating physician (hereafter referred to as "the provider"), requested prior authorization from Magellan to perform a MRI scan of the lumbar spine. Magellan denied this request on February 3, 2016 as not being medically necessary.

3. Magellan sent Petitioner a Denial Notice which contained the following reason for the denial:

> Unless otherwise indicated, details of a failure to respond to six weeks of conservative care including a combination of medications, physical therapy, chiropractic care, and/or a supervised home exercise program should be completed prior to approval.

4. The Petitioner's representative stated the Petitioner is in pain and the MRI scan should have been approved since it was prescribed by her doctor.

5. The Petitioner's witness [redacted] tated the Petitioner has been in pain for 4 months and tried using the medications Motrin and Prednisone in December, 2015. She also stated the Petitioner is in too much pain to attempt physical therapy and the MRI is warranted since it is a diagnostic tool.

6. The Respondent's expert witness, Dr. Benjakul, testified that the denial of the Petitioner's request for the MRI scan was appropriate because medical necessity guidelines require a failure of attempted physical therapy treatments or a home exercise program prior to approval of a MRI scan. He also stated the information submitted by

the Petitioner's provider did not document an attempt and failure of physical therapy or home exercise program.

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

CONCLUSIONS OF LAW

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

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

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

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

12. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the Respondent. The Medicaid Handbook referred to above is incorporated by reference in Fla. Admin. Code R. 59G-4.001.

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

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

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

15. Although Petitioner's witnesses testified she is suffering from pain, the Petitioner must also satisfy each of the remaining components of the rule's requirements concerning medical necessity. Respondent's medical expert testified that medical necessity guidelines require a failure of attempted physical therapy treatments or home exercise program prior to approval of a MRI scan, and this was not established in the Petitioner's pre-authorization request.

16. Although the Petitioner's treating physician has requested the MRI scan, this does not in itself establish that this service is medically necessary according to the rule provisions outlined above.

17. Petitioner has not established by a preponderance of the evidence that her requested MRI scan is medically necessary as defined by Fla. Admin. Code R. 59G-1.010(166). After considering the evidence and relevant authorities set forth above, the undersigned concludes that the Petitioner has not met the 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 indigence to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 03 day of June, 2016,

in Tallahassee, Florida.

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

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

Jun 30, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-02181

PETITIONER,

Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pasco
UNIT: 88272

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on June 3, 2016 at 10:08 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the petitioner:

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

STATEMENT OF ISSUE

Petitioner is appealing the Department's action to deny his Medicaid application for failure to complete the required interview and the Department's subsequent action to deny his Medicaid application due to not meeting the disability requirement. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

On March 15, 2016, the Department sent the petitioner a Notice of Case Action (NOCA) informing him that his application dated February 12, 2016 for Medicaid was denied because "you failed to complete an interview necessary for us to determine your eligibility for this program." The petitioner timely appealed this action on March 22, 2016. On May 13, 2016, the Department sent the petitioner a secondary NOCA informing him that his application for Medicaid dated February 12, 2016 was denied because "you or a member(s) of your household do not meet the disability requirement."

The petitioner presented 4 pages of evidence for the undersigned to consider, which was entered into the record as Petitioner's Exhibit 1. The Department presented a total of 41 pages of evidence for the undersigned to consider, which was entered into the record as Respondent's Composite Exhibits 1 and 2. The record was closed on June 3, 2016.

FINDINGS OF FACT

1. On February 12, 2016, the petitioner applied for Medicaid for himself. He is 61 years old. The petitioner claimed to be disabled. On February 16, 2016, the Department sent the petitioner a NOCA requesting that he complete a phone interview by February 19, 2016. On February 22, 2016, the Department sent the petitioner a Notice of Missed Interview (NOMI) informing him that he had missed his scheduled interview. The petitioner did contact the Department on several occasions to try and complete the required interview but was unable to do so. On March 15, 2016, the Department denied the petitioner's application stating he did not complete the required interview. The Department admitted that it was incorrect to only give petitioner three

days to complete an interview and to deny his application when he had clearly attempted to complete the interview.

2. The petitioner filed a disability application with the Social Security Administration (SSA) on February 23, 2016, which was denied on March 24, 2016. The petitioner appealed this denial and testified that it is currently pending.

3. On April 28, 2016, the petitioner completed the required interview and the Department sent a Disability Determination and Transmittal form to the Division of Disability Determination (DDD) to make a disability determination.

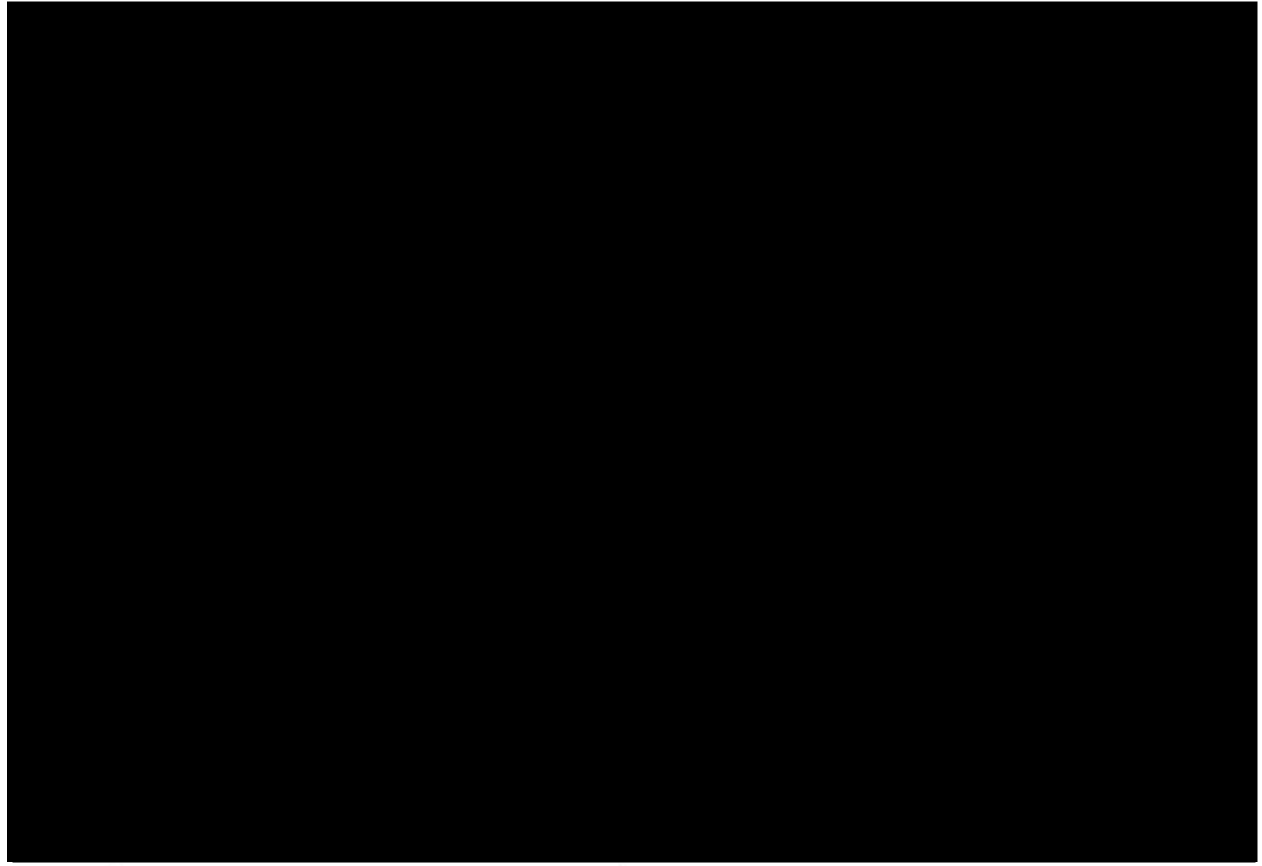
4. On May 4, 2016, DDD returned the transmittal to the Department informing it that an adoption of the SSA's decision was made. DDD did not conduct an independent review; instead, it denied the petitioner's disability claim by adopting the SSA denial.

5. The code used to deny was N32, which is non-pay- capacity for substantial gainful activity-other work, no visual impairment. The primary diagnosis was from the SSA Blue Book.

6. On May 13, 2016, the Department sent the petitioner a NOCA informing him that he was ineligible for Medicaid.

7. The petitioner reported his disabling condition to be eye deterioration. He testified that he is unable to see clearly and determine distance between objects. The petitioner testified that there were no new conditions.

8. The petitioner submitted his denial letter from SSA (Petitioner's Exhibit 1). The SSA denial letter gave the following explanation for its denial:



9. The condition the petitioner reported during the hearing was reported to the SSA and considered in the above decision. The petitioner was not clear on the eligibility requirements for adults to receive Medicaid in Florida. The Department explained that an adult must be 65 years old or older, have a child or tax dependent in the home, or be determined disabled by SSA or DDD. The petitioner feels that the process took too long which gave SSA the opportunity to deny him before DDD could make an independent determination.

CONCLUSIONS OF LAW

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

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

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

IN REGARDS TO THE MEDICAID DENIAL FOR FAILURE TO COMPLETE THE REQUIRED INTERVIEW:

12. Fla. Admin. Code R. 65A-1.205 Eligibility Determination Process, states in 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. **If the Department schedules a telephonic appointment, it is the Department's responsibility to be available to answer the applicant's phone call at the appointed time.(emphasis added)** If the information, documentation or verification is difficult for the applicant to obtain, the eligibility specialist must provide assistance in obtaining it when requested or when it appears necessary.

13. The above authority explains that the Department must be available to complete an applicant's interview when it schedules it. In this case, the Department admitted that the petitioner attempted to complete the required interview; however, the Department was not available and did not contact him back once it was notated that he attempted to complete it. The undersigned concludes the Department was incorrect in its action to deny the petitioner's Medicaid application on March 15, 2016 for failure to complete the interview. However, since the Department subsequently completed the interview and honored the petitioner's Medicaid application, dated February 12, 2016, the undersigned has no recourse available to rectify the issue. The denial of the

application for failure to complete the interview has no bearing on the Department's subsequent determination that the petitioner was not eligible for Medicaid.

IN REGARDS TO THE MEDICAID DENIAL DUE TO NOT MEETING THE DISABILITY REQUIREMENT:

14. Fla. Admin. Code R. 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. For an individual 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…

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

> (a) *Determinations made by SSA*. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.
> (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under § 435.909.
> (b) *Effect of SSA determinations*.
> (1) Except in the circumstances specified in paragraph (c)(3) of this section-
> (i) **An SSA disability determination is binding on an agency until the determination is changed by SSA**. [emphasis added]

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

16. The above federal regulation explains that the respondent may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.912 on the same issues presented in the Medicaid application. The respondent is bound by the federal agency's decision unless there is evidence of a new disabling condition not reviewed by SSA. The petitioner confirmed that his condition has been reported to the SSA. SSA denied the petitioner's disability claim on March 24, 2016 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.

17. 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 March 24, 2016 and denying the petitioner's Medicaid disability application.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 30 day of June, 2016,

in Tallahassee, Florida.

Brandy Ricklefs

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@myflfamilies.com

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

Jun 20, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-02189

PETITIONER,

Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 88317

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter on April 28, 2016 at 9:45 a.m.

APPEARANCES

For the petitioner:

For the respondent: Susan Martin, ACCESS Operations Management Consultant

STATEMENT OF ISSUE

At issue is the respondent's action to deny petitioner's application for SSI-Related Medicaid benefits on the basis that he did not meet the disability Program requirement. Petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

By notice dated November 16, 2015, the respondent notified the petitioner his Medicaid application was denied because he did not meet the disability requirement. Petitioner requested a hearing on March 22, 2016.

On March 29, 2016, the respondent submitted a Motion to Dismiss indicating the petitioner's hearing request was not timely. On March 30, 2016, the undersigned issued a Preliminary Order to Dismiss (POD) based on said Motion. On April 7, 2016, petitioner responded to the POD disputing the Department's Motion and objecting to the dismissal. Therefore, the undersigned reserved ruling on said Motion until the Final Order was issued.

Petitioner did not submit any exhibits at the hearing. Respondent submitted two exhibits, entered as Respondent's Exhibits "1" and "2". The record was held open until close of business on May 9, 2016 for submission of additional evidence from the petitioner. On May 5, 2016, petitioner contacted the undersigned and requested an extension to provide the additional evidence until May 13, 2016. The undersigned granted petitioner's request and the record remained open until close of business on May 13, 2016. On May 10, 2016, additional evidence was received from the petitioner, and entered as Petitioner's Exhibit "1". The record closed on May 13, 2016.

FINDINGS OF FACT

1. Petitioner (53) applied for Medicaid Assistance on October 2, 2015 for himself. Petitioner reported on his application that he is disabled. Petitioner is not aged 65 or older and does not have any minor children.

2. On August 17, 2015, petitioner applied for disability with Social Security Administration (SSA). On November 10, 2015, SSA denied petitioner's application for disability. SSA denied petitioner with reason code N-32. The code N-32 means the denial was based on "Capacity for substantial gainful activity-other work, no visual impairment".

3. The Division of Disability Determination (DDD) is responsible for making State disability determinations on behalf of the respondent when an applicant applies for Medicaid on the basis of disability. Petitioner's application was referred to DDD on October 22, 2015.

4. On November 13, 2015, DDD denied petitioner Medicaid disability because it adopted the SSA denial reason code N-32. On November 16, 2015, the respondent mailed the petitioner a Notice of Case Action denying the petitioner's Medicaid application based on DDD's decision.

5. Petitioner declared his disabilities to be amputation of right fingers, seizure, knee degenerate and L3-L4 spinal segment. These are the disabling conditions petitioner reported to SSA. Petitioner explained his physician discussed with him that the L3-L4 spinal segment and knee degenerate would cause deterioration and worsening in time.

6. The record was held open for the petitioner to provide evidence of the conditions reported to SSA. Evidence presented by the petitioner shows on May 2, 2016, petitioner requested a reconsideration of the denial from SSA.

CONCLUSIONS OF LAW

7. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to § 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. Before addressing the merits of the case, it is necessary to establish if the hearing was requested timely. Fla. Admin. Code R. 65-2.046, sets forth time limits in which to request a hearing and states in part:

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

10. The Code of Federal Regulations 7 C.F.R. § 273.15 set forth the rules for Fair hearings and states in part:

> (a) Availability of hearings. Except as provided in §271.7(f), each State agency shall provide a fair hearing to any household aggrieved by any action of the State agency which affects the participation of the household in the Program.
> …
> (g) Time period for requesting a hearing. A household shall be allowed to request a hearing on any action by the State agency or loss of benefits which occurred in the prior 90 days. Action by the State agency shall include a denial of a request for restoration of any benefits lost more than 90 days but less than a year prior to the request. In addition, at any time within a certification period a household may request a fair hearing to dispute its current level of benefits.
> …
> (j) Denial or dismissal of request for hearing. (1) The State agency must not deny or dismiss a request for a hearing unless:
> (i) The State agency does not receive the request within the appropriate time frame specified in paragraph (g) of this section…

11. Fla. Admin. Code R. 65-2.044 Right to Request a Hearing.

> Any applicant/recipient dissatisfied with the Department's action or failure to act has a right to request a Hearing. He/she may do so when it is believed that:
> …
> (5) **Reconsideration of the assistance/**service benefits is refused or delayed (emphasis added)

12. The above authorities explain that for all programs, an individual must file a request for an appeal within 90 calendar days of the date of the written notification of an Action. In this case, the Department's running record comments indicate on February 1, 2016, petitioner contacted the Department and requested a reconsideration of the Medicaid benefits. The Department did not begin the hearing process properly and timely. As the petitioner did exercise his right to a hearing within 90 days from the date of the notice (November 16, 2015), the respondent's Motion to Dismiss is denied.

13. Adults who are not elderly and do not have minor children must be considered disabled to be eligible for Medicaid benefits; medical assistance is based on the same disability standards as those used by SSA. Fla. Admin. Code R. 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled Individuals with income less than the Federal Poverty Level. For an individual less than 65 years of age to received benefits, he must meet the disability criteria of Title XVI of the Social Security Act appearing in the Code of Federal Regulations 20 C.F.R. § 416.905, "Basic definition of disability for adults". The regulations state, in part:

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

14. 42 C.F.R. § 435.541 addresses determinations of disability and states in part:

> (a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...
> (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility...
> (b) Effect of SSA determinations. (1)(i) An **SSA disability determination is binding on an agency until the determination is changed by SSA...**
> (c) Determination made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist...
> (4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA, and...
> **(i) Alleges a disability condition different from, or in addition to, that considered by SSA in making its determination…**(emphasis added).

15. The cited authorities explain the Department cannot 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. In the petitioner's case, his disabling conditions have been reported to SSA. SSA denied the petitioner's disability claim. On May 2, 2016, petitioner requested a reconsideration of the denial from SSA; therefore, the decision is binding on the Department.

16. In careful review of the evidence and controlling legal authorities, the undersigned concludes that the Department correctly followed rule in adopting the SSA disability denial and denying the petitioner's Medicaid disability application.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 20 day of June, 2016,

in Tallahassee, Florida.

Cassandra Perez

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

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

May 31, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-02200

PETITIONER,

Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 20 Hendry
UNIT: 883CF

RESPONDENT.
________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on May 11, 2016 at 10:08 a.m. CDT.

APPEARANCES

For the Petitioner:

For the Respondent: Mary Dahmer, Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of March 7, 2016 denying Medicaid benefits. The Division of Disability Determination (hereafter "DDD") adopted the denial made by the Social Security Administration (SSA). In accordance with Fla. Admin. Code R. 65-2.060(1) the burden of proof was assigned to the petitioner.

PRELIMINARY STATEMENT

The Department submitted a packet of information that was admitted into evidence as Respondent's Exhibits "1" through "12".

FINDINGS OF FACT

1. The petitioner is 39-years-old.

2. The petitioner applied for SSA benefits based on his disability on January 28, 2016. The request was denied on March 4, 2016 with code N32, "Non-pay – Capacity for substantial gainful activity – other work, no visual impairment."

3. The petitioner filed an appeal of the SSA denial on March 16, 2016.

4. The petitioner applied for Medicaid with the Department on January 28, 2016 based on his disability. It is the responsibility of DDD to determine disability in absence of a disability determination made by the SSA. The Department subsequently bases its eligibility determination on the DDD decision when disability is a technical factor of eligibility. DDD listed the petitioner's primary diagnoses as disease with remarks "Hankerson Denial (N32) Title 16."

5. The Department denied the request as it adopted the disability determination made by the SSA. The Department did not make an independent disability determination.

6. The petitioner's list of disabling conditions includes insulin dependent

Petitioner submitted medical records documenting each of these conditions to the SSA as part of the disability determination; therefore, there are no new disabling conditions.

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

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

9. Federal Medicaid Regulations at 42 C.F.R. section 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 §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.

10. 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 March 4, 2016. The petitioner applied for Medicaid with the Department in January 2016. The SSA denial date is within 12 months of the Medicaid application date.

11. The petitioner submitted medical records related to each of his reported disabling conditions to the SSA; therefore, the undersigned concludes there are no new disabling conditions not known by the SSA.

12. In accordance with the above controlling authority, the undersigned concludes that the Department correctly adopted the federal SSA disability decision rather than make an independent decision on petitioner's disability request.

13. 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 (20007) (incorporated by reference).

14. 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.

DONE and ORDERED this 31 day of May, 2016,

in Tallahassee, Florida.

Gregory Watson

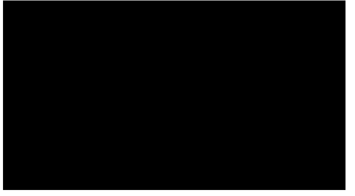
Gregory Watson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

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

Jun 07, 2016

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 16F-02203

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 April 29, 2016 at 10:00 a.m.

APPEARANCES

For the Petitioner:

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

STATEMENT OF ISSUE

At issue is whether the Respondent's action to deny Physical Therapy (PT) service hours that were requested for the Petitioner for the certification period December 7, 2015 through May 30, 2016 was correct. The Respondent bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

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

Appearing as a witness for the Respondent was Rakesh Mittal, M.D., Physician-Consultant with eQHealth Solutions, Inc. Respondent's composite Exhibit 1 was entered into evidence, consisting of documents such as a statement of matters, outpatient review history, denial notices, and therapy evaluation/plan of care.

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

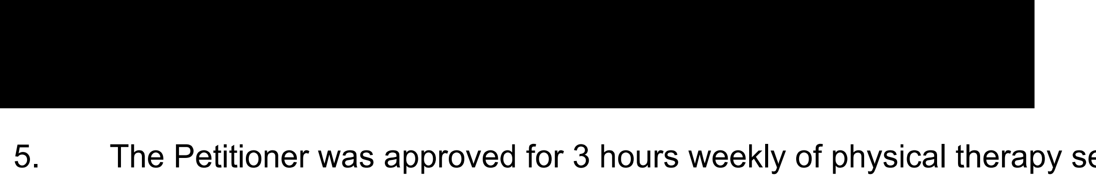
FINDINGS OF FACT

1. The Petitioner's PT service provider, Desire Health Care (hereafter referred to as "the provider"), requested the following PT service hours for the certification period at issue: 4 units (1 hour), three times per week, or a total of 3 hours weekly.

2. eQHealth Solutions, Inc. is the Quality Improvement Organization (QIO) contracted by the Respondent to perform prior authorization reviews for therapy services. The provider submitted the service request through an internet based system. The submission included, in part, information about the Petitioner's medical conditions; his functional limitations; and other pertinent information related to the household.

3. eQHealth Solutions' personnel had no direct contact with the Petitioner, his family, or his physicians. All pertinent information was submitted by the provider directly to eQ Health.

4. The medical information submitted by the provider contained, in part, the following information in regard to the Petitioner:



5. The Petitioner was approved for 3 hours weekly of physical therapy services in the prior certification period. He also currently receives occupational therapy services as well as 6 hours daily of home health aide services through the Medicaid program.

6. A Plan of Care was also submitted by the provider. The document was signed by a physician and outlined the type of assistance to be provided by the PT provider. The duties include, in part:

- Range-of-Motion exercises
- Heat treatment
- Massage
- Stretching exercises
- Caregiver education

7. A physician at eQHealth Solutions, who is board-certified in pediatrics, reviewed the submitted information and denied the requested PT services. This physician-reviewer wrote, in part: "… the request is for physical therapy to address range of motion exercises; however, the request has to be denied because the patient has a home health aide seven days a week. Physical therapy is not indicated." A notice of this determination was sent to all parties on March 4, 2016.

8. The above notice stated that a reconsideration review of this determination by eQHealth could be requested, and additional information could be provided with the

request for reconsideration. A reconsideration review was requested by the Petitioner's provider on March 10, 2016.

9. A second physician at eQ Health Solutions reviewed the submitted information and upheld the initial decision to deny the service. A notice of this reconsideration decision was sent to all parties on March 24, 2016.

10. The Petitioner thereafter requested a fair hearing and this proceeding followed. The Respondent administratively approved the requested service hours (3hours weekly) pending the outcome of the fair hearing process since these hours had been approved in the prior certification period.

11. The Respondent's witness, Dr. Mittal, testified that the denial of the Petitioner's request for PT services was appropriate because the plan of care provides for range-of-motion exercises, heat treatment, and massages, and these activities do not require a trained physical therapist. Nevertheless, he also stated it may be appropriate to approve 1 hour weekly of physical therapy so that the therapist may teach the caregivers (the home health aide and the family) to perform the therapy activities such as heat treatment and massage. He also stated some of the Petitioner's other needs should be addressed through occupational therapy, which he is also currently receiving.

12. The Petitioner's aunt testified that the physical therapy should continue at the current level because she needs help in transferring the Petitioner from his wheelchair or walker. She also stated the physical therapist helps her nephew with movements and exercises.

13. PT service for children is a covered service under the Medicaid State Plan in Florida. These services are provided in accordance with the Respondent's Therapy

Services Coverage and Limitations Handbook ("Therapy Handbook"), effective August, 2013.

CONCLUSIONS OF LAW

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

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

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

17. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the Respondent since the Petitioner had been previously approved for the PT services at issue, and the Respondent is seeking to reduce these services for the current certification period. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

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

19. The Petitioner has requested PT services. As the Petitioner is under 21 years of age, the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements apply to the evaluation of the Petitioner's eligibility for or amount of this service.

20. The Centers for Medicare and Medicaid Services, State Medicaid Manual makes available to all State Medicaid agencies informational and procedural material needed

by the States to administer the Medicaid program. It is the method by which the Health Care Financing Administration (HCFA) issues mandatory, advisory, and optional Medicaid policies and procedures to the Medicaid State agencies.

21. The State Medicaid Manual in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services section states in part:

> *5010. Overview*
> *A. Early and Periodic Screening, Diagnostic and Treatment Benefit.--Early and periodic screening, diagnostic and treatment services (EPSDT) is a required service under the Medicaid program for categorically needy individuals under age 21…*
>
> *5110. Basic Requirements*
>
> *OBRA 89 amended §§1902(a)(43) and 1905(a)(4)(B) and created §1905(r) of the Social Security Act (the Act) which set forth the basic requirements for the program. Under the EPSDT benefit, you[1] must 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 (PT services) is one of the services provided by the state to treat or ameliorate an individual's conditions under the State plan. Chapter 409.905, Fla. Stat., states, in part:

> *Any service under this section shall be provided only when medically necessary …*

[1] "You" in this manual context refers to the state Medicaid agency.

23. The issue to be decided is the medical necessity of the service or amount of service. The State Medicaid Manual provides for limitations on services as follows:

> *5110. Basic Requirements…*
> *…Services under EPSDT must be sufficient in amount, duration, or scope to reasonably achieve their purpose. The amount, duration, or scope of EPSDT services to recipients may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. Appropriate limits may be placed on EPSDT services based on medical necessity.*
>
> *5122. EPSDT Service Requirements*
> *F. Limitation of Services.--The services available in subsection E are not limited to those included in your State plan.*
> *Under subsection E, the services must be "necessary . . . to correct or ameliorate defects and physical or mental illnesses or conditions . . ." and the defects, illnesses and conditions must have been discovered or shown to have increased in severity by the screening services. You make the determination as to whether the service is necessary. You are not required to provide any items or services which you determine are not safe and effective or which are considered experimental.*
>
> *5124. Diagnosis and Treatment*
> *B. Treatment.--*
> *1. General. - You must make available health care, treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services. Treatment services may be limited as described in §5122 F.*

24. Once a service has been identified as requested under EPSDT, the Medicaid program determines the amount or necessity for that service based on the State of Florida's published definition of medical necessity. The Fla. Admin. Code R. 59G-1.010 defines medical necessity:

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

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

25. Based upon the information submitted by the Petitioner's provider, eQHealth Solutions completed a prior authorization review to determine medical necessity for the requested PT services.

26. In the Petitioner's case, the Respondent previously determined that physical therapy service is not medically necessary.

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. PT services are described on page 1-3 of the Therapy Handbook as follows:

Physical therapy is a specifically prescribed program to develop, maintain, improve or restore neuro-muscular or sensory-motor function, relieve pain, acquire a skill set, restore a skill set, or control postural deviations to attain maximum performance.
Physical therapy services include evaluation and treatment of range-of-motion, muscle strength, functional abilities and the use of adaptive and therapeutic equipment. Examples are rehabilitation through exercise, massage, the use of equipment and habilitation through therapeutic activities.

30. The Therapy Handbook on page 2-2 sets forth the requirements for PT 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 a PT service frequency greater than that approved by eQHealth Solutions. Rule 59G-1.010(166) (c), however, specifically states a prescription does not automatically mean the requirements of medical necessity have been satisfied.

32. The Respondent's witness, Dr. Mittal, stated that although the therapy activities listed in the plan of care (range-of-motion, heat treatment, massage) do not require the

services of a trained physical therapist, it would be appropriate to approve one hour weekly of physical therapy service to allow the therapist to train the caregivers in those activities.

33. The Petitioner's aunt stated the physical therapy services should continue because the Petitioner needs help in transferring and the therapist helps him with movements and exercises.

34. After considering all the documentary evidence and witness testimony presented, the undersigned concludes the Respondent has met its burden of proof in demonstrating it was correct in reducing the Petitioner's physical therapy services at this time. The caregivers can perform the activities listed in the therapy plan of care. In addition, the Petitioner receives daily home health aide services which can assist him with wheelchair or walker transfers. He also receives occupational therapy services to assist him in other areas. As stated by Dr. Mittal, it would be appropriate to approve one hour weekly of physical therapy service to allow the therapist to continue training the caregivers in the therapy activities.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is GRANTED, in part, and the Petitioner shall receive1 hour weekly of physical therapy services (4 units, 1 time per week) for the current certification period.

NOTICE OF RIGHT TO APPEAL

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

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

DONE and ORDERED this 07 day of June, 2016,

in Tallahassee, Florida.

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

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

Jun 15, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-02219

PETITIONER,
Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 04 Nassau
UNIT: 88779

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing telephonically in the above-referenced matter on May 4, 2016 at 10:18 a.m.

APPEARANCES

For the Petitioner: sister to the petitioner.

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

STATEMENT OF ISSUE

Petitioner is appealing the Department's action to not approve retroactive Medicaid beginning October 1, 2014 through September 30, 2015.

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

PRELIMINARY STATEMENT

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

The record was held open until 5:00 on May 11, 2016 to allow additional time for the petitioner to submit evidence. On May 11, 2016, the petitioner's representative requested an extension to the deadline to submit evidence. The petitioner's representative's request was granted and was given until 5:00 p.m. on May 27, 2016.

On May 27, 2016, the petitioner's representative requested another extension to submit evidence. Her request was granted. On June 1, 2016, the petitioner's representative submitted evidence, which was entered as the Petitioner's Exhibit 3.

The record was closed on June 1, 2016 at 5:00 p.m.

FINDINGS OF FACT

1. The petitioner was admitted into the [redacted] around in October 2014. The facility had been applying for Institutional Care Program (ICP) Medicaid on the petitioner's behalf since October 2014 but was denied each time due to her life insurance policy, with a cash value of $6551.66, not meeting the asset limit of $2000.

2. On February 8, 2016, the petitioner's sister applied once again for ICP Medicaid. The Department determined that the petitioner met the asset limit on February 8, 2016, when she took out a $4200 loan on her insurance policy to pay a portion of what is owed to the facility. The Department and approved her application for ICP Medicaid effective February 2016.

3. The petitioner's sister does not dispute the cash value of the petitioner's life insurance policy and believes the Department should grant a hardship in her sister's case because she did not understand what it meant to be over the asset limit. The petitioner's sister asserts that the facility informed her to put a loan on the life insurance policy. The petitioner's sister believes the Department should have informed her to do this when she first applied for ICP Medicaid. The petitioner's sister would like for the Department to grant approval for ICP Medicaid beginning October 2014 through September 2015. The petitioner submitted evidence post-hearing which shows that the life insurance policy's cash value was at $6551.66 as of November 1, 2015 *(Petitioner's Exhibit 1)*.

4. The Department's records show that the petitioner submitted applications for ICP Medicaid on January 13, 2015; February 15, 2015; April 20, 2015; June 25, 2015; October 19, 2015; and February 8, 2016.

5. The Department explained that the check written to pay the facility was in the petitioner's name and was dated January 28, 2016; however, the petitioner did not pay the facility until February 8, 2016 *(Respondent's Exhibit 2, pages 13 and 14)*. The Department contends that since the petitioner had access to the funds in January 2016 and did not pay the facility until February 8, 2016, she did not meet the asset limit for ICP Medicaid prior to February 2016. The Department further explained that even with the $2500 burial exclusion, she would still not be eligible. The Department explained that the petitioner would have been eligible for a higher asset limit of $5000 if her income was under the MEDS-AD income limit of $872. The petitioner's total countable

income is $1486 according to the Notice of Case Action dated March 11, 2016 *(Respondent's Exhibit 1).*

6. The Department explained that eligibility staff are not allowed to inform its clients on how to become eligible for ICP Medicaid because it is considered to be practicing law without a license. The Department further explained that its clients are advised to speak with an attorney regarding asset distributions. The Respondent's Exhibit 2, page 21, includes its Policy Transmittal Number I-13-07-0009, dated July 1, 2013 regarding "Unlicensed Practice of Law", which states in part: "This memorandum is to remind and caution staff about the unlicensed practice of law…Two examples that may be considered the unlicensed practice of law are: Telling a customer a specific amount of money to be deposited into a qualified trust account…Telling a customer how to spend down accumulated assets to qualify for Medicaid…"

CONCLUSIONS OF LAW

7. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to 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. Federal Regulations at 20 CFR §416.1201 Resources; general states:

> (a) *Resources; defined.* For purposes of this subpart L, resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance.

> (1) If the individual has the right, authority or power to liquidate the property or his or her share of the property, it is considered a resource. If a property right cannot be liquidated, the property will not be considered a resource of the individual (or spouse).
> …
> (b) *Liquid resources.* Liquid resources are cash or other property which can be converted to cash within 20 days, excluding certain nonwork days as explained in §416.120(d). Examples of resources that are ordinarily liquid are stocks, bonds, mutual fund shares, promissory notes, mortgages, life insurance policies…

10. The above regulation explains that an asset is cash, a liquid asset, real, or personal property owned by an individual that can be converted to cash. An example of a liquid asset is property that can be converted to cash within 20 days, such as a life insurance policy. The findings show that the petitioner owned a life insurance policy which had a cash value of $6551.66 for the period in question. Therefore, the undersigned concludes that the Department was correct to include as a liquid asset, the cash value from the petitioner's life insurance policy.

11. 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…"

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

13. The findings show that the petitioner had a life insurance policy with a cash value in the amount of $6551.66, which was not spent down to under the asset limit for

an individual until February 8, 2016. The petitioner's sister did not provide any evidence to show that the petitioner was under the asset limit for the requested months of coverage (October 2014 through September 2015). Therefore, the undersigned concludes the Department was correct to deem petitioner ineligible for ICP Medicaid prior to February 2016. Even with the $2500 burial fund exclusion, petitioner would still exceed her $2000 asset limit for ICP Medicaid during the time period 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.

DONE and ORDERED this 15 day of June, 2016,

in Tallahassee, Florida.

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

Copies Furnished To Petitioner
Office of Economic Self Sufficiency

Jun 21, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-02236

PETITIONER,

vs.

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

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice and agreement, Hearing Officer Patricia C. Antonucci convened hearing in the above-captioned matter on May 17, 2016 at approximately 2:00 p.m., Central Standard Time (CST). All parties and witnesses appeared via teleconference.

APPEARANCES

For the Petitioner: Petitioner's mother

For the Respondent: Cindy Henline, Medical/Health Care Program Analyst, Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is a decision by Respondent, the Agency for Health Care Administration (AHCA), through its contracted peer review organization, eQHealth Solutions, Inc., to terminate Petitioner's Prescribed Pediatric Extended Care (PPEC) services.

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

PRELIMINARY STATEMENT

At hearing, the minor Petitioner was not present, but was represented by her mother, who also presented three witnesses from Petitioner's PPEC facility: Administrator/Director of Nursing; Petitioner's Occupational Therapist; and Petitioner's Physical Therapist. Respondent was represented by Cindy Henline, Medical/Health Care Program Analyst, on behalf of AHCA. Respondent presented one additional witnesses: Rakesh Mittal, M.D., Physician Reviewer with eQHealth Solutions (eQHealth).

Respondent's Exhibits 1 through 12, inclusive, were admitted into evidence. Administrative Notice was taken of Fla. Stat. § 409.905, Fla. Admin. Code R. 59G-1.001, Fla. Admin. Code R. 59G-1.010, Fla. Admin. Code R. 59G-4.260, and pertinent pages of the September 2013 Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook (PPEC Handbook).

FINDINGS OF FACT

1. The Petitioner is a 1-year, 7-month-old female, born in 2014. She is diagnosed with The Petitioner suffers infrequent She also requires assistance with all activities of daily living (ALDs), is unable to walk independently, uses arm and leg braces, and has a speech delay. She has residual retinal scarring, but the effects of same on her vision are unknown at this time.

2. Petitioner resides at home with her single, working mother, who cares for three children and assists in caring for her own mother (Petitioner's grandmother), who is diagnosed with [redacted] Petitioner's mother has contacted various resources within the community for alternate day care or school options, but has been unable to locate a facility which would be able to meet Petitioner's needs. The mother notes that she is very nervous about leaving Petitioner with persons who have no medical training, given her fragility, and her history of being [redacted] while in someone else's care.

3. Petitioner is and has been eligible to receive Medicaid services at all times relevant to these proceedings.

4. On January 11, 2016, Petitioner underwent an EEG, the results of which were abnormal. More specifically, the results indicated:

5. More recently, on or about April 27, 2016, Petitioner suffered a seizure while at PPEC. The seizure was observed by PPEC staff, who monitored Petitioner for the remainder of the day, and instructed her mother as to home care, as well monitoring for signs of additional seizure activity. Since that event, PPEC staff (nursing, PT, OT, and ST) have all noticed regression in Petitioner's development, across domains. Her ambulation is limited to holding furniture while "cruising," or scooting on the floor. Her vocabulary has decreased, and she has demonstrated increased difficulty with

swallowing, which has set her back in terms of eating independently. The Petitioner has also started to engage in self-injurious behavior, such as head-banging.

6. On or about March 2, 2016, Petitioner's PPEC provider submitted a request on behalf of the Petitioner, to continue her previously authorized PPEC services into the new certification period, spanning March 3, 2016 through August 29, 2016.

7. 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).

8. On March 7, 2016 the PRO reviewed Petitioner's request for services and all supporting documentation. By letter dated March 9, 2016, the PRO notified Petitioner's provider of its decision to terminate PPEC, stating, in pertinent part:

> Clinical Rationale for Decision: The patient is a 16 month old with a history of [redacted] The patient's last seizure was in March 2015 and Keppra wean may be initiated. The patient is on an age-appropriate diet. The patient is on one scheduled medication. The patient is delayed and receives all therapies while at PPEC. The additional services are not warranted. There does not appear to be skilled services required and the patient does not meet the medical complexity requirement for PPEC services. The clinical information provided does not support the medical necessity of the requested PPEC services but 4 months will be approved to give the patient time to transition out of PPEC services. Partial approval: PPEC: Mon thru Fri:.: 3/3/2016 thru 7/3/2016.

9. The March 9, 2016 letter, which eQHealth 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.

10. In response to this notice, on or about March 14, 2016, Petitioner's provider requested reconsideration of the PRO's determination.

11. Via letter dated April 5, 2016, the PRO notified the provider of the results of its reconsideration review, stating, in part: "The information submitted for reconsideration provided no evidence to support the reversal of the previous decision. The original decision is upheld."

12. On March 23, 2016, Petitioner requested a hearing to challenge the PRO's determination. Petitioner's PPEC services continued at their previously authorized frequency, pending the outcome of his appeal.

13. At hearing, Dr. Mittal testified based upon his review of Petitioner's request for services, in conjunction with her Plan of Care, PPEC Assessment, and care coordination and progress notes. Dr. Mittal noted that while the Petitioner clearly requires precautions/monitoring, the only interventions indicated on the Plan (other than follow-up from therapies) are the administration of as-needed medications/nebulizer and age-appropriate ADL care.

14. Per Dr. Mittal, Petitioner's PPEC Assessments and notes reflect that Petitioner is not dependent upon mechanical devices, and does not have multiple seizures per day. While Dr. Mittal agrees that Petitioner requires Keppra, therapeutic services, and

assistance with ambulation and ADL development, he does not feel these needs indicate a medical necessity for continuation of PPEC.

15. With regard to the EEG results, Dr. Mittal indicated that although the results are abnormal, he does not know what Petitioner's baseline data shows, and as such, cannot determine what the specific results of her January, 2016 screening indicate. Dr. Mittal noted that [redacted] can have lifelong effects. He was not familiar with prior EEGs, nor was he aware of whether eQHealth had same on file.

16. It is Dr. Mittal's opinion that at this time, Petitioner does not require skilled nursing interventions on a regular basis, as her conditions have stabilized. Dr. Mittal opined that Petitioner's ambulation issues should continue to be addressed through PT, and her communication and swallowing issues should be addressed through ST, both of which, along with OT, Petitioner can request as a distinct service, outside of the PPEC setting.

17. Petitioner's PPEC providers emphasized that since eQHealth's reconsideration review, Petitioner's progress has halted. Her seizure from April, 2016 has resulted in regression on all fronts. The providers are concerned that if Petitioner were to transition into a regular/non-medical day care, she would be at significant risk of injury, as she cannot walk, cannot transition from a sitting position to kneeling/standing, cannot verbally make her needs known, and must now be monitored for self-injury. Both the OT and PT testified that although Petitioner is slotted for each type of therapy for a certain amount of time per week, those sessions only represent the time which the respective therapists actually bill as a distinct service. In reality, the therapists are present at the PPEC site throughout the day, and frequently intervene to protect

Petitioner from other children (who may fall into her or knock her over), adjust Petitioner's leg braces, work with her on her Plan of Care, and provide continuous oversight. As such, therapy services act as wraparound care, with ongoing interventions through the day. Additionally, while nursing services are, at present, mostly limited to monitoring and assessments, [redacted] testified that assessment, itself, is a skilled service, and something which (unlike administration of tube feedings, use of mechanical devices, etc.) can NOT be taught to non-nurses. It is [redacted] opinion that Petitioner is not ready to be transitioned out of PPEC at this time, particularly because her medical condition is less stable than it was, prior to April.

CONCLUSIONS OF LAW

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

19. Respondent, the Agency for Health Care Administration, administers the Medicaid Program. Legal authority governing the Florida Medicaid Program is found in Fla. Stat., Chapter 409, and in Chapter 59G of the Florida Administrative Code.

20. 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.

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

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

23. 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).)

24. 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.

25. 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 <u>to receive medical and therapeutic care</u> at a non-residential pediatric center." (emphasis added)

26. 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.
> (emphasis added)

27. 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)

28. 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.

29. Fla. Admin. Code Rule 59G-1.010(166) defines medical necessity, as follows:

> “Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;

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

30. As the petitioner is under the age of 21, a broader definition of medically necessary applies, to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) requirements. Both EPSDT and Medical Necessity requirements (both cited, above) have been considered in the development of this Order.

31. EPSDT augments the Medical Necessity definition contained in the Florida Administrative Code via the additional requirement that all services determined by the agency to be medically necessary for the *treatment, correction, or amelioration* of problems be addressed by the appropriate services.

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

> (1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.

(2) A state Medicaid plan must include “reasonable standards … for determining eligibility for and the extent of medical assistance” … and such standards must be “consistent with the objectives of” the Medicaid Act, specifically its EPSDT program.
(3) A state may adopt a definition of medical necessity that places limits on a physician’s discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, “a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case” and a treating physician is “required to operate within such reasonable limitations as the state may impose.”
(4) The treating physician assumes “the primary responsibility of determining what treatment should be made available to his patients.” Both the treating physician and the state have roles to play, however, and “[a] private physician’s word on medical necessity is not dispositive.”
(5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to provide medically unnecessary, albeit desirable, EPSDT services. However, a state’s provision of a required EPSDT benefit, such as private duty nursing services, “must be sufficient in amount, duration, and scope to reasonably achieve its purpose.”
(6) A state “may place appropriate limits on a service based on such criteria as medical necessity.” In so doing, a state “can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis” and my present its own evidence of medical necessity in disputes between the state and Medicaid patients (citations omitted).

33. In the instant case, PPEC is requested to treat and ameliorate the supervisory, monitoring, and continuous therapy needs which Petitioner’s health conditions require. As such, in a general sense, PPEC is in keeping with Fla. Admin. Code R. 59G-1.010(166)(1). Because PPEC is a recognized Medicaid service, it is consistent with generally accepted medical standards, per Fla. Admin. Code R. 59G-1.010(166)(3).

34. 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.

35. There is little evidence to suggest that the Petitioner is dependent upon 24-hour per day medical or nursing care, or that she is dependent upon life-sustaining medical intervention or equipment; however, it is apparent from Petitioner's EEG and recent seizure activity that her medical condition has not yet stabilized, her brain activity is still abnormal, and her development has regressed since April of 2016. As such, it is not clear that she should no longer be considered "Medically Complex" or "Medically Fragile." Moreover, pet her PPEC providers' testimony, she *does* require "intermittent continuous therapeutic interventions or skilled nursing care."

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 not met its burden of proof to terminate PPEC. While termination may be appropriate in the future, if and when Petitioner's condition is stable, the results of additional assessments reflect progress or plateau, and/or when she is strong enough to obtain therapy services in an outpatient or school setting, based upon her recent health setbacks, termination at this time is premature.

37. In terms of planning for any future termination, Petitioner's mother is encouraged to coordinate with AHCA, so as to determine Petitioner's options for other services, as needed. If any subsequent requests for PPEC are denied, she will retain the right to appeal that/those, specific denial(s).

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 21 day of June, 2016,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
Marshall Wallace, Area 1, AHCA Field Office Manager

Jun 22, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-02270

PETITIONER,

Vs.

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

RESPONDENT.

_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on May 25, 2016 at approximately 10:30 a.m.

APPEARANCES

For Petitioner: Petitioner's mother

For Respondent: Lisa Sanchez
Senior Human Services Program Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is Respondent's denial of Petitioner's request for a fixed-partial bridge. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

Petitioner's mother represented her at the hearing. She gave oral testimony, but did not move any exhibits into evidence. Respondent moved Exhibits 1 through 13 into evidence at the hearing.

The following individuals were present as witnesses for Respondent:

- Dr. Andrea Spurr, Dental Consultant, Liberty Dental
- Stephanie Shupe, Regulatory Research Coordinator, Staywell
- Kelly Carr, Vendor Account Manager, Staywell

FINDINGS OF FACT

1. Petitioner is a 16-year-old female. Petitioner is enrolled with Staywell as her Managed Medical Assistance (MMA) plan. Liberty Dental Plan ("Liberty") is Staywell's dental vendor.
2. On February 9, 2016, Petitioner's dentist submitted a pre-treatment authorization for a fixed bridge on teeth #'s 18 through 20.
3. On February 11, 2016, Staywell issued a Notice of Action denying the request on the basis that it was not covered by the plan.
4. Petitioner requested an internal appeal of the denial. On March 15, 2016, Liberty issued an Appeal Recommendation, recommending that Staywell uphold the denial on the basis of it not being a covered benefit.
5. Dr. Spurr testified that a medical necessity review was not performed because the case was auto-adjudicated as not covered. She said fixed partial bridges are not covered for children, except pediatric partial bridges. (Respondent's Exhibit 9). She testified that a pediatric partial bridge is usually used on young children who lose

their front teeth and it holds the teeth in place until the new one grows in. She said this would not be appropriate for Petitioner because she only has her adult teeth.

6. Dr. Spurr said removable bridges are covered. Petitioner had tooth # 19 extracted and had a root canal performed tooth # 18, which is awaiting a crown. Dr. Spurr said tooth # 18 is an anchor tooth and it is too weak for a removable device. Dr. Spurr testified a fixed bridge or an implant of the missing tooth would be common practice in Petitioner's situation, but the fixed bridge is simply not covered.

7. Dr. Spurr said the teeth would shift some over time. She said it would happen over a long period of time and that it does not cause a problem for most people. However, she said it can eventually cause a problem with chewing, but that would not happen for a long time, and not in the near future.

8. Staywell's contract with Respondent requires them to "provide full dental services for all enrollees age 20 and below." (Respondent's Exhibit 12). The contract continues, providing: "In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those in the Medicaid Dental Services Coverage and Limitations Handbook."

CONCLUSIONS OF LAW

9. By agreement between the Agency for Healthcare Administration ("AHCA" or "Agency") and the Department of Children and Families ("DCF"), the Office of Appeal Hearings has jurisdiction to conduct this hearing pursuant to § 120.80, Fla. Stat.

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

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

12. The standard of proof in an administrative hearing is a preponderance of the evidence. Fla. Admin. Code R.65-2.060(1). The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

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

14. The Florida Medicaid Dental Services Coverage and Limitations Handbook, November 2011 (“Dental Handbook”), is promulgated into law by Chapter 59G of the Florida Administrative Code[1].

15. Page 1-2 of the Dental Handbook provides:

> The adult Medicaid dental services program provides medically-necessary, emergency dental procedures to alleviate pain or infection to eligible Medicaid recipients age 21 and older.
>
> ….
>
> The children’s dental program provides full dental services for all Medicaid eligible children age 20 and below.

16. If the children’s dental program provides full dental services for all Medicaid eligible children age 20 and below, it logically follows that a fixed partial bridge is, in fact, a covered service under the Medicaid program.

17. Pursuant to page 2-2 of the Dental Handbook, Medicaid will only reimburse for services that are medically necessary.

---

[1] The November 2011 Handbook has subsequently been replaced by the May 2016 Handbook. At the time Respondent took the action, the November 2011 Handbook was in effect.

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

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

19. Since the Petitioner is under 21 years of age, a broader definition of medical necessity applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPDST) requirements. Section 409.905, Fla. Stat., Mandatory Medicaid services, provides that Medicaid services for children include:

> (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

20. Under the above statute, the Agency offers dental services as an EPSDT service to Medicaid-eligible recipients less than 21 years of age.

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

> (1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.
> (2) A state Medicaid plan must include "reasonable standards … for determining eligibility for and the extent of medical assistance" … and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.
> (3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."
> (4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."
> (5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to provide medically unnecessary, albeit desirable, EPSDT services. However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."
> (6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and may present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)) (emphasis added).

22. Consistent with these requirements, the state is obligated to provide services to recipients under 21 years of age, but only to the extent such services are medically necessary. The definition of medical necessity for services provided under the EPSDT benefit is established by the state and the state is authorized to establish the amount, duration, and scope of such services.
23. In the instant-matter, Liberty did not undertake a medical necessity analysis of Petitioner's request under the assumption that the fixed partial bridge is not a covered service. However, the plain language of the Dental Handbook states that full dental services are provided to children under 21 years of age. Staywell's contract with AHCA requires that they cannot be more stringent than the limitations imposed in the Dental Handbook.
24. Despite Liberty not performing a medical necessity analysis, Dr. Spurr candidly admitted that a fixed partial bridge would be a common practice for Petitioner's situation.
25. The undersigned has reviewed all pertinent rules and regulations, including EPSDT requirements. Petitioner has met her burden of proof to show, by the greater weight of the evidence, that denying her the fixed partial bridge was incorrect.

DECISION

Based upon the foregoing, Petitioner's appeal is GRANTED. Respondent is directed to provide Petitioner with the fixed partial bridge, consistent with her request.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this ___22_ day of ___June_________, 2016,

in Tallahassee, Florida.

Rick Zimmer

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

Copies Furnished To [redacted] Petitioner
Judy Jacobs, Area 7, AHCA Field Office

Jun 17, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-02271

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 April 29, 2016 at 1:30 p.m.

APPEARANCES

For the Petitioner: Petitioner's aunt

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

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny the petitioner's request for home health/personal care service (PCS) hours was correct. The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner submitted a physician's letter and medical records as evidence for the hearing, which were marked as Petitioner Exhibit 1. The petitioner was present for the hearing and was represented by her aunt. Also appearing as a witness for the petitioner was another aunt

Appearing as a witness for the respondent was Esther Pierre-Louis, Grievance and Appeals Supervisor from Prestige Health Choice, which is the petitioner's managed care health plan.

Respondent submitted the following documents as evidence for the hearing, which were marked Respondent composite Exhibit 1 – authorization request, denial notice, and medical records.

FINDINGS OF FACT

1. Petitioner is a twenty (20) year old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. She receives Medicaid services through Prestige Health Choice medical plan. Her medical conditions include developmental delay, learning disability, and obesity.

2. The Agency For Health Care Administration (AHCA) is responsible for management of the managed medical assistance 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 Prestige Health Choice provide services to Medicaid recipients pursuant to a contract with AHCA.

3. On or about January 13, 2016, the petitioner's treating physician submitted an authorization request to Prestige for approval of 4 hours daily of home health care services, 5 days per week.

4. On or about January 20, 2016, Prestige sent the petitioner a Notice of Action denying the requested home health services. The denial notice stated the following concerning the reason for the denial:

> Deny auth request for Home Health Aide as not meeting the AHCA (Medicaid) definition of medical necessity. Records do not show the specific need for assisting member with activities of daily living (ADL) including ambulation, eating, bathing. Records also do not show this is to assist the member with adherence to self-administered medications and/or special diet.

5. Thereafter, the petitioner initiated an internal grievance/appeal with Prestige, and subsequently requested a Medicaid Fair Hearing.

6. The petitioner's representative testified her niece needs the requested home health care hours because she requires assistance with activities of daily living (ADLs). In particular, the petitioner cannot cook for herself, cannot clean her room, and she needs assistance with basic hygiene (especially skin care) and dental care. The petitioner lives with her grandmother, but the grandmother is 80 years old and cannot provide assistance according to the representative. The petitioner has completed high school and attends a supported employment program 15 hours weekly. She is on a waiting list to receive services from the Agency for Persons with Disabilities (APD). The petitioner is seeking a continuous 4 hours of home health services daily, from the late morning to the early afternoon.

7. The respondent's witness stated the requested services were denied because the petitioner's physician submitted insufficient information to justify the need for the services. She also stated Prestige attempted to obtain additional information from the physician, but no additional information was ever submitted.

8. Personal Care Service (PCS) for individuals under 21 years of age is a covered service under the Medicaid State Plan in Florida. These services are provided in accordance with the Respondent's Home Health Services Coverage and Limitations Handbook (October 2014).

CONCLUSIONS OF LAW

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

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

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

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

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. The petitioner has requested personal care or home health 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.

15. 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.

16. 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

[1] "You" in this manual context refers to the state Medicaid agency.

> regardless of whether the service or item is otherwise included in your Medicaid plan.

17. The service the petitioner has requested (personal care or home health aide 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:

> 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.

18. 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.

19. 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.

20. Based upon the information submitted by the petitioner's physician, Prestige Health Choice completed a prior authorization review to determine medical necessity for the requested personal care services.

21. In the petitioner's case, the respondent (through Prestige) has determined that medical necessity for the requested service has not been established.

22. 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.

23. 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.

24. The AHCA contract with managed care plans such as Prestige includes a provision for home health services, as follows:

(a) The Managed Care Plan shall provide Home Health Services. 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.

(b) 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.

25. The petitioner's request for service is also 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:
- 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.

26. 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.

27. Page 2-25 of the Handbook imposes a parental or caregiver 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 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.

28. 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

29. The petitioner's physician ordered a service frequency greater than that approved by the respondent or Prestige. Rule 59G-1.010(166) (c), however, specifically states a prescription does not automatically mean the requirements of medical necessity have been satisfied.

30. The Prestige representative stated the requested services were denied because insufficient information was submitted by the petitioner's physician to justify the need for the daily home health services.

31. The petitioner's aunt stated the petitioner needs the requested services to help her with activities such as skin care, dental care, cooking, and cleaning.

32. After considering all the witness testimony and documentary evidence submitted, the undersigned concludes that the petitioner has not demonstrated that the respondent

was incorrect in denying the requested home health services. The medical records and physician letter submitted do not establish that the petitioner needs assistance with activities of daily living such as eating, bathing, and toileting. Her need for skin care is documented, however, there is no documentation to indicate the petitioner's grandmother is unable to assist her with skin care. Similarly, the physician letter outlines the petitioner's needs for assistance with IADLs such as cooking, cleaning, and financial management but there is no indication that the grandmother cannot assist with those types of activities. In summary, the petitioner has not established medical necessity for 4 hours of home health services daily, in accordance with the applicable Medicaid guidelines set forth above.

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 17 day of June, 2016,

in Tallahassee, Florida.

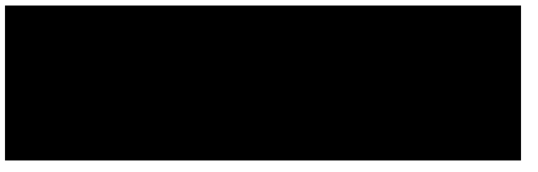
Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

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

Jun 29, 2016

Office of Appeal Hearings
Dept. of Children and Families

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



PETITIONER,

vs.

APPEAL NO. 16F-02272

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 08 Gilchrist
UNIT: AHCA

and

PRESTIGE HEALTH CHOICE,

RESPONDENTS.
_________________________________/

FINAL ORDER

Pursuant to notice, Hearing Officer Patricia C. Antonucci convened hearing in the above-captioned matter on May 18, 2016 at approximately 10:03 a.m. All parties and witnesses appeared via teleconference.

APPEARANCES

For the Petitioner:

For the Respondent, AHCA: Selwyn Gossett, Medical/Health Care Program Analyst, Agency for Health Care Administration

For the Respondent, Prestige: Herbert Peeples, Pharmacist

STATEMENT OF ISSUE

At issue is a decision by Respondent, the Agency for Health Care Administration (AHCA or “the Agency”), through its contracted health plan, Prestige Health Choice

(Prestige) to deny Petitioner's request for [redacted] (100mg). Petitioner contends that this medication was previously approved, and billed through his insurance. Due to confusion regarding whether the [redacted] was previously authorized, Prestige has been assigned the burden of proving, by a preponderance of the evidence, that its current denial is improper.

PRELIMINARY STATEMENT

The Agency for Health Care Administration is responsible for administering Florida's Medicaid Program. AHCA contracts with managed care plans to provide services, including prescription drug services, to Medicaid recipients residing in the State of Florida. The managed care plans, in turn, provide prior authorization reviews for all requested goods and services.

Consistent with this arrangement, Petitioner submitted a request for [redacted] to his health plan, Prestige. Prestige then reviewed this request to determine whether the specific medication requested was one covered by the plan and/or whether it was medically necessary to meet Petitioner's needs.

At hearing, the Petitioner was present, and acted as his own representative. Although Petitioner had not received Respondent's proposed evidence packet, Petitioner opted to proceed with hearing, and Respondent agreed to send a second copy of the evidence to Petitioner, for his records. Petitioner did not wish to file any post-hearing response upon receipt of the documentation.

Respondent was represented by Selwyn Gossett, Medical/Health Care Program Analyst, on behalf of AHCA. Two witnesses from Prestige were also present: Rachelle Narcisse, Appeals Coordinator, and Herbert Peeples, Pharmacist. In accordance with

42 C.F.R. § 438.408(f)(2), Prestige is hereby joined as a party/co-Respondent to this appeal.

Respondent's Exhibits 1 through 5, inclusive, were admitted into evidence. The record was held open for Respondent to supplement the record with additional documentation to show that Prestige had not received or paid any claims for [redacted] at any point prior to the instant request. The undersigned instructed the parties that if sufficient documentation to establish the lack of previous authorization was not provided, she would err on the side of caution and assigned the burden of proof to Respondent. No objections were raised.

Prestige did provide a written statement, signed by Mr. Peeples, concerning his conversation with Petitioner's provider pharmacy (a conversation which he also referenced at hearing); however, as this document constitutes uncorroborated hearsay, it does not suffice to establish a finding of fact with regard to prior authorization. As such, the statement has not been entered into evidence, and the burden of proof has been assigned to Respondent.

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, who suffered from [redacted] As part of his treatment, Petitioner had both testicles surgically removed.

2. At all times relevant to this proceeding, Petitioner has been eligible for and receiving Medicaid services, through Prestige Health Choice.

3. On or about February 16, 2016, Petitioner's treating physician submitted to Prestige a preauthorization request for [redacted] In support of this request, the physician also provided medical records establishing the failure of other, similar medications. The records note that Petitioner has been taking [redacted] to treat, per his physician: [redacted]

4. Following review of the request and all supporting documentation, Prestige issued to Petitioner a February 19, 2016 Notice of Action, stating that it had denied the request. As a reason for its denial, Prestige checked a box to indicate [redacted] was not medically necessary because it does not "meet medical standards… [without being] experimental or investigational." The Notice further specified:

> Your prior authorization has been denied. Your request does not meet pharmacy coverage criteria. Treatment of erectile dysfunction is not a covered benefit under Florida Medicaid.

5. Prestige's Notice of Action informed Petitioner of his grievance and appeal rights, noting, in pertinent part:

> You can ask for an appeal in writing or by calling us. Your case manager can help you with this, if you have one. We must receive the request *within 30 days* of the date of this letter. Here is where to call or send your request….

6. On or about February 29, 2016, Petitioner called Prestige to request an appeal. This call was confirmed via a March 4, 2016 "Receipt of Oral Appeal Letter," which informed Petitioner that Prestige had documented his phone call, but:

> You need to send in your Appeal in writing by March 10, 2016. We are sending you a form that you can use or you can just write a letter in your own words…. If we have not received your Appeal in writing with ten (10) days from your call, we will not consider your Appeal.

7. Petitioner contends that upon receipt of this letter, he began preparing a written confirmation of his request for appeal; however, before he had opportunity to finish and mail same, he received an additional notice.

8. Indeed, via notification dated March 11, 2016, Prestige informed the Petitioner:

> We are closing your file, because we have not gotten your appeal in writing by March 10, 2016. We will not be able to investigate your Appeal. It is too late to submit an Appeal in writing.

9. On March 24, 2016, Petitioner filed a hearing request with the Office of Appeal Hearings, to challenge Prestige's denial.

10. At hearing, Petitioner stated that he had been receiving [redacted] paying an out-of-pocket co-pay, and was on his 7th refill, when he requested more [redacted] from Prestige, and received their denial. Petitioner was not aware of how his prescription was billed, but understood that it was paid for by insurance. The Petitioner has no other insurance coverage, and does not understand why Prestige won't authorize the prescription drug.

11. Prestige explained that it did not show any prior authorizations for the medication, that [redacted] is not a medication typically covered by Florida Medicaid and/or Prestige, and that Prestige members do not incur co-payments at the point of sale (i.e., their pharmacy) for any drug benefits. As such, it was Prestige's position that the health plan, itself, had never previously approved [redacted] for Petitioner, but that he may have obtained it via pharmaceutical voucher, along with his doctor's prescription.

12. Prestige further explained that because [redacted] is not covered for the treatment of [redacted] under Florida Medicaid, and because Prestige had no other

indication as to its medical necessity for Petitioner, the [redacted] had been denied as a non-covered benefit.

13. It is Petitioner's position that he does not suffer from [redacted] as his impotence results from the surgical removal of his testicles. He does not agree with the diagnosis provided by his physician.

14. Petitioner also expressed frustration with Prestige's appeal process, noting that he followed their instructions for appealing the denial, received additional notices requiring a written request, and then had insufficient time to mail back same before Prestige denied his appeal.

15. It is Prestige's position that their contract with AHCA governs how appeals and grievances occur, and that they are following protocol by requiring written follow-up to verbally requested appeals. However, Prestige agreed to review the language of their notices to ensure information was properly conveyed to Prestige members. Prestige also agreed to assign to Petitioner a case manager, who can assist the Petitioner in coordinating with his physicians and submitting any additional or subsequent requests for services.

CONCLUSIONS OF LAW

16. The Department of Children and Families Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 120.80, Florida Statutes.

17. The Florida Medicaid program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. It is administered by AHCA.

18. This hearing was held as a *de novo* proceeding, pursuant to Fla. Admin. Code R. 65-2.056.

19. The standard of proof in an administrative hearing is “preponderance of the evidence,” as provided by Fla. Admin. Code R. 65-2.060(1).

20. Section 409.912, Florida Statutes, provides that AHCA shall purchase goods and services for Medicaid recipients in the most cost-effective manner possible, consistent with the delivery of quality medical care. To this end, the Agency has contracted with managed care organizations to provide medical coverage to enrolled recipients. In the instant case, Petitioner’s managed care plan is Prestige.

21. The July 2012 Florida Medicaid Provider General Handbook (“Provider Handbook”) is incorporated by reference into Fla. Admin. Code R. 59G-5.020. 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.
> (emphasis added)

22. Page 1-30 of the Provider Handbook states: “An HMO’s services cannot be more restrictive than those provided under Medicaid fee-for-service.”

23. All Medicaid covered services must be “medically necessary” as defined by law. 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.

24. In order to aid determination of the medical necessity of specific goods and services, the Agency has formulated certain guidelines, which govern its reviews. These guidelines are "consistent with generally accepted professional medical standards… and [are] not experimental or investigational."

25. As Prestige's own guidelines cannot be more restrictive than those that govern fee-for-service Medicaid, review of AHCA's guidelines is appropriate to establish a baseline for service provision.

26. AHCA's Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook (July 2014) ("the Handbook") is promulgated into law by Florida Administrative Code Rule 59G-4.250. On page 2-9, the Handbook specifies: "Drugs prescribed for [redacted]… are not covered."

27. In terms of expanded benefits -- i.e., those in addition to what is required under fee-for-service Medicaid -- AHCA has also published a "List of Approved State Plan Expanded Benefits," formatted as a Microsoft Excel spreadsheet, which is accessible via the Agency's website.[1] There is no indication that Viagra is covered as an expanded health plan benefit.

28. Absent evidence that [redacted] is not prescribed to Petitioner for [redacted] [redacted] *and* absent any evidence to suggest that Prestige is required to cover [redacted] as a prescribed drug service, the undersigned is unable to conclude that Respondent's denial was improper.

29. The hearing officer agrees with Petitioner that Prestige's instructions regarding internal appeals are confusing and misleading. Prestige specifically instructs members that they may file an appeal within 30 days of a denial, by writing <u>or</u> calling Prestige, only to then require written confirmation of all verbal requests. Additionally, Petitioner was allotted only 10 days from the date of his call (*not* 10 days from the date of Prestige's "Receipt of Oral Appeal Letter") to submit a written response, and received a denial of the request for review before he had a chance to mail out his written statement. Finally, although Prestige's March 11, 2016 rejection of appeal notice informs Petitioner that "It is too late to submit an appeal in writing," based upon Prestige's February 29, 2016 Notice of Action, Petitioner had until March 30, 2016 to request an appeal, in any form. It is troubling that Prestige allows such little turnaround time for its members to comply with instructions, provides conflicting information, and

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[1] Said list is available at: http://portal.flmmis.com/FLPublic/Provider_ManagedCare/Provider_ManagedCare_Support/Provider_Expanded%20Benefits/tabId/138/Default.aspx (last accessed June 24, 2016).

rejects appeals that are, indeed, timely, rather than facilitating communication and better customer service to serve their clientele. However, as frustrating as this process remains, there is no relief for Petitioner which the undersigned has authority to provide, in this regard.

30. Petitioner is strongly encouraged to continue working with his providers and with Prestige, to follow up with his case manager, as needed, and to continue seeking medical interventions that best match his needs. Prestige is encouraged to assist Petitioner in finding covered benefits and/or in requesting/obtaining any other goods and services that may be medically necessary. Should Petitioner wish to submit a new request for any service or prescribed drug, he is free to do so at any time. If said request is denied, he will be notified in writing, and will retain the right to appeal that, specific denial.

DECISION

Based upon the foregoing, Respondent's denial is AFFIRMED, and Petitioner's appeal is hereby DENIED.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 29 day of June, 2016,

in Tallahassee, Florida.

Patricia C. Antonucci
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: appeal.hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Debbie Stokes, Area 4, AHCA Field Office Manager
Medicaid Fair Hearing; Prestige Health Choice

May 23, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-02275
APPEAL NO. 16F-01967
APPEAL.NO. 16F-02178

PETITIONER,

Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 PALM BEACH
UNIT: 88322

B - Benefit Recovery (BR)

RESPONDENT.

_______________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on April 25, 2016 at 11:56 a.m.

APPEARANCES

For the Petitioner:

For the Respondent: Guillermo Carton, senior human service program specialist II, Benefit Recovery Unit.

ISSUE

The petitioner is appealing the Department's action to establish and collect multiple client error overpayment claims in the Food Assistance Program (FAP) benefits.

The petitioner is also appealing the respondent's action to establish and collect multiple client error overpayment claims in the Cash Assistance Program benefits.

The petitioner is also appealing the respondent's action to establish and collect client error overpayment claims in the Medicaid Program benefits. In accordance with Fla. Admin. Code R. 65-2.060 (1), the respondent carries the burden of proof by a preponderance of evidence in all appeals.

PRELIMINARY STATEMENT

At the hearing, the respondent presented one exhibit which was accepted into evidence and marked as Respondent's Composite Exhibit 1. The petitioner did not present any exhibits. The record was held open until April 27, 2016 for the petitioner to provide her evidence. She provided one exhibit which was accepted into evidence and marked as Petitioner's Composite Exhibit 1. The record was closed on April 27, 2016.

The respondent asked for the appeals to be dismissed as the petitioner failed to timely appeal the overpayment claims. The parties were advised during the hearing the undersigned was reserving ruling on jurisdiction until the Final Order was issued.

Present as an observer was Rhonda Cooley, program administrator.

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. For the Cash Assistance program, the respondent sent the petitioner at least five Notices of Case Action, informing her of the five overpayments. The dates, amounts and periods are as follows:

Date of Notice	Claim amount	Period of Overpayment
August 15, 1996	$1,060	February 1, 1993 to June 30, 1993
April 25, 1997	$1,597	June 1995 to September 1995 and July 1998 to October

		1998
June 23, 1997	$18	October 1, 1996 to October 31, 1996
May 15, 2000	$1,022	November 1996 to January1997
May 24, 2000	$18	March 1, 1997 to March 31, 1997

2. For the FAP benefits, the Department sent the petitioner two Notices of Case Action dated May 24, 2000 and June 21, 2000. The notices informed her of an overpayment claim in the amount of $4,036. The notices were for the period March 1, 1998 through March 31, 1999.

3. For the Medicaid program, the Department sent the petitioner a Notice of Case Action dated June 6, 2001, for an overpayment claim of $544. The notice was for the period April 1, 1999 through October 31, 1999.

4. The notices were mailed to [redacted] and [redacted] which was the address where the petitioner received her mail. The petitioner alleges she did not receive any of the above notices and was not aware of the claim until her income tax refund was intercepted in January 2015. The petitioner alleged she moved from that address as her home had been foreclosed. The notices advised of the right to a hearing within 90 days from the mailing date for FAP overpayments and 30 days from the mailing date for Cash Assistance overpayments.

5. The petitioner signed a Waiver of Administrative Disqualification Hearing form on April 25, 1997, for the Cash Assistance claim of $1,598 which occurred during the period June 1995 to September 1995 and July 1996 to October 1996. The Waiver was mailed to [redacted]

6. On June 6, 1997, the Department sent the petitioner a Notice of Disqualification informing that she will be disqualified for six months in the Cash Assistance program.

7. The petitioner requested a hearing on March 15, 2016 to appeal the respondent's action.

8. The petitioner stated she did not have any problems receiving her other mail but did not receive any mail from the Department. The respondent received no returned mail for the notices.

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.

JURISDICTION:

11. Federal Food Stamp Regulations at 7 CFR § 273.16 Disqualification for intentional Program violation states:

> (f) *Waived hearings.* Each State agency shall have the option of establishing procedures to allow accused individuals to waive their rights to an administrative disqualification hearing. For State agencies which choose the option of allowing individuals to waive their rights to an administrative disqualification hearing, the procedures shall conform with the requirements outlined in this section.
> (D) An opportunity for the accused individual to specify whether or not he/she admits to the facts as presented by the State agency. This opportunity shall consist of the following statements, or statements developed by the State agency which have the same effect, and a method for the individual to designate his/her choice:

(*1*) I admit to the facts as presented, and understand that a disqualification penalty will be imposed if I sign this waiver;
(2) *Imposition of disqualification penalties.* (i) If the household member suspected of intentional Program violation signs the waiver of right to an administrative disqualification hearing and the signed waiver is received within the timeframes specified by the State agency, the household member shall be disqualified in accordance with the disqualification periods specified in paragraph (b) of this section.
(**ii) No further administrative appeal procedure exists after an individual waives his/her right to an administrative disqualification hearing and a disqualification penalty has been imposed. The disqualification penalty cannot be changed by a subsequent fair hearing decision. The household member, however is entitled to seek relief in a court having appropriate jurisdiction. The period of disqualification may be subject to stay by a court of appropriate jurisdiction or other injunctive remedy. (emphasis added)**
(iii) Once a disqualification penalty has been imposed against a currently participating household member, the period of disqualification shall continue uninterrupted until completed regardless of the eligibility of the disqualified member's household. However, the disqualified member's household shall continue to be responsible for repayment of the overissuance which resulted from the disqualified member's intentional Program violation regardless of its eligibility for Program benefits.

12. The petitioner signed the waiver on April 25, 1997(claim amount $1,597 Cash Assistance) and the respondent issued a notice on June 6, 1997, notifying the petitioner that the disqualification period would begin. The above federal authority explains the Department has the option to allow an individual accused of an IPV to waive his or her right to an administrative disqualification hearing (ADH). If the Department chooses to allow an individual to waive his or her right to an ADH, the procedures must meet certain requirements. An individual is given the opportunity to choose whether he or she admits to the allegations made by the Department. The individual may choose from one of the three statements listed on the waiver, one of which includes the statement that the accused admits to the allegations and it is understood that by signing the waiver, he or she understands that a disqualification penalty will be imposed. Once the

waiver is signed, checking the selection of accepting the penalty, the individual will be disqualified. If the individual signs the waiver and the disqualification penalty has been imposed, no further administrative appeal procedures are available and the disqualification penalty cannot be changed by a subsequent fair hearing decision. The above authority provides the petitioner the right to seek relief in a court having appropriate jurisdiction.

13. Fla. Admin. Code R. 65-2.046 sets forth the time limits in which to request a hearing and states in relevant part, "(1) The appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs."

14. The petitioner argued that she did not receive any of the notices dated August 15, 1996, April 25, 1997, June 23, 1997, May 15, 2000 May 24, 2000, May 24, 2000, June 21, 2000 and June 6, 2001, informing of the Cash Assistance overpayments, Food Assistance overpayment and Medicaid overpayment. The respondent received no returned mail. 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). It is concluded that the petitioner received the notices in question.

15. It is necessary to establish if a hearing was requested timely. Fla. Admin. Code R. 65-2.046 Time Limits in Which to Request a Hearing, sets forth regulatory requirements 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.

16. The petitioner made an initial request for hearing on March 15, 2016. As the request for hearing was made beyond 90 days from the date of the mailing of the notices, the hearing officer lacks jurisdiction to rule on the merits of the case. The respondent's request to dismiss the hearing as untimely is granted.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are dismissed as non-jurisdictional.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this ___23_ day of ___May_________, 2016,

in Tallahassee, Florida.

Christiana Gopaul Narine
____

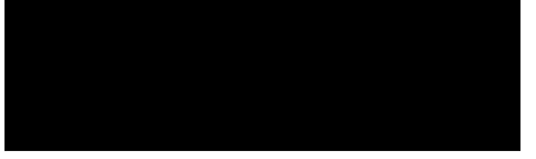
Christiana Gopaul-Narine
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

Jun 17, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS



APPEAL NO. 16F-02318

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 DADE
UNIT: AHCA
RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 3, 2016, at 1:30 p.m.

APPEARANCES

For the Petitioner:

For the Respondent: Monica Otalora, Senior Program Specialist

STATEMENT OF ISSUE

At issue is the Agency action partially denying the Petitioner's request for additional home health services (homemaker services, companion services, and personal care services) under the Long Term Care (LTC) Program. Petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner submitted documents as evidence for the hearing consisting of a letter from the daughter, a physician's letter, and medical records. These documents were marked as Petitioner Composite Exhibit 1.

Appearing as witnesses for the Respondent were Dr. Sloan Karver, Medical Director, and Christian Laos, Senior Compliance Analyst, from United Healthcare, which is the Petitioner's managed health care plan.

The respondent submitted documents as evidence for the hearing consisting of the following which were marked as Respondent Composite Exhibit 1: Statement of Matters, Notice of Action, Medical Assessment Form, and Member Notes Reports.

FINDINGS OF FACT

1. The petitioner is ninety-two (92) years of age and lives with her daughter. Her health deteriorated after sustaining a [redacted] in January, 2015. She is also [redacted] and has [redacted] She uses a walker or wheelchair for ambulation. Her other medical conditions include [redacted] She needs assistance with daily living activities such as bathing, meal preparation, and toileting.

2. The petitioner is a Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Long Term Care (LTC) Plan. She receives services under the plan from United Healthcare.

3. The Agency For Health Care Administration (AHCA) is responsible for management of the managed long-term care plan contracts; statewide policy decisions and interpretation of all federal and state laws; and rules and regulations governing the contract. Managed Care Organizations such as United Healthcare provide services to Medicaid recipients pursuant to a contract with AHCA.

4. The petitioner currently receives a total of twenty-two (22) hours weekly of home health services through United, which is allocated as follows: fourteen (14) hours weekly of personal care assistance, seven (7) hours weekly of homemaker services, and one (1) hour weekly of companion care. The home health aide currently comes to the home for 3 hours daily in the morning to assist the petitioner. The petitioner's family pays out-of-pocket for an aide to provide assistance during other times of the day.

5. On or about January 13, 2016, the petitioner made a request to United for additional hours of home health services. On January 19, 2016, United sent a letter to the petitioner denying her request for the additional home health services as not being medically necessary. The notice stated the following:

> 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.

6. The petitioner's daughter stated her mother should be approved for the additional hours because she needs assistance throughout the day with all her activities of daily living. The daughter also stated she is 60 years old herself and works more than 8 hours per day, and therefore she cannot provide all the assistance needed by her mother. She does not want her mother to be placed in a nursing home and she

doesn't believe adult day care would benefit her mother since she sleeps until 10:00 a.m. in the morning.

7. The respondent's witness, Dr. Karver, stated the petitioner did not meet the criteria to qualify for additional hours of care in the home. Dr. Karver also suggested that nursing home placement, adult day care, or hospice care are possible alternatives to provide more care to the petitioner.

CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat. § 409.285. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

9. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

10. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner since the issue involved a request for an increase in services. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

11. Fla. Stat. § 409.979 sets forth eligibility requirements for the Long-Term Care Program and states:

> (1) Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:

(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).

12. As stated in the Findings of Fact, the petitioner was determined to be eligible and enrolled in the Long Term Care Program.

13. The petitioner requested a fair hearing because she believes her services under the Program should be increased. The petitioner's daughter previously requested an additional 10 hours weekly of services, and also a total of 50 hours weekly of services. She stated during the hearing she is seeking the maximum number of home care hours possible rather than a specific number of hours.

14. Fla. Stat. § 409.98 lists the services which must be covered by Long-Term Care plans. Personal care assistance, homemaker services, and companion care are among the services available from Long-Term Care plans and are addressed in the AHCA contract.

15. The petitioner currently receives Homemaker services, which are defined in the contract as:

> General Household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control are included in this service.

16. The petitioner also currently receives Personal Care services, which are defined in the contract as follows:

> A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

17. The petitioner also currently receives 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.

21. After considering the evidence and testimony presented, the hearing officer concludes that the petitioner has not demonstrated that the home health services should be increased under the LTC Program. The petitioner needs assistance with all her activities of daily living (ADLs). However, she is already approved for approximately 3 hours daily of assistance in the home. Medical necessity for additional hours has not been established and it is unclear precisely how many additional hours the petitioner is requesting. Other services may also be available to provide additional assistance to the petitioner, such as respite care, adult day care, or hospice care.

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 17 day of June, 2016,

in Tallahassee, Florida.

Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] PETITIONER
RHEA GRAY, AREA 11, AHCA FIELD OFFICE MANAGER

Jun 20, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-02343

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 DADE
UNIT: AHCA

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 3, 2016 at 10:00 a.m.

APPEARANCES

For the Petitioner:

For the Respondent: Fathima Leyva, Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the respondent's action to partially deny the petitioner's request for a vaccination 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: Fair Hearing Summary, Authorization Request, Drug Evaluation Review, Denial Notice, and Policies/Procedures.

Appearing as witnesses for the respondent were Lauren Barnes, Pharmacy Operations Manager, and Alexandria Hicks, Regulatory Research Coordinator, from Staywell Health Plan, which is the petitioner's managed health care plan.

Also present for the hearing was a Creole language interpreter, Francoise, Interpreter Number 390, from Propio Language Services

FINDINGS OF FACT

1. The petitioner is an eight (8) month-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 Staywell Health Plan.

2. On or about March 17, 2016, the petitioner's treating physician (hereafter referred to as "the provider"), submitted a prior authorization request for 5 doses of the vaccination known as [redacted] Staywell partially denied this request on March 17, 2016 based on medical necessity criteria. Staywell approved 2 doses of the vaccination, rather than the 5 doses requested by the provider. The denial notice stated the following:

> The length of therapy requested is longer than the duration allowed based on approved guidelines. You have met the drug criteria. However, we

cannot approve the full length of therapy. Therefore, this drug has been approved for 2 doses from 3/17/2016 to 4/30/2016.

3. The petitioner's mother testified her daughter was born prematurely and needs the [redacted] vaccinations to prevent injury to her lungs. She stated the vaccination is given in the form of 1 injection per month.

4. The respondent's witness, Ms. Barnes, stated that premature infants are at risk for the respiratory virus known as RSV. However, she stated the [redacted] vaccination should be administered to these infants only during the RSV "season", which is from August through April. This is why the health plan approved 2 doses to be given in March and April. She also stated the petitioner will likely be able to receive the vaccination doses again in August if she meets the requirements at that time.

5. In response to the statements concerning the duration of the RSV season, the petitioner's mother stated there is no "season" for this virus and her daughter will remain at risk.

CONCLUSIONS OF LAW

6. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Fla. Stat. § 120.80.

7. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

8. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

9. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner. The standard of proof in an administrative hearing is a

preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

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 vaccinations. 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.

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*

---

[1] “You” in this manual context refers to the state Medicaid agency.

> *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 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.*

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.

16. 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.

17. Based upon the information submitted by the petitioner's provider, Staywell completed a prior authorization review to determine medical necessity for the requested vaccinations.

18. In the petitioner's case, Staywell has determined that the petitioner should receive the vaccinations, but approved only 2 doses rather than the requested 5 doses.

19. Section 409.913, Fla. Stat., governs the oversight of the integrity of the Florida Medicaid Program. Section (1)(d) sets forth the "medical necessity or medically necessary" standards, and states in pertinent part as follows:

> "*Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice….*

> Section (1)(d) goes on 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.*

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 petitioner's physician prescribed or requested 5 doses of the vaccination, but it was partially denied by Staywell. Rule 59G-1.010(166) (c), however, specifically states a prescription does not automatically mean the requirements of medical necessity have been satisfied.

22. The respondent's witness stated that the vaccination should only be given from August to April to protect against the RSV virus.

23. The petitioner's mother stated her daughter should receive all 5 doses since she does not believe there is a RSV "season."

24. After considering the evidence presented, the undersigned concludes that the petitioner has not met the burden of proof in establishing that the respondent's action was incorrect. Although the petitioner's mother believes the 5 doses should be given continuously without regard to any RSV season, the testimony of the respondent's witness indicates the vaccination should only be given during the months of August through April. Accordingly, the petitioner has not demonstrated that the 5 doses are medically necessary at this 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 the appropriate District Court of Appeal. The notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay

the court fees required by law or seek an order of indigence to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 20 day of June, 2016,

in Tallahassee, Florida.

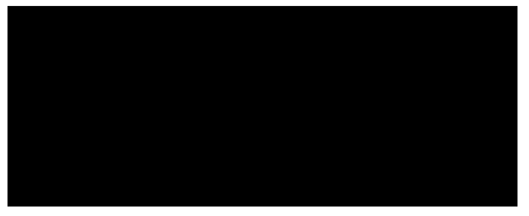
Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] PETITIONER
RHEA GRAY, AREA 11, AHCA FIELD OFFICE MANAGER

Jun 27, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS



APPEAL NO. 16F-02345

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 May 25, 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 DentaQuest, to deny the Petitioner's requests for dental procedure D7210-surgical extraction of tooth 9, 10, 12, 13, 22, 24, 23, 26, 27, 28, 29, 31 and D7310-alveoloplasty in conjunction with extractions, four or more teeth, upper right

quadrant. Because the issue under appeal involves requests for services, Petitioner bears the burden of proof.

PRELIMINARY STATEMENT

Mindy Aikman, Grievance and Appeals Specialist appeared as Respondent's witness from the Petitioner's managed care plan Humana Healthcare (Humana). Appearing as Respondent's witnesses from DentaQuest were: Dr. Daniel Dorrego, Dental Consultant; and Jackelyn Salcedo, Complaints and Grievance Specialist.

Respondent submitted a 39-page document which was entered into evidence and marked Respondent Exhibit 1. Petitioner submitted an eight-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 63 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. On May 26, 2015 the Petitioner's dentist sent a request for prior authorization for dental procedures D7210-surgical extraction of tooth 2, 9, 10, 11, 12, 20, 21, 24, 25, 26, 28, 29, and 31; four requests for D7310-alveoloplasty in conjunction with extractions; and D9248-non-intravenous sedation.

4. DentaQuest made its determination on June 15, 2015 approving D7210-surgical extractions for tooth 12, 1, 14, 20, 21, 25, 30; approving three of the D7310-alveoplasty

procedures; and approving D9248-non-intravenous sedation. Notice was sent to the provider providing the denial reasons:

> Procedure D7210-surgical extraction of tooth 9, 10, 12, 13, 22, 23, 24, 26, 27, 28, 29: the x-rays do not support the code requested. A less severe extraction code would be considered.
>
> Procedure 7210-surgical extraction of tooth 31: the submitted radiograph does not show the presence of this tooth.
>
> Procedure D7310-alveoloplasty in conjunction with extraction, four or more teeth or tooth spaces per quadrant (fourth request): There are less than four extractions in the quadrant that require alveoloplasty.

5. Petitioner filed a grievance with Humana on October 18, 2015. Humana sent An Update on Your Request on December 1, 2015 stating in relevant part:

> The claim has been reviewed and the denial is upheld. In regards to the appeal submitted by Ms. Davis, please note that our Dental Director reviewed the case and upheld the denial due to the member having 65% bone loss and extraction should be performed as simple extractions. D7310 was also denied due to services cannot be paid in conjunction with surgical extraction that we previously approved.

6. Petitioner filed a fair hearing request on March 28, 2016.

7. Petitioner is very ill and is on anti-coagulation medication due to past strokes. He needs medical staff present when his teeth are extracted to ensure any medical complications can be readily addressed. He needs dentures to improve his diet and overall health.

8. Respondent's dental consultant explained that all teeth extractions constitute oral surgery. He explained that the surgical extractions were denied for the referenced teeth because there is significant bone loss for each that a simple extraction (D7140) would be sufficient.

9. The dental consultant noted that surgical extraction of tooth 31 was denied because the tooth could not be seen on the x-rays provided.

10. The dental consultant also explained that the fourth request for D-7310: alveoloplasty in conjunction with extractions, four or more teeth, upper right quadrant was denied because there were less than four teeth being extracted in the upper right quadrant. He noted that this procedure is used to remove an area of bone fragments and sharp edges to allow for proper denture fit. Removal of bone fragments and sharp edges can be done at the same time a single tooth is removed.

CONCLUSIONS OF LAW

11. By agreement between the Agency for Health Care Administration and the Department of Children and Families, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80 Florida Statutes.

12. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

13. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Florida Administrative Code Rule 65-2.060(1).

14. 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.

15. Section 409.912, Fla. Stat. also provides that the Agency may mandate prior authorization for Medicaid services.

16. 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:
>
> 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.

18. Florida Administrative Code Rule 59G-4.060 provides the following on Medicaid Dental Services:

> (1) This rule applies to any person or entity prescribing or reviewing a request for dental services and to all providers of dental services who are enrolled in or registered with the Florida Medicaid program.

> (2) All persons or entities described in subsection (1) must be in compliance with the provisions of the Florida Medicaid Dental Services Coverage Policy, May 2016, incorporated by reference. The policy is available on the Agency for Health Care Administration's website at http://ahca.myflorida.com/Medicaid/review/index.shtml, and at http://www.flrules.org/Gateway/reference.asp?No=Ref-06593.

19. Florida Medicaid Dental Services Coverage Policy (Dental Policy), paragraph 4.1, General Criteria (page 3) states:

> Florida Medicaid reimburses for services that meet all of the following:
> - Are determined medically necessary
> - Do not duplicate another service
> - Meet the criteria as specified in this policy

20. Paragraph 4.2.9, Surgical Extractions and Extractions of the Dental Policy states in relevant part:

> Florida Medicaid reimburses for emergency dental services for recipients age 21 years and older to alleviate pain, infection, or both, and procedures essential to prepare the mouth for dentures.

21. Petitioner argues he needs to have his teeth removed so he can have dentures. The dentures are needed to improve his ability to eat and improve his diet.

22. Respondent does not disagree that tooth 9, 10, 12, 13, 22, 24, 23, 26, 27, 28, 29 need to be removed. Respondent disagrees that surgical extraction is needed because the bone loss for these teeth is 65%. Simple extraction would be sufficient. Surgical extraction of tooth 31 was denied because the tooth could not be seen on the x-rays submitted. Procedure D7310- alveoloplasty in conjunction with extractions, four or more teeth, upper right quadrant was denied because less than four teeth are being extracted in the upper right quadrant.

23. Petitioner has failed to meet his burden of proof. Respondent has provided medical testimony and evidence that supports the agency's denials.

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 27 day of June, 2016,

in Tallahassee, Florida.

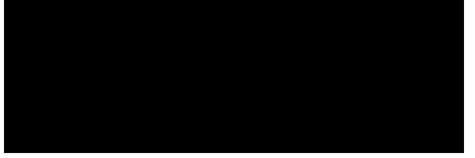
Warren Hunter
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

Jun 20, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS



APPEAL NO. 16F-02349

PETITIONER,
Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 DADE
UNIT: AHCA

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 6, 2016 at 11:30 a.m.

APPEARANCES

For the Petitioner: Petitioner's case manager

For the Respondent: Fathima Leyva, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the respondent's partial denial of the petitioner's request for physical therapy services was correct. The petitioner has the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any documents as evidence for the hearing.

Appearing as a witness for the respondent was Michelle Rigler, Compliance Officer from Magellan Complete Care, which is the petitioner's managed health care plan.

The respondent submitted several documents as evidence for the hearing, which were marked as follows: Exhibit 1 – Hearing Summary and Authorization Request; Exhibit 2 – Notice of Action Letters; and Exhibit 3 – Therapy Services Handbook.

FINDINGS OF FACT

1. The petitioner is a forty-nine (49) year-old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. She receives services under the plan from Magellan Complete Care.

2. On or about March 16, 2016, the Petitioner's treating physician (hereafter referred to as "the provider"), submitted a prior authorization request for approval of physical therapy services. On March 17, 2016, Magellan approved 1 physical therapy evaluation and 72 physical therapy treatment visits, but denied the request for procedure code 97140 (manual therapy). The denial notice stated this request was denied since it was not a covered benefit under the plan.

3. The petitioner's representative stated the petitioner needs physical therapy services because ligaments and nerves in her arm were affected by a 2014 surgery for breast cancer and she does not want to lose mobility in that arm.

4. The respondent's witness stated that Medicaid guidelines provide very limited physical therapy services for adults and the health plan would ordinarily have denied the requested services. However, in the petitioner's case, Magellan decided to approve most of the requested therapy services due to her medical conditions. Magellan denied

the request for procedure code 97140 (manual therapy) since that code is not listed in the Medicaid fee schedules.

5. Physical therapy services under the Medicaid State Plan in Florida are provided in accordance with the respondent's Therapy Services Coverage and Limitations Handbook ("Therapy Handbook"), effective August, 2013.

. **CONCLUSIONS OF LAW**

6. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Fla. Stat. § 120.80.

7. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

8. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

9. The standard of proof in an administrative hearing is a preponderance of the evidence, in accordance with Rule 65-2.060 (1), Fla. Admin. Code. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

10. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the Respondent. The Therapy Handbook incorporated by reference in Chapter 59G-4, Florida Administrative Code.

11. The Therapy Handbook and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

> "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide;
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
> . . .
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

12. The Florida Medicaid Program provides limited physical therapy services for adults. The Therapy Handbook describes the covered services for adults as follows:

> Medicaid reimburses for medically necessary therapy services that are provided to Medicaid recipients under the age of 21. Medicaid also reimburses limited services to recipients age 21 and older, specifically: SLP services pertaining to the provision of augmentative and alternative communication systems and PT and OT services pertaining to wheelchair evaluations and fittings. These are the only services in the therapy program that Medicaid reimburses for adults.

13. Managed care plans, such as Magellan, may provide more generous benefits but cannot be more restrictive than the Medicaid guidelines contained in the Therapy Handbook. In this case, Magellan has approved the request for a physical therapy evaluation and 72 physical therapy treatment visits, but denied the request for procedure code 97140 (manual therapy) as being a non-covered benefit.

14. After considering the evidence and testimony presented, the undersigned concludes that the petitioner has not demonstrated that the requested service for procedure code 97140 should have been approved by Magellan. The requested physical therapy services are non-covered services for adults under the Medicaid guidelines referenced above. Although Magellan approved most of the requested services, it was not obligated to also approve procedure code 97140 since this code does not appear in the Medicaid fee schedules. Since that is also a non-covered service, the hearing officer cannot make a determination that this service 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 indigence to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 20 day of June, 2016, in Tallahassee, Florida.

Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal_Hearings@myflfamilies.com

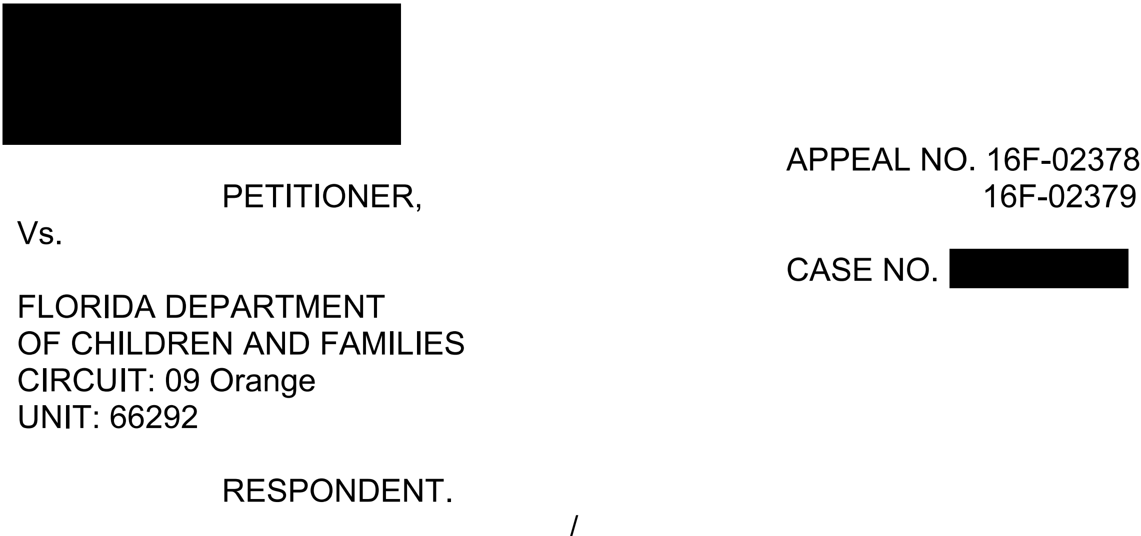
Copies Furnished To: [redacted], PETITIONER
RHEA GRAY, AREA 11, AHCA FIELD OFFICE MANAGER

FILED

Jun 23, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS



PETITIONER,

Vs.

APPEAL NO. 16F-02378
16F-02379

CASE NO.

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 May 16, 2016 at 9:45 a.m.

APPEARANCES

For the petitioner:

For the respondent: Jennie Rivera, ACCESS Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

Petitioner is appealing the following:

I. The respondent's action to terminate the petitioner's Food Assistance Program (FAP) benefits. Respondent carries the burden of proof by a preponderance of the evidence.

II. The respondent's action to terminate the petitioner's full Medicaid benefits and enroll her in the Medically Needy (MN) Program with a share of cost (SOC).

Petitioner is seeking full Medicaid. Respondent carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

By noticed dated March 17, 2016, respondent notified the petitioner that her FAP benefits would end on March 31, 2016 due to "your household's income is too high to qualify for this Program". The petitioner timely requested a hearing to challenge the respondent's action. There was no notice submitted by the respondent to the undersigned informing the petitioner of the respondent's action to terminate her full Medicaid benefits and enroll her in the MN Program with a SOC of $855.00 beginning May 2016.

Serving as an interpreter for the hearing was [redacted] from [redacted]

Petitioner did not submit any exhibits at the hearing. Respondent submitted six exhibits, entered as Respondent's Exhibits "1" through "6". The record was held open until close of business on May 23, 2016 for submission of additional evidence from the parties. On May 18, 2016, the petitioner submitted documents, which were entered into evidence as Petitioner's Exhibit "1". On May 18, 2016, the respondent submitted documents, which were entered into evidence as Respondent's Exhibit "7". The record closed on May 23, 2016.

FINDINGS OF FACT

1. On January 5, 2016, the petitioner submitted an application for Medicaid and FAP benefits. On this application, she listed herself and her child. Petitioner reported rent of

$750.00 per month as her only expense, and her sources of income to be Social Security benefits for her child of $723.00 and a contribution from her husband of $600.00. This amount totaled to $1,323.00.

2. Petitioner completed a phone interview on January 25, 2016. During the interview, the petitioner reported her husband was residing in [redacted] and anticipated to move to Florida by the end of February 2016. Based on this and other qualifying factors, the respondent approved $136.00 in FAP benefits for the petitioner's household size of two effective January 2016 and $157.00 effective February through June 30, 2016. Petitioner's household was approved for Medicaid benefits beginning January 2016. The husband was not included in the FAP or Medicaid benefits.

3. On February 10, 2016, the petitioner completed a change report to notify the respondent that her husband had moved into the home and his income. The respondent reviewed the case. The respondent removed the contribution income from the FAP budget and included the husband's Social Security Disability Income (SSDI) of $1,447.80. The total household gross income was calculated as $2,170.80 ($723.00 + $1,447.80). The respondent updated the income in the FAP budget to $2,170.00.

4. The respondent calculated the income and expenses included in the FAP budget as follows:

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ABFN                FOOD STAMP NET INCOME BUDGET             04/19/2016 11:51

                                              TOTAL GROSS INCOME:          2170.00
                                              EARNED INCOME DEDUCTION: -       .00
                                              STANDARD DEDUCTION:      -    155.00
 TOTAL MEDICAL COSTS:              105.80
 MEDICAL DEDUCTION:          -      35.00
 EXCESS MEDICAL EXPENSES:    =      70.80     EXCESS MEDICAL EXPENSES: -     70.80
                                              DEPENDENT CARE DEDUCTION:-       .00
 SHELTER COSTS:                    750.00     CHILD SUP PAYMENT DEDUCT:-       .00
 UTILITY STD.( SUA/ BUA/ PH) : +   345.00     HOMELESS INCM DEDUCTION: -       .00
 SHELTER/UTILITY COSTS:      =    1095.00     ADJUSTED INCOME:         =   1944.20
 SHELTER STD(50% ADJ NET INC): -   972.10
 EXCESS SHELTER/DEDUCTION:   =     122.90     SHELTER DEDUCTION:       -    122.90
                                              FOOD STAMP ADJ INCOME:   =   1821.30
        ASSISTANCE GROUP SIZE:          3     MAX NET MONTHLY INCOME:      1675.00

     ASSISTANCE GROUP HAS FAILED THE FOOD STAMP NET INCOME BUDGET
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5. It was determined that the household adjusted income exceeded the net income standard of $1,675.00 for a household size of three. On March 17, 2016, the respondent mailed the petitioner a Notice of Case Action informing her that her FAP benefits would end on March 31, 2016 citing that her household's income was too high to qualify for this Program.

6. The respondent also took action to terminate the petitioner's full Medicaid. The respondent enrolled the petitioner in the MN SOC. The respondent determined the petitioner's $855.00 SOC as follows:

ABMG FAMILY RELATED MEDICAID/MEDICALLY NEEDY BENEFIT DETERMINATION BUDGET 04/19/2016 11:53

EARNED INCOME:+	.00	SFU SIZE:	3
UNEARNED INCOME:+	1447.80	INCOME STANDARD:	.00
TOTAL REPORTED INCOME:=	1447.80	MNIL:-	486.00
ALLOWABLE TAX DEDUCTIONS:-	.00	SHARE OF COST:=	961.00
MODIFIED ADJUSTED GROSS INC:=	1447.80	MED INSURANCE PREMIUM:-	105.80
STANDARD DISREGARD:-	.00	RECURRING MED EXPENSE:-	.00
MAGI DISREGARD(5% OF FPL):-	.00	REMAINING SOC:=	855.00
COUNTABLE NET INCOME:=	1447.80	COUNT OF OOTHS:	0

AG HAS PASSED THE FAM RELATED MEDICAID/MED NEEDY BENEFIT DETERMINATION BUDGET

7. The respondent excluded the child's income and only included the husband's SSDI of $1,447.80. The respondent determined Medicaid eligibility for the petitioner, the household income of $1,447.80 was compared to the Medicaid income limit for a household size of three ($303.00). The respondent determined the petitioner was ineligible for full Medicaid benefits as the household income exceeded the Medicaid income limit.

8. Petitioner did not dispute the income budgeted on either the FAP or MN benefits. Petitioner does not believe her income exceeds the FAP income standard. Petitioner argues that she needs full Medicaid because she has reoccurring [redacted] and pinch nerves and a damaged disc since 2014. She applied for Social Security Administration (SSA) disability on August 4, 2015 and the decision remains pending. It is unknown why the petitioner did not report on her application she was disabled.

9. Petitioner presented a copy of her pending appeal with SSA, the hearing was scheduled on April 7, 2016.

10. Evidence presented by the respondent includes a print out from the Department's State of Florida On-Line Query. The print out indicates on March 2013, SSA determined the petitioner was no longer disabled with code T-8. Petitioner's SSA benefits ended on March 2013. On August 4, 2015, the petitioner submitted an application for SSA disability and now included degenerative disc as a new condition.

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.

FOOD ASSISTANCE ISSUE

13. The Code of Federal Regulations 7 C.F.R. § 273.9 defines income and allowable deductions in the FAP budget 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) 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…
> (d) Income deductions. Deductions shall be allowed only for the following household expenses:

> (1) Standard deduction… 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. For household sizes greater than six, the standard deduction shall be equal to the standard deduction for a six-person household....
> (3) Excess medical deduction. That portion of medical expenses in excess of $35 per month, excluding special diets (emphasis added), incurred by any household member who is elderly or disabled as defined in § 271.2. Spouses or other persons receiving benefits as a dependent of the SSI or disability and blindness recipient are not eligible to receive this deduction but persons receiving emergency SSI benefits based on presumptive eligibility are eligible for this deduction….
> …
> (6) Shelter costs…
> …
> (ii) Excess shelter deduction. Monthly shelter expenses in excess of 50 percent of the household's income after all other deductions in paragraphs (d) (1) through (d)(5) of this section have been allowed…If the household does not contain an elderly or disabled member, as defined in § 271.2 of this chapter, the shelter deduction cannot exceed the maximum shelter deduction limit established for the area.
> (iii) Standard utility allowances…

14. 7 C.F.R. § 273.10 defines determining household eligibility and benefit levels and states in relevant part:

> (d) Determining deductions…
> …
> (7) Households which contain a member who is a disabled SSI recipient in accordance with paragraphs (2), (3), (4) or (5) of the definition of a disabled member in §271.2 or households which contain a member who is a recipient of SSI benefits and the household is determined within the 30-day processing standard to be categorically eligible (as discussed in §273.2(j)) or determined to be eligible as an NPA household and later becomes a categorically eligible household, shall be entitled to the excess medical deduction of §273.9(d)(3) and the uncapped excess shelter expense deduction of §273.9(d)(5) for the period for which the SSI recipient is authorized to receive SSI benefits or the date of the food stamp application, whichever is later, if the household incurs such expenses. Households, which contain an SSI recipient as discussed in this paragraph, which are determined ineligible as an NPA household and later become categorically eligible and entitled to restored benefits in

accordance with §273.2(j)(1)(iv), shall receive restored benefits using the medical and excess shelter expense deductions from the beginning of the period for which SSI benefits are paid, the original food stamp application date or December 23, 1985, whichever is later, if the household incurs such expenses….
(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 § 273.9(d)(3), determine if total medical expenses exceed $35.00 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…
(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. (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…

15. The Department's Program Policy Manual (Policy Manual), Appendix A-1, sets forth the following Food Assistance Income Eligibility Standards and Deductions:

$511.00 maximum FAP benefit for a household size of three
$345.00 standard utility allowance
$155.00 standard deduction for a household size of three

$504.00 maximum shelter deduction for AGs without elderly or disabled member
Uncapped maximum shelter deduction for AGs with an elderly or disabled member
$1,675.00 Monthly 100% Net Income Limit for a household size of three

16. The Policy Manual, CFOP 165-22, passage 2610.0103 Budgets and Tests (FS), states:

> Assistance groups must meet the gross income standards to be eligible for food stamps with the following exceptions:
> 1. assistance groups that contain an elderly or disabled member and are not categorically eligible must meet the net income limits; and
> 2. standard filing units (SFUs) that are broad-based categorically eligible must meet the 200% gross income limits.

17. The above authority explains that households without an elderly or disabled member must meet both the gross income limit (200% of the federal poverty level) and the net income limit (100% of the federal poverty level). However, households with an elderly or disabled member must meet only the net income limit. This household contains a disabled member.

18. The respondent reviewed all allowable expenses and deductions with the petitioner that were calculated in the FAP budget. The household met the gross income limit for a household size of three ($3,349). After the computation of the gross income and allowable expenses, the respondent compared the household's net income of $1,821.30 to the net income standard limit of $1,675.00; and determined the household did not pass the net income test.

19. The undersigned reviewed the respondent's calculations and found no errors. Therefore, based on the evidence and authorities cited, the undersigned concludes the

respondent's action to terminate the petitioner's FAP benefits for exceeding the net income standard was correct.

MEDICALLY NEEDY ISSUE

20. 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 §435.814, the individual or family is eligible for Medicaid…

21. Fla. Admin. Code R. 65A-1.716 Income and Resource Criteria continues:

> (2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows:

Family Size	Income Level
1	$180
2	$241
3	$303

22. Pursuant to the above authority, the petitioner's household income of $1,447.80 is more than the $303.00 Medicaid income limit; therefore, she is not eligible for full Medicaid.

23. The Policy Manual, Appendix A-7, Family-Related Medicaid Income limits chart, sets forth the Medically Needy Income Level (MNIL) for a household size of three as $486.00. It further indicates that the MNIL "includes the appropriate standard disregard." The respondent subtracted the $105.80 Medicare premium and $486.00 MNIL from $1,447.80 (household income) to arrive at the $855.00 SOC for the petitioner.

24. The Policy Manual, CFOP 165-22, passage 0830.0600 EX PARTE

DETERMINATIONS (MFAM) states in part:

> An ex parte determination assesses whether a Medicaid individual who is no longer eligible under one coverage group is eligible under a different coverage group. Continue Medicaid until the ex parte process has been completed.
> An ex parte determination does not require a new application. There is no requirement for the individual to contact the Department to initiate the ex parte determination. When the determination is complete, send the individual a notice of case action advising of their eligibility. If no one is eligible or is eligible only for Medically Needy with a SOC, notify the individual, ensuring 10 days advance notice.
> Perform ex partes when:
> 1. An increase in income causes ineligibility…

25. Fla. Admin. Code R. 65A-1.707 Family-Related Medicaid Income and Resource

Criteria, states in part:

> (1) Family-related Medicaid income is based on the definitions of income, resources (assets), verification and documentation requirements as follows:
> (a) Income. Income is earned or non-earned cash received at periodic intervals from any source such as wages, self-employment, benefits, contributions, rental property, etc. Cash is money or its equivalent, such as a check, money order or other negotiable instrument. Total gross income includes earned and non-earned income from all sources...For Medically Needy coverage groups, the amount by which the gross income exceeds the applicable payment standard income level is a share of cost as defined in Rule 65A-1.701, F.A.C. For the CNS criteria, refer to subsection 65A-1.716(1), F.A.C. For the payment standard income levels, refer to subsection 65A-1.716(2), F.A.C.
> …
> (2) The department considers income in excess of the medically needy income level available to pay for medical care and services. Available income from a one month period is used to determine the amount of excess countable income available to meet medical care and services. To be allowable, a paid expense may not have been previously deducted from countable income during a period of eligibility.

26. The above authority explains that the Medically Needy Program is coverage for individuals who meet the technical requirements of the particular coverage group but whose income exceeds the income limit for full Medicaid.

27. In careful review of the cited authorities and evidence, the undersigned concludes the respondent correctly terminated the petitioner's full Medicaid benefits due to the household's income exceeding the income standard. Furthermore, the respondent was correct to enroll her in the MN Program with a SOC of $855.00 beginning May 2016.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are denied and the Department's actions are affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 23 day of June, 2016,

in Tallahassee, Florida.

Cassandra Perez
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To [redacted] Petitioner
Office of Economic Self Sufficiency

Jun 17, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-02386

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION (AHCA)
CIRCUIT: 07 St. Johns
UNIT: AHCA

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 11, 2016 at 10:08 a.m.

APPEARANCES

For the Petitioner:

For the Respondent: Sheila Broderick, registered nurse specialist with AHCA

STATEMENT OF ISSUE

Whether it is medically necessary for the petitioner to receive Prescribed Pediatric Extended Care (PPEC) services. The petitioner holds the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (Agency or AHCA or respondent) administers the Florida Medicaid Program. The Agency contracts with eQ Health Solutions (eQ) to perform prior services authorizations for certain Medicaid services, including PPEC services.

By notice dated February 27, 2016, eQ informed the petitioner that her request to receive PPEC services for six months (March 2016 – August 2016) was denied in-part. eQ approved one month of PPEC services for education and training of natural supports. Ongoing PPEC services was denied.

The petitioner requested reconsideration.

By notice dated April 5, 2016, eQ informed the petitioner that the original decision was upheld.

The petitioner timely requested a hearing to challenge the partial denial decision. The PPEC services have been continued pending the outcome of the hearing.

Present as a witness for the respondent from eQ: Dr. Rakesh Mittal, physician consultant. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

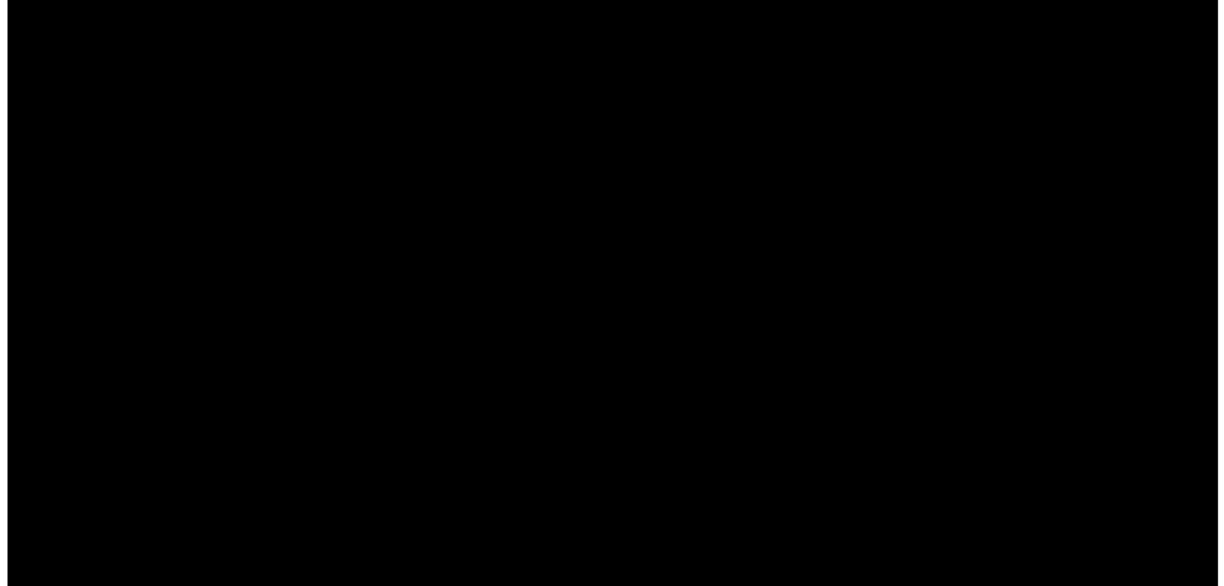
FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. The petitioner (age 4 months) is a Florida Medicaid recipient.

2. The petitioner's diagnoses include and

3. The petitioner's treating physician submitted a request for PPEC (specialized medical day care for children with complex medical needs) services 6 days per week to eQ (AHCA's contracted review agent) on February 15, 2016. The petitioner's medical condition is described as follows:



4. All Medicaid services must be medically necessary as determined through a prior service authorization process. eQ reviews the authorization request form and all supporting documentation. eQ has no direct contact with the child or child's family.

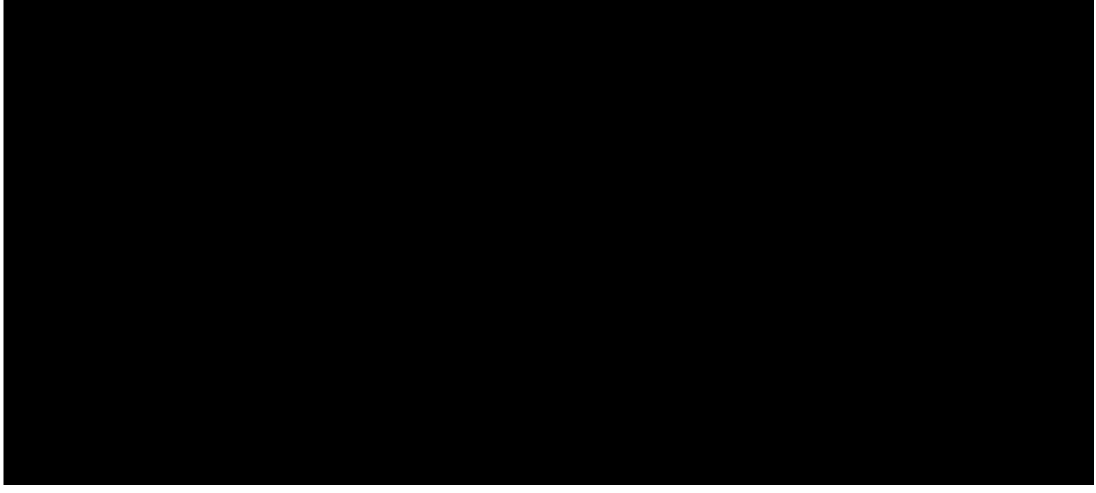
5. In the instant case, eQ reviewed the petitioner's Plan of Care (a document which defines the patient's need for services and service goals) and Home Assessment

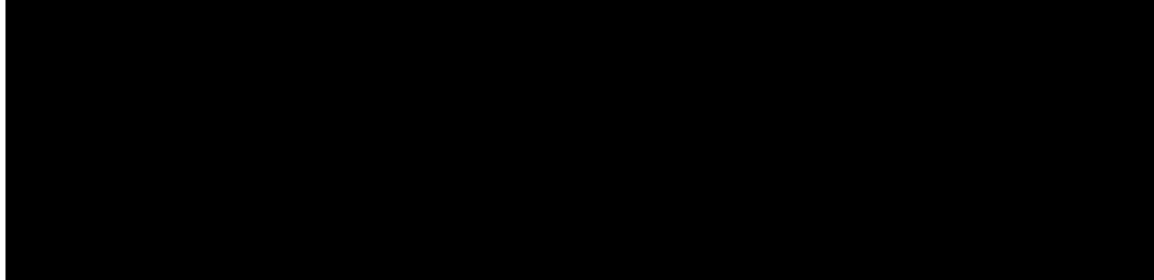
(a document which summarizes the patient's medical condition, functioning level, living arrangement, and natural supports).

6. The Plan of Care described the petitioner as a child with a serious medical condition that needs monitoring and supervision because her mother works outside the home.

7. The Home Assessment explained that the petitioner lived in the family home with her mother and sibling. The petitioner has a serious medical condition (; however, she does not use a ventilator, does not require G-tube feeding, does not use nebulizers, does not use oxygen, does not use IV medications, does not require suctioning, and does not use monitors. The petitioner's ADLs, alertness and attention are "appropriate for recipient's age." There have been no emergency room visits or hospitalizations since birth.

8. eQ approved one month of PPEC services in order for skilled nursing staff to train the petitioner's mother how to care for her at home. eQ concluded that the petitioner's medical condition was serious, but did not require continuous skilled nursing care. The clinical rationale section of eQ's evaluation explains the decision:





9. Dr. Rakesh Mittal, physician reviewer with eQ, explained that the petitioner's needs can be met by any responsible adult and does not require the services of a skilled nurse. Dr. Mittal described the type of presenting conditions which require PPEC services: G-tube feedings, ventilator dependency, IV medications, and multiple seizures daily. Dr. Mittal opined that it is not medically necessary that the petitioner receive PPEC services.

10. The petitioner's mother asserted that her needs cannot be met by a non-specialized day care center. The petitioner cannot be laid on her back. She must be monitored for seizure activity. In addition, her bowel movements and urine output must be monitored.

11. director of nursing at the petitioner's PPEC, attested to her need for PPEC services. Ms. noted that the petitioner suffers from weakness in her lower extremities and would benefit from PPEC physical therapy. In addition, she requires monitoring for hypothyroidism and weight gain.

12. The petitioner was in the hospital at the time of the hearing, receiving antibiotics to treat an infection she contracted after a recent surgery. She was to be discharged to home later in the week. Ms. noted that the petitioner would be continue to need antibiotics and pain medications after discharge; she believes the petitioner's medications needs could best be addressed at the PPEC.

13. On rebuttal, Dr. Mittal reiterated that the April 2016 denial decision was correct. The petitioner's future need for PPEC services after she is discharged from the hospital can be addressed by a new service request and supporting clinical documentation. Future need does not impact the current decision under challenge.

CONCLUSIONS OF LAW

14. By agreement between the AHCA and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Section 120.80, Florida Statutes.

15. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.

16. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

17. In accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof was assigned to the petitioner.

18. The standard of proof in an administrative hearing is by a preponderance of the evidence (See Fla. Admin. Code R. 65-2.060(1)). The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

19. The Florida Medicaid Program is authorized by Chapter 409 Florida Statutes and Fla. Admin. Code Chapter 59G.

20. Fla. Admin. Code R. 59G-1.010(166) explains that medical or allied care, goods, or services furnished or ordered must meet the definition of medically necessary or medical necessity, and defines medical necessity as:

> "Medical necessary" or "medical necessity" means that medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational;
> 4. Be reflective of the level of service that can safely be furnished, for which no equally effective and more conservative or less costly treatment is available statewide; and,
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. . .
> ….
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods or services medically necessary, or a medical necessity, or a covered service.

21. As the petitioner is under 21, a broader definition of medically necessary applies to include the EPSDT requirements. Section 409.905, Florida Statutes, Mandatory Medicaid services, defines Medicaid services for children to include:

> (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical

> therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

22. The above citation explains that the respondent must provide treatment and services to Medicaid recipients under 21 years of age, but only to the extent such services are medically necessary. The state is authorized to establish the amount, duration, and scope of such services.

23. Page 1-1 of the PPEC Handbook notes that, "[t]he purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) Services Program is to enable recipients under the age of 21 years with medically complex conditions to receive medical and therapeutic care at a non-residential pediatric center."

24. On page 2-1 thru 2-2, the PPEC Handbook lists the requirements for PPEC services.

> To receive reimbursement for PPEC services, a recipient must meet all of the following criteria:
>
> - Be Medicaid eligible.
> - Diagnosed with a medically-complex or medically fragile condition as defined in Rule 59G-1.010, F.A.C.
> - Be under the age of 21 years.
> - Be medically stable and not present significant risk to other children or personnel at the center.
> - Require short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care due to a medically-complex condition.

25. Fla. Admin. Code R. 59G-1.010 defines "medically complex" and "medically fragile" as follows:

> (164) "Medically complex" means that a person has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention.

> (165) "Medically fragile" means an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, e.g., requires total parenteral nutrition (TPN), is ventilator dependant, or is dependent on a heightened level of medical supervision to sustain life, and without such services is likely to expire without warning.

26. The respondent, through its agent eQ, denied the petitioner's request for ongoing PPEC services. The respondent determined that the services were not medically necessary because the petitioner did not meet the eligibility requirements.

27. The evidence proves that the petitioner has a serious medical condition, spina bifida, which requires monitoring and supervision. However, the evidence does not prove that the petitioner requires continuous therapeutic interventions or skilled nursing care. She does not require G-tube feedings or IV medications; she is not ventilator dependent nor does she require a medical apparatus to maintain life.

28. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the petitioner did not meet her burden of proof in this matter. The petitioner did not prove by a preponderance of the evidence that it is medically necessary that she receive ongoing PPEC services.

DECISION

The appeal is denied. The respondent's decision in this matter is upheld.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay

the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 17 day of June, 2016,

in Tallahassee, Florida.

Leslie Green
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Debbie Stokes, Area 4, AHCA Field Office Manager

Jun 29, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-02537
APPEAL NO. 16F-02538

PETITIONER,

Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 10 Polk
UNIT: 88222

RESPONDENT.
_________________________________/

FINAL ORDER

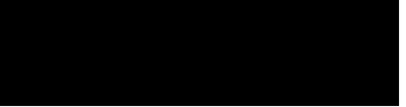
Pursuant to notice, the undersigned convened an administrative hearing by phone in the above-referenced matter on May 27, 2016 at 1:03 p.m.

APPEARANCES

For Petitioner:

For Respondent: Susan Martin, Operations Management Consultant I

STATEMENT OF ISSUE

At issues are whether the respondent's action to terminate (hereafter S.L.) Medicare Savings Program (MSP) Medicaid benefits effective January 31, 2016; and to deny  (hereafter P.L.) MSP Medicaid benefits effective May 2016 and ongoing are correct. The burden of proof is assigned to the respondent for the termination of S.L.'s MSP benefits by a preponderance of the

evidence. The burden of proof is assigned to the petitioners for the denial of P.L.'s MSP benefits by a preponderance of the evidence

PRELIMINARY STATEMENT

Petitioners (S.L. and P.L.) were present and testified. Petitioners did not submit any exhibits at the hearing. Respondent was represented by Susan Martin with the Department of Children and Families (hereafter "DCF", "Respondent" or "Agency"). Ms. Martin testified. Respondent submitted eleven exhibits, which were entered and marked as Respondent's Exhibits "1" through "11".

FINDINGS OF FACT

1. On October 5, 2015, a nursing home facility submitted an application on behalf of S.L. for Institutional Care Program (ICP) Medicaid benefits. The application listed S.L. as the only member applying for benefits; and S.L.'s Social Security income as her only source of income. The application did not list S.L.'s husband (P.L.) nor his income.

2. On November 5, 2015, the respondent mailed the nursing home facility a Notice of Case Action indicating the petitioners' application for Medicaid benefits dated October 5, 2015 was denied as "No household members are eligible for this program. We did not receive all the information requested to determine eligibility". The notice did not list any information concerning S.L.'s MSP benefits.

3. On December 14, 2015, the petitioners submitted a redetermination application for Medically Needy (MN) Medicaid and QMB benefits. MN Medicaid benefits are not an issue under appeal. Petitioners and their Social Security incomes were considered in their redetermination of benefits.

4. On December 23, 2015, the respondent mailed S.L. a Notice of Case Action indicating her Qualified Medicare Beneficiary (QMB) Medicaid benefits would end effective January 31, 2016 as “Your household’s income is too high to qualify for this program”.

5. S.L. received QMB benefits for the period of October 1, 2015 through January 31, 2016.

6. P.L. never received any MSP benefits from the respondent.

7. On May 11, 2016, P.L. submitted an application for Food Assistance (FA) benefits. FA benefits are not an issue under appeal. The application listed P.L and S.L as the only members in the household; and no income or expenses for the household.

8. On May 16, 2016, the respondent mailed P.L. a Notice of Case Action indicating the petitioners’ FA and MN Medicaid application dated May 11, 2016 was approved. The notice did not list any information concerning the petitioners’ MSP benefits.

9. On May 18, 2016, the respondent mailed P.L. a Notice of Case Action indicating the petitioners’ FA and MN Medicaid benefits would remain the same. The notice also indicated the petitioners’ Qualifying Individual (QI1) application dated May 17, 2016 was denied as “Your household’s income is too high to qualify for this program”.

10. S.L. receives Social Security Disability Insurance (SSDI) income in the amount of $843.80 (gross) per month; and P.L. receives SSDI income in the amount of $1,543.90 (gross) per month. The petitioners both receive Medicare Part A and B.

11. Initially, the respondent considered only SL’s SSDI income when determining her eligibility for QMB benefits.

12. Initially, the respondent determined S.L. eligible for QMB benefits effective October 2015 through January 2016 as follows:

$ 843.00	SL's SSDI income
-$ 20.00	unearned income disregard
$ 823.00	total countable unearned income
$ 823.00	total countable income
$ 981.00	QMB income standard for a household of one

13. Respondent determined S.L. ineligible for Qualifying Individuals 1 (QI1) benefits effective February 2016 and ongoing as follows:

$2386.00	S.L. and P.L.'s SSDI income
-$ 20.00	unearned income disregard
$2366.00	total countable unearned income
$2366.00	total countable income
$1803.00	QI1 income standard for a household of two

14. Respondent determined the petitioners ineligible for QI1 benefits effective May 2016 and ongoing as follows:

$2386.00	S.L. and P.L.'s SSDI income
-$ 20.00	unearned income disregard
$2366.00	total countable unearned income
$2366.00	total countable income
$1803.00	QI1 income standard for a household of two

15. Respondent considered S.L. and P.L.'s SSDI income when determining (1) S.L.'s ineligibility for QMB benefits; and (2) for both S.L. and P.L's. ineligibility for QI1 benefits.

16. P.L. cares for S.L. twenty-four hours a day because S.L. cannot clean, lift her arms, and bathe herself. S.L. requires both oxygen and supervision twenty-four hours per day as well.

17. S.L. does not agree with the respondent not considering household expenses, such as mortgage, in the determination of MSP Medicaid benefits.

18. Respondent determined S.L. and P.L. were not eligible for the MSP Medicaid benefits because the total amount of their SSDI incomes was over the income limit for the aforementioned programs.

CONCLUSIONS OF LAW

19. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to § 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

20. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

21. The Code of Federal Regulations at 20 C.F.R. § 416.1121 defines unearned income as:

> Some types of unearned income are—(a) Annuities, pensions, and other periodic payments. This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veterans benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits…

22. Pursuant to the above authority, both S.L. and P.L.'s SSDI incomes are considered included income in the determination of their eligibility for MSP Medicaid benefits.

23. The Fla. Admin. Code R. 65A-1.702, Medicaid Special Provisions, states in relevant part:

> …

> (12) Limits of Coverage
> (a) Qualified Medicare Beneficiary (QMB). Under QMB coverage, individuals are entitled only to Medicare cost-sharing benefits, including payment of Medicare premiums.
> (b) Special Low-Income Medicare Beneficiary (SLMB). Under SLMB coverage, individuals are entitled only to payment of the Part B Medicare premium…
> …
> (d) Part B Medicare Only Beneficiary (QI1). Under QI1 coverage, individuals are only entitled to payment of their Medicare part B premium. (This is coverage for individuals who would be eligible for QMB or SLMB coverage except their income exceeds time limits for those programs.)

24. The Fla. Admin. Code R. 65A-1.713 further addresses the SSI-Related Medicaid Income Eligibility Criteria as follows:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
> …
> (b) For QMB, income must be less than or equal to the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.
> …
> (g) For SLMB, income must be greater than 100 percent of the federal poverty level but equal to or less than 120 percent of the federal poverty level.
> …
> (j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. QI1 is eligible only for payment of the Part B Medicare premium through Medicaid.

25. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, Appendix A-9, lists the SSI-Related Income Limits for a household size of two for the months of December 2015 through March 2016 as follows: the Income Standard for Qualified Medicare Beneficiaries (QMB) as $1,328; the Income Standard for Special Low Income Medicare Beneficiary (SLMB) as $1,593; and the Income Standard for QI1 as $1,793.

26. The Policy Manual, CFOP 165-22, Appendix A-9, lists the SSI-Related Income Limits for a household size of two for the month of April 2016 and ongoing as follows: the Income Standard for QMB as $1,335; the Income Standard for SLMB as $1,602; and the Income Standard for QI1 as $1,803.

27. 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."

28. S.L. and P.L's SSDI incomes exceed the income limits for all three of the aforementioned Medicare Savings Programs; therefore, the respondent correctly terminated S.L.'s QMB benefits effective February 2016 and ongoing and correctly denied P.L.'s QI1 benefits effective May 2016 and ongoing.

29. In careful review of the cited authorities and evidence, the undersigned concludes the respondent met the burden of proof indicating S.L.'s Medicare Savings Program Medicaid benefits were correctly terminated effective February 2016 and ongoing.

30. In careful review of the cited authorities and evidence, the undersigned concludes the petitioners did not meet the burden of proof indicating respondent incorrectly denied P.L.'s Medicare Savings Program Medicaid benefits effective May 2016 and ongoing.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, S.L. and P.L's 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 29 day of June, 2016,

in Tallahassee, Florida.

Mary Jane Stafford

Mary Jane Stafford
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: [redacted] Petitioner
itioner
Office of Economic Self Sufficiency

May 17, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-02567
16F-02568

PETITIONER,

Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 02 Leon
UNIT: 88113

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on May 4, 2016 at 11:06 a.m.

APPEARANCES

For the Petitioner:

For the Respondent: Antoinette Santillo, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of February 9, 2016 denying his application for Food Assistance and Adult Related Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The Department submitted evidence on April 28, 2016, which was entered as Respondent Exhibit 1.

FINDINGS OF FACT

1. The petitioner filed an application on January 7, 2016 for Food Assistance and Adult Related Medicaid. The petitioner is age 61. He resides in the home with his wife, age 60.

2. The Department issued a Notice of Case Action to the petitioner and representative on January 13, 2016 requiring an interview to be completed on or before January 22, 2016. This notice was not program specific but intended for all programs.

3. The petitioner and representative confirmed their addresses on the Notices were correct, but both state they did not receive the Notice requesting an interview. The representative did acknowledge that sometimes the mail for her office is delayed due to routing through the hospital.

4. The Department issued a Notice of Case Action on January 25, 2016 to the petitioner and his representative. This Notice informed the petitioner of the missed interview and the requirement to complete the interview within 30 days of the date of application.

5. The petitioner and representative confirmed their addresses on the Notices were correct, but both state they did not receive the Notice of missed interview.

6. The Department has not received any returned mail on the petitioner's case for either the petitioner or his representative. The Department assumed as the mail was not returned the petitioner and his representative received it.

7. Due to the discrepancy of whether or not the Notices were received, the undersigned must make the finding. The Department mailed the notices following proper business practice and they have not been returned to the Department. The petitioner confirmed his address and made no claim of difficulty receiving his mail. The petitioner's representative acknowledge problems with receiving mail once it arrived at the facility, but it was not a postal issue, but a "sorting and delivery" issue within the facility. The undersigned relied on the presumption that correspondence properly mailed and not returned with no rebuttal evidence received (Brown v. Giffen Industries., Fla. 1973, 281 So.2d 897, 1973 Fla. SCt 997) to make the finding that the petitioner and representative did receive the Notices at issue.

8. The Department issued a Notice of Case Action on February 9, 2016 to the petitioner informing him of the case denial for Food Assistance and Adult Related Medicaid due to failure to complete an interview necessary to determine eligibility for the program.

9. The petitioner's representative questioned why an interview was required as the disability report was submitted with his application. It is her understanding that an interview can be waived if the completed disability report was submitted with the application.

10. The Department confirmed the receipt of the disability report on January 7, 2016.

11. The Department was unaware of any policy that allowed the interview to be waived for either the Food Assistance or Medicaid program.

CONCLUSIONS OF LAW

12. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

13. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

FOOD ASSISTANCE

14. Federal Food Assistance Regulations found at 7 C.F.R. § 273.2 "Office operations and application processing state in relevant part:

> (e) Interviews. (1) Except for households certified for longer than 12 months, and except as provided in paragraph (e)(2) of this section, households must have a face-to-face interview with an eligibility worker at initial certification and at least once every 12 months thereafter. State agencies may not require households to report for an in-office interview during their certification period, though they may request households to do so. For example, State agencies may not require households to report en masse for an in-office interview during their certification periods simply to review their case files, or for any other reason. Interviews may be conducted at the food stamp office or other mutually acceptable location, including a household's residence.
> ...
> (2) The State agency must notify the applicant that it will waive the face-to-face interview required in paragraph (e)(1) of this section in favor of a telephone interview on a case-by-case basis because of household hardship situations as determined by the State agency. These hardship conditions include, but are not limited to: Illness, transportation difficulties, care of a household member, hardships due to residency in a rural area, prolonged severe weather, or work or training hours which prevent the household from participating in an in-office interview. The State agency must document the case file to show when a waiver was granted because of a hardship. The State agency may opt to waive the face-to-face interview in favor of a telephone interview for all households which have no earned income and all members of the household are elderly or disabled. Regardless of any approved waivers, the State agency must

> grant a face-to-face interview to any household which requests one. The State agency has the option of conducting a telephone interview or a home visit that is scheduled in advance with the household if the office interview is waived.

15. Fla. Admin. Code § 65A-1.205 “Eligibility Determination Process” states in relevant part:

> (1)...
> (a) The Department must determine an applicant’s eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter. **It is the applicant’s responsibility to keep appointments with the eligibility specialist and furnish information, documentation and verification needed to establish eligibility. If the Department schedules a telephonic appointment, it is the Department’s responsibility to be available to answer the applicant’s phone call at the appointed time.** If the information, documentation or verification is difficult for the applicant to obtain, the eligibility specialist must provide assistance in obtaining it when requested or when it appears necessary. (emphasis added)

16. The findings show the Department issued a Notice that required the petitioner to call in for an interview on or before January 22, 2016. The findings also show the petitioner did not call in for that interview or prior to the 30th day from date of application. The undersigned concludes the Department correctly denied the petitioner’s Food Assistance application due to failure to complete an interview necessary to determine eligibility.

ADULT-RELATED MEDICAID

17. The findings show the petitioner is a 61-year-old male with no minor children in the home. Fla. Admin. Code 65A-1.705 “Family-Related Medicaid General Eligibility Criteria, sets forth the rules to be eligible under the Family-Related Medicaid groups. The petitioner is over age 21 and has no minor children in his home. The undersigned concludes the petitioner does not meet the criteria to be eligible for

Medicaid under the Family-Related Medicaid Program. The undersigned further concludes the Department correctly began to review the petitioner's case for potential eligibility under the Adult-Related Medicaid Program rules.

18. The definition of the MEDS-AD Demonstration Waiver is found in Fla. Admin. Code R. 65A-1.701 "Definitions":

> (20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services.

19. Fla. Admin. Code R. 65A-1.711 "SSI-Related Medicaid Non-Financial Eligibility Criteria" states in relevant part:

> To qualify for Medicaid an individual must meet the general and categorical requirements in 42 C.F.R. Part 435, subparts E and F (2007) (incorporated by reference), with the exception that individuals who are neither aged nor disabled may qualify for breast and cervical cancer treatment, and the following program specific requirements as appropriate. Individuals who are in Florida temporarily may be considered residents of the state on a case-by-case basis, if they indicate an intent to reside in Florida and can verify that they are residing in Florida.
> (1) For MEDS-AD Demonstration Waiver, the individual must be age 65 or older, or disabled as defined in 20 C.F.R. § 416.905 (2007) (incorporated by reference).

20. 20 C.F.R. § 416.905 "Basic definition of disability for adults" states in relevant part:

> (a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see §416.960(b)) or any other substantial gainful work that exists in the national economy.

21. The Department's Program Policy Transmittal I-11-12-0017 "Change in Expedited Disability Interview Procedure" dated December 2, 2011 states in relevant part:

> The purpose of this memorandum is to provide ACCESS Florida staff with information about conditions under which the expedited disability interview can be waived.
>
> Background
> Certain Medicaid applications require a disability determination. An interview is conducted with the customer or his representative and information needed by the Division of Disability Determinations (DDD) is entered onto the Disability Determination (DSUM) driver on FLORIDA. Prior to the addition of the DSUM driver to the FLORIDA system, the eligibility specialist manually completed the Disability Report (CF-ES 2911) and if needed a Supplemental Mental Disability Report (CF-ES 2912) based on responses from the customer during the interview. The 2911 and 2912 forms have remained available and are sometimes submitted with a Medicaid application.
>
> New Procedure
> The interview may be waived when Disability Report(s) with sufficient information to complete the DSUM driver are received with an application. Attempt to contact the customer or his representative by phone to let him or her know the interview requirement has been waived, explain the application process and address any outstanding questions. If unable to reach the customer, record attempted contact in CLRC.
> To waive the interview, minimum information to be included on the Disability Report(s) includes:
> • Specific medical condition(s).
> • Information regarding physicians and medical facilities visited in the last 12 months.
> Reminders:
> • The time standard to complete the disability packet and request a disability decision from DDD has not changed.
> • Include any available medical records when submitting the disability packet. DDD indicated that complete information including hospital admission notes, discharge summaries, consultation notes from medical specialists and level of education are especially helpful when evaluating an individual's medical condition and lessen the time to issue a disability decision. Ensure that all verifications are scanned into document imaging.

• Applicants are not pended to provide medical records as the responsibility continues to reside with DDD to request these documents from providers, however, if the customer has and provides them, the process for DDD may be shortened.

22. The findings show the petitioner has not previously been established as disabled by Social Security. The findings also show the petitioner did submit a disability report with his application on January 7, 2016. The undersigned concludes the Department failed to follow the above policy and waive the interview requirement for the petitioner for Adult-Related Medicaid as the disability report was received with his application.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted in part and denied in part. The appeal (16F-02567) for Food Assistance is denied. The appeal (16F-02568) for Adult-Related Medicaid is remanded to the Department for the determination of disability by DDD and then for the determination of eligibility by the Department. The Department is to issue appropriate notices to include appeal rights regarding the new eligibility decision by the Department.

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 ___May__________, 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: [redacted] Petitioner
Office of Economic Self Sufficiency
[redacted]

May 24, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-02575

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 10 Polk
UNIT: AHCA

RESPONDENT.

_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 4, 2016, at approximately 1:05 p.m. All parties appeared from separate locations.

APPEARANCES

On behalf of Petitioner:

On behalf of Respondent: Stephanie Lang, RN Specialist
Agency for Healthcare Administration ("Agency")

STATEMENT OF ISSUE

Whether the Respondent was correct to partially deny Petitioner's request for a 20 hour increase in personal care service hours. Respondent approved 11 additional hours per week (for a total of 26 hours per week) for Petitioner but denied the remaining 9 hours of her request. Petitioner holds the burden of proof in this case by a preponderance of the evidence.

PRELIMINARY STATEMENT

Petitioner's representative was her only witness at the hearing. Respondent's witnesses from United Health Plan were as follows: Christian Laos (Senior Compliance Analyst) and Dr. Sloane Karver (Long Term Care Medical Director).

Petitioner submitted one exhibit, marked and entered as Petitioner's Exhibit 1. Respondent admitted four exhibits, marked and entered as Respondent's Exhibits 1 through 4. The record closed at the end of the hearing on May 4, 2016.

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 an elderly female with [redacted] She is a Medicaid recipient who receives services through United Healthcare. Petitioner is on the participant-directed option (PDO) plan, which means she can pay a caregiver of her own choice. Her granddaughter is currently serving as her paid caregiver.

2. Petitioner was living with her husband until his death in February 2016. Her granddaughter was the caregiver for both of them. During that time, the granddaughter was paid for her services. She was paid for approximately 30-40 hours per week for caring for both adults. Petitioner was receiving 15 hours per week of care for herself only. Since Petitioner's spouse's death, the granddaughter's income has declined. Her income went down because she lost the hours she received for caring for Petitioner's spouse.

3. Since Petitioner's spouse's death, Petitioner's health has declined. She requires more assistance with activities of daily living (ADLs) and she is depressed. She

requires constant supervision because she is at risk of hurting herself or leaving the home and getting lost.

4. The plan completed an assessment of Petitioner's functional skills on March 14, 2016. As a result of that assessment, her case manager, along with Petitioner's caregiver, requested an increase in hours. The request was for 35 hours per week of care. The plan agreed to approve part of the additional hours requested, granting a total of 26 hours per week to Petitioner. The remaining nine hours requested were denied.

5. A notice dated March 21, 2016 explaining the denial was sent to Petitioner. It denied the additional nine hours as not medically necessary. The plan's notice indicated that based on the assessment, 26 hours per week was enough to meet her needs.

6. The assessment indicates the number of minutes and hours that the plan believes are necessary overall to complete the listed activities. It bases this number off of the amount of time it would take to complete each activity for a nursing home resident of similar need. Then it indicates the minutes or hours that the family (also called unpaid natural supports) would be expected to assist with care. The total amount of time needed for care minus the amount of expected family contribution equals the amount of hours that the plan approves to pay for care. The amount is rounded to the nearest number. The plan's care is considered a supplement to existing supports.

7. The plan will only pay for the hours that would be considered necessary for a paid caregiver to assist the family. In this case, the family member is also the paid caregiver through the PDO program. The plan does not factor this in during its medical

necessity analysis. It will not grant a family member more hours of care than it would pay an independent provider, nor does the provider's financial need factor into the analysis.

8. The plan offered Petitioner various options to assist with care and give the caregiver a break. The plan offered respite hours, adult day care, or nursing home placement. Petitioner's caregiver believes that as Petitioner has a cognitive disorder, a change in environment or caregiver will not benefit Petitioner but harm her instead. Petitioner does not want nursing home placement. Petitioner is encouraged to review these potential options with her case manager should the need arise.

CONCLUSIONS OF LAW

9. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80, Florida Statutes.

10. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.

11. This hearing was held as a de novo proceeding pursuant to Florida Administrative Code Rule 65-2.056.

12. Florida Administrative Code, 59G-1.010(202) defines personal care as "medically necessary assistance with daily living activities."

13. Florida Administrative Code, 59G-1.010(166), defines medical necessity as follows:

> "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

14. The Florida Medicaid Home Health Services Coverage and Limitations Handbook (October 2014) ("Medicaid Handbook") has been incorporated by reference into Florida Administrative Code Rule 59G-4.130(2).

15. Page 1-2 of the Medicaid Handbook defines personal care services:

> Personal care services provide medically necessary assistance with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL) that enable the recipient to accomplish tasks that they would normally be able to do for themselves if they did not have a medical condition or disability.
>
> ADLs include:
> • Eating (oral feedings and fluid intake);
> • Bathing;
> • Dressing;
> • Toileting;
> • Transferring; and
> • Maintaining continence (examples include taking care of a catheter or colostomy bag or changing a disposable incontinence product when the recipient is unable to control his bowel or bladder functions).

16. While fee-for-service Medicaid restricts personal care services to children under age 21, these services are offered under some long term care plans such as Petitioner's

plan. In the absence of a long term care plan Handbook, the service definitions and explanations in the Medicaid Handbook referenced above provide guidance. Personal care hours are intended to assist a person with their normal ADLs and IADLs to ensure they are healthy at home.

17. Respondent approved 26 hours of home health services, and 21 of these hours are used as personal care services. Personal care services are for ADL assistance only, not for supervision. Appendix L of the Medicaid Handbook, titled “Medicaid Review Criteria for Personal Care Services”, contains a list of tasks and a general time allowance for each in order to assess a recipient’s needs and necessary hours.

18. The time that the plan noted in the assessment is consistent with the general time allowances set forth at page L-4 of the Medicaid Handbook. For example, both the plan and the Handbook permit 15 minutes for dressing. Petitioner was given 30 paid minutes per day for dressing, which is 15 minutes twice per day. The time given for grooming was also consistent with the Handbook, but the plan determined this assistance could be provided by unpaid family support. The plan also did not provide any paid support for helping with walking, escorting her, assistance with medications, or shopping, as the family can provide these things. There was no evidence presented that indicated Petitioner needed additional time to complete tasks or that the family was unable to help with the less intensive tasks the plan determined.

19. There is no evidence that Petitioner’s needs are not being met with the current hours. There is no evidence that her health and safety are in jeopardy without providing more hours. This request is mostly for the caregiver’s benefit, as she would like to make additional income. Although Petitioner does have significant needs and requires

assistance and supervision, there is no evidence that she does not have enough hours to care for her needs between the paid and unpaid supports.

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 24 day of May, 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 T[redacted] Petitioner
Don Fuller, Area 6, AHCA Field Office Manager
MEDICAID FAIR HEARING United Healthcare

Jun 28, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-02581

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 DADE
UNIT: AHCA

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 10, 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 action to partially deny the petitioner's request for Speech Therapy (ST) service hours for the certification period February 23, 2016 through August 20, 2016, was correct. The respondent bears the burden of proof by a preponderance of the evidence in this matter

PRELIMINARY STATEMENT

Appearing as a witness for the petitioner was [redacted], the petitioner's speech therapist. The petitioner did not submit any documents as evidence for the hearing.

Appearing as a witness for the respondent was Darlene Calhoun, D.O., Physician-Consultant with eQHealth Solutions, Inc. Respondent submitted the following documents as evidence for the hearing, which were marked as Respondent composite Exhibit 1: Statement of Matters, Outpatient Review History, Denial Notices, and Speech Therapy reports.

Also present for the hearing was a Spanish language interpreter, [redacted] Interpreter Number [redacted] from [redacted]

FINDINGS OF FACT

1. The petitioner's ST service provider, [redacted] (hereafter referred to as "the provider"), requested the following ST service hours for the certification period at issue: 12 units (3 hours) weekly. Each unit is the equivalent of fifteen (15) minutes.

2. eQHealth Solutions, Inc. is the Quality Improvement organization (QIO) contracted by the respondent to perform prior authorization reviews for therapy services. The provider submitted the service request through an internet based system. The submission included, in part, information about the petitioner's medical conditions; his functional limitations; and other pertinent information related to the household.

3. eQHealth Solutions' personnel had no direct contact with the petitioner, his family, or his physicians. All pertinent information was submitted by the provider directly to eQHealth Solutions.

4. The medical information submitted by the provider contained, in part, the following information in regard to the petitioner:

5. The petitioner has been receiving speech therapy services since at least 2011, and he also receives occupational therapy and physical therapy through the Medicaid Program. He received 12 units (3 hours) weekly of speech therapy in the prior certification period.

6. A Plan of Care was also submitted by the provider. The document was signed by a physician and outlined the type of assistance to be provided by the ST provider. The long-term goals include the following:

- Improving articulation skills
- Improving expressive language skills
- Improving receptive language skills
- Improving pragmatic skills

7. A physician at eQHealth Solutions, who is board-certified in pediatrics, reviewed the submitted information and partially denied the requested ST services, approving 4 units (1 hour) weekly rather than the requested 12 units (3 hours) weekly. The rationale for the decision was: "Submitted information does not support the medical necessity for the requested frequency and/or duration. Therapy is needed to improve

articulation, expressive language, receptive language, and pragmatic skills. The patient has been receiving therapy since 2011 with modest progress." A notice of this determination was sent to all parties on February 25, 2016.

8. The above notice stated that a reconsideration review of this determination by eQHealth could be requested, and additional information could be provided with the request for reconsideration. A reconsideration review was requested on February 29, 2016 by the petitioner's provider.

9. A second physician at eQHealth Solutions reviewed the submitted information and upheld the initial decision to approve 1 hour weekly of ST services. A notice of this reconsideration decision was mailed to all parties on March 3, 2016.

10. The petitioner thereafter requested a fair hearing and this proceeding followed.

11. The respondent's witness, Dr. Calhoun, testified that the reduction of the petitioner's speech therapy service to 1 hour weekly was appropriate because he has been receiving therapy since 2011 and has made only modest progress since then. In addition, she stated the therapy goals are the same as the prior goals with targeted performance levels being increased from 70% to 80%. She also stated that services should be reduced over time as a home therapy program is developed.

12. The petitioner's mother testified her son's ST services should not be reduced because she believes he is making progress in therapy and people at his school can understand him better now.

13. The petitioner's therapy provider testified that he has achieved a 23 point gain in articulation skills since August of 2015 when he changed therapy providers. She also

stated the therapy goals have remained the same because he has not yet mastered them, although he is making progress toward his goals.

14. ST service for children is a covered service under the Medicaid State Plan in Florida. These services are provided in accordance with the respondent's Therapy Services Coverage and Limitations Handbook ("Therapy Handbook"), effective August, 2013.

CONCLUSIONS OF LAW

15. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Fla. Stat. § 120.80.

16. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

17. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

18. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the respondent since the petitioner had been previously approved for 12 units weekly of speech therapy service and the Respondent is seeking to reduce this service to 4 units weekly. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

19. The Florida Medicaid Program is authorized by Chapter 409, Fla. Stat. and Chapter 59G, Fla. Admin. Code. The Medicaid Program is administered by the respondent.

20. The petitioner has requested ST services. As the petitioner is under 21 years of age, the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements apply to the evaluation of the petitioner's eligibility for or amount of this service.

21. The Centers for Medicare and Medicaid Services, State Medicaid Manual makes available to all State Medicaid agencies informational and procedural material needed by the States to administer the Medicaid program. It is the method by which the Health Care Financing Administration (HCFA) issues mandatory, advisory, and optional Medicaid policies and procedures to the Medicaid State agencies.

22. The State Medicaid Manual in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services section states in part:

> 5010. Overview
> A. Early and Periodic Screening, Diagnostic and Treatment Benefit.--
> Early and periodic screening, diagnostic and treatment services (EPSDT) is a required service under the Medicaid program for categorically needy individuals under age 21…
>
> 5110. Basic Requirements
>
> OBRA 89 amended §§1902(a)(43) and 1905(a)(4)(B) and created §1905(r) of the Social Security Act (the Act) which set forth the basic requirements for the program. Under the EPSDT benefit, you[1] must provide for screening, vision, hearing and dental services at intervals which meet reasonable standards of medical and dental practice established after consultation with recognized medical and dental organizations involved in child health care. You must also provide for medically necessary screening, vision, hearing and dental services regardless of whether such services coincide with your established periodicity schedules for these services. Additionally, the Act requires that any service which you are permitted to cover under Medicaid that is necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be provided to EPSDT participants regardless of whether the service or item is otherwise included in your Medicaid plan.

[1] "You" in this manual context refers to the state Medicaid agency.

23. The service the petitioner has requested (ST services) is one of the services provided by the state to treat or ameliorate an individual's conditions under the State plan. Chapter 409.905, Fla. Stat., states, in part:

> Any service under this section shall be provided only when medically necessary …

24. The issue to be decided is the medical necessity of the service or amount of service. The State Medicaid Manual provides for limitations on services as follows:

> 5110. Basic Requirements…
> …Services under EPSDT must be sufficient in amount, duration, or scope to reasonably achieve their purpose. The amount, duration, or scope of EPSDT services to recipients may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. Appropriate limits may be placed on EPSDT services based on medical necessity.
>
> 5122. EPSDT Service Requirements
> F. Limitation of Services.--The services available in subsection E are not limited to those included in your State plan.
> Under subsection E, the services must be "necessary . . . to correct or ameliorate defects and physical or mental illnesses or conditions . . ." and the defects, illnesses and conditions must have been discovered or shown to have increased in severity by the screening services. You make the determination as to whether the service is necessary. You are not required to provide any items or services which you determine are not safe and effective or which are considered experimental.
>
> 5124. Diagnosis and Treatment
> B. Treatment.--
> 1. General. - You must make available health care, treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services. Treatment services may be limited as described in §5122 F.

25. Once a service has been identified as requested under EPSDT, the Medicaid program determines the amount or necessity for that service based on the State of Florida's published definition of medical necessity. The Fla. Admin. Code R. 59G-1.010 defines medical necessity:

> (166) 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider…
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services do not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

26. Based upon the information submitted by the petitioner's provider, eQHealth Solutions completed a prior authorization review to determine medical necessity for the requested ST services.

27. In the Petitioner's case, the respondent has determined that 4 units (1 hour) weekly of ST service is medically necessary, rather than the 12 units (3 hours) weekly requested by the petitioner. The petitioner was previously approved for 12 units of speech therapy weekly.

28. Fla. Stat. § 409.913 governs the oversight of the integrity of the Florida Medicaid Program. Section (1)(d) sets forth the "medical necessity or medically necessary" standards, and states in pertinent part as follows:

> "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice*….*

Section (1)(d) goes on to further state:

> …For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided*.*

29. Section (1)(d) highlights that the Agency makes the final decision regarding whether or not a requested service is medically necessary. As stated above, this proceeding is a de novo proceeding for the purpose of the Agency reaching its final decision. The final decision making authority for this proceeding has been delegated to the hearing officer in Fla. Admin. Code R. 65-2.066.

30. ST services, also referred to as speech-language pathology services, are described on page 1-4 of the Therapy Handbook as follows:

> Speech-language pathology services involve the evaluation and treatment of speech-language disorders.
>
> Services include the evaluation and treatment of disorders of verbal and written language, articulation, voice, fluency, phonology, mastication, deglutition, cognition, communication (including the pragmatics of verbal communication), auditory processing, visual processing, memory, comprehension and interactive communication as well as the use of instrumentation, techniques, and strategies to remediate, maintain communication functioning, acquire a skill set, restore a skill set, and

> enhance the recipient’s communication needs, when appropriate. Services also include the evaluation and treatment of oral pharyngeal and laryngeal sensorimotor competencies.

31. The Therapy Handbook on page 2-2 sets forth the requirements for ST services, as follows:

> Medicaid reimburses for services that are determined medically necessary and do not duplicate another provider’s service.

32. The petitioner’s physician ordered a ST service frequency greater than that approved by eQHealth Solutions. Rule 59G-1.010(166) (c), however, specifically states a prescription does not automatically mean the requirements of medical necessity have been satisfied.

33. The respondent’s witness, Dr. Calhoun, stated she believes the services should be reduced at this time since the petitioner has only made only modest progress in therapy and he is working on the same therapy goals.

34. The petitioner’s witnesses stated he has made some improvements and progress in therapy and his goals have stayed the same because he has not yet mastered them.

35. After considering all the documentary evidence and witness testimony presented, the undersigned concludes the respondent has not met its burden of proof in demonstrating it was correct in reducing the requested speech therapy services for the certification period at issue. The petitioner’s speech therapist provided testimony that supports continuing the therapy at the current level. Although he may have been making modest progress toward his therapy goals, he has demonstrated some

improvements according to the therapy reports and the testimony of his mother and therapist.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is GRANTED, and the petitioner shall continue receiving 12 units (3 hours) of speech therapy services weekly for the current certification period.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigence to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 28 day of June, 2016, in Tallahassee, Florida.

Rafael Centurion
Hearing Officer
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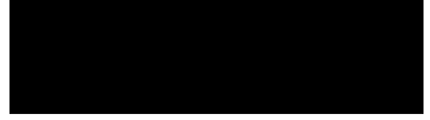
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] PETITIONER
RHEA GRAY, AHCA AREA 11, FIELD OFFICE MANAGER

Jun 03, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS



APPEAL NO. 16F-02583

PETITIONER,
Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 DADE
UNIT: AHCA,

And

HUMANA, INC.

RESPONDENTS.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 10, 2016 at 11:30 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 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 submitted documents and medical records as evidence for the hearing, which were marked as Petitioner Exhibit 1.

The Respondent submitted the following documents into evidence, which were marked as Respondent Exhibit 1: fair hearing summary, notice of action and related documents, and medical records.

Appearing as witnesses for the Respondent were Stacy Larsen, Clinical Analyst, and Dr. Ian Nathanson, Medical Director, for Humana, which is the Petitioner's managed health care plan.

Humana was added as a Respondent pursuant to its request to be added as a party to this proceeding.

FINDINGS OF FACT

1. The Petitioner is a fifty-eight (58) year old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. She receives services under the plan through Humana.

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 Humana provide services to Medicaid recipients pursuant to a contract with AHCA.

3. The Petitioner lives with her 17-year-old son, who attends school. Her medical issues include [redacted]. She uses a walker for ambulation.

4. On or about February 29, 2016, Petitioner's home health services provider submitted an authorization request to Humana for approval of four (4) hours of home health aide services daily – 2 hours in the morning and 2 hours in the afternoon.

5. On or about March 1, 2016, Humana informed the Petitioner by written notice that her request for home health aide services had been partially denied. The notice from Humana stated it would approve only 1 hour per day of home health aide services. Humana's decision was based on medical necessity considerations.

6. The Petitioner subsequently made a request for a fair hearing and this proceeding followed. Humana administratively approved the continuation of the 4 hours of services daily while the hearing process was pending, but due to an apparent misunderstanding or miscommunication between Humana and/or the service provider, the Petitioner has not been receiving home health services since the partial denial notice was issued.

7. The Petitioner testified she needs assistance at least twice per day from a home health aide to help her with daily living activities such as bathing, skin care, hair care, foot care, meal preparation, light housekeeping, laundry, and shopping. She stated she cannot get into the bathtub by herself.

8. The Respondent’s witness, Dr. Nathanson, stated he would be willing to approve 2 home health aide visits daily for the Petitioner after having heard her testimony about her needs. He also pointed out that since the Petitioner is over age 21, the appropriate service for her is home health visits rather than hourly home health aide services. A home health aide visit can be up to 3 hours. He also stated that activities such as shopping are not appropriate tasks to be performed by a home health aide under Medicaid guidelines.

9. 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

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 Fla. Stat. § 120.80.

11. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

12. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

13. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the Respondent since it was seeking a reduction in Petitioner’s services. The standard of proof in an administrative hearing is a preponderance of the evidence.

The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

14. 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, AHCA. The Home Health Handbook is incorporated by reference in Chapter 59G-4, Florida Administrative Code.

15. 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.

16. 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.

17. Humana 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 her is home health visits. Therefore, Humana was correct in transitioning the Petitioner from hourly home health services to home health visits.

18. Humana, through Dr. Nathanson, has indicated its willingness to approve 2 home health aide visits daily for the Petitioner. This will provide her with assistance in the morning and afternoon, which was what she was receiving previously. The hearing officer cannot address the customer service issues which the Petitioner referred to in her testimony which resulted in her going without any services for a period of time. The Petitioner should continue to work with Humana and the home health provider to resolve any such issues.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is GRANTED, in part, and the Petitioner shall receive two (2) home health aide 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 __03___ day of __June__________, 2016,

in Tallahassee, Florida.

Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] PETITIONER
RHEA GRAY, AHCA AREA 11, FIELD OFFICE MANAGER
HUMANA, INC.

Jun 29, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-02612

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 DADE
UNIT: AHCA

RESPONDENT.

______________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on May 20, 2016 at 10:00 a.m. in Doral, Florida.

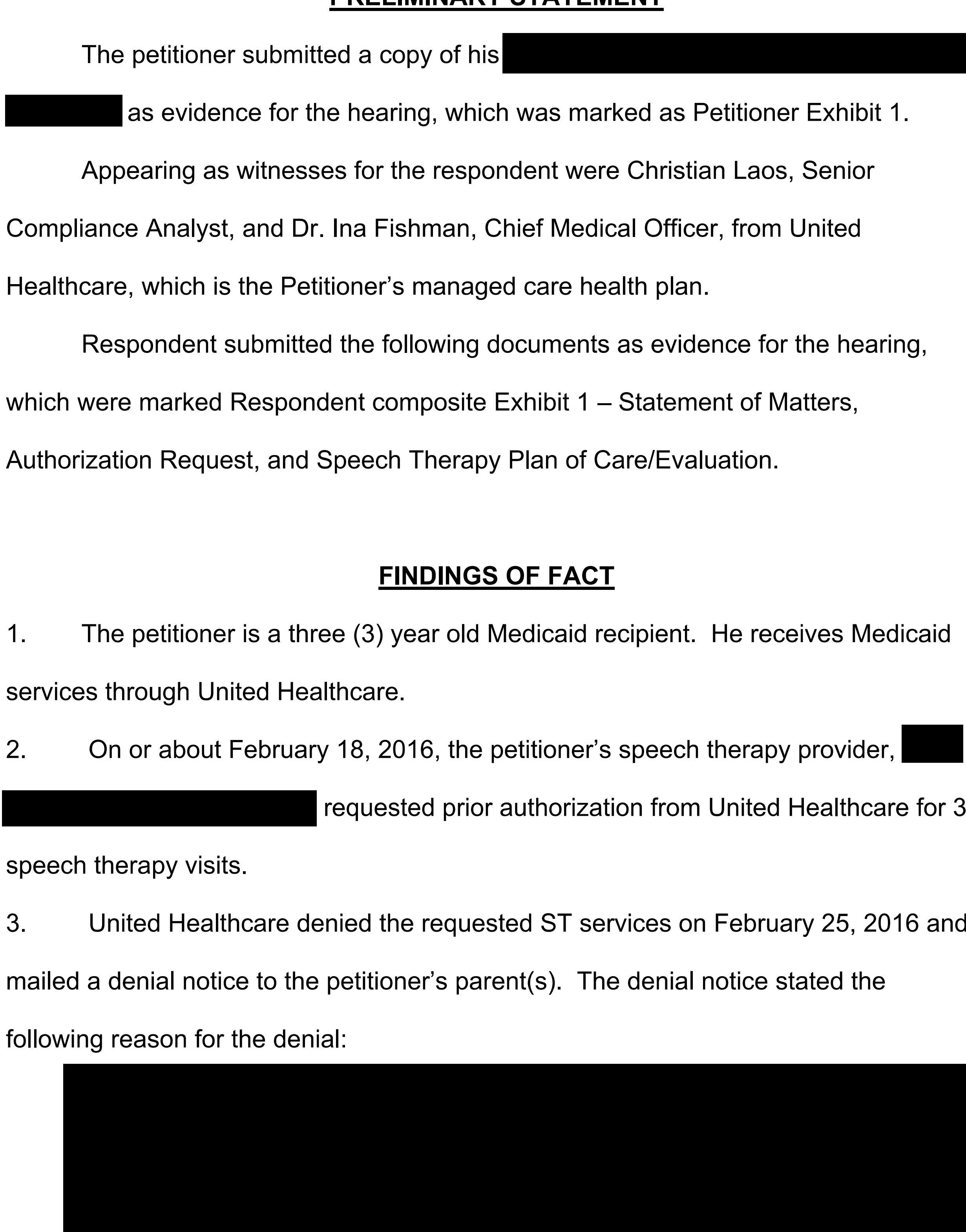
APPEARANCES

For the Petitioner:

For the Respondent: Monica Otalora, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny the petitioner's request for approval of an out-of-network Speech Therapy (ST) provider was correct. The petitioner bears the burden of proof in this matter by a preponderance of the evidence.



PRELIMINARY STATEMENT

The petitioner submitted a copy of his as evidence for the hearing, which was marked as Petitioner Exhibit 1.

Appearing as witnesses for the respondent were Christian Laos, Senior Compliance Analyst, and Dr. Ina Fishman, Chief Medical Officer, from United Healthcare, which is the Petitioner's managed care health plan.

Respondent submitted the following documents as evidence for the hearing, which were marked Respondent composite Exhibit 1 – Statement of Matters, Authorization Request, and Speech Therapy Plan of Care/Evaluation.

FINDINGS OF FACT

1. The petitioner is a three (3) year old Medicaid recipient. He receives Medicaid services through United Healthcare.

2. On or about February 18, 2016, the petitioner's speech therapy provider, requested prior authorization from United Healthcare for 36 speech therapy visits.

3. United Healthcare denied the requested ST services on February 25, 2016 and mailed a denial notice to the petitioner's parent(s). The denial notice stated the following reason for the denial:

> guidelines, care must be given by doctors who work with your child's health plan. The request for services from [redacted] Therapy is not approved.

4. The petitioner thereafter requested a fair hearing and this proceeding followed.

5. The petitioner's mother explained that her son had been receiving therapy services from this particular provider since August of 2015. This provider was performing the therapy at the petitioner's school three times weekly. However, in February of 2016, the provider ceased being a part of the United Healthcare network of providers.

6. The petitioner's mother also stated she attempted to arrange for therapy services with other providers within United's network, but some were not taking new patients, some were not open late enough in the afternoon, and some were far away from her home. She prefers a provider who is able to provide the therapy services at her son's school as the previous provider was doing. She also mentioned her son receives group therapy at his school through the school system, but he also ne0eds additional individualized therapy services. She also expressed her frustration that she was not given a completely accurate list of network providers by United when this issue first arose.

7. The respondent's witness, Dr. Fishman, stated the requested provider actually ceased to be a part of United's network in December of 2015, but services were approved for 60 days thereafter due to continuity of care requirements. She also stated that United has a large network of therapy providers and United will only approve an out-of-network provider if there is a lack of providers in the area or there is a need for a

unique service. She also stated United will not approve an out-of-network provider based on convenience factors.

8. ST service for children is a covered service under the Medicaid State Plan in Florida. These services are provided in accordance with the respondent's Therapy Services Coverage and Limitations Handbook ("Therapy Handbook"), effective August, 2013.

CONCLUSIONS OF LAW

9. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Fla. Stat. § 120.80.

10. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

11. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

12. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

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. United Healthcare provides services to certain Medicaid recipients based on a contract with AHCA.

14. In the petitioner's case, United Healthcare is not disputing the medical necessity of the requested ST services, but has denied the service because the provider requested is not a part of the United Healthcare network of providers.

15. The petitioner's mother expressed her desire for her son to continue seeing the same therapy provider.

16. United Healthcare's position is that there are other in-network therapy providers that are able to provide the requested therapy services.

17. After considering all the documentary evidence and witness testimony presented, the undersigned concludes the petitioner has not demonstrated that United Healthcare was incorrect in denying the request for the out-of-network therapy provider. Although the petitioner's mother understandably prefers that her son continuing seeing the same provider that was providing services to him for the past 8 or 9 months, United Healthcare has other providers within its network that can provide speech therapy services. The petitioner's mother should seek out these other providers and arrange for her son's 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 indigence to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 29 day of June, 2016,

in Tallahassee, Florida.

Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] PETITIONER
RHEA GRAY, AHCA AREA 11, FIELD OFFICE MANAGER

May 26, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-02639
APPEAL NO. 16F-03813
APPEAL NO. 16F-03814

PETITIONER,

Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 19 MARTIN
UNIT: 88230

RESPONDENT.

______________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on May 7, 2016 at 11:35 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner:

For the Respondent: Stacy Ann Mills, supervisor

STATEMENT OF ISSUE

A. At issue is the amount of Food Assistance Program (FAP) benefits the petitioner was approved to receive.

B. 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.

C. The petitioner is appealing the denial of eligibility for the Medicare Savings Program (MSP). In accordance with Fla. Admin. Code R. 65-2.060 (1), the petitioner carries the burden of proof by a preponderance of evidence in the three appeals.

PRELIMINARY STATEMENT

The respondent 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 May 18, 2016, for the petitioner to provide verification of his medical expenses to the respondent and for the respondent to update the petitioner's case and to provide updated budgets, new Notices of Case Action and the Running Record Comments (CLRC). The undersigned allowed additional time to both parties to provide the information. On May 20, 2016 the respondent provided Notices of Case Action. Budgets and the CLRC. The evidence was accepted, entered into evidence and marked and Respondent's Composite Exhibit 2. The record was closed on May 20, 2016.

FINDINGS OF FACT

1. On March 16, 2016, the petitioner submitted an application for Food Assistance Program (FAP) benefits and Medicaid benefits for himself (age 66) and his wife (age 63). On March 22, 2016 the petitioner submitted a second application for MSP. The petitioner receives Social Security (SS) Retirement of $1,778 monthly and Medicare part B. His Medicare Part B premium is $104.90. His wife receives Social Security Disability Income (SSDI) of $828. She does not receive Medicare. His household expenses are rent of $850, electricity of $125, telephone of $200 and water of $60. The petitioner also pays medical insurance with United Health Care of $27.50.

2. The Department processed the petitioner's applications and found the household over the income for FAP benefits, full Medicaid and the Medicare Savings Plan (MSP). Only eligibility for the Medically Needy Program was found.

3. On March 24, 2016, the respondent mailed the petitioner a Notice of Case Action, informing him that his Food Assistance application dated March 16, 2016 was denied. The reason given for the denial was that his household income was too high for the program. The same notice informed the petitioner and his wife that they were enrolled in the Medically Needy program with an estimated SOC of $2,344 and that they were both ineligible for the Qualifying Individual 1 program. The reason given for the denial was that their income was too high for the program.

4. On March 29, 2016, the petitioner requested a hearing to challenge the Department's actions.

5. At the hearing, the petitioner reported that he is paying for Medicare Part B of $104.70, United Health Care of $27.50 and prescriptions of an average of $200 monthly. He informed the undersigned that he sent his medical expenses to the Department. The respondent agreed to update the petitioner's case with his medical expenses and his insurance premium. The respondent also agreed to provide updated notices and new budgets. The new budgets updates are as follows.

Income(SS $1,882.90+SSDI $828	$2,711
Total household income	$2,711
Standard deduction for a household of 1	($155)
Excess medical expenses ($312.90-$35)=277.90	$277.90
Adjusted income after deductions	$2,278.

Shelter costs	$850
Standard utility Allowance	$345
Total rent/utility cost	$1,195
Shelter standard (50% adjusted income)	$1,139.05
Excess shelter deduction	$55.95
Adjusted income	$2,178.10
Excess Shelter Deduction	($55.95)
Adjusted income after shelter deduction	$2,222.15

6. The Department determined that the petitioner was over the net income limit; however, the minimum FAP allotment of $16 was issued.

7. On May 17, 2016, the respondent sent the petitioner a Notice of Case Action informing him that he was eligible for $16 in FAP benefits effective June 2016.

8. The respondent determined eligibility for the Medicare Savings Program by comparing the petitioner’s monthly household income of $2,711 to the maximum income for a couple of $1,803 for QI1 and found the household’s income was more than the maximum income limit allowed for the program.

9. On May 17, 2016, the respondent informed the petitioner that he was ineligible for Qualifying Individual 1.

10. On May 19, 2016, the respondent sent an updated Notice of Case Action informing the petitioner and his wife that each has a SOC of $2,345. The SOC was determined as follows. The respondent used the household monthly gross income of $2,711 and deducted a $20 unearned income disregard resulting to $2,691. The Medically Needy Income Limit (MNIL) for household of two, $241 was subtracted resulting to $2,450. The Medicare Part B of $104.90 was then subtracted resulting to the SOC of $2,345.

11. At the hearing, the respondent's representative stated she updated the petitioner's Medicare premium of $104.90 and his insurance premium of $27.50 as medical expenses. The respondent issued $16 for April 2016 ongoing, but no benefits were issued for March 2016 as March was a prorated month (the month of the application). The respondent looked at the petitioner's income as a couple.

12. The petitioner argues that he cannot purchase medication with the money he is getting from his SS and his wife's SSDI.

CONCLUSION OF LAW

13. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

14. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

The FAP benefits issue will be addressed first.

15. Federal regulation C.F.R. § 273.9 addresses income/allowable deductions budgeting in the FAP in part and states:

> (a) Income eligibility standards. Participation in the Program shall be limited to those households whose incomes are determined to be a substantial limiting factor in permitting them to obtain a more nutritious diet.
> (b) Definition of income…
> (2) Unearned income shall include, but not be limited to: …
> (ii) Annuities; pensions; retirement, veteran's, or disability benefits; worker's or unemployment compensation including any amounts deducted to repay claims for intentional program violations as provided in §272.12; old-age, survivors, or social security benefits…

16. Federal regulation 7 C.F.R. § 273.9(d) sets forth the specific deductions allowable in the calculation of the final Food Assistance Program benefit allotment. These **potential allowable deductions** are limited to include only: (1) standard deduction, (2) earned income deduction, (3) excess medical deduction, (4) dependent care deduction, (5) child support deduction, (6) standard utility allowance, and (7) shelter expenses.

17. The respondent must follow these federal budgeting guidelines when determining eligibility. It also directs the Department to consider Social Security Disability Income and retirement income as unearned income that must be included in the eligibility determination.

18. The federal regulation 7 C.F.R. § 273.10 (e) addresses "Calculating net income and benefit levels" as follows:

> (1) Net monthly income (i)…
> (A) Add the gross monthly income earned by all household members and the total monthly unearned income of all household members, minus income exclusions, to determine the household's total gross income…
> (C) Subtract the standard deduction.
> (D) If the household is entitled to an excess medical deduction as provided in §273.9(d)(3), determine if total medical expenses exceed $35. If so, subtract that portion which exceeds $35.
> (H) Total the allowable shelter expenses to determine shelter costs, unless a deduction has been subtracted in accordance with paragraph (e)(1)(i)(G) of this section. Subtract from total shelter costs 50 percent of the household's monthly income after all the above deductions have been subtracted. The remaining amount, if any, is the excess shelter cost, compute the shelter deduction according to paragraph (e)(1)(i)(I) of this section.
> (I) Subtract the excess shelter cost up to the maximum amount allowed for the area (unless the household is entitled to the full amount of its excess shelter expenses) from the household's monthly income after all other applicable deductions. Households not subject to a capped shelter expense shall have the full amount exceeding 50 percent of their net

income subtracted. The household's net monthly income has been determined.
(2) Eligibility and benefits…
(ii)(A)…the household's monthly allotment shall be equal to the maximum food stamp allotment for the household's size reduced by 30% of the household's net monthly income…
(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…

19. In accordance with the federal regulations, the Food Assistance standards for income and deductions appear in the Department's Program Policy Manual (Policy Manual), CFOP 165-22, at Appendix A-1. The 200% Federal Poverty level (FPL) for a household size of two effective October 2015 is $2,655. A two-person assistance group's net income limit is $1,328, the standard deduction was $155 and the standard utility allowance was $345. The same reference shows the maximum FAP benefits for two persons as $357 effective October 2015 and the minimum allotment is $16.

20. 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)(vi)(C) of this section, one- and two-person households shall be provided with at least the minimum benefit."

21. Federal regulations at 7 C.F.R. §273.10(e) (2)(ii)(B) states, "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."

22. The petitioner is aged and his wife is disabled and the household income is over 200% of the FPL, therefore he must meet 130% of the gross income level and 100% of the net income limit for be eligible for FAP benefits.

23. The above-cited regulation describes the eligibility process and defines deductions. The Standard Utility Allowance and the petitioner's rent expense make up his total shelter cost. The petitioner was credited with a standard deduction, an excess shelter deduction for the FAP budgets and an excess medical deduction. There is no indication the petitioner was eligible for any other deductions.

24. After considering the evidence, the testimony and the appropriate authorities cited above, the hearing officer could not find a more favorable outcome.

Medicaid Benefits will now be addressed

25. The Department determined the petitioner's Medicaid benefits under the SSI Related Program.

26. Fla. Admin. Code R. 65A-1.701, Definitions, states in part:

> (20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services.

27. The above authority explains that the MEDS-AD (full Medicaid for an aged or disabled person) has an income limit of 88% of the federal poverty level and in addition to meeting that limit the person must not have Medicare.

28. The Policy Manual, at Appendix A-9, lists the MEDS-AD income limit as $1,175 for a couple effective April 2016.

29. The above controlling authorities explain the full Medicaid coverage group (MEDS-AD Demonstration Waiver) in the SSI-Related Program is for individuals whose income is below the federal poverty level and are not receiving Medicare. The MEDS-

AD income limit for a couple is $1,175. The petitioner has Medicare benefits and the household income exceeds the income limit for full Medicaid benefits. Therefore, eligibility for full Medicaid benefits is not found. The undersigned further concludes Medically Needy eligibility must be explored for the petitioner.

<u>The Medically Needy share of cost will now be addressed</u>

30. Fla. Admin. Code R. 65A-1.701 (30) defines Share of Cost (SOC) as:

> Share of Cost (SOC): SOC represents the amount of recognized medical expenses that a Medically Needy enrolled individual or family must incur each month before becoming eligible to receive Medicaid benefits for medical expenses incurred during the remainder of the month.

31. Fla. Admin. Code R. 65A-1.710, SSI-Related Medicaid coverage Groups, states in part:

> (5) Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. §§ 1396a and 1396d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance due to their level of income or resources.

32. The above authority explains the Medically Needy Program is a coverage group for aged, blind or disabled individuals who do not qualify for full Medicaid due to their level of income.

33. Fla. Admin. Code R. 65A-1.702 (13) Determining Share of Cost (SOC). "The SOC is determined by deducting the Medically Needy Income Level from the individual's or family's income."

34. Federal Regulations at 20 C.F.R. § 416.1124 (c) (12), Unearned Income we do not count, states in part, "The first $20 of any unearned income in a month…"

35. Income budgeting is set forth in Fla. Admin. Code R. 65A-1.713. It states:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
> (h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses…
> (4) (c) Medically Needy. The amount by which the individual's countable income exceeds the Medically Needy income level, called the "share of cost", shall be considered available for payment of medical care and services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical costs. If countable income exceeds the Medically Needy income level the department shall deduct allowable medical expenses in chronological order, by day of service. Countable income is determined in accordance with subsection 65A-1.713(2), F.A.C. To be deducted the expenses must be unpaid, or if paid, must have been paid in the month for which eligibility is being determined or incurred and paid during the three previous calendar months to the month for which eligibility is being determined but no earlier than the three retroactive application months. The paid expense may not have been previously deducted from countable income during a period of eligibility. Medical expenses reimbursed by a state or local government not funded in full by federal funds, excluding Medicaid program payments, are allowable deductions. Any other expenses reimbursable by a third party are not allowable deductions. Examples of recognized medical expenses include:
> **1. Allowable health insurance costs such as medical premiums,** other health insurance premiums, deductibles and co-insurance charges; and,
> 2. Allowable medical services such as the cost of public transportation to obtain allowable medical services; medical services provided or prescribed by a recognized member of the medical community; and personal care services in the home prescribed by a recognized member of the medical community.

36. Fla. Admin. Code R. 65A-1.716 (2), Income and Resource Criteria, sets forth the Medically Needy Income Level for two person at $241.

37. The Policy Manual at passage 2440.0102, Medically Needy Income Limits (MSSI) states:

> When the assistance group has met the technical eligibility criteria and the asset limits, it is enrolled. There is no income limit for enrollment. The assistance group is income eligible (entitled to Medicaid) once income is less than or equal to the Medically Needy Income Level (MNIL) or medical

> bills equal the amount by which his income exceeds the MNIL. Once medical bills are equal to this surplus income, referred to as share of cost, the assistance group is eligible.
> The eligibility specialist must determine eligibility for Medically Needy any time the assistance group's income exceeds the income limits for another full Medicaid Program.

38. 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.

39. The hearing officer reviewed the respondent's calculation of the petitioner's SOC and found the respondent did not include the Humana Health Care premium of $27.50. The undersigned's calculation of the petitioner's SOC is as follows. A $20 unearned disregard, MNIL of $241, Medicare Part B premium of $104.90 and Humana Health Care of $27.50 was subtracted from the household's monthly income of $2,711, which resulted in a SOC of $2,318 ongoing (as the petitioner reported at the hearing and the respondent stated they received verification). The petitioner is found eligible for a lower remaining SOC than the respondent determined.

<u>The Medicare Saving Program will now be addressed</u>

40. Income limits for Medicare savings plan benefits are set forth in the Fla. Admin. Code R. 65A-1.713:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
> (b) For QMB, income must be less than or equal to the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C…
> (g) For SLMB, income must be greater than 100 percent of the federal poverty level but less than 120 percent of the federal poverty level.…
> (j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent

> of the federal poverty level. QI1 is eligible only for payment of the Part B Medicare premium through Medicaid.
> (2) Included and Excluded Income. For all SSI-related coverage groups the department follows the SSI policy specified in 20 C.F.R. 416.1100, et seq…
> (4) Income Budgeting Methodologies. To determine eligibility SSI budgeting methodologies are applied except where expressly prohibited by 42 U.S.C. §1396, or another less restrictive option is elected by the state under 42 U.S.C. §1396a(r)(2)...

41. The Policy Manual at 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.

42. 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…"

43. In Winick v. Dep't of Children and Family Services, 161 So.3d 464 (Fla. 2d DCA 2014), where an individual who receives Medicare Part A is applying for the Medicare Buy-In Program and lives with his/her spouse, the Department must determine eligibility using the family size of two. The facts show the petitioner is married and living with his wife. He is the only one in the household receiving Medicare, and he is requesting assistance with the payment of his Medicare Part B premium. The Policy Manual at Appendix A-9 sets forth that the income limit for QMB for a couple of $1,335, SLMB for a couple $1,602 and QI1 for a couple of $1,803 benefits. It is concluded that the

petitioner is ineligible for the MSP as his household income is over the income limit for the QMB, SLMB, or QI1 Program.

DECISION

1. Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal for FAP benefits is denied.

2. The appeal related to the Medicaid benefits is partially denied and partially granted. The respondent action to deny full Medicaid benefits is denied. The Department correctly determined enrollment in the Medically Needy Program, however, the remaining SOC is overstated. It is granted in part, in that the petitioner is eligible for a lower SOC, therefore the respondent is to take corrective action and include the medical insurance premium of $27.50 in the determination of the SOC.

3. The appeal related to the MSP is denied and the respondent's decision is upheld.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this ___26___ day of ___May___________, 2016,

in Tallahassee, Florida.

Christiana Gopaul Narine

Christiana Gopaul-Narine
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

May 11, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-02660
16F-02661

PETITIONER,

Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 Lake
UNIT: 88256

RESPONDENT.

_______________________________/

ORDER OF DISMISSAL DUE TO WITHDRAWAL

Pursuant to notice, a telephone hearing convened before the undersigned at 10:55 a.m. on May 4, 2016. Petitioner represented herself. Respondent was represented by Sylma Dekony, ACCESS Economic Self-Sufficiency Specialist II.

The parties completed a pre-hearing conference prior to going on the record, during which the Hearing Officer did not participate. Resulting, in the petitioner verbally withdrawing her hearing request on the record. Therefore, the appeals are dismissed as withdrawn.

DONE and ORDERED this __11__ day of __May__________, 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

May 25, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-02679

PETITIONER,

Vs.

CASE NO

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 08 Union
UNIT: 88328

RESPONDENT.
______________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on April 6, 2016 at 10:37 a.m.

APPEARANCES

For the Petitioner:

For the Respondent: Diane Washington, Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of March 7, 2016 closing her family's Medicaid as not a resident of the state of Florida. The respondent carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The Department submitted evidence prior to hearing. This evidence was entered as Respondent's Exhibit 1. The record was held open through April 18, 2016 for

information specific to Medicaid. The Department submitted additional information on April 13, 2016. This was entered as Respondent's Exhibit 2.

The petitioner filed an appeal 16F-01721 regarding her Food Assistance benefits closure for the same reason. The petitioner withdrew that appeal during hearing. Appeal 16F-01721 was dismissed by separate order.

FINDINGS OF FACT

1. The petitioner submitted an application to recertify her Food Assistance and Family-Related Medicaid benefits on February 26, 2016.

2. The petitioner identified her living address as [redacted] on her application. The household consists of the petitioner and her three children.

3. The Department completed an investigation on the petitioner's case due to complete use of her Food Assistance benefits in Georgia consistently. The Department's investigation found the petitioner is employed in [redacted] The investigation also revealed the petitioner's children are registered and attending school in Georgia. The Department had no report by the petitioner of "temporary residence" out of state.

4. The Department issued a Notice of Case Action on March 7, 2016 informing the petitioner her Medicaid benefits for family will end on March 31, 2016 as "You are not a resident of florida, A child(ren) does not meet eligibility requirements for this program, We have received information that your child(ren) is no longer living with you".*[sic]*

5. The petitioner identifies herself as a Florida resident as she has a home in Florida, which she is purchasing, her driver's license is from Florida, and her car is registered (tag) in Florida. The petitioner further states she files her taxes in Florida.

6. The petitioner explained she and her children have been staying with her mother in Georgia while she cares for her sick mother. They have been staying there primarily since August 2015.

7. The petitioner explained she intends to live in her home in Florida, but it is two to two and a half hours from her mother's home and her employment. She made the decision to stay primarily in Georgia to save time and money.

8. The petitioner did not identify when she anticipates returning to live in her home in Florida.

9. The Department explained the rules allow for "temporary absence" but it appears the petitioner has moved to Georgia, with no plan of when she will return to live in Florida.

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. Section 1902 of the Social Security Action (2007) states in relevant part

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) of this section, except that he shall not approve any plan which imposes, as a condition of eligibility for medical assistance under the plan—
(1) an age requirement of more than 65 years; or
(2) any residence requirement which excludes any individual who resides in the State, regardless of whether or not the residence is maintained permanently or at a fixed address; or
(3) any citizenship requirement which excludes any citizen of the United States." (emphasis added)

13. Florida Admin. Code R. 65A-1.705 "Family Related Medicaid General Eligibility Criteria" states in relevant part:

(5) The individual must be a resident of Florida as provided by s. 1902(a) and (b) of the Social Security Act (2007), incorporated by reference. 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.

14. The Department's Program Policy Manual, CFOP 165-22, section 1430.0300 "Residency (MFAM)" states:

In order to receive Medicaid, all individuals must be eligible on the factor of residency. Homeless individuals and residents of public or private nonprofit shelters for the homeless are considered residents. An otherwise eligible individual must not be required to reside in a permanent dwelling or have a fixed mailing address.

Residency exists when the intent of the individual is to remain in the state. Residency is not dependent upon the duration of the stay. Residency does not exist when the stay is for a temporary purpose such as a vacation and there is intent to return to a residence in another state.

When a child is in the child's usual family setting, the residency of the child is considered in the context of the family situation. If the child leaves the family setting to reside elsewhere, residence is determined based on the extent and nature of the child's own stay.

A child is considered a resident when the parent or caretaker relative is a migrant agricultural worker who maintains Florida as a home for the children and intends to return to Florida. Children born in the U.S. of undocumented or ineligible noncitizen parents residing in the state may

meet the residency requirement if they intend to remain even if parents may not legally remain due to USCIS status.
An individual must satisfy one of the following residence requirements:
1. must reside in the State of Florida with the intent to remain, (individuals statement as to their intent to remain is acceptable) or
2. must be living in the State of Florida for employment purposes without intent to remain and meets the following conditions:
a. the individual or caretaker relative is not receiving assistance from another state, and
b. the individual or caretaker relative came to Florida with a job commitment or is actively seeking employment during the stay in the state.

Verification of residency for employment purposes must be verified and includes:
1. letter from employment agency,
2. letter of employment offer,
3. home visits,
4. collateral contacts,
5. rent/mortgage or utility receipts,
6. other forms of ID,
7. driver's license records, and
8. institutionalized in Title XIX facilities.

Some individuals in the U.S. with a temporary visa and their U.S. born children may meet the Florida residency requirement if they verify their residency and state an intent to remain. Examples of verification of residency include:
1. employment or school records,
2. bank statements,
3. lease agreements,
4. utility bills,
5. Florida driver’s license or state ID card, and
6. other reliable information.

15. The Department’s Policy Manual section 1430.0310 “Temporary Absence from the State (MFAM) states: “An individual may be temporarily absent from the state if the person intends to return when the purpose of the absence has been accomplished, unless another state has determined the individual is a resident there for purposes of Medicaid.”

16. The findings show the petitioner has a home, driver's license and car registered in Florida. However, the findings also show the petitioner is employed, has her children registered and attending school in Georgia. The findings show the petitioner identified she began residing primarily with her mother in Georgia in August 2015. The petitioner has not identified when she anticipates she will be residing at her home in Florida again. The undersigned concludes the petitioner does not meet the definition of "temporary absence" as she has not identified when she intends to return to residing in her home in Florida. The undersigned concludes the petitioner does not meet the requirement of being a Florida resident, which is a requirement for eligibility for Medicaid in the state of Florida.

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 __25__ day of __May__________, 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: [redacted] Petitioner
Office of Economic Self Sufficiency

Jun 30, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-02685

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 June 1, 2016 at 8:40 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 request for dental procedure D8080-comprehensive orthodontic treatment (braces) and D8670-periodic orthodontic treatment (monthly visits for the braces). Because the issue under appeal involves a request for services, Petitioner bears the burden of proof.

PRELIMINARY STATEMENT

Dr. Franciso Fernandez, Medical Director, and Diana Anda, Grievance and Appeals Manager, appeared as Respondent's witnesses from the Petitioner's managed care plan Better Health.

Complaints and Grievance Specialist, appeared as Respondent's witnesses from DentaQuest. Respondent's exhibit 1 was entered into evidence.

FINDINGS OF FACTS

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following Findings of Fact are made:

1. The Petitioner is an eleven year-old Medicaid recipient enrolled with 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 review prior authorization requests.

3. The Petitioner's dentist sent a prior authorization request for dental procedure D8660: pre-orthodontic treatment examination to monitor growth and development; D8080: comprehensive orthodontic treatment of the adolescent dentition (braces); and D8670: periodic orthodontic treatment visit).

4. DentaQuest made its determination on February 4, 2016, approving procedure D8660 and denying procedures D8080 and D8670. Notice was sent to the provider providing the denial reason:

> [A] score of 26 points must be reached in order to qualify for orthodontic treatment [braces].

5. Petitioner filed a timely fair hearing request on April 8, 2016.

6. Petitioner complains of pain when eating. Pain may be the result of a misaligned jaw which the mother reported in her appeal letter received by Better Health on March 29, 2016. No medical documentation on Petitioner's jaw was provided.

7. Petitioner's gums often bleed when he brushes and/or flosses his teeth. Petitioner's bleeding is the result of gingivitis and not the spacing of his teeth.

8. Petitioner's dentist submitted a Medicaid Orthodontic Initial Assessment Form (IAF) showing a score of 17.

9. Respondent scored Petitioner a 9 on the IAF. The Respondent's dental consultant noted the photographs submitted by Petitioner's dentist show Petitioner has one tooth that is very crooked but the other teeth are fairly straight. He concluded the Petitioner's occlusion is not severe enough to warrant treatment at this time.

10. Petitioner's score on the IAF needs to be 26 or more in order to qualify for braces.

CONCLUSIONS OF LAW

11. By agreement between the Agency for Health Care Administration and the Department of Children and Families, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80 Florida Statutes.

12. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

13. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Florida Administrative Code Rule 65-2.060(1).

14. 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.

15. Section 409.912, Fla. Stat. also provides that the Agency may mandate prior authorization for Medicaid services.

16. 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:
>
> 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.

18. Since the Petitioner is under twenty-one years-old, a broader definition of medical necessity applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPDST) requirements. Fla. Stat. § 409.905, Mandatory Medicaid services, provides that Medicaid services for children include:

> (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

19. The United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in Moore v. Reese, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, which involved a dispute over private duty nursing:

> (1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.
> (2) A state Medicaid plan must include "reasonable standards … for determining eligibility for and the extent of medical assistance" … and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.
> (3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical

> condition. Furthermore, “a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case” and a treating physician is “required to operate within such reasonable limitations as the state may impose.”
> (4) The treating physician assumes “the primary responsibility of determining what treatment should be made available to his patients.” Both the treating physician and the state have roles to play, however, and “[a] private physician’s word on medical necessity is not dispositive.”
> (5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to provide medically unnecessary, albeit desirable, EPSDT services. However, a state’s provision of a required EPSDT benefit, such as private duty nursing services, “must be sufficient in amount, duration, and scope to reasonably achieve its purpose.
> (6) A state “may place appropriate limits on a service based on such criteria as medical necessity.” In so doing, a state “can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis” and my present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)).

20. 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.

21. Florida Medicaid’s Dental Services Coverage and Limitations Handbook – November 2011 (Handbook), incorporated by reference into Chapter 59G-4.060, Fla. Admin. Code at the time of the Agency action, provides a description of Orthodontic Services on page 2-15:

> Prior authorization is required for all orthodontic services. Orthodontic services are limited to those recipients with the most handicapping malocclusion. A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the patient by causing impaired mastication, dysfunction of the temporomandibular articulation, susceptibility to periodontal disease,

susceptibility of dental caries, and impaired speech due to malpositions of the teeth (emphasis added)

22. On page 2-17, the Handbook explains the use of the Medicaid Orthodontic Initial Assessment Form (IAF):

> The Medicaid Orthodontic Initial Assessment Form (IAF) is to be completed by the orthodontic provider at the initial evaluation of the recipient.
>
> The IAF is:
>
> - Designed for use as a guide by the provider in the office to determine whether a prior authorization (PA) request should be sent to the Medicaid orthodontic consultant; and
> - A means by which the orthodontic provider may communicate to Medicaid's orthodontic consultant all the distinctive details pertaining to an individual case.
>
> ….
>
> The conditions listed in the IAF index should be considered in the context of whether they contribute to a disabling malocclusion. The provider scores each applicable condition and totals the recipient's index score. Special or mitigating circumstances, such as deep bites with palatal trauma or occlusion related temporomandibular joint dysfunction (TMD) must be described in detail. Include description of limited mobility history (locking open or closed) and other severe symptoms of TMD.

23. On page 2-18 of the Handbook, the required index score on the IAF is explained:

> A score of 26 or greater may indicate that treatment of the recipient's condition could qualify for Medicaid reimbursement, and the orthodontic provider should submit a prior authorization request to Medicaid for consideration of orthodontic services. A score of 26 or greater on the IAF is not a guarantee of approval. It is used by the provider to determine whether diagnostic records should or should not be sent to the orthodontic consultant.
>
> ….
>
> A score of less than 26 indicates that treatment of the recipient's condition may not qualify for Medicaid reimbursement, and the request for prior authorization may be denied.

> This does not say that such cases do not represent some degree of malocclusion, but simply that the severity of the malocclusion does not qualify for coverage under the Florida Medicaid Orthodontic Program.

24. Petitioner is requesting braces because of the difficulty he has eating. He complains of jaw pain but no medical diagnosis or treatment information was provided that addresses this condition.

25. Petitioner needs to score at least 26 points on the Medicaid Orthodontic Initial Assessment Form (IAF) to qualify for braces. The score represents the severity of the occlusion.

26. Petitioner's dentist scored the IAF a 17 while the agency's dental consultant scored Petitioner's IAF a 9. The dental consultant noted Petitioner has one very crooked tooth but the rest are fairly straight. He concluded Petitioner's occlusion is not severe enough to warrant treatment.

27. Petitioner failed to present evidence or testimony to rebut the dental consultant's conclusion that his occlusion is not severe enough to warrant treatment. Petitioner's IAF score was only 17 points, which is well short of the 26 points required by the Dental Handbook. Petitioner's medical necessity for braces has not been established.

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 30 day of June, 2016,

in Tallahassee, Florida.

Warren Hunter
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

Jun 10, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-02723
16F-03375

PETITIONER,
Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 88999

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 12, 2016 at 1:00 p.m.

APPEARANCES

For the petitioner: pro se

For the respondent: Sylma Dekony, ACCESS Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

Petitioner is appealing the following:

I. The respondent's action to terminate his Food Assistance Program (FAP) benefits beginning May 2016. The respondent carries the burden of proof by a preponderance of the evidence.

II. The respondent’s subsequent action to decrease his FAP benefits from $158.00 to $92.00 beginning June 2016. Petitioner is seeking a higher amount. The petitioner carries the burden of proof by a preponderance of the evidence.

III. The respondent’s action to terminate his children’s Medicaid benefits on April 30, 2016. The respondent carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

On April 6, 2016, the respondent notified the petitioner that his FAP benefits would end on April 30, 2016 due to his “income is too high to qualify for this Program”. The petitioner timely requested a hearing to challenge the respondent’s action to remove his children as part of his household, which affected his eligibility. There was no notice submitted by the respondent to the undersigned informing the petitioner that his children’s Medicaid benefits were terminated on April 30, 2016.

Appearing as a witness for the respondent was Shawna Mackin, ACCESS Program Office Policy Manager.

During a supervisory review, the respondent determined it had erred in removing the petitioner’s children from his FAP case. The respondent added the children back to the petitioner’s FAP case and determined the petitioner was eligible for $92.00 beginning May 2016.

Petitioner submitted one exhibit, entered as Petitioner’s Exhibit “1”. Respondent submitted five exhibits, entered as Respondent’s Exhibits “1” through “5”. The record was held open until the end of business on May 20, 2016 for submission of additional

evidence from the respondent. No additional evidence was received by the due date; therefore, the record closed on May 20, 2016. On May 23, 2016, additional evidence was received from the respondent. The undersigned reopened the record and entered the additional evidence as Respondent's Exhibit "6". The record closed on May 23, 2016.

FINDINGS OF FACT

1. Prior to the action under appeal, petitioner was receiving Medicaid and FAP benefits of $158.00 for himself and his two children, ages 6 and 8[1]. His certification period was for six months, beginning September 2015 through February 29, 2016. On February 8, 2016, petitioner submitted an on-line application to reapply for Medicaid and FAP benefits for his household which included his two children.

2. Petitioner listed his monthly expenses as rent of $805.00, electric, water and telephone. Petitioner also listed on his application court-ordered child support payment of $399.60 for the two children. Petitioner reported his source of income is his employment, paid bi-weekly.

3. This was a passive redetermination; therefore, no interview was completed. Petitioner submitted to the respondent paychecks dated January 15, 2016 for $1,121.67 gross pay and January 29, 2016 for $1,030.52 gross pay. The respondent calculated the petitioner's monthly income by averaging both paychecks, which resulted in $1,076.10, then used a conversion factor of 2.15 to determine petitioner's monthly gross

[1] Petitioner did not have an issue with the Medicaid benefits for himself.

earned income of $2,313.62. Respondent approved the petitioner for ongoing FAP and Medicaid benefits for himself and his two children.

4. On April 5, 2016, the respondent removed the petitioner's children from his FAP case and terminated his FAP benefits due to being over the income standard for a household size of one beginning May 2016. The respondent explained the children were removed from the petitioner's FAP benefits because their mother applied for FAP benefits for herself and the two children.

5. The respondent realized it had erred in removing the petitioner's children from the petitioner's case and adding them to their mother's case. The children were then added back to the petitioner's FAP benefits.

6. The respondent determined petitioner was eligible for $92.00 FAP benefits as of May 2016 based on the following income and allowable expenses:

		US			
			TOTAL GROSS INCOME:		2313.62
			EARNED INCOME DEDUCTION:	-	462.72
			STANDARD DEDUCTION:	-	155.00
TOTAL MEDICAL COSTS:		.00			
MEDICAL DEDUCTION:	-	.00			
EXCESS MEDICAL EXPENSES:	=	.00	EXCESS MEDICAL EXPENSES:	-	.00
			DEPENDENT CARE DEDUCTION:	-	.00
SHELTER COSTS:		805.00	CHILD SUP PAYMENT DEDUCT:	-	.00
UTILITY STD.(SUA/ BUA/ PH) :	+	345.00	HOMELESS INCM DEDUCTION:	-	.00
SHELTER/UTILITY COSTS:	=	1150.00	ADJUSTED INCOME:	=	1695.90
SHELTER STD(50% ADJ NET INC):	-	847.95			
EXCESS SHELTER/DEDUCTION:	=	302.05	SHELTER DEDUCTION:	-	302.05
			FOOD STAMP ADJ INCOME:	=	1393.85
ASSISTANCE GROUP SIZE:		3	MAX NET MONTHLY INCOME:		1675.00

7. Petitioner's FAP benefits were reduced beginning May 2016. Respondent explained an error occurred in the petitioner's case previously. The respondent gave

the petitioner a child support deduction of $333.00. The child support payment cannot be included as an allowable deduction because the children receiving the payments are included in the FAP budget. This mistake caused the petitioner to receive more FAP benefits than he was eligible to receive.

8. Petitioner disputed the expenses and income used in the FAP budget, petitioner explained that as part of the court-ordered child support payment agreement, he must pay childcare costs to the children's mother. The childcare costs are included in the court-ordered child support payment, not in addition to this expense. Petitioner also disputed the paychecks used in the FAP budget. Petitioner explained the paychecks include holiday and overtime pay which he does not receive on a regular basis.

9. Petitioner presented no evidence of his current earnings at the hearing. Evidence presented by the respondent shows overtime is a pattern. Court documents also indicate petitioner confirmed he receives overtime pay regularly.

10. Petitioner could submit current paychecks to the respondent; the respondent would then re-evaluate the petitioner's eligibility using its change reporting procedures.

11. The respondent explained that according to the Department's policy on joint custody for Medicaid, the petitioner must obtain consent from the mother or neither party can receive Medicaid benefits for the children. When the petitioner's children were removed from his case on April 5, 2016, the respondent terminated their Medicaid benefits effective April 30, 2016 due to the household 50/50 joint custody. At this time, the children's Medicaid benefits remain closed.

12. The petitioner submitted a copy of the [redacted] Judicial Circuit Court, in and for [redacted] County, "FINAL JUDGMENT OF PATERNITY AND ORDER ON REPORT OF GENERAL MAGISTRATE." The Order indicates that the parties agree to equally share time with the minor children. A Child Support Guidelines Worksheet shows the petitioner spends 50.14% of the time with the children on overnight stays and the mother spends 49.86% of the time on overnight stays.

13. According to the Department's policy on joint custody for Medicaid benefits, for a parent to derive Medicaid eligibility for themselves, their child must spend most of the nights in their home. It is unknown why the children's Medicaid benefits were terminated. The issue does not relate to the petitioner's Medicaid benefits; the petitioner is concerned that his two children have been left without any Medicaid coverage since April 30, 2016.

CONCLUSIONS OF LAW

14. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to § 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

15. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

FOOD ASSISTANCE ISSUE

16. The Code of Federal Regulations 7 C.F.R. § 273.9 defines "Income", "Exclusions" and "Deductions" in the Food Assistance Program. The passage reads in relevant part:

(a) Income eligibility standards. Participation in the Program shall be limited to those households whose incomes are determined to be a substantial limiting factor in permitting them to obtain a more nutritious diet…
(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...
…
(c) Income exclusions. Only the following items shall be excluded from household income and no other income shall be excluded:
(1) Any gain or benefit which is not in the form of money payable directly to the household, including in-kind benefits and certain vendor payments…Payments made to a third party on behalf of the household are included or excluded as income as follows:
…
(vii) Other third-party payments. Other third-party payments shall be handled as follows: moneys legally obligated and otherwise payable to the household which are diverted by the provider of the payment to a third party for a household expense shall be counted as income and not excluded…
(C) A household receives court-ordered monthly support payments in the amount of $400. Later, $200 is diverted by the provider and paid directly to a creditor for a household expense. The payment is counted as income. Money deducted or diverted from a court-ordered support or alimony payment (or other binding written support or alimony agreement) to a third party for a household's expense shall be included as income because the payment is taken from money that is owed to the household. However, payments specified by a court order or other legally binding agreement to go directly to a third party rather than the household are excluded from income because they are not otherwise payable to the household. For example, a court awards support payments in the amount of $400 a month and in addition orders $200 to be paid directly to a bank for repayment of a loan. The $400 payment is counted as income and the $200 payment is excluded from income. Support payments not required by a court order or other legally binding agreement (including payments in excess of the amount specified in a court order or written agreement) which are paid to a third party on the household's behalf shall be excluded from income.
…
(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.
…
(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…
(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.
(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**,(emphasis added) comply with the employment and training requirements as specified under §273.7(e), or attend training or pursue education which is preparatory to employment, except as provided in §273.10(d)(1)(i). The maximum monthly dependent care deduction amount households shall be granted under this provision is $200 a month for each dependent child under two (2) years of age and $175 a month for each other dependent.
(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**, (emphasis added) including payments made to a third party on behalf of the nonhousehold member (vendor payments) and amounts paid toward child support arrearages. Alimony payments made to or for a nonhousehold member shall not be included in the child support deduction. A State agency that chooses to provide a child support deduction rather than an exclusion in accordance with this paragraph (d)(5) must specify in its State plan of operation that it has chosen to provide the deduction rather than the exclusion.
(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…

17. 7 C.F.R. § 273.10 addresses budgeting in the FAP and states in relevant part:

> …
> (c) Determining income—(1) Anticipating income. (i) For the purpose of determining the household's eligibility and level of benefits, the State agency shall take into account the income already received by the household during the certification period and any anticipated income the household and the State agency are reasonably certain will be received during the remainder of the certification period. If the amount of income that will be received, or when it will be received, is uncertain, that portion of the household's income that is uncertain shall not be counted by the State agency. For example, a household anticipating income from a new source, such as a new job or recently applied for public assistance benefits, may be uncertain as to the timing and amount of the initial payment. These moneys shall not be anticipated by the State agency unless there is reasonable certainty concerning the month in which the payment will be received and in what amount. If the exact amount of the income is not known, that portion of it which can be anticipated with reasonable certainty shall be considered as income. In cases where the receipt of income is reasonably certain but the monthly amount may fluctuate, the household may elect to income average. Households shall be advised to report all changes in gross monthly income as required by §273.12.
> (ii) Income received during the past 30 days shall be used as an indicator of the income that is and will be available to the household during the certification period. However, the State agency shall not use past income as an indicator of income anticipated for the certification period if changes in income have occurred or can be anticipated. If income fluctuates to the extent that a 30-day period alone cannot provide an accurate indication of anticipated income, the State agency and the household may use a longer period of past time if it will provide a more accurate indication of anticipated fluctuations in future income. Similarly, if the household's income fluctuates seasonally, it may be appropriate to use the most recent season comparable to the certification period, rather than the last 30 days, as one indicator of anticipated income. The State agency shall exercise particular caution in using income from a past season as an indicator of income for the certification period. In many cases of seasonally fluctuating income, the income also fluctuates from one season in one year to the same season in the next year. However, in no event shall the State agency automatically attribute to the household the amounts of any past

income. The State agency shall not use past income as an indicator of anticipated income when changes in income have occurred or can be anticipated 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 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.
…
(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.
(ii) Expenses shall only be deductible if the service is provided by someone outside of the household and the household makes a money payment for the service. For example, a dependent care deduction shall not be allowed if another household member provides the care, or compensation for the care is provided in the form of an inkind benefit, such as food.
…
(e) Calculating net income and benefits levels—(1) Net monthly income.
(i) To determine a household's net monthly income, the State agency shall
(A) Add the gross monthly income …
(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…
(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) 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.

18. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 2410.0323, Dependent Care Disregard (FS) states:

> Actual costs for the care of a child or other dependent may be allowed, as billed, if verified according to requirements. The costs are allowed when:
> 1. it is necessary for a household (standard filing unit) member to accept or continue employment,
>
> Passage 2410.0324, Verification of Dependent Care Expenses (FS) states:
>
> An assistance group's (AG's) dependent care expenses must be verified any time the monthly expense exceeds $200 per child. If the individual fails to provide verification of the dependent care expense exceeding $200, the AG is only eligible for a $200 per child deduction.

19. The above-cited regulations explain that participants in the FAP are required to meet income standards. The regulations set forth above also explain income, deductions and detailed budgeting process on how the net income is determined in the FAP budget. The respondent properly credited the standard deduction and earned income deduction. Petitioner makes court-ordered child support payments for his two children who he has joint custody of and are included in his FAP benefits. Pursuant to the above authority, child support payments are an allowable deduction only if paid by a household member to or for a non-household member. In this case, the petitioner's children are members of his FAP household; therefore, the child support payments cannot be included as an allowable deduction in the petitioner's FAP budget. There is no indication that petitioner is eligible for any other deductions.

20. Petitioner testified overtime pay is not received on a regular basis. However, the paychecks presented show overtime is a pattern as well as court documents indicate petitioner confirmed he receives overtime pay regularly. Therefore, the respondent was correct in its determination of the petitioner's income using the two paychecks provided by the petitioner (1/15/16 gross pay $1,121.67 and 1/29/16 gross pay $1,030.52); the average income amount of $2,313.62 is accurate.

21. At the hearing, petitioner argued he has a childcare cost obligation that is part of his court-ordered child support agreement. The evidence presented did not show the actual childcare cost was billed to the petitioner and that childcare is necessary to continue employment. Childcare expenses are an allowable expense in the FAP budget when verified and necessary to continue employment.

22. Based on the controlling legal authorities, testimony and evidence, the undersigned concludes that the Department's action to reduce the petitioner's FAP benefits effective May 2016 was correct.

MEDICAID ASSISTANCE ISSUE

23. Section 409.904, Fla. Stat. explains continuous Medicaid for any child that was eligible for Medicaid- Optional payments for eligible persons states in part:

> …
> (6) A child who has not attained the age of 19 who has been determined eligible for the Medicaid program is deemed to be eligible for a total of 6 months, regardless of changes in circumstances other than attainment of the maximum age. Effective January 1, 1999, a child who has not attained the age of 5 and who has been determined eligible for the Medicaid program is deemed to be eligible for a total of 12 months regardless of changes in circumstances other than attainment of the maximum age.

24. The Department of Children and Families published Transmittal No. C-16-04-0003 on April 25, 2016 relating to "Continuous Medicaid Policy Clarification," it states in part:

> This memorandum provides staff with policy clarification about Continuous Medicaid periods for children under age 19. It also, provides case processing guidance about when a child is removed from one case and added to another, the child is not reported on an additional benefit request or renewal, or the Primary Information Person (PIP) is deceased or out of the household.
>
> Current Policy
>
> There has been no change in the application of Continuous Medicaid periods. When a change in eligibility results in the loss of Medicaid coverage for a child under age 19, staff must continue Medicaid coverage for a child(ren) during the Continuous Medicaid period, including children receiving Child In Care (CIC) coverage. The Continuous Medicaid period is determined from the last application, renewal or addition to Medicaid coverage and automatically displays on the Individual Eligibility History (IQEL) screen.
>
> - Children up to age 5 receive twelve months of Continuous Medicaid coverage.
> - Children age 5 up to 19 receive six months of Continuous Medicaid coverage.
>
> **Child Moved to Another Case**
>
> **Staff must continue Medicaid coverage for a child(ren) during the Continuous Medicaid period, including when a child is removed from one case and added to another case.**
>
> **Staff must document the Running Record Comments (CLRC) screen about the removal from the original case in which Continuous Medicaid eligibility was established on both case files.**(emphasis added)
>
> FLORIDA System
>
> When a change is reported during the Continuous Medicaid period that would result in the loss of Medicaid coverage, the Medicaid coverage cannot be terminated unless a valid reason exists.

25. The Policy Manual, CFOP 165-22, passage 1430.0710, Joint Custody (MFAM) states:

> When parents of a child have joint custody and there is question regarding which parent has custody, staff must determine with whom the child resides based on the parent granted primary custody via a court order or binding separation agreement, divorce or custody agreement **or with**

> **whom the child spends the most nights**. (emphasis added) The Department will follow the order of a legally binding court order unless no order exists.
>
> Passage 1430.0800, LIVING IN THE HOME (MFAM) continues:
>
> **There is no requirement for a child to live with an adult caretaker for the child to qualify for Medicaid**. (emphasis added)
> <u>As a condition of eligibility for a parent or other caretaker relative to derive Medicaid for themselves, a child must be living in the home of the parent or other caretaker relative.</u>

26. According to the Department's own policy, there is no requirement for a child to live with a parent in order to qualify for Medicaid. In this case, the petitioner and the mother of the children have time-shared custody. Respondent argued parents in a 50/50 joint custody situation must agree on who will apply for Medicaid or neither can receive these benefits. However, the Department's own policies do not indicate Medicaid benefits for the children are based on 50/50 joint custody. The respondent was asked specifically to provide a policy, rule, or law that states a minor child must be in the home more than 50% of the time or that there must be an agreement between the parents on who can apply for Medicaid for the children in order for the children to be eligible for Medicaid benefits. According to the policy, as a condition of Medicaid eligibility for a <u>parent</u> with joint custody to be included in the Medicaid benefits, the children must spend most the nights with that parent. Petitioner presented court documents that show he spends 50.14% of the time with the children on overnight stays and the mother spends 49.86% of the time with the children on overnight stays. Furthermore, the issue concerns Medicaid benefits for the petitioner's children only. Petitioner is not seeking Medicaid benefits for himself; he is seeking Medicaid benefits for his children. Therefore, the

undersigned concludes the Medicaid benefits for the petitioner's children were terminated incorrectly.

27. The respondent has the burden of proof by a preponderance of the evidence to show that the petitioner's children cannot continue to be included in the petitioner's case for the Medicaid benefits.

28. In careful review of the cited authority and policies, the undersigned concludes the respondent did not meet its burden of proof. The undersigned remands the matter to the Department to add the petitioner's children back to the Medicaid benefits effective May 1, 2016 and determine their Medicaid eligibility based on all other factors of eligibility (petitioner may request to be included in the Medicaid benefits). Once an eligibility determination is made, the respondent is to issue a new Notice of Case Action to the petitioner, including his appeal rights.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Medicaid appeal (16F-02723) is granted and remanded back to the respondent to take corrective action as specified in the Conclusions of Law.

The FAP appeal (16F-03375), is ruled on as follows:

In regards to the Department's action to terminate the petitioner's FAP benefits effective May 2016, the appeal is dismissed as moot as the Department has already taken corrective action and reinstated the petitioner's FAP benefits effective May 2016.

In regards to the Department's action to decrease the petitioner's FAP benefits from $158.00 to $92.00 effective May 2016, 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 10 day of June, 2016,

in Tallahassee, Florida.

Cassandra Perez
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

Jun 06, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-02727
APPEAL NO. 16F-04099
APPEAL NO. 16F-04123

PETITIONER,

Vs.

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 May 4, 2016 at 2:58 p.m.

For the Petitioner:

For the Respondent: Dionne Hopkins, supervisor

STATEMENT OF ISSUE

A. At issue is the reduction of the petitioner's Food Assistance Program (FAP) benefits.

B. At issue is the date she receives her FAP benefits. She would like her benefits issued on the 3rd of the month instead of the 14th of the month.

C. At issue is the denial of full Medicaid and enrollment in the Medically Needy Program with an estimated share of cost (SOC). She is seeking full Medicaid.

In accordance with Fla. Admin. Code R. 65-2.060 (1), the respondent carries the burden of proof in the FAP appeal and the petitioner carries the burden of proof in the Medicaid appeal by a preponderance of evidence.

PRELIMINARY STATEMENT

The respondent 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 May 6, 2016, for the respondent to provide the FAP budget and the Notice of Case Action. The respondent provided the FAP budget as an additional exhibit which was accepted into evidence and marked as Respondent's Composite Exhibit 2. Additional time was allowed for the Notice of Case Action. The Notice of Case Action was received on June 1, 2016, entered into evidence and marked as Respondent's Composite Exhibit 3. The record closed on June 1, 2016.

FINDINGS OF FACT

1. On October 13, 2015, the petitioner submitted an application for FAP and Medicaid benefits. She was the only household member. Her household expenses were rent of $650, telephone of $50, and water. The petitioner receives Social Security Disability Income (SSDI) of $864. She also receives Medicare Parts A and B paid by the state. The respondent reviewed the petitioner's application and found that the incorrect utility standard was given, as her electricity was included in her rent. The respondent updated the petitioner's case and corrected the utility standard from the Standard Utility Allowance to the Basic Utility Allowance. She was found eligible for $152 monthly in FAP benefits based on her income and expenses. The FAP budget is as follows.

SSDI income	$864
Total household income	$ 864
Standard deduction for a household of 1	($155)
Excess medical expenses)	0.00
Adjusted income after deductions	$709
Shelter costs	$650
Standard utility Allowance	$274
Total rent/utility cost	$924
Shelter standard (50% adjusted income)	$354.50
Excess shelter deduction	$569.50
Adjusted income	$709
Excess Shelter Deduction	($569)
Food Assistance Adjusted income after shelter deduction	$139.50
30% of 139	$42
Maximum FAP	$194
Less	($42)
Monthly recurring FAP amount	$152

2. By notice date April 1, 2016, the respondent mailed a Notice of Case Action informing the petitioner her FAP benefits would decrease from $173 to $152 effective May 1, 2016. The reason for the reduction was due to a change in her utility standard.

3. The respondent determined eligibility for Medicaid and found the petitioner ineligible for full Medicaid benefits as she was receiving Medicare Parts A and B. The respondent proceeded to enroll her in the Medically Needy Program with an estimated SOC. Her SOC was determined as follows. The respondent subtracted a $20 unearned income disregard from her monthly gross income of $864 resulting in $844. The Medically Needy Income Limit (MNIL) of $180 for household size one was subtracted resulting to $664 as the petitioner's SOC.

4. On April 11, 2016, the petitioner requested a hearing to challenge the reduction in her FAP benefits and the enrollment in the Medically Needy Program.

5. At the hearing, the petitioner requested that her FAP benefits be issued on the 3rd of the month rather that the 14th of the month. She reported that she has medical expenses and that is why she is working. The petitioner also asserts that after paying her rent and other household expenses there is no money left to pay for her special food/water for her medical conditions.

CONCLUSION OF LAW

6. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

7. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

The FAP benefits issue will be addressed first.

8. 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…

(d) *Income deductions.* Deductions shall be allowed only for the following household expenses
(1) *Standard deduction*—
(3) *Excess medical deduction.* That portion of medical expenses in excess of $35 per month, **excluding special diets**, incurred by any household member who is elderly or disabled as defined in §271.2...(emphasis added)
(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…

9. The above sets forth the specific deductions allowable in the calculation of the final Food Assistance Program benefit allotment. These potential allowable deductions are limited to include only: (1) standard deduction, (2) earned income deduction, (3) excess medical deduction, (4) dependent care deduction, (5) child support deduction, (6) utility allowance, and shelter expenses. The petitioner was credited with a standard deduction, excess shelter deduction and an excess medical deduction. There is no allowance for special diets. There is no indication that the petitioner was eligible for any other deductions from her income.

10. 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.

11. The federal regulation 7 C.F.R. § 273.10 (e) addresses "Calculating net income and benefit levels" as follows:

> (1) Net monthly income (i)…
> (A) Add the gross monthly income earned by all household members and the total monthly unearned income of all household members, minus income exclusions, to determine the household's total gross income…
> (C) Subtract the standard deduction.
> (D) If the household is entitled to an excess medical deduction as provided in §273.9(d)(3), determine if total medical expenses exceed $35. If so, subtract that portion which exceeds $35.
> (H) Total the allowable shelter expenses to determine shelter costs, unless a deduction has been subtracted in accordance with paragraph (e)(1)(i)(G) of this section. Subtract from total shelter costs 50 percent of the household's monthly income after all the above deductions have been subtracted. The remaining amount, if any, is the excess shelter cost, compute the shelter deduction according to paragraph (e)(1)(i)(I) of this section.
> (I) Subtract the excess shelter cost up to the maximum amount allowed for the area (unless the household is entitled to the full amount of its excess shelter expenses) from the household's monthly income after all other applicable deductions. Households not subject to a capped shelter expense shall have the full amount exceeding 50 percent of their net income subtracted. The household's net monthly income has been determined.
> (2) Eligibility and benefits…
> (ii)(A)…the household's monthly allotment shall be equal to the maximum food stamp allotment for the household's size reduced by 30% of the household's net monthly income…
> (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…

12. The Food Assistance standards for income and deductions appear in the Department's Program Policy Manual (Policy Manual), CFOP 165-22, at Appendix A-1. The 200% Federal Poverty level (FPL) for a household size of one effective October 2015 is $1,962. A one-person assistance group's net income limit is $981, the standard deduction is $155 and the Basic Utility Allowance is $274. The same reference shows the maximum FAP benefits for one person as $194 effective October 2015.

13. The above-cited regulation describes the eligibility process and defines deductions. The Basic 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 in the FAP budget. There is no indication the petitioner was eligible for any other deductions. The petitioner is encouraged to report her income, medical expenses, and provide verification of those expenses and the respondent will update her case according to its procedure. The undersigned concludes that the respondent correctly determined the FAP benefits.

Medicaid Benefits will now be addressed

14. The respondent determined the petitioner's Medicaid benefits under the SSI Related Program.

15. 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.

16. The above authority explains that the MEDS-AD (full Medicaid for an aged or disabled person) has an income limit of 88% of the federal poverty level and in addition to meeting that limit the person must not have Medicare.

17. The Policy Manual, at Appendix A-9, lists the MEDS-AD income limit as $872 for an individual effective April 2016. The petitioner's income is below the income limit for full Medicaid however she is ineligible as she is receiving Medicare. 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 undersigned concludes the respondent's action to deny full-coverage Medicaid benefits is a correct action. The undersigned further concludes Medically Needy eligibility must be explored for the petitioner.

<u>The Medically Needy share of cost will now be addressed</u>

18. 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.

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 the Medically Needy Program is a coverage group for aged, blind or disabled individuals who do not qualify for full Medicaid.

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.

22. 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…"

23. 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.

24. Fla. Admin. Code R. 65A-1.716 (2), Income and Resource Criteria, sets forth the Medically Needy Income Level for one person at $180.

25. The Policy Manual at passage 2440.0102, Medically Needy Income Limits (MSSI) states:

> When the assistance group has met the technical eligibility criteria and the asset limits, it is enrolled. There is no income limit for enrollment. The assistance group is income eligible (entitled to Medicaid) once income is less than or equal to the Medically Needy Income Level (MNIL) or medical

> bills equal the amount by which his income exceeds the MNIL. Once medical bills are equal to this surplus income, referred to as share of cost, the assistance group is eligible.
> The eligibility specialist must determine eligibility for Medically Needy any time the assistance group's income exceeds the income limits for another full Medicaid Program.

26. The above states the SOC is determined by subtracting a $20 unearned disregard, the Medically Needy Income Limit (MNIL) from the family’s income. The undersigned concludes the respondent applied the correct authority when it determined the SOC of $664.

Request to have FAP benefits issued on the 3rd of every month instead of the 14th of every month will now be addressed

27. The USDA Food and Nutrition Service determines the issuance date of FAP benefits. In this case the petitioner’s FAP is posted on her card on the 14th day of every month. She is in disagreement with the issuance date.

28. Fla. Admin. Code R. 65-2.042, Applicant/Recipient Fair Hearings in part states:

> The Department of Children and Family Services, hereinafter referred to as Department or Agency, is required to provide notice and an opportunity of a hearing to any applicant or recipient when the Department’s action, intended action or failure to act would adversely affect the individual’s or family’s eligibility for an amount or type of Financial Assistance, Medical Assistance, Social Services, or Food Stamp Program Benefits, or where action on a claim for such assistance or services is unreasonably delayed…

29. Fla. Admin. Code R 65-2.044 Right to Request a Hearing in part states:

> Any applicant/recipient dissatisfied with the Department’s action or failure to act has a right to request a Hearing. He/she may do so when it is believed that:
> (1) Opportunity to make application has been denied.
> (2) The application has been rejected.
> (3) The application has not been acted upon within a reasonable length of time.

(4) The benefits have been modified or discontinued.
(5) Reconsideration of the assistance/service benefits is refused or delayed.
(6) Opportunity has not been given to make a choice of service.
(7) Any other DCF action (or inaction) is incorrect.

30. The above authorities explain a Fair Hearing may be requested on action taken by DCF. The USDA is not part of DCF; it is a Federal Agency that mandates FA Programs. Consequently, the Office of Appeal Hearings does not have jurisdiction over this matter. Therefore, the appeal is dismissed due to lack of jurisdiction.

DECISION

1. Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal for FAP benefits is denied.

2. The appeal related to full Medicaid benefit is denied. Enrollment in the Medically Needy Program is correct.

3. The appeal regarding the FAP benefits issuance date is dismissed as non-jurisdictional.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 06 day of June, 2016,

in Tallahassee, Florida.

Christiana Gopaul Narine

Christiana Gopaul-Narine
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To [redacted], Petitioner
Office of Economic Self Sufficiency

May 10, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-02730
16F-02731

PETITIONER,
Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 20 Collier
UNIT: 88695

RESPONDENT.
________________________________/

ORDER OF DISMISSAL AND CANCELLATION OF HEARING

A request for hearing in the above-styled matter is before the undersigned. On May 5, 2016, the petitioner, via counsel, submitted a Voluntary Withdrawal of the Request for Fair Hearing. The matter has been resolved satisfactorily. The undersigned therefore dismisses these appeals as withdrawn per the petitioner's request. The hearing scheduled for May 10, 2016 is cancelled.

DONE and ORDERED this 10 day of May, 2016,

in Tallahassee, Florida.

Gregory Watson

Gregory Watson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: Petitioner
Office of Economic Self Sufficiency
SUNSHINE HEALTH

Jun 03, 2016
Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-02740

PETITIONER,
Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 15 PALM BEACH
UNIT: AHCA

And

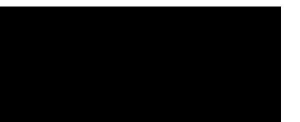
MOLINA HEALTHCARE

RESPONDENTS.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 6, 2016 at 8:38 a.m.

APPEARANCES

For the Petitioner: 

For the Respondents: Cindy Henline, Medical/Health Care Program Analyst
Agency for Healthcare Administration

Carlos Galvez, Government Contract Specialist
Molina Healthcare

ISSUE

At issue is whether respondent's denial of magnetic resonance imaging (MRI) of petitioner's right hand was proper. The burden of proof was assigned to the petitioner.

The standard of proof in an administrative hearing is by a preponderance of the evidence.

PRELIMINARY STATEMENT

Petitioner entered no exhibits into evidence.

Present for the respondents from Molina Healthcare (Molina) were: Dr. Alfredo Torralbas, Medical Director; Dr. Theresa Blanco, Medical Director; Bonnie Blitz, Nurse Director of Health Care Services; Elvis Leiva, Manager of Health Care Services; and Rebecca Quintana, Director of Government Contracts. Respondent's exhibits "1" and "2" were accepted into evidence.

Administrative Notice was taken of Florida Statutes § 409.815; § 409.963; § 409.971; § 409.973; § 409.913; Fla. Admin. Code Rules 59G-1.010(166); and the Practitioner Services Coverage and Limitations 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. Petitioner's birthdate is [redacted] She was Medicaid eligible at all times relevant to this proceeding.

2. Petitioner is enrolled in respondent's Managed Medical Assistance Program. Molina is the managed care entity which provides petitioner's medical services through the Florida Medicaid Program.

3. For several years, petitioner has experienced pain in her right middle finger. [redacted] was suspected. Based on that diagnosis, a procedure was thereafter completed.

4. After treatment, petitioner's pain did not subside.

5. A glomus tumor was then suspected.

6. In March 2016 petitioner was referred t[redacted]s a hand surgeon. An x-ray of the finger was completed.

7. The x-ray showed no fractures; dislocations; or arthritic changes.

8. A prior authorization request for a MRI was then submitted to Molina. The request included physician notes dated March 10, 2016 and a prescription. A copy of the x-ray was not included.

9. Submitted information was then reviewed by a physician who is board certified in Family Practice.

10. On March 30, 2016 Molina issued a Notice of Action which denied the MRI as not being medically necessary. The notice stated, in part, provided information did not identify:

- Signs of infection or blood flow issues
- Damage or instability of ligaments or tendons
- Six weeks of splint or cast therapy

11. On April 8, 2016 the Office of Appeal Hearings timely received petitioner's request for a fair hearing.

12. Petitioner states a MRI was previously completed. There are two tumors on her right middle finger. A new MRI is needed to determine where the tumors are now located. The x-ray did not provide sufficient clarity.

13. Petitioner states physical therapy is not possible due to the level of pain. Also, a splint was in use at the time of her appointment with[redacted]

14. Respondents state the narrative provided by [redacted] makes no reference to the x-ray showing tumors and there was no mention of splint therapy. The decision was made based on the limited data provided. In addition to the x-ray not being provided, the prior MRI was not provided.

CONCLUSIONS OF LAW

15. By agreement between the Agency for Health Care Administration and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to § 120.80, Fla. Stat.

16. This is a final order pursuant to § 120.569 and § 120.57, Fla. Stat.

17. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

18. The 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. Fla. Admin. Code R. 59G-1.010(166) explains that medical or allied care, goods, or services furnished or ordered must meet the definition of medically necessary or medical necessity, and defines medical necessity as:

> (a) “Medical necessary” or “medical necessity” means that medical or allied care, goods or services furnished or ordered must meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patent’s needs;
> 3. Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational;
> 4. Be reflective of the level of service that can safely be furnished, for which no equally effective and more conservative or less costly treatment is available statewide; and,
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider. . .
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods or services medically necessary, or a medical necessity, or a covered service.

20. The pain associated with petitioner’s finger is noted. For a MRI to be approved, however, petitioner must demonstrate each condition of medical necessity has been satisfied. Medical necessity is not subject to a personalized definition.

21. Other than physician notes and a prescription, actual imaging information was not submitted by the referring physician. Specifically, the x-ray performed in March 2016 and the prior MRI were not submitted.

22. It is noted petitioner’s treating physician prescribed the MRIs at issue. Fla. Admin. Code R. 59G-1.010(166), however, directs that a prescription on its own does

not establish medical necessity. The prescription must be accompanied by persuasive medical information to warrant the treatment or procedure.

23. Compelling information in support of the MRI was not included with the petitioner's prior authorization request. As such, 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;

24. If desired, more extensive diagnostic information can be re-submitted to Molina for review. Petitioner would have hearing rights associated with any future decision issued by Molina.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, petitioner's appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this __03___ day of __June____________, 2016,

in Tallahassee, Florida.

Frank Houston

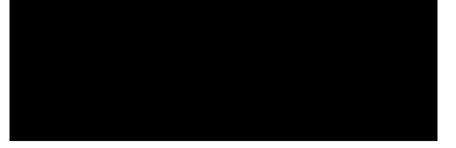
Frank Houston
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] PETITIONER
JUDY JACOBS, AREA 7, AHCA FIELD OFFICE
ALICE QUIROS, MOLINA HEALTHCARE

Jun 03, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS



APPEAL NO. 16F-02743

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 15 Palm Beach
UNIT: AHCA

RESPONDENT.
________________________________/

FINAL ORDER

Pursuant to notice, a telephonic administrative hearing in the above-referenced matter was convened on May 6, 2016 at 11:06 a.m.

APPEARANCES

For the Petitioner: Pro Se

For the Respondent: Lisa Sanchez
Medical/Healthcare Program Analyst

ISSUE

Whether the partial denial of inpatient services through Florida's Emergency Medicaid for Aliens Program was proper. The dates at issue are February 1, 2016 through February 7, 2016. The burden of proof was assigned to the petitioner. The standard of proof in an administrative hearing is by a preponderance of the evidence.

PRELIMINARY STATEMENT

Petitioner entered no exhibits into evidence. To establish residency status, the

record was held open through May 13, 2016 for petitioner to provide documentation. The record was also held open through May 13, 2016 for bills received from

No response was received from the petitioner.

Ms. Sanchez appeared both as a representative and witness for the respondent. Present from eQHealth Solutions (eQHealth) was Rakesh Mittal, M.D. Respondent's exhibit "1" was accepted into evidence. The record was held open through May 13, 2016 for respondent to provide additional information. Information was timely received and entered as respondent's exhibit "2".

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following Findings of Fact are made:

1. Petitioner is an adult male who entered the United States from Jamaica.

2. Petitioner presented no evidence that he is a lawful resident in the United States.

3. Respondent's Emergency Medicaid for Aliens (EMA) Program offers limited medical benefits for aliens meeting all Medicaid eligibility requirements except for citizenship or alien status. The EMA Program covers emergency medical services, only. Coverage is limited to the duration of the emergency situation.

4. Petitioner was, for certain dates in 2015, approved for medical assistance through the EMA Program.

5. On February 1, 2016 petitioner was admitted into for treatment of He received intravenous antibiotics and underwent an incision and drainage of an He remained hospitalized through February 7, 2016.

6. Respondent contracts with eQHealth to review payment requests for services rendered through the EMA Program If the individual is an undocumented non-citizen, eQHealth determines the length of time emergency treatment is necessary. The provider can then bill Medicaid for that timeframe. A provider cannot be reimbursed for services provided outside the identified emergency period.

7. Bethesda submitted a claim to eQHealth for the inpatient service dates of February 1, 2016 through February 7, 2016.

8. A physician at eQHealth thereafter reviewed all information submitted by Bethesda. A Notice of Denial – Emergency Coverage: Undocumented Non-Citizen was issued on April 4, 2016. EMA coverage was approved for February 1, 2016 through February 3, 2016, only. Coverage for February 4, 2016 through February 7, 2016 was denied. Based on submitted medical information, it was determined emergency medical care was not warranted after February 3, 2016. As petitioner had no fever and his white blood count was improving, outpatient care starting on February 4, 2016 was appropriate.

9. On April 11, 2016 petitioner contacted the Office of Appeal Hearings and timely requested a fair hearing.

Conclusions of Law

10. 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.

11. This is a final order pursuant to § 120.569 and § 120.57, Fla. Stat.

12. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

13. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

14. The Florida Medicaid program is authorized by Fla. Stat. Chapter 409 and Fla. Admin. Code Chapter 59G. The Medicaid program is administered by the respondent.

15. The Findings of Fact establish petitioner provided no documentation that he is a lawful resident of the United States.

16. Regarding Medicaid services, Fla. Admin. Code R. 65A-1.715 states:

> 65A-1.715 Emergency Medical Services for Aliens.
>
> (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. Flordia Statute § 409.901 provides the following definition:

> (10) "Emergency medical condition" means:
> (a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
> 1. Serious jeopardy to the health of a patient, including a pregnant woman or a fetus.
> 2. Serious impairment to bodily functions.

3. Serious dysfunction of any bodily organ or part.
(b) With respect to a pregnant woman:
1. That there is inadequate time to effect safe transfer to another hospital prior to delivery.
2. That a transfer may pose a threat to the health and safety of the patient or fetus.
3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

18. Regarding the petitioner, the need for emergency medical care is not disputed. The issue, however, focuses upon the length of the emergency period.

19. The Florida Medicaid Provider General Handbook states on page 3-22

Medicaid for Aliens

Eligibility can be authorized only for the duration of the emergency. Medicaid will not pay for continuous or episodic services after the emergency has been alleviated.

All claims must be accompanied by documentation of the emergency nature of the services. Exceptions are labor, delivery, and dialysis services. These are considered emergencies and are payable without documentation …

20. Petitioner was admitted into the hospital for the treatment of [redacted] Neither documentary evidence nor testimony establishes [redacted] was necessary. The Findings of Fact also establish the petitioner is a male.

21. Compelling evidence was not presented refuting respondent's position that emergent care was required after February 3, 2016.

22. Although the record was held open for petitioner to present documentation that he is a lawful resident in the United States, information of such was not received.

23. Petitioner has not established, in a preponderant manner, that respondent's action in this matter was improper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, petitioner's appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this __03___ day of __June____________, 2016,

in Tallahassee, Florida.

Frank Houston

Frank Houston
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] PETITIONER
JUDY JACOBS, AREA 7, AHCA FIELD OFFICE

Jun 29, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-02748

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 19 MARTIN
UNIT: AHCA

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 10, 2016 at 8:45 a.m.

APPEARANCES

For the Petitioner:

For the Respondent: Donald and Deborah West
Petitioner's Parents

STATEMENT OF ISSUE

Whether respondent's partial denial of Prescribed Pediatric Extended Care (PPEC) services 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

Present for the petitioner from Petitioner's pediatrician, also

appeared. Petitioner's exhibit "1" was accepted into evidence.

Present for the respondent from eQHealth Solutions (eQHealth) was Dr. Rakesh Mittal, M.D. Respondent's Exhibits "1" and "2" were accepted into evidence.

The record was held open through May 17, 2016 for respondent to provide a position regarding definitions for continuous therapeutic intervention and health supervision. The record was held open through May 24, 2016 for petitioner to file a written response. Respondent thereafter requested an extension to provide the requested information. Respondent was allowed through May 26, 2016. Petitioner was allowed through June 2, 2016 for a response. Information was timely received from the respondent and entered as respondent's exhibit "3". A response was not received from the petitioner.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following Findings of Fact are made:

1. Petitioner's date of birth is She was Medicaid eligible at all times relevant to this proceeding.

2. At three months of age, petitioner was diagnosed with failure to thrive. Shortly thereafter she was removed from the biological parent's household. Petitioner was adopted in September 2014.

3. Due to frequer

4. Petitioner is undergoing testing for

5. Petitioner is on an age appropriate diet.

6. Petitioner has experienced no recent hospitalizations or emergency room treatments.

7. Petitioner's medical status does not include:

- A gastrostomy tube for feeding
- A tracheostomy
- Oxygen therapy
- A ventilator
- The use of any type of catheter
- A colostomy or ileostomy
- Intravenous medications or fluids
- Skin ulcers or other conditions which require dressing changes
- Seizures

8. A PPEC Center provides non-residential services to children with medically complex conditions. Attendees receive both medical and therapeutic services at the PPEC facility. PPEC facilities are staffed with skilled nurses.

9. Petitioner attends a PPEC from 7:30 a.m. to 3:00 p.m.; Monday through Friday. While at the PPEC, she receives speech; occupational; and physical therapy.

10. eQHealth is the Peer Review Organization contracted by the respondent to perform prior authorization reviews for PPEC services.

11. On January 26, 2016 petitioner's PPEC submitted information to eQHealth for a continuation of services for the period April 10, 2016 through July 8, 2016.

12. Information submitted included a Plan of Care for PPEC Services submitted by petitioner's physician. The physician directed PPEC nurses to complete daily

- head-to-toe assessments;
- temperature, pulse, and respiration checks;
- hygiene requirements;
- Address developmental therapy goals including range of motion;

- Medication administration

13. The physician also calls for monitoring of slow growth and respiratory complications. Breathing treatments with albuterol are called for on an as needed basis.

14. Medications identified on the Plan of Care are:

- [redacted] Every four hours as needed for respiratory distress
- [redacted] Every four hours as needed for pain or fever
- [redacted] Apply to diaper area as needed
- [redacted] Every four hours as needed for allergic reactions
- [redacted] Every four hours as needed for pain or fever

15. On January 29, 2016 an eQHealth board certified pediatrician completed a review of submitted information.

16. On February 5, 2016 a Notice of Outcome – Partial Denial of Prescribed Pediatric Extended Care Services was issued to the petitioner's parent; physician; and PPEC provider. The notice sent to the physician stated, in part:

> The clinical information provided does not support the medical necessity of the requested PPEC services but 90 days will be approved to allow the patient to transition out of PPEC. There does not appear to be skilled services required and the patient does not meet the medical complexity requirement for PPEC services.

17. 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.

18. Reconsideration was requested.

19. A second physician reviewer thereafter reviewed all information submitted both before and after the initial denial. On April 5, 2015 eQHealth issued a Notice of Reconsideration Determination. The original denial was upheld.

20. On April 11, 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.

21. Petitioner's representatives argue the therapies received at the PPEC have been of tremendous help. The family lacks the resources to provide the therapies.

22. Should PPEC services be terminated, petitioner's representatives are concerned she would regress. Additionally, due to swallowing issues, petitioner easily chokes. PPEC staff carefully monitors the petitioner when eating.

23. Respondent asserts petitioner requires no skilled nursing services. Nebulizer treatments can be administered by any competent adult. All medications are on an as needed basis. Additionally, the therapies received at PPEC can be received in another setting.

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, 7th 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 Handbook (September 2013) has been promulgated into rule by Fla. Admin. Code R. 59G-4.260.

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:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider…
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

34. 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.

35. 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. To qualify for PPEC services, petitioner must be either medically complex or medically fragile.

37. Analysis is first directed to the definition of medically complex.

38. It is noted petitioner's medication regime is on an as needed basis. No evidence was presented that any of the medications must be administered by a medical professional.

39. No evidence was presented that petitioner receives skilled nursing services outside of the PPEC Center. As such, petitioner appears to function during the evening and weekends without any skilled nursing interventions.

40. Petitioner's possible diagnosis of Williams Syndrome is, at this point, speculative.

41. Petitioner receives certain therapies at the PPEC Center. Respondent's promulgated Therapy Services Coverage and Limitations Handbook states, in part:

> Page 1-2
>
> The purpose of the therapy services program is to provide medically necessary physical therapy (PT), occupational therapy (OT), respiratory

> therapy (RT) and speech-language pathology (SLP) services to recipients under the age of 21
>
> P2-17
>
> Physical, occupational, and respiratory therapy and speech language pathology treatment services can be provided in the recipient's place of residence or other community setting, such as school, Prescribed Pediatric Extended Care (PPEC) centers, or day care centers.

42. The above authority establishes the therapies received by the petitioner can also be provided in a setting other than a PPEC Center.

43. Petitioner's need for supervision is noted. The PPEC Handbook states on Page 1-2 "PPEC services are not emergency services." Monitoring for the sole purpose should a medically emergency arise is not within the parameters of the PPEC Program.

44. The greater weight of evidence does not establish petitioner currently meets the definition of being medically complex. This definition must be satisfied to qualify for PPEC services.

45. Regarding the definition of medically fragile, Fla. Admin Code R. 59G-1.010 (165) requires the individual be both medically complex and technologically dependent on medical equipment to sustain life.

46. Although the undersigned concludes petitioner does not meet the definition of being medically complex, it is noted that petitioner does not require the use of a ventilator; does not have a colostomy or ileostomy; and has no catheters. No evidence was presented any medication is administered intravenously. Additionally, compelling evidence was not presented that petitioner requires an advanced level of medical supervision to sustain life and the absence of such would lead to death.

47. The greater weight of evidence does not, at this time, establish petitioner meets the definition prescribed by Florida Administrative Code of being either medically complex or medically fragile.

48. When considering the requirements of EPSDT; the PPEC Handbook; and medical necessity criteria, the respondent has met the required evidentiary burden in this matter.

49. Respondent has demonstrated that petitioner's request for continuation of PPEC services has not satisfied the following conditions of medical necessity:

2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

DECISION

Based upon the foregoing Findings of Fact and controlling authorities, petitioner's appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees 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 June, 2016,

in Tallahassee, Florida.

Frank Houston

Frank Houston
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished T[redacted] PETITIONER
JUDY JACOBS, AREA 7, AHCA FIELD OFFICE

Jun 20, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-02753
16F-03872

PETITIONER,

Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 Dade
UNIT: 88601

RESPONDENT.

_______________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on May 18, 2016 at 3:13 p.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner:

For the Respondent: Kenesha Hanley,
Operations Management Consultant I

STATEMENT OF ISSUE

At issue is the respondent's action to deny the petitioner's request for Food Assistance Program benefits due to not completing a face to face interview. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner.

PRELIMINARY STATEMENT

The appeal 16F-02753 is invalid. The appeal was created in error as a Medicaid hearing when petitioner was appealing a pharmacy denial and will be heard under a new appeal by a different hearing officer.

The petitioner submitted no exhibits. The respondent submitted 24 pages of evidence, which were marked and entered into the record as Respondent's Exhibits "1" through "5".

FINDINGS OF FACT

1. The petitioner submitted an application for Food Assistance Program (FAP) benefits on February 8, 2016.

2. The petitioner is the only member of the household.

3. The petitioner receives $733 Supplemental Security Income (SSI) per month. He also has a shelter expense of $300 and a telephone expense of $43 per month.

4. On February 15, 2016, the respondent sent a Notice of Case Action (NOCA) to the petitioner requesting he appear in person:" PLEASE HEAD TO YOUR NEAREST SERVICE CENTER WITH YOUR ID FOR AUTHENTICATION WHILE THERE YOU MAY USE THE PHONE IN THE LOBBY FOR YOUR INTERVIEW", to the address on record for the petitioner,

5. The respondent states there has been no returned mail for the petitioner.

6. The petitioner cannot recall if he actually received the NOCA requesting that he appear in person for customer authentication.

7. On March 11, 2016 the respondent sent a NOCA to the petitioner informing him his application had been denied: "WE DID NOT RECEIVE ALL THE INFORMATION RQUESTED TO DETERMINE ELIGIBILITY".

8. The petitioner timely requested the hearing.

9. The petitioner states he was unsure if it was "legal" for him to actually receive FAP benefits. He also states he has been receiving assistance with his applications and is unsure if he is getting all the correct 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 Section 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

11. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

12. Fla. Admin. Code R. 65A-1.205 Eligibility Determination Process, addresses the verification process in part and states:

> (1)(a) The Department must determine an applicant's eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter. It is the applicant's responsibility to keep appointments with the eligibility specialist and furnish information, documentation and verification needed to establish eligibility…
> (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… 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...
> (4) **If an applicant or recipient does not keep an appointment without arranging another time with the eligibility specialist; or does not sign and date the applications described in subsection (1); or does not submit required documentation or verification the Department will deny benefits as it cannot establish eligibility.** (*emphasis added)*

13. The above cited authority explains that, as an applicant for benefits, the petitioner has the ultimate responsibility to keep appoints with the department and provide the verifications necessary for the respondent to make an eligibility determination. The respondent sent written notice on February 15, 2016 requesting a face to face authentication to verify his identity. The petitioner failed to keep the appointment.

14. The notice at issue was sent to the address given by the petitioner, mailed in the normal course of business to [redacted] The respondent has no record of the NOCA being returned. Where mail has been properly addressed, stamped, and mailed pursuant to normal office procedure, there is a presumption that the addressee received the mails. See (Brown v. Giffen Industries, Inc., 281 So. 2d 897 (Fla. 1973).

15. After reviewing the evidence presented, the undersigned concludes that the petitioner received the notice dated February 15, 2016 requesting that he appear at one of the local service centers.

16. Federal Regulation C.F.R. §273.2 Office operations and application processing, states in the pertinent part:

> (f) Verification. Verification is the use of documentation or a contact with a third party to confirm the accuracy of statements or information. The State

> agency must give households at least 10 days to provide required verification…
> (1) Mandatory verification. State agencies shall verify the following information prior to certification for households initially applying:..
> (vii) Identity. **The identity of the person making application shall be verified.** Where an authorized representative applies on behalf of a household, the identity of both the authorized representative and the head of household shall be verified. (*emphasis added*)

17. In accordance with the above cited authority, the department must verify the identity of the person making application. The respondent informed the petitioner his identity must be verified at the local service center. The petitioner failed to verify his identity.

18. In careful review of the evidence and testimony provided, the undersigned has concluded that the petitioner failed to keep his face to face appointment with the respondent and further, failed to verify his identity. Therefore, the respondent was correct in denying the petitioner's request for FAP benefits.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the respondent's action is affirmed.

Appeal 16F-02753 is closed 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 20 day of June, 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: [redacted] Petitioner
Office of Economic Self Sufficiency

Jun 29, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-02759

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 Jun 6, 2016 at 8:30 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 dental services was correct. The petitioner has the burden of proving his case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing in this matter was originally scheduled for May 16, 2016, but was rescheduled at the petitioner's request to allow him more time to review the documents submitted on behalf of the respondent.

The petitioner did not submit any documents as evidence for the hearing.

Appearing as witnesses for the respondent were Alice Quiros, A.V.P. of Government Contracts, and Carlos Galvez, Contract Specialist, from Molina Healthcare, which is the petitioner's managed health care plan. Also present as a witness for the respondent was Jackeline Salcedo, Complaints and Grievance Specialist, from DentaQuest, which reviews dental claims on behalf of Molina Healthcare.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Composite Exhibit 1: Fair Hearing Summary, Authorization Request, Denial Notice, and Dental Plan Provisions.

Also present for the hearing was a Spanish language interpreter, [redacted] Interpreter Number [redacted] from [redacted] Language Services.

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 from Molina Healthcare. Molina utilizes DentaQuest for review of requests for dental services.

2. On or about March 22, 2016, the petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from DentaQuest and/or Molina

Healthcare to perform re-bonding of 2 dental crowns. On or about March 23, 2016, Molina denied this request. The reason for the denial was that the requested procedure was a non-covered service or benefit.

3. The petitioner testified he is not able to pay for the re-bonding of the dental crowns himself because he is on disability.

4. Ms. Salcedo from DentaQuest testified that re-bonding of dental crowns is not a covered service under Molina Healthcare's dental plan provisions for individuals over age 21.

5. Dental services under the Medicaid State Plan in Florida are provided in accordance with the Respondent's Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012 and the Dental Services Coverage and Limitations Handbook ("Dental Handbook"), effective November 2011.

.

CONCLUSIONS OF LAW

6. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Fla. Stat. § 120.80.

7. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

8. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

9. The standard of proof in an administrative hearing is a preponderance of the evidence, in accordance with Rule 65-2.060 (1), Fla. Admin. Code. The

preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

10. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the respondent. The Medicaid Handbook and the Dental Handbook are incorporated by reference in Chapter 59G-4, Florida Administrative Code.

11. The Medicaid Handbook and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

> "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide;
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
> . . .
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

12. The petitioner's request for re-bonding of dental crowns was not denied due to any medical necessity considerations, but because that procedure is a non-covered service according to his dental plan provisions.

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 Molina 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 Molina Healthcare. The re-bonding of existing dental crowns is a non-covered service for adults under the Medicaid guidelines referenced above and under the Molina Healthcare dental plan provisions. Therefore, the hearing officer cannot make a determination that this service 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 indigence to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 29 day of June, 2016,

in Tallahassee, Florida.

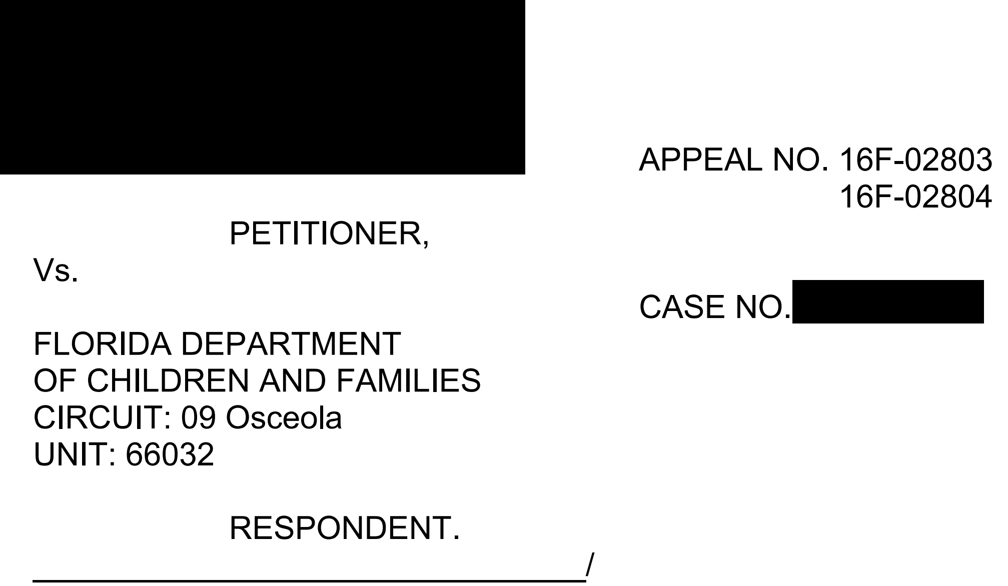
Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] PETITIONER
RHEA GRAY, AREA 11, AHCA FIELD OFFICE MANAGER
ALICE QUIROS, MOLINA HEALTHCARE

Jun 13, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS



APPEAL NO. 16F-02803
16F-02804

PETITIONER,

Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Osceola
UNIT: 66032

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on May 11, 2016 at 2:30 p.m. All parties appeared telephonically from different locations.

APPEARANCES

For the petitioner

For the respondent: Jennie Rivera, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action to approve him for $238 Food Assistance Program (FAP) benefits per month. The petitioner carries the burden of proof by a preponderance of the evidence.

Petitioner is also appealing the Department's action to close his full Medicaid and enroll him in the Medically Needy (MN) program with a Share of Cost (SOC). Petitioner

is seeking full Medicaid. The respondent carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

On March 30, 2016, the Department sent the petitioner a Notice of Case Action (NOCA) informing him that his recertification application dated March 7, 2016 was approved for $223 in FAP benefits per month and that he was enrolled in the MN program with a SOC of $540 per month. The petitioner timely appealed these actions on April 13, 2016.

The petitioner presented no evidence for the undersigned to consider. The Department presented a total of 126 pages of evidence, which was entered into the record as Respondent's Composite Exhibit 1. The record was closed on May 11, 2016.

FINDINGS OF FACT

1. On March 7, 2016, the petitioner submitted an application for FAP and Medicaid benefits for himself, his wife and their two mutual children. The petitioner reported earned income from [redacted] for his daughter, age 19, and Social Security Disability Income (SSDI) for himself of $801.39 per month. The petitioner has Medicare Part B and his premium is paid for by the State of Florida. He also reported a mortgage of $914.78 per month and an electric expense that includes heating and cooling. The mortgage includes property taxes and homeowner's insurance.

2. On March 14, 2016, the petitioner sent the following paystubs to verify his daughter's gross income from [redacted] February 26, 2016 $420.38 and March 11, 2016 $358.02. The paystub dated February 26, 2016 was not

considered representative as it included a bonus of $80; therefore, it was not used in the calculation of the earned income. The Department converted her income to a monthly average by multiplying the representative paystub of $358.02 by 2.15 to equal $769.74.

3. On March 22, 2016, the Department was made aware through a data exchange alert that the petitioner's daughter was also working at the On March 23, 2016, the following paystubs were returned to verify her gross income from the February 22, 2016 $290.04 and March 7, 2016 $332.99. Both paystubs were used as representative. The Department converted these paystubs to a monthly average. The sum of both paystubs was divided by 2 and then multiplied by 2.15 for a monthly average of $669.77.

4. On March 31, 2016, a change was received from the petitioner reporting that his shelter obligation increased by $50. The Department took action to include this and sent the petitioner a NOCA on April 1, 2016 informing him that his FAP benefits would increase to $238 per month effective May 2016.

5. The Department used the following methodology to calculate the petitioner's FAP benefits:

$1,439.51 Total earned income
<u>+$ 801.00 Total unearned income</u>
$1,627.71 Total gross income
-$ 287.90 Earned income deduction (20% of the total earned income)
<u>-$ 168.00 Standard deduction</u>
$1,784.61 Adjusted income

$ 964.78 Shelter cost
+$ 345.00 Standard utility allowance
$1,309.78 Total shelter cost
-$ 892.30 Shelter standard (50% of the adjusted net income of $1,784.61)
$ 417.48 Excess shelter deduction

$1,784.61 Adjusted income
-$ 417.48 Excess shelter deduction
$1,367.13 Adjusted FAP income

$1,367.13 x 30% = $411 (benefit reduction)
$649 (Maximum FAP benefit amount for 4 persons) - $411(benefit reduction) = $238

6. The petitioner's FAP benefits were $483 during his previous recertification. The Department explained that the petitioner's FAP benefits decreased this certification as his daughter's income from the Osceola County School District was not reported and included before. The petitioner believes that his 19 year old daughter is "under age" and that her earned income should not be counted in the budget. The Department clarified that his daughter is required to be included in his household as she is under the age of 22, but as she is over the age of 17, her earned income is included in the calculation of FAP benefits.

7. The petitioner was receiving full Medicaid while he was receiving Supplemental Security Income (SSI), but when the Social Security Administration (SSA) transferred him to SSDI he lost his full Medicaid. The Department placed him in transitional Medicaid. His transitional Medicaid ended March 2016.

8. The Department determined the petitioner's Medicaid eligibility under the SSI-Related Medicaid Program as he is disabled. The petitioner's standard filing unit for this program is himself and his wife. The Department used his SSDI income of

$801. The Department testified that the petitioner was over income to receive full Medicaid. However, it did not include the income limit chart for SSI-Related Medicaid.

9. The Department calculated the petitioner's SOC by subtracting a $20 unearned income disregard from the total income of $801 for a countable unearned income of $781. The Medically Needy Income Limit (MNIL) for a two person household is $241. The MNIL was subtracted from the total countable income to equal a $540 SOC amount. The petitioner was enrolled in the MN program with a SOC of $540 per month. The Department explained that the petitioner received a lower SOC than other members of his household because he is disabled and was evaluated under the SSI-Related Medicaid program instead of the Family-Related Medicaid program. No other deductions were found for the petitioner. The petitioner believes that with his income amount, he should be on full Medicaid.

CONCLUSIONS OF LAW

10. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to § 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

11. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

IN REGARDS TO THE FAP ISSUE:

12. The Code of Federal Regulations appearing in 7 C.F.R. § 273.1, Household concept, states in 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.
>
> (i) Spouses;
>
> (ii) A person under 22 years of age who is living with his or her natural or adoptive parent(s) or step-parent(s); and…

13. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 2210.0304, Parents and Children Included (FS) states in part:

> Children under age 22 living in a household with a parent must be included in the same food stamp assistance group as their parent whether or not they purchase and prepare food together.

14. The Policy Manual, CFOP 165-22, passage 2210.0100, Standard Filing Unit (FS) states:

> The Standard Filing Unit (SFU) is the single individual or group of individuals whose income, assets, or needs are considered in the eligibility determination and benefit, income, and asset levels of the assistance group, because they share a legal or blood relationship and/or live together. Eligibility of the assistance group is based on a review of the total income and assets of all individuals in the SFU.

15. Based upon the above cited authority and policies, the undersigned concludes that the Department was correct to include the petitioner's 19 year old daughter in the standard filing unit along with her earned income in the determination of his FAP benefits.

16. The Code of Federal Regulations appearing in 7 C.F.R. § 273.9, income, exclusions and deductions states in part:

> (a) Income eligibility standards. Participation in the Program shall be limited to those households whose incomes are determined to be a substantial limiting factor in permitting them to obtain a more nutritious diet…
> (b) Definition of income…
> (1) Earned income shall include: (i) All wages and salaries of an employee.
> (2) Unearned income shall include, but not be limited to:
> (ii) Annuities; pensions; retirement, veteran's, or disability benefits; worker's or unemployment compensation…; old-age, survivors, or social security benefits…
> (c) Income exclusions. Only the following items shall be excluded from household income and no other income shall be excluded…
> (7) The earned income (as defined in paragraph (b)(1) of this section) of any household member who is under age 18, who is an elementary or secondary school student, and who lives with a natural, adoptive, or stepparent…
> (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...
> (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…
> (iii) Standard utility allowances…

17. The above-cited legal authority states earned income and social security benefits are included in the budget used to calculate FAP benefits. The Department included a standard deduction of $168 per month. The Department gave the petitioner an earned income deduction of $287.90 (20% of the total earned income). The petitioner's $964.78 per month mortgage and $345 for the standard utility allowance were also included in the FAP budget. There was an excess shelter deduction of

$417.48 allowed in the FAP budget. The petitioner was not found to be eligible for any other deductions.

18. The Code of Federal Regulations appearing in 7 C.F.R. § 273.10, determining household eligibility and benefit levels states in part:

> (e)(1) 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…
> (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…
> (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.
> (e)(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.
> (1) The State agency shall round the 30 percent of net income up to the nearest higher dollar;

19. The Policy Manual at Appendix A-1 shows that effective October 1, 2015 the standard deduction for a four-person household is $168. It further shows that the maximum FAP benefit is $649 for a household of four persons. The standard utility

allowance is $345 per month for a household that incurs an electric expense with heating and cooling.

20. The above authorities explain that the monthly FAP benefit allotment is determined by multiplying the net monthly income by 30% and rounding the result up to the next whole dollar amount. The result of this calculation is deducted from the maximum benefit allotment for the appropriate assistance group size. In this case, the petitioner’s household consists of four persons and his benefit reduction was calculated as $411. The benefit reduction of $411 was subtracted from $649, resulting in $238 per month in FAP benefits.

21. After carefully considering the testimony and evidence presented, along with the pertinent rules and regulations stated above, the undersigned cannot find a more favorable outcome for the petitioner. The undersigned concludes that the Department’s calculation of the petitioner’s FAP benefits in the amount of $238 effective May 1, 2016 was correct.

IN REGARDS TO THE MEDICAID ISSUE FOR PETITIONER:

22. Fla. Admin. Code R. 65A-1.710, SSI-Related Medicaid Coverage Groups, states in part:

> The Department covers all mandatory coverage groups and the following optional coverage groups:
> (1) MEDS-AD Demonstration Waiver. A coverage group for aged and disabled individuals (or couples), as provided in 42 U.S.C. § 1396a(m).
> …
> (5) Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. §§ 1396a and 1396d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance due to their level of income or resources. The program does not cover nursing facility care, intermediate care for the developmentally disabled services, or other long-term care services.

23. Fla. Admin. Code R. 65A-1.701(20) defines MEDS-AD Demonstration Waiver as:

> Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and **are not receiving Medicare** [emphasis added] or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services.

24. Section § 409.904, Fla. Stat. sets forth the following regarding Medicaid:

> Optional payments for eligible persons.—The agency may make payments for medical assistance and related services on behalf of the following persons who are determined to be eligible subject to the income, assets, and categorical eligibility tests set forth in federal and state law…
> (1) Subject to federal waiver approval, a person who is age 65 or older or is determined to be disabled, whose income is at or below 88 percent of the federal poverty level, whose assets do not exceed established limitations, **and who is not eligible for Medicare** [emphasis added]…

25. The Policy Manuat, CFOP 165-22, passage 2040.0813.03, Technical Requirements for MEDS-AD (MSSI) states:

> The individual must meet all of the following criteria:
> 1. Age or disability,
> 2. U.S. residency,
> 3. Citizenship,
> 4. Welfare enumeration,
> 5. Third party liability,
> 6. Application for other benefitss they may be eligible to receive,
> 7. **Not be receiving Medicare** [emphasis added]…

26. According to the above regulations, an individual who receives Medicare is not eligible to receive full Medicaid. In this instance, the petitioner has Medicare benefits through SSA; therefore, he does not meet one of the technical requirements for full Medicaid. Therefore, the undersigned concludes that the Department was correct in its action to enroll the petitioner in the MN program with a SOC; instead of full Medicaid.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are denied and the Department's actions are affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 13 day of June, 2016,

in Tallahassee, Florida.

Brandy Ricklefs

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@myflfamilies.com

Copies Furnished To [redacted], Petitioner
Office of Economic Self Sufficiency

Jun 08, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-02893

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 15 PALM BEACH
UNIT: AHCA

And

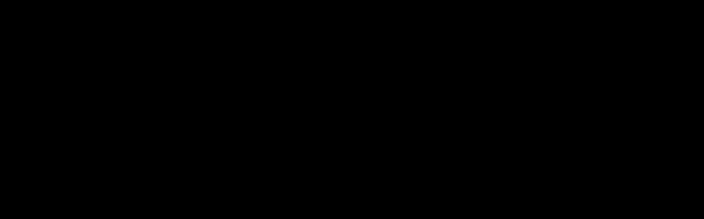
COVENTRY HEALTHCARE OF FLORIDA

RESPONDENTS.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above matter on May 13, 2016 at 8:35 a.m.

APPEARANCES

For the Petitioner: 

For the Respondent: Janet Saldana
Petitioner's Sister

STATEMENT OF ISSUE

Whether respondent's denial of food thickener (B4100) 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

On May 3, Coventry requested to be added as a party to this proceeding. The request was granted. As such, Coventry is a co-respondent in this matter.

Petitioner was present and represented by her sister. Petitioner's exhibit "1" was accepted into evidence.

Present for respondent from Coventry was Dr. Darwin Caraballo, Medical Director. Present as an observer was Sommer Brooks, Senior Compliance Consultant. Respondent's exhibit "1" was accepted into evidence.

The record was held open through May 20, 2016 for respondent to provide a Medical Supplies Fee Schedule and certain service definitions. Information was timely received and entered as respondent's exhibit "2"

The record was held open through May 27, 2016 for petitioner to submit a written response to post hearing submissions. A response was not received.

Coventry approved a food thickener for petitioner through February 1, 2016. At the end of the authorization period, a Notice of Action was not issued by Coventry. Upon becoming aware of the termination, petitioner thereafter requested the food thickener be re-approved. That request was denied on March 7, 2016.

At the hearing, the undersigned assigned the burden of proof to the petitioner but stated further analysis was warranted. After further consideration, the burden is re-assigned to the respondent. As petitioner was not notified of the February 1, 2016 termination, petitioner was not afforded the opportunity to request a fair hearing until she once again requested the service. Essentially, the action taken by Coventry reflects a termination of a service.

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 receives Medicaid services through respondent's Statewide Medicaid Managed Care Program. Long Term Managed Care (LTMC) services are provided by Coventry. Services through the Managed Medical Assistance Program are provided by Molina Health Care.

2. The LTMC Program is the primary provider for medical supplies.

3. Food thickener is considered a medical supply.

4. Petitioner's date of birth is [redacted] Approximately four years ago she experienced a stroke. The stroke resulted in paralysis on her left side.

5. Petitioner has difficulty swallowing and can choke when eating. A food thickener facilitates her ability to safely swallow.

6. Medical supplies covered by the Florida Medicaid Program are found on the Durable Medical Equipment and Medical Supply Services Provider Fee Schedule (July 2014).

7. The Florida Medicaid Program does not cover food thickener.

8. A food thickener is neither an expanded benefit provided by Coventry nor part of their over the counter program.

9. Coventry last approved food thickener for the period November 1, 2015 through February 1, 2016.

10. After attempting to secure food thickener in February 2016, petitioner learned the authorization expired.

11. On February 25, 2016, a new request was submitted to Coventry.

12. On March 7, 2016 Coventry issued a Notice of Action which denied the request. The notice states food thickener is not a covered benefit.

13. On April 11, 2016 the Office of Appeal Hearings timely received petitioner's request for a fair hearing.

14. Coventry is unsure why a food thickener was previously approved.

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.

16. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

17. The standard of proof in an administrative hearing is by a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

18. The Florida Medicaid State Plan is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The program is administered by the respondent.

19. Section 409.973, Fla. Stat. addresses the minimum benefits provided under Medicaid managed care plans and states, in part:

> (1) MINIMUM BENEFITS. – Managed care plans shall cover, at a minimum, the following services:
> (p) Medical supplies …

20. Fla. Admin. Code R. 59G-1010(163) defines medical supplies as "medical or surgical items that are consumable, expendable, disposable or non-durable and that are used for treatment or diagnosis of a patient's specific illness, injury, or condition…"

21. In addition to the above, respondent's LTMC contract with Coventry provides the following definition:

> (14) Medical Equipment and Supplies — Medical equipment and supplies, specified in the plan of care, include: (a) devices, controls or appliances that enable the enrollee to increase the ability to perform activities of daily living; (b) devices, controls or appliances that enable the enrollee to perceive, control or communicate the environment in which he or she lives; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment that is necessary to address enrollee functional limitations; (e) necessary medical supplies not available under the State Plan including consumable medical supplies such as adult disposable diapers. This service includes the durable medical equipment benefits available under the state plan service as well as expanded medical equipment and supplies coverage under this waiver. All items shall meet applicable standards of manufacture, design and installation. This service also includes repair of such items as well as replacement parts.

22. Regarding provider fee schedules, the Florida Medicaid Web Portal at

http://portal.flmmis.com/flpublic/Provider_ProviderServices/Provider_ProviderSupport/Provider_ProviderSupport_FeeSchedules/tabid/51/desktopdefault/+/Default.aspx

states: "The current Medicaid Provider Fee Schedule are to furnish the Medicaid provider with the **appropriate fee schedules for covered services** [Emphasis Added] provided to eligible Florida Medicaid recipients."

23. The Findings of Fact establish a food thickener (B4100) is not included on respondent's durable medical equipment fee schedule.

24. Respondent's LTMC contract enumerates expanded benefits to be offered in the program (Respondent's Exhibit 2). Included are over the counter medications and supplies.

25. The Findings of Fact establish a food thickener is not part of Coventry's over the counter program.

26. It is not clear why a food thickener was previously approved. Regardless, B4100 does not appear on the DME Fee Schedule, nor is it considered by Coventry to be an over the counter medication.

27. As the item at issue is not covered by either the Medicaid State Plan or Coventry, a medical necessity review was not warranted. Additionally, petitioner is over 21 years of age. As such, requirements associated with Early Periodic Screening, Diagnosis, and Treatment are not applicable.

28. When considering all evidence and testimony on a comprehensive basis, respondent has demonstrated the action taken in this matter was appropriate.

DECISION

Based upon the foregoing Findings of Fact and controlling authorities, petitioner's appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The

petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 08 day of June, 2016,

in Tallahassee, Florida.

Frank Houston

Frank Houston
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] ETITIONER
JUDY JACOBS, AREA 7, AHCA FIELD OFFICE
SOMMER BROOKS, COVENTRY HEALTH CARE

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

FILED
Jun 03, 2016
Office of Appeal Hearings
Dept. of Children and Families

APPEAL NO. 16F-02894

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 15 PALM BEACH
UNIT: AHCA

And

MOLINA HEALTHCARE

RESPONDENTS.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 11, 2016 at 11:11 a.m.

APPEARANCES

For the Petitioner:

For the Respondents: Lisa Sanchez
Agency for Healthcare Administration
Senior Human Services Program Specialist

Carlos Galvez
Molina Healthcare
Government Contract Specialist

ISSUE

Whether respondent's denial of a deep gum and root cleaning (Procedure D4341) 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

On April 27, 2016 a request was received from Molina Healthcare (Molina) to be added as a party to this proceeding. At the hearing, the request was granted. As such, Molina is a co-respondent in this matter.

Petitioner appeared pro se and entered no exhibits into evidence.

Present for the respondents from Molina was Alice Quiros, AVP of Government Contracts. Present from DentaQuest were: Jacelyn Salcedo, Appeals and Grievance Specialist; Yvie Labady, Compliance and Grievance Specialist; Nicolas Calderon, Grievance and Appeals Supervisor; and Omeshia Smith, Complain and Grievance Specialist.

Hearing Officer's exhibit "1" and respondent's exhibit "1" were 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. Petitioner's date of birth is [redacted].

2. Petitioner receives Medicaid services through the Statewide Medicaid Managed Care Program, specifically, the Managed Medical Assistance Program. Since February 3, 2016, Molina is the managed care entity which provides petitioner's Medicaid services.

3. The Florida Medicaid Program provides limited dental services for individuals over the age of 21.

4. DentaQuest is Molina’s dental vendor. All requests for dental services are reviewed by DentaQuest. DentaQuest determines whether the requested procedure is in compliance with pertinent rules and regulations.

5. On February 25, 2016 DentaQuest received from petitioner’s dentist a request for periodontal scaling and root planning (Procedure D4341).

6. Procedure D4341 is a periodontal service. The procedure involves a deep cleaning of the gums and roots.

7. The requested procedure was not related to the treatment of an abscess or preparation of petitioner’s mouth for dentures.

8. The Florida Medicaid Program covers dental procedure D4341 for individuals under the age of 21 only.

9. Dental procedure D4341 is not an expanded service provided by Molina to individuals over the age of 21.

10. On February 26, 2016, Molina issued a Notice of Action which denied the requested procedure. The notice stated: “The requested service is not a covered benefit.”

11. On April 13, 2016, the Office of Appeal Hearings timely received petitioner’s request for a fair hearing.

12. Petitioner argues although the referring dentist requested dental procedure D4341, he only desires a regular dental cleaning.

13. A regular dental cleaning is an oral prophylaxis.

14. An oral prophylaxis is a service provided to Molina members over the age of 21.

15. Petitioner asserts the referring dentist stated an oral prophylaxis would not be appropriate. Additionally, the request procedure was previously approved by the Medicaid Program in New York.

16. Respondent asserts a second opinion regarding an oral prophylaxis could be received from another Molina enrolled dentist.

CONCLUSIONS OF LAW

17. By agreement between the Agency for Health Care Administration and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to § 120.80, Fla. Stat.

18. This is a final order pursuant to § 120.569 and § 120.57, Fla. Stat.

19. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

20. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

21. The Florida Medicaid Provider General Handbook (Provider Handbook) – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code R. 59G-4. The Provider Handbook states on page 1-27:

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.

Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

22. Page 1-30 of the Provider Handbook continues by stating: “An HMO’s services cannot be more restrictive than those provided under Medicaid fee-for-service.”

23. At the time of the denial at issue, respondent’s Dental Services Coverage and Limitations Handbook (Dental Handbook) was in effect. Such served as the authority for dental services until the Dental Services Coverage Policy (Dental Policy) became effective on May 3, 2016.

24. To ensure proper analysis, the undersigned has directed analysis to both authorities.

25. 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.

26. The Findings of Fact establish petitioner is over the age of 21 and the requested procedure is not related to treatment of an abscess or preparation of the mouth for dentures.

27. Based on the Dental Handbook, the requested dental service is not covered by the Medicaid Program. The Findings of Fact also establish procedure D4341 is not an expanded service provided by Molina.

28. Analysis is next direct to respondent's Dental Policy which became effective in May 2016 and promulgated in Rule Division 59G, Fla. Admin. Code.

29. The Dental Policy states, in relevant parts:

> 2.2 Who Can Receive
>
> Florida Medicaid recipients requiring medically necessary dental services. Some services may be subject to additional coverage criteria as specified in section 4.0.
>
> If a service is limited to recipients under the age of 21 years, it is specified in section 4.0. Otherwise, Florida Medicaid reimburses for services for recipients of all ages.
>
> 4.0 Coverage Information
>
> General Criteria
>
> Florida Medicaid reimburses for services that meet all of the following:
>
> - Are determined medically necessary
> - Do not duplicate another service
> - Meet the criteria as specified in this policy
>
> 4.2.5 Periodontal Services
>
> Florida Medicaid reimburses for periodontal services for recipients under the age of 21 years to diagnose and treat the diseases of the supporting and surrounding tissues of the teeth.
>
> 4.2.6.1Oral Prophylaxis
>
> One oral prophylaxis in a 181 day period, per recipient.
>
> 5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not reimbursed when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

30. The Findings of Fact establish dental procedure D4341 is a periodontal service. The above authority specifies the procedure is covered only for those individuals under 21 years of age.

31. Neither the Dental Handbook nor the Dental Policy identifies Procedure D4341 as a covered service for individuals over the age of 21.

32. Petitioner has not established, by the greater weight of evidence, that respondent's action in this matter was improper.

33. If desired, petitioner can further discuss with Molina the appropriate process for securing an oral prophylaxis.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, petitioner's appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay

the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this ___03___ day of ___June___________, 2016,

in Tallahassee, Florida.

Frank Houston

Frank Houston
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] PETITIONER
JUDY JACOBS, AREA 7, AHCA FIELD OFFICE
ALICE QUIROS, MOLINA HEALTHCARE

May 11, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-02901

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 07 Volusia
UNIT: AHCA

RESPONDENT.
________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on May 9, 2016 at 10:08 a.m.

APPEARANCES

For the Petitioner: pro se

For the Respondent: Sheila Broderick, registered nurse specialist

STATEMENT OF ISSUE

At issue is the quality of service the petitioner received from a Medicaid transportation provider.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (Agency or AHCA or respondent) administers the Florida Medicaid Program. Medicaid rules require that most recipients receive their Medicaid services through the Managed Care Plan. The Agency contracts

with numerous health care organizations to provide medical services to its program participants. Staywell Health Plan (Staywell) is the contracted health care organization in the instant case.

There were no additional witnesses for the petitioner. The petitioner did not submit documentary evidence.

The respondent presented two witnesses from Staywell: Alexandra Hicks, regulatory research coordinator and Michelle Hadley, ancillary vendor account coordinator. The respondent presented two witnesses from the Medicaid provider, Medical Transportation Management (MTM): Robert Ferguson, client relationship manager; and Jane Ann Bosch, quality resolutions specialist. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. The petitioner is a Florida Medicaid recipient. The petitioner is enrolled with Staywell HMO.

2. A MTM van transported the petitioner to a medical appointment on May 8, 2015. It was a hot day. The van's air conditioning system was not working and only one window was operable. The petitioner was on the van for an extended period of time (between one and three hours); she became ill due to the heat, but did not require medical attention.

3. The petitioner filed a complaint about her experience with Staywell. The petitioner alleged that Staywell's written incident report contained factual errors regarding the period of time she was on the van (Staywell's report stated she was on the van one hour, the petitioner stated she was on the van three hours) and the number of passengers on the van (Staywell's report stated the petitioner was the sole passenger, the petitioner stated there was another passenger on the van). The petitioner seeks to have the alleged inaccuracies in Staywell's incident report corrected. The petitioner also wants to prevent anyone else from having a similar experience.

4. The respondent provided instructions regarding how Medicaid recipients can register complaints about Medicaid providers with AHCA.

5. The respondent filed a dismissal motion stating that the issue under appeal is non-jurisdictional because it does not involve an adverse action which affects the petitioner's receipt of Medicaid goods or services.

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:
> - 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

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 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 petitioner's issue involves the quality of service she received from a Medicaid provider. The Office of Appeal Hearings does not have jurisdiction over provider relations issues. The petitioner may address her concerns about the Medicaid provider by calling AHCA's Consumer Complaint Office at 1-888-254-1055.

DECISION

The respondent's dismissal motion is hereby granted. 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 ___11___ day of ___May___________, 2016,

in Tallahassee, Florida.

Leslie Green
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Debbie Stokes, Area 4, AHCA Field Office Manager
[redacted]

Jun 16, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-02904

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 04 Duval
UNIT: AHCA

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on June 15, 2016 at 10:06 a.m.

APPEARANCES

For the Petitioner:

For the Respondent: Sheila Broderick, registered nurse specialist

STATEMENT OF ISSUE

1. Denial of petitioner’s request for metal partial dentures.
2. Petitioner’s dissatisfaction with a Medicaid provider.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (Agency or AHCA or respondent) administers the Florida Medicaid Program. Medicaid rules require that most recipients receive their Medicaid services through the Managed Care Plan. The Agency contracts

with numerous health care organizations to provide medical services to its program participants. United Healthcare (United) is the contracted health care organization in the instant case.

There were no additional witnesses for the petitioner. The petitioner did not submit documentary evidence.

The respondent presented three witnesses from United: Susan Frishman, senior compliance analyst; Lori Eubanks, account manager and; Dr. Brittany Voe, dental consultant. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. The petitioner is a Florida Medicaid recipient. The petitioner is enrolled with United HMO.

2. The petitioner's treating dentist submitted a request for upper and lower partial metal dentures to United in October 2015. United denied the request in a notice dated October 9, 2015. The notice reads in pertinent part:

> The request for a cast metal framework partial denture is denied. The submitted x-rays show presence of periodontally involved teeth. A resin based partial denture may be considered a more appropriate restoration for the member's current underlying condition.

3. The petitioner's treating dentist submitted a request for upper and lower partial acrylic (resin based) dentures to United in October 2015. United approved the request in a notice dated October 21, 2015.

4. The petitioner received the acrylic partial dentures in January 2016.

5. The petitioner was not satisfied with the fit and feel of the acrylic dentures. The treating dentist made adjustments once or twice. The petitioner still was not satisfied with the dentures. The petitioner eventually returned the dentures to the dentist's office and filed a provider quality of service grievance with United on January 25, 2016.

6. United addressed the petitioner's grievance in a letter dated April 8, 2016. The letter reads in pertinent part:

> You told us you were unhappy with Dr. Desai. You got acrylic partials from him on January 13, 2016. You said they cause you to gag. You told use you are having a difficult time talking. You said you want to go back to metal partials.
>
> We spoke with Dr. Desai….Dr. Desai did a study model on you to see if you would like acrylic. He said he told you he would not be able to do cast iron because there is not enough clearance….The acrylics were done. They told us you returned once for an adjustment. Dr. Desai said you can come in for an adjustment if needed. He said he cannot help you if you are not going to follow his advice….Dr. Desai said he would do what he can for you. You need to call the office to plan a time to see him.
>
> We called you several times. We were unable to reach you. Please call us if you still need help.

7. The petitioner would like United to provide him with metal partials. The petitioner asserted that acrylic partials are "too hard and they have me gagging all the time."

8. United argued that the petitioner did not timely appeal the October 9, 2015 denial of his request for metal partials and the appeal should be dismissed. United further argued that the remaining issue, the petitioner's dissatisfaction with the fit and

feel of his acrylic partials, is a provider relations issue and also not under the jurisdiction of the Office of Appeal Hearings. United argued that both issues are non-jurisdictional.

CONCLUSIONS OF LAW

9. By agreement between the AHCA and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Section 120.80, Florida Statutes.

10. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes

11. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

DENIAL OF METAL PARTIALS WILL BE ADDRESSED FIRST

12. Fla. Admin. Code R. 65-2.046, Time Limits in Which to Request a Hearing, sets forth the regulatory requirements as follows:

> (1) **The appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs.** [emphasis added]

13. The authority cited above explains that a request for hearing must be filed with 90 days of the adverse action notice.

14. The respondent issued a denial notice regarding the petitioner’s request for metal partials on October 9, 2015. The petitioner requested a hearing on April 18, 2016, more than six months after issuance of the denial notice. The courts have liberally interpreted what constitutes a request for hearing. In keeping with the courts’ interpretation, the undersigned concluded that the January 25, 2016 provider grievance the petitioner filed with United could be interpreted as a request for hearing. The

grievance request was filed 109 days after issuance of the denial notice and therefore is also outside of the 90 day limit set forth in rule. The undersigned concludes that the petitioner did not timely request a hearing regarding the denial of his request of metal partial dentures.

DISATISFACTION WITH PROVIDER ISSUE WILL NOW BE ADDRESSED

15. 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…"

16. 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

17. 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.

18. The petitioner is dissatisfied with the quality of service he received from a Medicaid provider. This is a provider relations issues. The Office of Appeal Hearings does not have jurisdiction over provider relations issues. The petitioner may address his concerns about the Medicaid provider by calling AHCA’s Consumer Complaint Office at 1-877-254-1055.

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 16 day of June, 2016,

in Tallahassee, Florida.

Leslie Green

Leslie Green
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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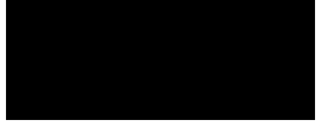
Copies Furnished To: [redacted], Petitioner
Debbie Stokes, Area 4, AHCA Field Office Manager
[redacted]

Jun 21, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS



APPEAL NO. 16F-02912

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 15 PALM BEACH
UNIT: AHCA

And

MAGELLAN COMPLETE CARE

RESPONDENTS.

_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in on June 2, 2016 at 1:35 p.m.

APPEARANCES

For the Petitioner:

For the Respondents: Dianna Chirino
Agency for Healthcare Administration
Senior Human Services Program Specialist

Michelle Riegler
Magellan Complete Care
Compliance Officer

ISSUE

Whether the denial of the following dental procedures was proper:

- D2740: 6 Crowns
- D2950: Core buildup 9 teeth
- D6740: Fixed Crowns 3 Teeth
- D6245: Prosthodontics Fixed 1 Tooth
- D3320: Endodontic Therapy 2 Teeth
- D3330: Endodontic Therapy 1 Tooth
- D4211: Gingivectomy Upper and Lower Quadrants

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

On May 5, 2016 a request was received from Magellan Complete Care (Magellan) to be added as a party to this proceeding. At the hearing, the request was granted. As such, Magellan is a co-respondent in this matter.

Petitioner's exhibit "1" was entered into evidence.

Ms. Chirino appeared in person for the respondent. Ms. Riegler appeared by phone. Present by phone from DentaQuest were Jacelyn Salcedo, Complaint and Grievance Specialist and Omeshia Smith, Complaint and Grievance Specialist. Respondent's exhibit "1" was entered into evidence.

Administrative Notice was taken of the Dental Services Coverage and Limitations Handbook (November, 2011).

The record was held open through June 9, 2016 for respondent to provide a Dental Fee Schedule. Information was timely received and entered as respondent's exhibit "2". The record was held open through June 16, 2016 for petitioner to provide a written response to the post hearing submission. A response was not received.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following Findings of Fact are made:

1. Petitioner's date of birth [redacted]

2. Petitioner receives Medicaid services through the Statewide Medicaid Managed Care Program. Specifically, the Managed Medical Assistance Program. Magellan is the managed care entity which provides petitioner's Medicaid services.

3. DentaQuest is Magellan's dental vendor. All requests for dental services are reviewed by DentaQuest. DentaQuest determines whether the requested procedure is in compliance with pertinent rules and regulations.

4. The Florida Medicaid Program provides limited dental services for individuals over the age of 21. Services are limited to the treatment of an abscess or preparation of the mouth for dentures.

5. The dental procedures requested by petitioner are not related to treatment of an abscess or preparation of his mouth for either a partial or full denture.

6. The requested procedures are not an expanded dental service provided by Magellan/DentaQuest for individuals over the age of 21.

7. On or about April 5, 2016 DentaQuest received from petitioner's dentist a request for the dental procedures at issue.

8. Dental procedures D2740; D2950; D6740; and D6245 are restorative services.

9. Dental procedures D3320 and D3330 are endodontic services.

10. Dental procedure D4211 is a periodontal service.

11. On April 6, 2016 Magellan and DentaQuest issued several Notices of Action which denied all requested procedures. The notices stated the services were not a covered benefit.

12. On April 18, 2016 the Office of Appeal Hearings timely received petitioner's request for a fair hearing.

13. Petitioner's dental problems makes it difficult for him to eat. Petitioner also experiences consistent pain.

CONCLUSIONS OF LAW

14. By agreement between the Agency for Health Care Administration and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to § 120.80, Fla. Stat.

15. This is a final order pursuant to § 120.569 and § 120.57, Fla. Stat.

16. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

17. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

18. The Florida Medicaid Provider General Handbook (Provider Handbook) – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code R. 59G-4. The Provider Handbook states on page 1-27:

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain

> contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee. Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

19. Page 1-30 of the Provider Handbook continues by stating: “An HMO’s services cannot be more restrictive than those provided under Medicaid fee-for-service.”

20. At the time of the denials at issue, respondent’s Dental Services Coverage and Limitations Handbook (Dental Handbook) was in effect. Such served as the authority for dental services until the Dental Services Coverage Policy (Dental Policy) became effective on May 3, 2016.

21. To ensure a comprehensive analysis, the undersigned has considered both authorities.

22. 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.

23. The Findings of Fact establish petitioner is over the age of 21 and the requested procedure is not related to treatment of an abscess or preparation of the mouth for dentures. As such, the requested procedures are not covered.

24. The Findings of Fact establish the requested dental procedures are not expanded dental benefits provided by Magellan.

25. Analysis is next direct to respondent's Dental Policy which became effective in May 2016 and promulgated in Rule Division 59G, Fla. Admin. Code.

26. The Dental Policy states, in relevant parts:

> 2.2 Who Can Receive
>
> Florida Medicaid recipients requiring medically necessary dental services. Some services may be subject to additional coverage criteria as specified in section 4.0.
>
> If a service is limited to recipients under the age of 21 years, it is specified in section 4.0. Otherwise, Florida Medicaid reimburses for services for recipients of all ages.
>
> 4.0 Coverage Information
>
> General Criteria
>
> Florida Medicaid reimburses for services that meet all of the following:
>
> - Are determined medically necessary
> - Do not duplicate another service
> - Meet the criteria as specified in this policy
>
> 4.2.3 Endodontic Services
> Florida Medicaid reimburses for endodontic services for recipients under the age of 21 years to treat the dental pulp and surrounding tissues.
>
> 4.2.5 Periodontal Services
> Florida Medicaid reimburses for periodontal services for recipients under the age of 21 years to diagnose and treat the diseases of the supporting and surrounding tissues of the teeth.
>
> 4.2.8 Restorative Services
>
> Florida Medicaid reimburses for all-inclusive restorative services for recipients under the age of 21 years as follows:
> - Restorations
> - Crowns

27. The Findings of Fact establish petitioner requested the following services: endodontic; periodontal; and restorative. Each of these service categories are limited to individuals under the age of 21 years.

28. It is again noted that the Findings of Fact establish none of the requested procedures are an expanded dental benefit provided by Magellan.

29. When considering all evidence and relevant authorities, petitioner has not demonstrated the action taken in this matter was improper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, petitioner's appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 21 day of June, 2016, in Tallahassee, Florida.

Frank Houston

Frank Houston
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700

Office: 850-488-1429
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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] PETITIONER
JUDY JACOBS, AREA 7, AHCA FIELD OFFICE
MICHELLE RIEGLER, MAGELLAN COMPLETE CARE

Jun 29, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-02981

PETITIONER,

Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 Dade
UNIT: 88690

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on June 1, 2016 at 9:02 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner:

For the Respondent: Edith Hiraldo, Economic-Self-Sufficiency Supervisor

STATEMENT OF ISSUE

At issue is the respondent's action to deny the petitioner's request for Medicaid as an additional benefit and close her Presumptively Eligible for Pregnant Women (PEPW) Medicaid coverage. The burden of proof was assigned to the petitioner by a preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner submitted no exhibits. The respondent submitted 40 pages of evidence, which were marked and enter as Respondent's Exhibits "1" through "8". The record was held open until June 3, 2016 for additional evidence including, the Notice of Case Action dated March 26, 2016 and the policy related to Medicaid for noncitizens. The above mentioned information was provided on June 3, 2016 and marked and entered as Respondent's Exhibits "9" through "11". The record was closed the same day.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner was receiving limited Presumptively Eligible for Pregnant Women (PEPW) Medicaid through the health department.

2. On April 15, 2016 the petitioner submitted an application for recertification of her Food Assistance Program benefits and the additional benefit of Medicaid due to her pregnancy.

3. The petitioner's household consists of the petitioner, her husband, and their minor child. She incurs a shelter and utility expense. Both the petitioner and her husband will be filing taxes this year.

4. The petitioner asserts she has been living in the United States over 15 years and is currently only Work Authorized through the Department of Homeland Security.

5. The respondent submitted the petitioner's Immigration and Naturalization Service (INS) number to Systematic Alien Verification for Entitlements (SAVE) to verify her current immigration status.

6. The response was that the petitioner's date of entry is September 6, 2002 with a Temporary Protected Status – Employment Authorized.

7. The petitioner does not dispute she has no current Lawful Permanent Resident (LPR) status. She is currently in the process of attaining LPR status.

8. On May 26, 2016, the respondent sent the petitioner a Notice of Case Action (NOCA) informing her that the request for Medicaid was denied "REASON: YOU OR A HOUSEHOLD MEMBER DO NOT MEET THE CITIZENSHIP REQUIREMENT".

9. The petitioner timely requested the hearing.

10. The petitioner asserts that she does not understand why she cannot have Medicaid because her husband is a citizen and she has been here a long time. The petitioner also states she does not know why the PEPW coverage cannot remain open since she has to visit the doctor once a week.

11. The respondent states the petitioner is not eligible due to her noncitizen status.

CONCLUSIONS OF LAW

12. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

13. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

14. Fla. Admin. Code R. 65A-1.704 Family-Related Medicaid Eligibility Determination Process states:

> (3) Presumptive Eligibility for Pregnant Women. The period of presumptive eligibility for pregnant women begins when a qualified Medicaid provider determines that the woman is eligible based on her family income. **Presumptive eligibility ends when a determination of ongoing eligibility is made or, on the last day of the month following the month the presumptive eligibility determination is made, if an application for ongoing Medicaid coverage is not filed**.(*emphasis added*)

15. The above cited authority explains Presumptively Eligibility for Pregnant Women (PEPW) is based on solely on family income. This coverage ends when a determination of ongoing eligibility is made or the last day of the month following the month the presumptive eligibility determination is made. The respondent closed the petitioner's PEPW coverage effective April 30, 2016 in accordance with the above cited authority.

16. Fla. Admin. Code R. 65A-1.301 Citizenship states in the pertinent part:

> (3) The eligibility specialist must verify the immigration status of noncitizens through the United States Citizenship and Immigration Service (USCIS), formerly the United States Bureau of Citizenship and Immigration Services. Verification will be requested electronically using the alien number, or based on a USCIS or prior Immigration and Naturalization Services (INS) document provided by the applicant. The system of verification is known as the Verification Information System-Customer Processing System (VIS-CPS), which is part of the Systematic Alien Verification for Entitlements (SAVE) Program…

17. The above cited authority states that the department must verify the immigration status of noncitizens through the SAVE system. The petitioner provided her INS document and the respondent verified her immigration status as A12, employment authorized only.

18. Fla. Admin. Code R. 65A-1.704 Family-Related Medicaid Eligibility Determination

Process states in the pertinent part:

> …(2) Simplified Eligibility for Pregnant Women…
> (c) The following information must be verified or obtained, as indicated below, prior to approval for Medicaid for a pregnant woman:..
> 4. A declaration of citizenship is required. The applicant's statement on the Health Insurance Application for Pregnant Women, CF-ES 2700, is acceptable as a declaration of citizenship. U.S. citizens must provide proof of their U.S. citizenship and identity, if they are not subject to an exemption as specified in 42 C.F.R. 435.406…
> 5. Noncitizens must provide proof of immigration status through the United States Citizenship and Immigration Service (USCIS), formerly the United States Bureau of Citizenship and Immigration Services. The department will request verification of immigration status of noncitizens electronically through the Verification Information System-Customer Processing System (VIS-CPS), which is part of the Systematic Alien Verification for Entitlements (SAVE) Program, using the noncitizen's alien number. If the pregnant woman is a noncitizen, she may provide her alien number to the eligibility specialist on the application.

19. The Code of Federal Regulations at 42 C.F.R. § 435.406, Citizenship and alienage

sets forth:

> (a) The agency must provide Medicaid to otherwise eligible residents of the United States who are—
> (1) Citizens: (i) Under a declaration required by section 1137(d) of the Act that the individual is a citizen or national of the United States; and
> (ii) The individual has provided satisfactory documentary evidence of citizenship or national status, as described in § 435.407.
> (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.

20. The Department's Program Policy Manual, CFOP 165-22 (The Policy Manual),

passage 1440.0106, Lawful Permanent Resident (MSSI), states in part:

> A lawful permanent resident (LPR) is a noncitizen who lawfully immigrates to the U.S. and has permission to live and work in the U.S. LPRs may be eligible for Medicaid based on citizenship if they entered the U.S.:
> 1. prior to 8/22/96 and have remained continuously present,…
> 3. on or after 8/22/96 and have lived in the U.S. as a qualified noncitizen for at least five years…
> Note: LPRs who entered after 8/22/96 are subject to the five-year ban, unless otherwise noted.
> LPRs who are in the five-year ban may be eligible for Emergency Medicaid for Aliens, (EMA).

21. The above authority and Policy Manual explain that a non-citizen must provide verification of immigration status. Those noncitizens that entered the United States after August 22, 1996, must have resided in the United States as a Legal Permanent Resident (LPR) for a period of five years to be eligible for Medicaid benefits. The petitioner provided proof of her immigration status and has resided in the United States; however, she does not have LPR status at this time.

22. Based on the INS documentation presented, the petitioner is not eligible for Medicaid. The petitioner must obtain LPR status for a period of five years.

23. After careful review of the cited authorities and policy, the undersigned concludes the department action to deny Medicaid for the petitioner was within rule.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the department's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this __29__ day of __June________, 2016,

in Tallahassee, Florida.

Pamela B. Vance

Pamela B. Vance
Hearing Officer
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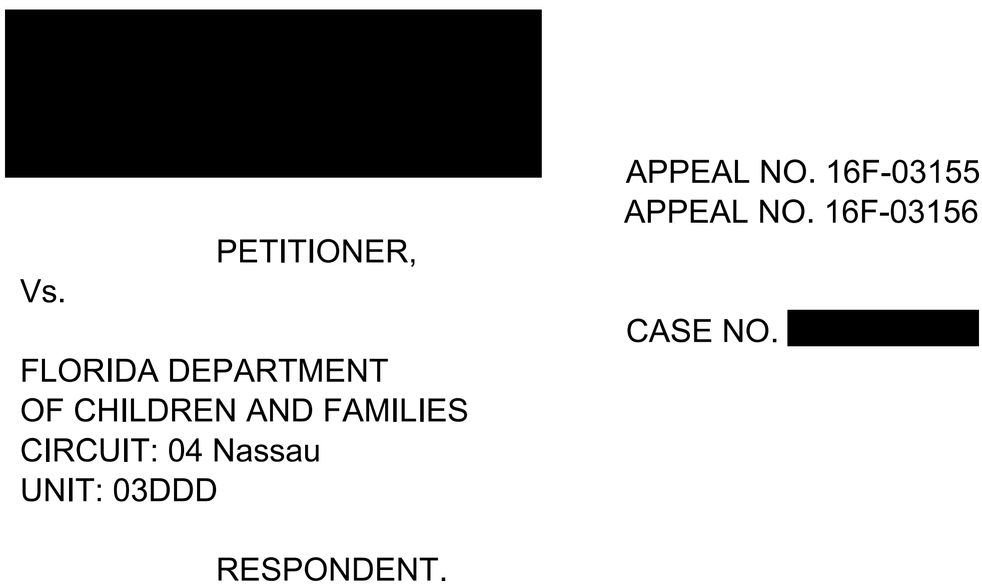
Copies Furnished To [redacted] Petitioner
Office of Economic Self Sufficiency

Jun 23, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS



APPEAL NO. 16F-03155
APPEAL NO. 16F-03156

PETITIONER,

Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 04 Nassau
UNIT: 03DDD

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on May 31, 2016 at 11:34 a.m.

APPEARANCES

For the Petitioner: Petitioner was present and represented herself.

For the Respondent: Kenneth Wilson, Economic Self-Sufficiency Specialist II with the Department of Children and Families (DCF).

STATEMENT OF ISSUE

Petitioner is appealing the Department's action on March 1, 2016 to deny her application for Food Assistance Program (FAP) benefits as her income is too high to qualify for the program.

Also at issue is the Department's action on March 1, 2016 to enroll her into the Medically Needy program with an estimated share of cost in the amount of $2111.

Also at issue is the Department's action on May 24, 2016 to deny her application for the Qualifying Individual 1 (QI1) program due to exceeding the income limit for the program.

The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

Evidence was submitted and entered as the Respondent's Exhibits 1 through 2. The petitioner did not submit evidence.

FINDINGS OF FACT

1. On February 19, 2016, the petitioner (age 44) applied for FAP benefits and Medicaid for herself. The petitioner receives Social Security income for her disability and alimony payments.

2. The petitioner submitted a printout of her alimony payments. The petitioner received alimony payments for the month of February 2016 as follows: $288.46 for February 2, 2016; $288.46 for February 8, 2016; $288.46 for February 17, 2016; $257.33 for February 22, 2016; and $288.46 for February 29, 2016. The total income for the month of February 2016 was $1411.17. The ongoing months included the alimony payments received for the month of March 2016 as follows: $268.81 for March 8, 2016; $257.33 for March 14, 2016; $272.64 for March 21, 2016; and $288.46 for March 29, 2016. The Department calculated the total gross alimony payments for the month of March 2016 and ongoing months at $1087.24.

3. The Department's calculations for the FAP budget for the month of February 2016 include Social Security income in the amount of $995 and $1411.17 in alimony

income for a total gross unearned income of $2406.17. The standard deduction of $155 was subtracted to calculate $2251.17 total net income. The petitioner was allowed an out-of-pocket medical expense in the amount of $52; the $52 was reduced by the $35 medical standard to result in an excess medical expense of $17. The total net income in the amount of $2251.17 was reduced by the excess medical expense in the amount of $17 to result in an adjusted net income of $2234.17. The adjusted net income was multiplied by 50% to result in an $1117.09 shelter standard. The petitioner was allowed a shelter cost in the amount of $500 for rent and the standard utility allowance (SUA) in the amount of $345, for a total shelter cost in the amount of $845. The Department subtracted the shelter standard in the amount of $1117.09 from the $845 total shelter to equal to a $0 excess shelter deduction. The excess shelter deduction was subtracted from the adjusted net income which resulted in $2234.17 net income. The petitioner's $2234.17 exceeded the net income standard of $981 for a household size of one; therefore, she was ineligible for FAP benefits for the month of application (February 2016).

4. The Department's calculations for the FAP budget ongoing months include Social Security income in the amount of $995 and alimony payments in the amount of $1087.24 for a total gross unearned income of $2082.24. The standard deduction of $155 was subtracted to calculate $1927.24 total net income. The petitioner was allowed an out-of-pocket medical expense in the amount of $52; the $52 was reduced by the $35 medical standard to result in an excess medical expense of $17. The total net income in the amount of $1927.24 was reduced by the excess medical expense in

the amount of $17 to result in an adjusted net income of $1910.24. The adjusted net income was multiplied by 50% to result in a $955.12 shelter standard. The petitioner was allowed a shelter cost in the amount of $500 for rent and the SUA in the amount of $345, for a total shelter cost in the amount of $845. The Department subtracted the shelter standard in the amount of $955.12 from the $845 total shelter to equal to a $0 excess shelter deduction. The excess shelter deduction was subtracted from the adjusted net income which resulted in $1910.24 net income. The petitioner's adjusted net income of $1910.24 exceeded the net income standard of $981 for a household size of one; therefore, she was ineligible for FAP benefits for the ongoing months.

5. The Department revised the original budget for the MN program for the month of February 2016 to include the actual income. The MN budget for the month of February 2016 was calculated by including the actual total gross income of $2406.17. The total gross unearned income was subtracted by the unearned income disregard in the amount of $20 to result in $2386.17 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 $2206.17. The SOC was further reduced by the $52 insurance premium for a remaining share of cost in the amount of $2154.

6. The Department revised the original budget for the MN program for ongoing months. The MN budget for the ongoing months was calculated by including the total gross income of $2082.24. The total gross unearned income was subtracted by the unearned income disregard in the amount of $20 to result in $2062.24 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 $1882.24. The SOC was further reduced by the $52 insurance premium for a remaining share of cost in the amount of $1830.

7. The total income included in the QI1 budget for the petitioner as an individual was $2082.24. The $20 unearned income disregard was subtracted from the total gross income which resulted in a countable income of $2062.24.

8. The Department determined that the petitioner was ineligible for the QI1 program as the income exceeded the QI1 income standard for an individual of $1325.

9. The petitioner does not dispute the income or expenses included in the Department's calculations. The petitioner argues that the judge in her case increased her alimony payments because her ex-husband was not paying for a while; she is receiving back payments to make up for when he was not paying. The petitioner believes she is being penalized for her ex-husband's failure to pay as ordered. The petitioner argues that the times he was not paying alimony is not being considered. The petitioner argues that her alimony goes to pay her car payment, car insurance, prescriptions, and doctor's visits.

10. The petitioner does not understand how the MN program works; she argues that she needs Medicaid. The petitioner argues that her physicians will not see her unless she pays upfront for her office visits. The petitioner argues that she cannot afford to pay for her therapy. The petitioner pays a health insurance premium in the

amount of $52 each month. The petitioner believes she spends approximately $70 each month in prescriptions.

11. The Department explained that it used the petitioner's actual gross income for the month of February 2016. The Department believes that the increase in the petitioner's alimony payments would not cause a significant difference in her eligibility for FAP benefits. The Department explained that the petitioner is receiving Medicare Part A but is ineligible for Medicare Part B.

12. The petitioner is not receiving any waiver services at this time.

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.

The Food Assistance Program denial will be addressed:

15. Federal Regulation at 7 CFR § 273.9 Income and deductions 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. Households which contain an elderly or disabled member shall meet the net income eligiblity standards for the Food Stamp Program. Households which do not contain an elderly or disabled member shall meet both the net income eligibility standards and the gross income eligibility standards for the Food Stamp Program.
> ...

> (2) Unearned income shall include, but not be limited to:
> …
> (ii) Annuities; pensions; retirement, veteran's, or disability benefits; worker's or unemployment compensation including any amounts deducted to repay claims for intentional program violations as provided in § 272.12; oldage, survivors, or social security benefits; strike benefits;
> (iii) Support or alimony payments made directly to the household from nonhousehold members.
> …
>
> (d) Income deductions. Deductions shall be allowed only for the following household expenses:
> (1) Standard deduction….
> (3) Excess medical deduction. That portion of medical expenses in excess of $35 per month, excluding special diets, incurred by any household member who is elderly or disabled as defined in § 271.2.
> …
> (ii) Excess shelter deduction.
> (A) Continuing charges for the shelter occupied by the household, including rent…
> (C) The cost of fuel for heating; cooling; electricity or fuel used for purposes other than heating or cooling;
> (iii) Standard utility allowances.

16. The above authority explains that households including an elderly or disabled member need only pass the net income standard. Unearned income includes Social Security income and alimony payments. Households are entitled to receive a deduction to income, such as the standard deduction, medical expenses excluding the $25 medical standard (if elderly or disabled), excess shelter, rental obligation, and the standard utility allowance. The findings show that the petitioner is disabled. The petitioner receives Social Security income and alimony payments. The petitioner was allowed a deduction for her health insurance premium, rent, and heating and cooling costs. Based on the above authority, the undersigned concludes that the petitioner is only required to meet the net income standard as she is disabled. The undersigned

concludes that the Department was correct to include the petitioner's Social Security income and alimony payments as income.

17. Federal Regulation at 7 CFR § 273.10 Determining household eligibility and benefit levels states:

> (a) *Month of application*—(1) *Determination of eligibility and benefit levels.* (i) A household's eligibility shall be determined for the month of application by considering the household's circumstances for the entire month of application…
> …
> (c) *Determining income*—(1) *Anticipating income.* (i) For the purpose of determining the household's eligibility and level of benefits, the State agency shall take into account the income already received by the household during the certification period and any anticipated income the household and the State agency are reasonably certain will be received during the remainder of the certification period…
> (ii) Income received during the past 30 days shall be used as an indicator of the income that is and will be available to the household during the certification period.
>
> (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.

18. In this case, the petitioner's net income exceeded the established income limit for a household size of one. The petitioner argues that she is receiving an increase in her alimony payments due to her ex-husband's failure to pay the support in the past. The undersigned was unable to locate any governing authorities that would allow the Department to exclude the additional alimony payments as income. The petitioner also presented during the hearing that she pays $70 in prescriptions, in addition to the $52 insurance premiums that was already included in the Department's calculations. The undersigned concludes that including the additional medical expense in the

Department's calculations would not result in a more favorable outcome for the petitioner. After carefully reviewing the governing authorities and evidence presented, the undersigned concludes that the Department's action to deny the petitioner's application for FAP benefits due to exceeding the net income limit was correct.

The petitioner's enrollment in the Medically Needy Program will now be addressed:

19. 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.

20. The above controlling authorities explain 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 the petitioner does not qualify for full-coverage Medicaid.

The denial of the QI1 will now be addressed:

21. Fla. Admin. Code R. 65A-1.702 Special Provisions states:

> …
>
> (12) Limits of Coverage.
> (a) Qualified Medicare Beneficiary (QMB). Under QMB coverage,

> individuals are entitled only to Medicare cost-sharing benefits, including payment of Medicare premiums.
> (b) Special Low-Income Medicare Beneficiary (SLMB). Under SLMB coverage, individuals are entitled only to payment of the Part B Medicare premium. If eligible, AHCA shall pay the premium for up to three months retroactive to the month of application.
> …
> (d) Part B Medicare Only Beneficiary (QI1). Under QI1 coverage, individuals are only entitled to payment of their Medicare Part B premium. (This is coverage for individuals who would be eligible for QMB or SLMB coverage except their income exceeds limits for those programs.)

22. Fla. Admin. Code R. 65A-1.713 SSI-Related Medicaid Income Eligibility Criteria states:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
> (b) For QMB, income must be less than or equal to the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.
> (g) For SLMB, income must be greater than 100 percent of the federal poverty level but equal to or less than 120 percent of the federal poverty level.
> (j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. QI1 is eligible only for payment of the Part B Medicare premium through Medicaid.

23. 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. 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.

24. The Department's Program Policy Manual, CFOP 165-22, Appendix A-9, sets forth the income standards for an individual effective January 2016 as $981 for the QMB program, $1177 for the SLMB program, and $1325 for the QI 1 program. The income standards are a percentage of the Federal Poverty Level as explained above.

25. The above authority sets the income standard for an individual applying for the QI1 program at $1325 effective January 2016.

26. The petitioner's countable income was $2062.24, which exceeds the income limit for an individual in the QI1 Program, which has the highest income limit of the MSP programs. Therefore, the undersigned concludes that the Department correctly denied QI1 program benefits.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, both appeals are denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 23 day of June, 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
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

Jun 14, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-03179
16F-03180

PETITIONER,

Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 Dade
UNIT: 88601

B - Benefit Recovery (BR)

RESPONDENT.

_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on June 2, 2016 at 9:11 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner:

For the Respondent: Guillermo Carton, Senior Human Services Program Specialist with the Benefit Recovery Program (BRP)

STATEMENT OF ISSUE

At issue is the respondent's action to establish an overpayment of $1,559 in Food Assistance Program (FAP) benefits for the period of February 1, 2013 through July 31, 2013, a Medicaid overpayment of $3,427.82 for the time period of November 2010 through June 2011, and a Medicaid overpayment of $271.37 for the time period of

July 2011. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the respondent.

PRELIMINARY STATEMENT

A continuance was granted to the petitioner for the prior scheduled hearing.

Jose Lopez, Client Relations Coordinator for Child Support Enforcement (CSE) with the Miami-Dade County State attorney's office appeared as a witness for the respondent.

The petitioner submitted no exhibits. The respondent submitted 116 pages of evidence which were marked and entered as Respondent's Composite Exhibit "1".

During the hearing, the respondent entered a verbal Motion to Dismiss the appeals of all overpayment claims due to an untimely request. A ruling on the Motion was reserved to allow the hearing officer to review the case file before making a decision in the Final Order.

FINDINGS OF FACT

1. The petitioner submitted applications for recertification of FAP and Medicaid benefits on July 7, 2010, December 10, 2010, and June 1, 2011.

2. Each application listed the petitioner and her minor daughter as the only household members.

3. The petitioner had no income. The petitioner incurred a shelter and utility expense. The shelter expense was vendor paid.

4. The petitioner submitted an application for recertification on January 22, 2013 of FAP and Medicaid benefits. The petitioner's household include the petitioner and her minor

daughter. The petitioner had child support income of $411.81 and incurred a monthly shelter and utility expense.

5. The petitioner acknowledged reviewing her Rights and Responsibilities and the Statement of Understanding on all applications. The Rights and Responsibilities notified the petitioner that she was responsible to give complete and correct information to the department and to report changes immediately but no later than 10 days. By answering “Yes” to the Statement of Understanding, the petitioner certified the information provided on the application was true and correct.

6. The respondent sent the petitioner a Notice of Overpayment on November 17, 2011 that states, “A review of your case showed that between November 1, 2010 and June 30, 2011 you received $3,427.82 more in Medicaid than you were eligible to receive. We believe the overpayment occurred because YOU DID NOT REPORT CHILD SUPPORT OR ALIMONY RECEIVED BY A MEMBER.”

7. The petitioner asserts that she never received Medicaid benefits. She claims she never used Medicaid during that time period. She also asserts she was not receiving child support regularly.

8. An additional notice was sent on November 17, 2011 that states, “A review of your case showed that between July 1, 2011 and July 31, 2011 you received $271.37 more in Medicaid than you were eligible to receive. We believe the overpayment occurred because WE DID NOT BUDGET YOUR INCOME CORRECTLY OR TIMELY.”

9. The respondent contends that medical bills were paid for the petitioner under her Personal Identification Number (PIN) for Medicaid.

10. The department determined the Medicaid overpayment as $3,427.82 for the period of November 2010 through June 2011 and $271.37 for the month of July 2011, including capitation payments. All payments were made for the PIN number assigned to the petitioner, 7779683435, which is assigned to the petitioner through the Florida Medicaid Managed Information System (FLMMIS). The amounts are as follows:

Date of Service	Type of Service	Amount Paid
11/01/2010	Capitation	$ 15.11
12/01/2010	Capitation	$ 15.11
12/01/2010	Pharmacy	$ 7.32
01/01/2011	Capitation	$ 15.11
01/16/2011	Pharmacy	$ 7.32
02/01/2011	Capitation	$ 15.11
02/28/2011	Pharmacy	$ 7.32
03/01/2011	Capitation	$ 14.73
03/22/2011	Professional	$ 93.01
04/01/2011	Capitation	$ 14.73
04/13/2011	Professional	$ 41.46
04/19/2011	Pharmacy	$ 7.82
04/19/2011	Pharmacy	$117.53
04/19/2011	Pharmacy	$ 4.62
05/01/2011	Capitation	$ 14.73
05/12/2011	Outpatient	$172.53
05/12/2011	Professional	$ 18.75
05/13/2011	Pharmacy	$ 4.62
05/13/2011	Pharmacy	$ 7.82
05/13/2011	Pharmacy	$ 5.17
06/01/2011	Capitation	$ 14.73
06/06/2011	Pharmacy	$ 4.44
06/07/2011	Outpatient	$745.01
06/07/2011	Outpatient	$862.65
06/07/2011	Professional	$ 35.38
06/07/2011	Professional	$ 98.01
06/08/2011	Outpatient	$895.15
06/08/2011	Outpatient	$172.53
Total Overpayment		$3,427.82

Date of Service	Type of Service	Amount Paid
07/01/2016	Capitation	$ 14.73
07/13/2011	Professional	$ 51.83
07/13/2011	Professional	$117.65
07/14/2011	Professional	$ 87.16
Total Overpayment		$271.37

13. The petitioner disputes using Medicaid. She states she and her daughter have the same name and it may be a confusion based on that.

14. The respondent asserts the PIN number assigned to the petitioner with the petitioner's date of birth is the PIN that has incurred the charges.

15. In determining the Medicaid budget for each month, the department used the child support (CS) income provided by the Department of Revenue Child Support Enforcement of $87.69 weekly. The income limit, during the time periods in review, was $241. The petitioner was determined to be over the income limit for full Medicaid and eligible for Medically Needy (MN) with a Share of Cost (SOC).

16. The respondent states although the petitioner was determined eligible for Medically Needy during the time period in review, the petitioner's bills cannot be used to meet the share of cost. They have already been paid by Medicaid.

17. An additional Notice of Overpayment was sent to the petitioner on July 29, 2013 that states, "A review of your case showed that between February 1, 2013 and July 31, 2013, you received $1,559 more in food assistance benefits than you were eligible to receive. We believe the overpayment occurred because WE DID NOT BUDGET YOUR INCOME CORRECTLY OR TIMELY."

18. All notices were sent to the address of record, [redacted] [redacted] The petitioner claims she did not receive the notices as she has had

problems over the years with her mail being delivered to [redacted] and she also receives mail from [redacted]

19. The respondent states no returned mail has been received.

20. The respondent used the income received from the State Data Exchange Inquiry for Unemployment Compensation (DEUC), which is considered verified upon receipt, minus the standard deductions to determine the petitioner's household income.

21. The petitioner's FAP budget for February 2013 was determined as follows:

$911.81	total countable income
- 149.00	standard deduction
$765.81	adjusted net income
$338.00	shelter/utility expense
- 381.41	50% adjusted net income ($765.81 / 2)
$ 0.00	excess shelter/deduction
$765.81	adjusted net income
- 0.00	excess shelter/deduction
$765.81	food stamp adjusted income

30% of 765.81 = 229

$367	thrifty food plan (maximum allotment for household)
- 229	benefit reduction
$138	monthly allotment

22. The department determined the FAP overpayment as $1,556 for the period of February 2013 through July 2013. The amounts are as follows:

Month	Issuance	Correct Amount	Overissuance
February 2013	$332	$138	$ 194
March 2013	$332	$0.00	$ 332
April 2013	$332	$157	$ 175
May 2013	$332	$0.00	$ 332
June 2013	$332	$138	$ 194
July 2013	$332	$0.00	$ 332
Total Overissuance			$1,559

23. The petitioner claims she was unaware of the overpayment until her income tax refund was intercepted. She also asserts that she did not do anything wrong and she reported all income as she was supposed to by policy and she did not commit any type of fraud. She believes that the error is not hers and she should not be held responsible for a “miscalculation” by the department.

24. The petitioner requested the hearing April 26, 2016 after her income tax refund was intercepted.

25. The petitioner also added she made attempts to report her unemployment income at the local service center.

26. The respondent affirms no fraud was committed by the petitioner.

CONCLUSIONS OF LAW

27. 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.

28. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

The Motion to Dismiss all appeals for overpayment will now be addressed based on an untimely request and jurisdiction:

29. Fla. Admin. Code R. 65-2.046 (1) sets forth that an appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs.

30. The above authority indicates that any petitioner who chooses to challenge the department's actions must do so within the allotted time.

31. The notice at issue was sent to the address of record given by the petitioner, mailed in the normal course of business to [redacted] The department has no record of returned mail.

32. The petitioner asserts that over the years, she has had trouble with her mail being delivered to [redacted] She also claims that she has had mail from [redacted] delivered to her address. She states the home on [redacted] has had numerous owners so she is unsure whether all her mail has been returned to her or not.

33. The petitioner states she was informed of the overpayment after she received a letter from the Internal Revenue Service indicating her income tax refund had been intercepted.

34. The petitioner states she then called the department and requested a hearing on April 26, 2016.

35. After reviewing the evidence and testimony, the undersigned cannot conclude the petitioner actually received the notices of overpayment sent to her. Therefore, the Motion to Dismiss is denied.

The $3,427.82 Medicaid overpayment due to client error will now be addressed:

36. Fla Admin. Code R. 65A.1.707 Family-Related Medicaid Income and Resource Criteria defines income as:

> (1) Family-related Medicaid income is based on the definitions of income, resources (assets), verification and documentation requirements as follows.
> (a) Income. Income is earned or non-earned cash received at periodic intervals from any source such as wages, self-employment, benefits,

> contributions, rental property, etc. Cash is money or its equivalent, such as a check, money order or other negotiable instrument. **Total gross income includes earned and non-earned income from all sources.** To be financially eligible for family-related Medicaid, except for Medically Needy coverage, the coverage group's gross income minus the $90 earned income disregard cannot exceed the consolidated need standard (CNS) (100% of the federal poverty level).

37. The Department Program Policy Manual (The Policy Manual), CF-OP 165-22, Appendix A-7, sets forth the income limit for a household size of two effective March 2009 as $241.

38. The above authority and Policy Manual explains the income limits for family-related Medicaid and defines income as cash received at periodic intervals. Based on evidence and testimony, the petitioner received child support income weekly during the time period in review, November 1, 2010 through June 31, 2011 and July 2011. Therefore, she has been determined ineligible for full Medicaid.

39. Fla. Admin. Code R. 1.900 Overpayment and Benefit Recovery, defines who is responsible for repayment of an overpayment: "(2) Individuals Responsible for Repayment of Overpayment…(c) Individuals who received Medicaid overpayments as an adult will be responsible for repayment of the overpayment. (3) Monthly Repayment Amounts…(c) Any adult who applied for and/or received Medicaid benefits for themselves or the assistance group is liable or responsible for repayment."

40. The above authority states that the individual that received Medicaid benefits is liable for repayment of the benefits. The respondent made Medicaid payments on behalf of the petitioner although she was ineligible for Medicaid during period in review; therefore, the petitioner is responsible for repayment of the benefits.

41. After careful review of the controlling authorities, the undersigned concludes that the department's action to establish and seek repayment of $3,427.82 from November 1, 2010 through June 31, 2011 due to client error and $271.37 for July 2011 due to agency error is proper. The petitioner incurred Medicaid expenses during these time periods that she was not eligible for based on her unearned income.

The $1,559 FAP agency error overpayment claim will now be addressed:

42. Fla. Admin. Code R. 65A-1.900 Overpayment and Benefit Recovery, defines the administrative policies applicable to the establishment and recovery of overpayment in the public assistance programs.

> The purpose of this section is to define the administrative policies applicable to the establishment and recovery of overpayment in the public assistance programs.
> (1) Administrative Definitions Applicable to Overpayment and Benefit Recovery.
> (a) Overpayment: Overpayment is the amount of public assistance received for which an individual was not entitled...
> (2) Individuals Responsible for Repayment of Overpayment…
> (b) Food assistance overpayments will be recovered from an individual as specified in 7 C.F.R. §273.18(a) (4) (2010), incorporated by reference.

43. Federal regulation C.F.R. § 273.9 addresses income/allowable deductions budgeting in the FAP in part and states as follows:

> (a) Income eligibility standards. Participation in the Program shall be limited to those households whose incomes are determined to be a substantial limiting factor in permitting them to obtain a more nutritious diet.
> (b) Definition of income…
> (2) Unearned income shall include, but not be limited to:…
> (ii) Annuities; pensions; retirement, veteran's, or disability benefits; worker's or **unemployment compensation**…(*emphasis added*)
> (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…

44. The Policy Manual at Appendix A-1, sets forth for a household size of two as the following, effective October 2012:

> $367 maximum FAP benefit
> $149 standard deduction
> $338 standard utility allowance (SUA)

45. Federal Regulations at 7 C.F.R. § 273.10, explains income and deduction calculations:

> (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…
> (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 …

46. In accordance with the above cited authorities and The Policy Manual, the respondent included the petitioner's unemployment income and allowable deductions (standard deduction, SUA) in determining the petitioner's FAP budget.

47. After careful review of the department's budget calculations, the undersigned concludes there were no mathematical errors.

48. Recovery of payments made due to mistake or fraud is set forth in Section 414.41, Fla. Stat. It states:

> (1) Whenever it becomes apparent that any person or provider has received any public assistance under this chapter to which she or he is not entitled, through **either simple mistake** or fraud **on the part of the department** or on the part of the recipient or participant, **the department shall take all necessary steps to recover the overpayment** (*emphasis added*)

49. The above citation sets forth the legal authority necessary for the department to pursue and recover all overpayment claims from any liable individual, whether due to department error or household error. The department failed to accurately budget the petitioner's unemployment compensation income; however, the petitioner is responsible for repayment of the FAP benefits she received.

50. After careful review of the controlling authorities, the undersigned concludes that the department's action to establish and collect $1,559 in overpayment of FAP benefits due to agency error for the periods of February 1, 2013 through July 31, 2013 was within the rule of the program.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are denied and the department's actions affirmed. The department may proceed to

seek repayment of the $3,427.82 in Medicaid benefits, $271.37 in Medicaid benefits, and $1,559 Food Assistance Program 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.

DONE and ORDERED this 14 day of June, 2016, in Tallahassee, Florida.

Pamela B. Vance
Hearing Officer
Building 5, Room 255
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Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
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Copies Furnished To [redacted] Petitioner
Office of Economic Self Sufficiency

May 26, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
FFICE OF APPEAL HEARINGS

APPEAL NO. 16F-03194
APPEAL NO. 16F-03195

PETITIONER,

Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 Palm Beach
UNIT: 88071

RESPONDENT.
_________________________________/

ORDER OF DISMISSAL DUE TO WITHDRAWAL ON RECORD

Pursuant to notice, an administrative hearing was telephonically convened before the undersigned in the above-referenced matter on May 25, 2016, at 8:31 a.m. The petitioner represented herself. Emiliene Elien, supervisor, represented the respondent.

Once on record, the petitioner withdrew the hearing request. As the petitioner's request for a hearing has been withdrawn and there is no further issue for the undersigned to consider, the issue is moot and the appeal is dismissed as withdrawn.

DONE and ORDERED this ___26__ day of ___May___________, 2016,

in Tallahassee, Florida.

Christiana Gopaul Narine

Christiana Gopaul-Narine
Hearing Officer
Building 5, Room 255
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Copies Furnished T[redacted]Petitioner
Office of Economic Self Sufficiency

Jun 30, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-03260

PETITIONER,
Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 14 Bay
UNIT: AHCA

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 1, 2016 at 3:08 p.m. EST.

APPEARANCES

For Petitioner:

For Respondent: Dianne Soderlind, Registered Nurse Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Respondent's denial of Petitioner's request for continued Prescribed Pediatric Extended Care (PPEC) services for full and partial days, Monday through Friday for the certification period of April 6, 2016 to October 6, 2016, is appropriate. Because the matter under appeal involves a termination of PPEC services, the burden of proof is assigned to the Respondent.

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).

Administrative notice was taken of Florida Administrative Code Rules 59G-1.010 and 59G-4.290, as well as AHCA's Prescribed Pediatric Extended Care (PPEC) Services Coverage and Limitations Handbook.

Respondent's exhibits 1 through 3 were entered in evidence. .

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following Findings of Fact are made:

1. The Petitioner is a three year-old male Medicaid recipient. He is diagnosed with [redacted] He has had three surgeries for [redacted] and may need two more. No surgery, however, is scheduled at this time.

2. Petitioner takes children's Tylenol and Motrin as needed.

3. Petitioner tolerates a soft pureed diet. He is unable to chew food due to difficulty swallowing. He is ambulatory and feels his way around in familiar surroundings. He is incontinent. He has no history of seizures or any other neurological issues.

4. Petitioner has difficulty gaining weight (failure to thrive) and is delayed in his growth and development. He is non-verbal and receives occupational therapy, physical therapy, and speech therapy at the PPEC center.

5. Petitioner lives with his single mother who works full time. He attends a special needs school and uses PPEC services after school and on non-school days.

6. The Agency contracts with a Quality Improvement Organization (QIO) to perform medical utilization reviews for PPEC services through a prior authorization process for Medicaid State Plan beneficiaries. The prior authorization review determines the medical necessity of the hours requested pursuant to the requirements and limitations of the Medicaid State Plan. The Agency's QIO is eQHealth Solutions.

7. A request for service is submitted by a provider along with all information and documentation necessary for the QIO to make a determination of medical necessity for the level of service requested. A review is conducted for every new certification period and a request for modification may be submitted by a beneficiary during a certification period.

8. The Petitioner is continuing to receive PPEC full and partial day services, Monday through Friday, pending the outcome of this appeal. Full day services are no more than ten and a half hours in a day and partial day services are up to five hours of care in a day.

9. On April 11, 2016, a request for PPEC full and partial day services Monday through Friday was submitted by the Petitioner's provider for the certification period April 10, 2016 to October 6, 2016. The request represents a continuation of PPEC services received in the preceding certification period.

10. On April 14, 2016, an eQHealth Solutions physician consultant reviewed the request and denied the PPEC services. A "Notice of Outcome-Denial Prescribed Pediatric Extended Care Services" was issued to Petitioner on April 14, 2016, which

notified Petitioner that PPEC full and partial day services were denied. The rationale for the denial was that the PPEC services were not medically necessary as defined in 59G-1.010 (166), Florida Administrative Code.

11. On April 14, 2016, a “Notice of Outcome” was issued to Petitioner’s provider and provided the clinical rationale as:

> The patient is a 2 year old with a history of cleft lip and palate. The patient is nonverbal and is blind in one eye. The patient is on a pureed diet. The patient is ambulatory and is incontinent. The patient attends a special needs school and uses PPEC for non-school days and after school. The clinical information provided does not support the medical necessity of the requested services. The patient no longer appears to have a skilled need and does not meet the medical complexity requirement for PPEC services. Request is not approved.

12. A reconsideration was not requested.

13. On April 27 2016, Petitioner’s mother timely requested a fair hearing.

14. The Respondent’s physician consultant witness reviewed the Petitioner’s medical condition and his medication regimen (see paragraph 2 above). He reviewed the documentation submitted by the provider in support of the request for PPEC services and noted that the Petitioner did not have a need for skilled nursing services. He explained that the occupational therapy, physical therapy, and speech therapy the Petitioner receives at the PPEC center can be provided at any therapy school.

15. He further explained that PPEC services are meant for those needing skilled nursing intervention such as those who have frequent seizures, are on a gastrostomy tube (G-tube) for feeding, or on a ventilator machine.

16. Referring to page 72 of Respondent Exhibit 3, the physician consultant noted “Mom states she has to work and every childcare facility she has checked with declined

to take him". The mother commented that the childcare centers are concerned with potential injury the Petitioner could incur due to his blindness. His frequent spitting up of food was also a health and safety concern.

17. The mother feels her son should be at a PPEC center because he is blind, unable to feed himself, and can't speak. He doesn't eat solid foods and spits up frequently.

18. The physician consultant acknowledged the medical challenges the Petitioner faces but explained that PPEC is not a daycare provider but provides skilled professional care to those with medically complex conditions.

CONCLUSIONS OF LAW

19. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80 Fla. Stat. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

20. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

21. 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).

22. 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.

23. 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.”

24. Rule 59G-1.010 (164), Florida Administrative Code (F.A.C.) defines “medically complex” as follows:

> … 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.

25. Rule 59G-1.010 (165), Florida Administrative Code (F.A.C.) defines "medically fragile" as follows:

> …an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, e.g., requires total parenteral nutrition (TPN), is ventilator dependent, or is dependent on a heightened level of medical supervision to sustain life, and without such services is likely to expire without warning.

26. Because the Petitioner is under twenty-one-years-old, the requirements of Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT) must be

considered. Florida Statute § 409.905, Mandatory Medicaid services, provides that Medicaid services for children must include:

> (2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

27. 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 approved ongoing PPEC services but is providing PPEC services to the Petitioner, administratively pending outcome of this appeal. Therefore, Respondent needs to determine that PPEC services are not medically necessary in order to be in compliance with EPSDT requirements.

28. The Prescribed Pediatrics Extended Care Services (PPEC) Coverage and Limitations Handbook provides the purpose and definition of PPEC 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.

29. On page 2-1, the PPEC Handbook provides the following requirements for those who can receive PPEC services:

> To receive reimbursement for PPEC services, a recipient must meet **all** of the following criteria [emphasis added]:
>
> • 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.

30. On page 2-5, the PPEC Handbook also provides, 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**, social work, developmental evaluations, and child life [emphasis added].

31. The mother argued that her son needs PPEC services because he is blind, non-verbal, and has difficulty swallowing food which causes him to throw up frequently.

32. The Respondent's witness explained that PPEC services cannot be approved because the child must need skilled nursing interventions.

33. The undersigned concludes that the Respondent has met its burden of proof and that PPEC services are not medically necessary for the Petitioner. The Petitioner's medical conditions do not require ongoing skilled nursing intervention.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner's appeal is DENIED and the Respondent's action is AFFIRMED.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the Petitioner disagrees with this decision, the Petitioner may seek a judicial review. To begin the judicial review, the Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The Petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 30 day of June, 2016,

in Tallahassee, Florida.

Warren Hunter
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Marshall Wallace, Area 2, AHCA Field Office Manager

Jun 21, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-03304

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 15 PALM BEACH
UNIT: AHCA

And

UNITED HEALTHCARE

RESPONDENTS.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above matter on June 7, 2016 at 11:04 a.m.

APPEARANCES

For the Petitioner:

For the Respondents: Lisa Sanchez
Medical/Healthcare Program Analyst
Agency for Healthcare Administration

Susan Frishman
Senior Compliance Analyst
United Healthcare

ISSUE

Whether the denial of petitioner's request for an additional 10 hours per week of personal care, homemaker, and companion services was proper. The burden of

proof was assigned to the petitioner. The standard of proof in an administrative hearing is by a preponderance of the evidence.

PRELIMINARY STATEMENT

On May 4, 2016 a request was received from United Healthcare to be added as a party to this proceeding. At the hearing, the request was granted. As such, United Healthcare is a co-respondent in this matter.

Petitioner was not present and, at the time of hearing, no exhibits were entered into evidence.

Present for the respondents was Dr. Sloan Karver, M.D. and Long Term Medical Director for United Healthcare. Respondent's exhibit "1" was entered into evidence.

The record was held open through June 10, 2016 for respondents to provide contract definitions of the services at issue. Information was timely received and entered as respondent's exhibit "2". The record was held open through June 15, 2016 for petitioner to provide a written response to the post hearing submission. Information was received and entered as petitioner's exhibit "1" and "2"

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following Findings of Fact are made:

1. Petitioner is enrolled in respondents Long Term Managed Care (LTMC) Program. Services are provided by United Healthcare.

2. Petitioner was, at all times relevant to this proceeding, Medicaid eligible.

3. Respondent administers Florida's Medicaid Program and contracts with Health Maintenance Organizations (HMOs) to provide comprehensive, cost-effective medical services to Medicaid recipients in the LTMC Program.

4. Petitioner is 69 years of age and resides with her daughter[1]. The daughter is petitioner's primary care giver.

5. The daughter experienced a heart in March 2016 and has been on medical leave. She plans to return to work in late June 2016. She is employed as a nurse and will only work daytime hours.

6. Petitioner diagnoses include disease. Nutrition and medications are administered through a Total assistance is required with bathing; dressing; grooming; and transferring. Petitioner is unable to walk. A Hoyer lift is used for transfer purposes.

7. Petitioner is incontinent and has numerous bowel movements each day.

8. LTMC services are defined by contract.

9. Services approved for petitioner through the LTMC Program include:

- Personal Care: 21 hours per week
- Homemaker: 10 hours per week
- Companion: 24 hours per week

- TOTAL: 55 hours per week

10. To facilitate the daughter's recovery, United Healthcare also approved for petitioner three weeks (24 hours per day) of facility based respite. Shortly after arrival at the respite facility, hospitalization was required.

[1] The daughter is also the petitioner's representative in this matter.

11. On or about April 14, 2016 petitioner requested an additional 10 hours per week of companion; personal care; and homemaker services. Dr. Karver thereafter reviewed all submitted information.

12. On April 19, 2016 a Notice of Action was issued which denied the request as not being medically necessary.

13. On April 29, 2016 petitioner's representative contacted the Office of Appeal Hearings and timely requested a fair hearing.

14. Petitioner's representative, who is a nurse, wishes to keep petitioner in the family home. Petitioner's health status will not improve and around the clock care is needed. Additionally, the representative will be returning to work.

15. Respondent argues petitioner was evaluated by a case manager. Based on that assessment, 34 hours of direct care services were indicated. However, due to petitioner's overall health status, 55 hours per week were determined to be medically necessary.

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 § 120.80, 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. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

19. 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.

20. Florida Medicaid, which includes the LTMC Program, only covers those services determined to be medically necessary. See § 409.905 (4) (c), Fla. Stat.

21. 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.

22. Respondent's contract with United Healthcare provides the following service definitions:

> (1) Adult Companion Care– Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist

> or supervise the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discreet services. The provision of companion services does not entail hands-on nursing care. The service includes light housekeeping tasks incidental to the care and supervision of the enrollee.
>
> (11) Homemaker Services — General household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control may be included in this service.
>
> (19) Personal Care — A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

23. The Findings of Fact establish petitioner is approved for 55 hours per week of direct care services through the LTMC Program. This equates to 11 hours per day; five days a week or 7.9 hours per day; seven days a week.

24. The request for an addition 10 service hours per week was to be divided between companion; homemaker; and personal care services. It was not established, however, whether a need existed on an equal basis for each service category. Additionally, it was not clear how each service component contributed to the need for an additional 10 hours per week.

25. Petitioner's overall health status is noted. To establish the need for additional hours, however, it is necessary to detail how those hours would be used and how those hours would satisfy an unmet need. That need must be medically necessary as defined by Fla. Admin. Code R. 59G-1.010.

26. It is noted petitioner's primary caregiver is returning to work. This factor, on its own, does not establish the need for additional services beyond the 55 hours per week currently approved.

27. The burden of proof in this matter is vested with the petitioner. Petitioner must establish, by the required evidentiary standard, that the requested services are medically necessary. To do so, each condition of medical necessity must be satisfied.

28. A hearing officer must consider all evidence and draw permissible inferences from that evidence. After reviewing documentary evidence and testimony on a comprehensive basis, petitioner has not demonstrated an additional 10 hours per week of personal care; homemaker; and companion services are medically necessary. The following conditions of medical necessity have not been satisfied:

> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider…

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, petitioner's appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the

judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 21 day of June, 2016,

in Tallahassee, Florida.

Frank Houston

Frank Houston
Hearing Officer
Building 5, Room 255
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Tallahassee, FL 32399-0700
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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] PETITIONER
JUDY JACOBS, AREA 7, AHCA FIELD OFFICE
SUSAN FRISHMAN, UNITED HEALTHCARE

Jun 15, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-03360

PETITIONER,

Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 07 St. Johns
UNIT: 88316

RESPONDENT.

_______________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an in-person administrative hearing in the above-referenced matter on March 31, 2016 at 11:15 a.m. in St. Augustine, Florida.

APPEARANCES

For the Petitioner: The petitioner was present and represented herself.

For the Respondent: Ernestine Bethune, Economic Self-Sufficiency Specialist II (ESSSII) for the Department of Children and Families (DCF).

ISSUE

The petitioner is disputing her enrollment in the Medically Needy program with a share of cost in the amount of $1397.

Also at issue is the denial of the petitioner's application for the Qualifying Individual 1 (QI1) program due to being over the income limit for the program.

The petitioner held the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing was originally scheduled for a telephonic hearing on March 21, 2016 at 11:30 a.m.

On March 4, 2016, the petitioner contacted the undersigned to request an in-person hearing in [redacted] The petitioner's request was granted and the hearing was rescheduled to March 31, 2016 at 11:00 a.m.

Appearing as a witness for the respondent was Stephanie Ross, ESSS II for DCF.

The respondent and the petitioner submitted evidence that was entered as the Respondent Exhibits 1-2.

During the in-person hearing, the petitioner presented issues with her enrollment in the Medically Needy program and the denial of her application for the QI1 program. The Department requested additional time to provide copies of the Notice of Case Action for the application dated February 18, 2016 for Medicaid and Medicare Savings Program (MSP) and the corresponding MN and QI1 budgets, as it was aware of an issue with only the Food Assistance Program (FAP).

The record was held open until 5:00 p.m. on April 8, 2016 to allow the petitioner and the respondent to submit additional evidence.

Evidence was received and entered as the Respondent's Exhibit 3 and the Petitioner's Exhibit 1.

A copy of the NOCA dated February 18, 2016 was not provided; however, the Department provided a screen print of Notice History Detail screen to show that a Notice of Case Action was sent to the petitioner on February 18, 2016.

A Final Order for the FAP appeal (16F-01421) has already been issued to the petitioner.

On June 9, 2016, the petitioner contacted the Office of Appeal hearings to report that she did not receive a copy of the Final Order for 16F-01421 as she has moved to Connecticut. The petitioner's address has been updated to reflect current address in Connecticut.

FINDINGS OF FACT

1. On February 18, 2016, the petitioner (age 68) applied for SSI-Related Medicaid and MSP. The petitioner listed on her application Social Security income of $834 and alimony in the amount of $714.

2. The Department calculated the MN budget by including the petitioner's gross monthly Social Security income in the amount of $834 and alimony in the amount of $763, for a total unearned income in the amount of $1597. The total gross income was subtracted by the unearned income disregard in the amount of $20 to result in $1577 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 $1397.

3. The total income included in the QI1 budget for the petitioner as an individual was $1597. The $20 unearned income disregard was subtracted from the total gross income which resulted in a countable income of $1577.

4. The Department determined that the petitioner was ineligible for the QI1 program as the income exceeded the QI1 income standard for an individual of $1337.

5. The petitioner disputes the figures included in the Department's calculations because she has always reported her alimony income. The petitioner argues that her alimony is normally $714 but is temporarily receiving $763 for now until her husband repays monies owed to her. The petitioner does not know why she is being denied for Medicaid. The petitioner is receiving Medicare A and Medicare B. The petitioner is able to care for herself and does not receive any institutional care services (ICP), hospice services, or community based waiver services at this time. The petitioner argues that the Department does not give any information or gives incorrect information.

6. The Department explained that its running records comments (CLRC) shows $714 in alimony but will review another system to check which verifications were provided to verify the $763 included in its calculations and will provide post-hearing. This verification was not received, post-hearing.

CONCLUSIONS OF LAW

7. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

8. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

9. Federal Regulations at 20 CFR § 416.1121 Types of unearned income states:

> Some types of unearned income are—
> (a) *Annuities, pensions, and other periodic payments.* This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veterans benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits.
> (b) *Alimony and support payments.* For SSI purposes, alimony and support payments are cash or in-kind contributions to meet some or all of a person's needs for food, clothing, or shelter. Support payments may be made voluntarily or because of a court order.

10. The above authority explains that unearned income, such as Social Security income and alimony payments, are included as income in determining eligibility for the Medicaid programs. The findings show that the petitioner is receiving Social Security income and alimony payments. Therefore, the undersigned concludes that the Department was correct to include the petitioner's Social Security income and alimony payments in its calculations.

The petitioner's enrollment in the Medically Needy Program will be addressed first:

11. Fla. Admin. Code R. 65A-1.701, Definitions, states in part:

> (20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services.

12. The above controlling authorities explain that the full coverage Medicaid coverage group (MEDS-AD Demonstration Waiver) in the SSI-Related program 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 also show that the petitioner is receiving Medicare but is not receiving ICP, hospice, or community based services. Therefore, the undersigned concludes that the petitioner does not qualify for full-coverage Medicaid, even if the petitioner's alimony payments in the amount of $714 was included in the Department's calculations.

The denial of the QI1 will now be addressed:

13. Fla. Admin. Code R. 65A-1.702 Special Provisions states:

…

(12) Limits of Coverage.
(a) Qualified Medicare Beneficiary (QMB). Under QMB coverage, individuals are entitled only to Medicare cost-sharing benefits, including payment of Medicare premiums.
(b) Special Low-Income Medicare Beneficiary (SLMB). Under SLMB coverage, individuals are entitled only to payment of the Part B Medicare premium. If eligible, AHCA shall pay the premium for up to three months retroactive to the month of application.
…
(d) Part B Medicare Only Beneficiary (QI1). Under QI1 coverage, individuals are only entitled to payment of their Medicare Part B premium. (This is coverage for individuals who would be eligible for QMB or SLMB coverage except their income exceeds limits for those programs.)

14. Fla. Admin. Code R. 65A-1.713 SSI-Related Medicaid Income Eligibility Criteria states:

(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
(b) For QMB, income must be less than or equal to the federal poverty level after application of exclusions specified in subsection 65A-1.713(2),

F.A.C.
(g) For SLMB, income must be greater than 100 percent of the federal poverty level but equal to or less than 120 percent of the federal poverty level.
(j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. QI1 is eligible only for payment of the Part B Medicare premium through Medicaid.

15. 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. An individual may qualify for the QMB program if her 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.

16. The Department's Program Policy Manual, CFOP 165-22, Appendix A-9, sets forth the income standards for an individual effective January 2016 as $981 for the QMB program, $1177 for the SLMB program, and $1325 for the QI 1 program. The income standards are a percentage of the Federal Poverty Level as explained above.

17. The above authority sets the income standard for an individual applying for the QI1 program at $1325 effective January 2016.

18. The petitioner's countable income was $1597, which exceeds the income limit for an individual in the QI1 Program, which has the highest income limit of the MSP programs. The petitioner argues that her regular alimony payments are $714 and not

$763. The findings show that petitioner's countable income would still exceed the income limit for an individual for the QI1 program, even if the Department included her regular alimony payments in the amount of $714. Therefore, the undersigned concludes that the Department correctly denied QI1 program benefits.

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 15 day of June, 2016, in Tallahassee, Florida.

Paula Ali
Hearing Officer
Building 5, Room 255
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Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished T[redacted] Petitioner
Office of Economic Self Sufficiency

Jun 22, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-03361

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 DADE
UNIT: AHCA

And

UNITED HEALTHCARE

RESPONDENTS.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 14, 2016 at 8:37 a.m.

APPEARANCES

For the Petitioner:

For the Respondents: Dianna Chirino
Senior Human Services Program Specialist
Agency for Healthcare Administration

Susan Frishman
Senior Complaint Analyst
United Healthcare

ISSUE

Whether the denial of petitioner's reimbursement request for orthodontic treatment 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

On May 10, 2016 a request was received from United Healthcare to be added as a party to this proceeding. At the hearing, the request was granted. As such, United Healthcare is a co-respondent in this matter.

Petitioner was not present but represented by his father. Petitioner's exhibit "1" was accepted into evidence.

Present for the respondents from United Healthcare were Dr. Brittany Vo, Dental Consultant and Lori Eubanks, Account Manager. 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 receives Medicaid services through respondent's Statewide Medicaid Managed Care Program. Specifically, the Managed Medical Assistance (MMA) Program.

2. Petitioner's MMA services are provided by United Healthcare.

3. Petitioner was eligible for Medicaid services at all times relevant to this proceeding.

4. Petitioner's date of birth is [redacted]

5. When medically necessary, orthodontic treatments are covered for individuals under 21 years of age.

6. In December 2015 a family friend recommended [redacted] for orthodontic services. An appointment was thereafter scheduled.

7. [redacted] is not an enrolled provider with United Healthcare.

8. On December 17, 2015 petitioner paid [redacted] $175.00 for a "Preliminary Study/Records". Additional payments were made on January 14, 2016; February 3, 2016 and March 2, 2016.

9. On January 14, 2016 a treatment plan was signed which called for, in part:

- $900.00: Initial Fee
- $120.00: Due monthly for 24 months

10. Petitioner has paid at least $1075.00 for orthodontic services thus far provided by [redacted]

11. When completed, the entire cost for orthodontic services is estimated to be $3995.00.

12. On January 7, 2016 [redacted] addressed a letter to an unspecified source outlining the nature of petitioner's orthodontic status. The letter states a contract of fees was attached for review.

13. [redacted] thereafter submitted a claim to United Healthcare. The claim was received on February 25, 2016. The date of service was February 11, 2016 and the claim was for $3780.00. Due to [redacted] being an out of network provider, the claim was denied.

14. On March 15, 2016 United Healthcare received petitioner's request for reimbursement.

15. On April 29, 2016 United Healthcare issued correspondence to petitioner's parents which denied the reimbursement request. The correspondence stated, in part: "We reviewed our records. Our records show that your child's provider is not in our network. You child's plan does not cover services given by an Out-of-Network dentist. Because of this, we cannot reimburse you."

16. On May 2, 2016 the Office of Appeal Hearings timely received petitioner's request for a fair hearing.

17. Petitioner asserts [redacted] stated he accepted United Healthcare dental insurance.

18. Respondent asserts a proper prior authorization request was not received. Had petitioner contacted United Healthcare prior to starting services, he would have known [redacted] was not part of the network. A referral could have been made to several in network orthodontists located near petitioner's residence.

Conclusions of Law

19. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to § 120.80, Fla. Stat.

20. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

21. The standard of proof in an administrative hearing is by a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

22. 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.

23. 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.
> …
>
> When a provider verifies a recipient's eligibility for Medicaid, he must also verify whether the recipient is enrolled in an HMO. **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** [Emphasis Added], unless it is an emergency.

24. Neither testimony nor evidence establish orthodontic services rendered and for which reimbursement is sought were based on a medical emergency.

25. The Findings of Fact establish orthodontic services started in December 2015. The first known correspondence to an unidentified party was on January 7, 2016.

26. It is noted the above information was not sent on a United Healthcare prior authorization document.

27. 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.

28. Fla. Admin Code R 59G-5110, “Claim Payments” provides information regarding 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, Medicaid-covered services received from the beginning date of eligibility (including the three-month retroactive period) and paid for during the period of time between an erroneous denial or termination of Medicaid eligibility and a successful appeal or an agency determination in the recipient’s favor** [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.

29. Effective June 2, 2016 Fla. Admin. Code R. 59G-5110 was modified and now states, in part:

> (1) Purpose. This rule describes the circumstances when the Agency for Health Care Administration (AHCA) may directly reimburse eligible Florida Medicaid recipients; how AHCA reimburses recipients; and documentation requirements for direct reimbursement.
> (2) Determination Criteria. Florida Medicaid recipients may be eligible for direct reimbursement if:

(a) Medical goods and services were paid for by the recipient or a person legally responsible for their bills from the date of an erroneous denial or termination of Florida Medicaid eligibility to the date of a reversal of the unfavorable eligibility determination.

(b) The goods and services were medically necessary as defined in Rule 59G-1.010, Florida Administrative Code (F.A.C.); rendered by a provider that is qualified to perform the service including meeting any applicable certification or licensure requirements (the provider is not required to be enrolled or registered as a Florida Medicaid provider); and covered by Florida Medicaid for the recipient's eligibility group on the date of service.

(c) Reimbursement for the medical goods or services is not available through any third-party payer on the date of service for which direct reimbursement is requested.

7.2 Specific Criteria

Providers must obtain authorization from the quality improvement organization for orthodontic and prosthodontic related services when indicated on the applicable Florida Medicaid fee schedule(s).

Providers must include the following additional information with the authorization request for orthodontic services:
- Orthodontic initial assessment
- Clinical photographs (prints or slides) showing:
− Frontal view, relaxed, teeth in occlusion
− Profile, right or left
− Intraoral, right or left sides, teeth in occlusion
− Intraoral, frontal, teeth in occlusion
− Occlusal view (if photos are submitted without complete records)
- Study models
- Lateral cephalometric radiograph
- Panoramic radiograph

30. Each of the above states 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.

31. Neither testimony nor evidence establish 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.

32. The definition of medical necessity is found in Fla. Admin. Code R. 59G-1.010 (166) and states, in part:

> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not in itself, make such care, goods or services medically necessary or a medical necessity or a covered service."

33 As orthodontic treatment was initiated, it is presumed such was based on [redacted] Due to the lack of a prior authorization, however, United Healthcare was not able to conduct a medical necessity review.

34. It is noted information was submitted by [redacted] That information, however, did not rise to the specifications found in Fla. Admin. Code R. 59G-5110 7.2.

35. Had a prior authorization been submitted, petitioner would have known that Dr. [redacted] was not enrolled with United Healthcare. At that time, securing a list of in network orthodontists could have been secured.

36. The petitioner has not demonstrated, by the greater weight of the evidence, that the denial for reimbursement 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 22 day of June, 2016,

in Tallahassee, Florida.

Frank Houston

Frank Houston
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] PETITIONER
RHEA GRAY, AREA 11, AHCA FIELD OFFICE MANAGER
SUSAN FRISHMAN, UNITED HEALTHCARE

Jun 14, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-03366

PETITIONER,
Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 20 Lee
UNIT: 88287

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on June 1, 2016 at approximately 2:30 p.m. CDT.

APPEARANCES

For the Petitioner:

For the Respondent: Mary Dahmer, Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of April 11, 2016 denying her Medicaid eligibility. In accordance with Fla. Admin. Code R. 65-2.060(1) the burden of proof was assigned to the petitioner.

PRELIMINARY STATEMENT

The respondent submitted a packet of information that was admitted into evidence as Respondent's Exhibits "1" through "10".

FINDINGS OF FACT

1. Petitioner is a 53 year-old woman who is not pregnant, has no minor children in her care and has not been deemed to be disabled by the Social Security Administration (SSA). Prior to the SSA denial, the petitioner was receiving Medicaid benefits from the Department. These benefits were terminated on December 31, 2015 when the Department adopted the SSA decision.

2. On March 24, 2016, petitioner submitted an application for Food Assistance, Temporary Assistance for Needy Families and SSI-Related Medicaid (Supplemental Security Income).

3. Petitioner's Fair Hearing request concerns only the Medicaid denial.

4. Petitioner applied for Social Security Disability Insurance (SSDI) benefits through the SSA on November 5, 2014. The claim was denied and appealed. The appeal was denied on May 26, 2016, "code N32 (Non-pay – Capacity for substantial gainful activity – other work, no visual impairment)."

5. The March 2016 Medicaid application was denied by the Department as it adopted the SSA decision. Petitioner has obtained counsel to represent her interests in the on-going SSA appeal.

5. Petitioner applied with the Department for SSI-Related Medicaid again on April 12, 2016. The Division of Disability Determinations returned the disability packet without determination as it was submitted within 90 days of the previous denial.

6. The petitioner alleges conditions of trouble sleeping, [redacted] [redacted] She states that she is forced to stay with her 88-year-old grandmother and all she can comfortably do from day to day is watch

television. Petitioner alleged that there were no new disabling conditions; however, she also stated that she could not afford her medications for [redacted] so she is no longer taking them.

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, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

8. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

9. Federal Medicaid Regulations at 42 C.F.R. section 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 §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.

10. The findings show that petitioner applied for disability benefits with the SSA and was denied as she was found not disabled. The denial date was May 26, 2016. The

petitioner applied for Medicaid with the Department in March and April 2016. The SSA denial date is within 12 months of the Medicaid application date.

11. Petitioner stated that she had no new disabling conditions not considered by the SSA; therefore, the undersigned concludes there are no new disabling conditions not known by the SSA.

12. 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.

13. 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 (20007) (incorporated by reference).

14. 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, 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.

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 __June__________, 2016,

in Tallahassee, Florida.

Gregory Watson

Gregory Watson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To [redacted] Petitioner
Office of Economic Self Sufficiency

Jun 29, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16F-03660

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 Dade
UNIT: AHCA

And

UNITED HEALTHCARE

RESPONDENTS.
_______________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above matter on June 17, 2016 at 1:05 p.m.

APPEARANCES

For the Petitioner:

For the Respondents: Fathima Leyva
Agency for Healthcare Administration (AHCA)
Senior Human Services Program Specialist

Dr. Brittany Vo, DDS
United Healthcare

ISSUE

Whether the denial of deep gum cleaning – four quadrants (D4341); upper dentures (D5213); and lower dentures (D5214) 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

On May 21, 2016 a request was received from United Healthcare to be added as a party to this proceeding. At the hearing, the request was granted. As such, United Healthcare is a co-respondent in this matter.

Petitioner entered no exhibits into evidence.

Present for Respondents from United Healthcare was Susan Frishman, Senior Compliance Analyst. 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 [redacted]

2. Petitioner receives Medicaid services through the Statewide Medicaid Managed Care Program. Specifically, the Managed Medical Assistance Program. United Healthcare is the managed care entity which provides petitioner's Medicaid services.

3. Petitioner was Medicaid eligible at all times relevant to this proceeding.

4. Petitioner is disabled. She has one remaining molar in her mouth. Most chewing takes places directly on her gums.

5. On or about April 28, 2016 United Healthcare received from petitioner's dentist a prior authorization for the following dental procedures:

Dental Procedure:
D7210: Extraction of tooth #18 (molar)
D4341: Deep Gum Cleaning of four quadrants
D5213: Upper Denture
D5214: Lower Denture

6. No x-rays were included with the prior authorization.

7. A deep gum cleaning (D4341) is a periodontal service.

8. Dental procedure D4341 is not a covered Medicaid service for individuals over 21 years of age.

9. Dental procedure D4341 is not an expanded benefit provided by United Healthcare for individuals over 21 years of age.

10. When medically necessary, upper and lower dentures are a covered benefit for all Medicaid recipients.

11. On May 2, 2016 United Healthcare issued a Notice of Action which enumerated the following determinations:

Determinations:
D7210: Approved
D4341: Denied - Not a covered benefit
D5213: Denied - Incomplete information
D5214: Denied - Incomplete information

12. On May 11, 2016 the Office of Appeal Hearings timely requested Petitioner's request for a fair hearing.

13. At time of hearing, tooth # 18 was not extracted. The treating dentist states a medication is needed to prevent infection. The cost is $150.00. Petitioner cannot afford to make the payment

14. United Healthcare has received no prior authorization request for the above medication.

15. Regarding dentures, Respondent argues not enough information was provided to make a medical necessity determination. [redacted] checked Petitioner's file prior to the hearing and x-rays still had not been received.

16. Post hearing, Petitioner contacted the Office of Appeal Hearings and stated she secured x-rays from the dentist.

CONCLUSIONS OF LAW

17. By agreement between the Agency for Health Care Administration and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to § 120.80, Fla. Stat.

18. This is a final order pursuant to § 120.569 and § 120.57, Fla. Stat.

19. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

20. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

21. The Florida Medicaid Provider General Handbook (Provider Handbook) – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code R. 59G-4. The Provider Handbook states on page 1-27:

> Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.
>
> Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.

Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

22. Page 1-30 of the Provider Handbook continues by stating: “An HMO’s services cannot be more restrictive than those provided under Medicaid fee-for-service.”

23. AHCA’s promulgated Dental Services Coverage Policy (Dental Policy) became effective on May 3, 2016.

24. The Dental Policy states, in relevant parts:

1.1 Description

Florida Medicaid dental services provide for the study, screening, assessment, diagnosis, prevention, and treatment of diseases, disorders, and conditions of the oral cavity.

1.1.2 Statewide Medicaid Managed Care Plans

This Florida Medicaid policy provides the minimum service requirements for all providers of dental services. This includes providers who contract with Florida Medicaid managed care plans (i.e., provider service networks and health maintenance organizations). Providers must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the Agency for Health Care Administration’s (AHCA) contract with the Florida Medicaid managed care plan. The provision of services to recipients in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

4.0 Coverage Information

General Criteria
Florida Medicaid reimburses for services that meet all of the following:
- **Are determined medically necessary** [Emphasis Added]
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2.5 Periodontal Services

Florida Medicaid reimburses for periodontal services for recipients under the age of 21 years [Emphasis Added] to diagnose and treat the diseases of the supporting and surrounding tissues of the teeth.

4.2.7 Prosthodontic Services

Florida Medicaid reimburses for prosthodontic services to diagnose, plan, rehabilitate, fabricate, and maintain dentures as follows:
− One upper, lower, or complete set of full or removable partial dentures per recipient
− One reline, per denture, per 366 days, per recipient
− One all-acrylic interim partial (flipper) for the anterior teeth, per recipient under the age of 21 years

25. The Findings of Fact establish:

- Petitioner is over the age of 21 years
- A deep gum cleaning is a periodontal service
- A deep gum cleaning is not an expanded dental benefit provided by United Healthcare

26. The Dental Policy specifies that periodontal services are covered only for those individuals under the age of 21 years.

27. Petitioner has not demonstrated in a preponderant matter than respondent's denial of a deep gum cleaning was improper.

28. Regarding upper and lower dentures, both are covered by the Florida Medicaid Program for all recipients. To be approved, the Dental Policy requires a service meet medical necessity criteria.

29. 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.

30. The Findings of Fact establish the referring dentist provided no x-rays with the prior authorization request for upper and lower dentures. X-rays are a key component of a comprehensive medical necessity evaluation. Without such, medical necessity cannot be determined.

31. Petitioner has not met the required evidentiary burden that United Healthcare's denial of dentures was improper.

32. It is noted Petitioner has since received x-rays. If desired, Petitioner can discuss with United Healthcare how the x-rays can be submitted for a medical necessity review. Should the dentures be once again denied, United Healthcare would issue a new Notice of Action with Fair Hearing rights.

33. Regarding the medication needed with the extraction of tooth #18, a request for that medication has not been submitted to United Healthcare. As such, the matter is not yet ripe for appeal.

34. When considering all evidence and relevant authorities, Petitioner has not demonstrated the denials of D4341; D5213; and D5214 were improper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner's appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 29 day of June, 2016,

in Tallahassee, Florida.

Frank Houston

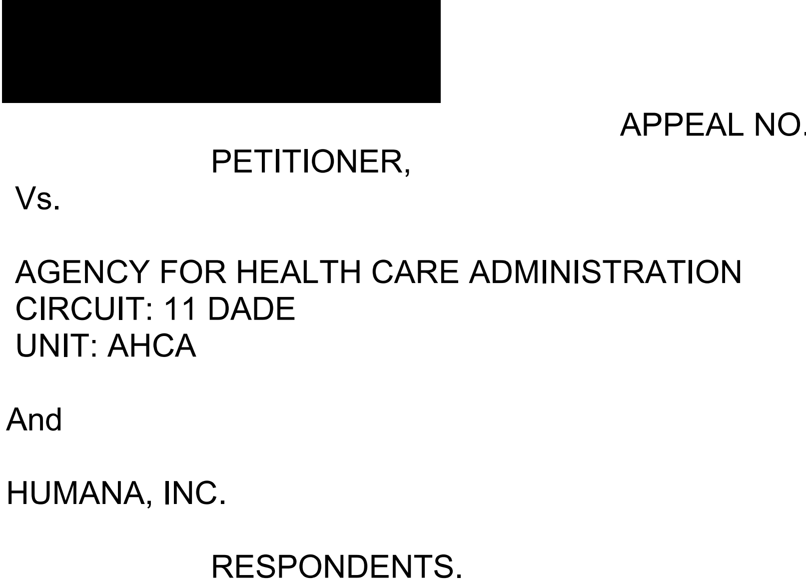
Frank Houston
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] PETITIONER
RHEA GRAY, AREA 11, AHCA FIELD OFFICE MANAGER
SUSAN FRISHMAN, UNITED HEALTHCARE

Jun 29, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS



APPEAL NO. 16F-03662

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 DADE
UNIT: AHCA

And

HUMANA, INC.

RESPONDENTS.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 21, 2016 at 8:38 a.m.

APPEARANCES

For the Petitioner:

For the Respondents: Dianna Chirino
Agency for Healthcare Administration (AHCA)
Senior Human Services Program Specialist

Mindy Aikman
Humana, Inc.
Grievance and Appeals Specialist

ISSUE

Whether the denial of dental procedure D9630 (other drugs and/or medicines) was proper. The burden of proof was assigned to the petitioner. The standard of

of proof in an administrative hearing is by a preponderance of the evidence.

PRELIMINARY STATEMENT

An interpreter from Services provided both and translation.

At the hearing, a verbal request was made for Humana to be added as a party to this proceeding. The request was granted.

Petitioner entered no exhibits into evidence.

Present for the respondents from DentaQuest was Jackelyn Salcedo, Appeals 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

2. Petitioner receives Medicaid services through AHCA's Statewide Medicaid Managed Care Program. Specifically, the Managed Medical Assistance Program. Humana is the managed care entity which provides petitioner's Medicaid services.

3. DentaQuest is Humana's dental vendor. All requests for dental services are reviewed by DentaQuest. DentaQuest determines whether the requested procedures are in compliance with pertinent rules and regulations.

4. On or about May 4, 2016 DentaQuest received a request for the surgical extraction of tooth #12 (D7210); analgesia (D9230); and other drugs or medicines (D9630).

5. Dental procedures D7210 and D9230 were approved.

6. D9630 is not a covered benefits under the Florida Medicaid Program.

7. D9630 is not an expanded dental benefit provided by Humana.

8. On May 5, 2016 DentaQuest issued a Notice of Action which denied D9630. The rationale is recorded as "The requested service is not a covered benefit."

9 On May 11, 2016 the Office of Appeal Hearings timely received petitioner's request for a fair hearing.

10. Petitioner is diabetic and the treating dentist states D9630 is necessary to prevent infection. The dentist will not extract tooth #12 without the requested drug/medicine.

11. Respondent argues the Florida Medicaid program offers limited dental services for individuals over the age of 21. Respondent suggests petitioner attempt to get a prescription for the medication as opposed to the drug being administered in the dental office. Another Humana enrolled dental provider could also be consulted.

Conclusions of Law

12. By agreement between the Agency for Health Care Administration and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to § 120.80, Fla. Stat.

13. This is a final order pursuant to § 120.569 and § 120.57, Fla. Stat.

14. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

15. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

16. The Florida Medicaid 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.

17. Page 1-30 of the Provider Handbook continues by stating: “An HMO’s services cannot be more restrictive than those provided under Medicaid fee-for-service.”

18. AHCA’s promulgated Dental Services Coverage Policy (Dental Policy) became effective on May 3, 2016.

19. The Dental Policy states, in relevant parts:

> **1.1 Description**
> Florida Medicaid dental services provide for the study, screening, assessment, diagnosis, prevention, and treatment of diseases, disorders, and conditions of the oral cavity.
>
> **1.1.2 Statewide Medicaid Managed Care Plans**
> This Florida Medicaid policy provides the minimum service requirements for all providers of dental services. This includes providers who contract with Florida Medicaid managed care plans (i.e., provider service networks and health maintenance organizations). Providers must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the Agency for Health Care Administration’s (AHCA) contract with the Florida Medicaid managed care plan. The provision of services to recipients in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

2.2 Who Can Receive
Florida Medicaid recipients requiring medically necessary dental services. Some services may be subject to additional coverage criteria as specified in section 4.0.

5.2 Specific Non-Covered Criteria

Florida Medicaid does not reimburse for the following:

- Services that are not listed on the fee schedule

20. The above referenced fee schedules are found on the Florida Medicaid Web Portal at:

http://portal.flmmis.com

21. D9630 is not identified on the dental fee schedule.

22. The undersigned lacks jurisdiction to order respondents to cover a service not covered by the Florida Medicaid Program.

23. The Findings of Fact also establish D9630 is not an expanded dental benefit provided by Humana.

24. After considering all evidence and relevant authorities, petitioner has not demonstrated the action taken in this matter was improper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, petitioner's appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 29 day of June, 2016,

in Tallahassee, Florida.

Frank Houston

Frank Houston
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
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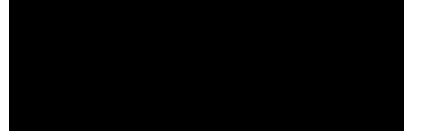
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] PETITIONER
RHEA GRAY, AREA 11, AHCA FIELD OFFICE MANAGER
MINDY AIKMAN, HUMANA, INC.

Jun 13, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS



APPEAL NO. 15F-09161

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 April 27, 2016 at 10:04 a.m.

APPEARANCES

For the Petitioner: Pro se

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 surgical procedure 17999-facial reconstruction. Because the matter at issue involves a request for a service, Petitioner carries the burden of proof.

PRELIMINARY STATEMENT

Appearing as Respondent's witnesses from Molina Healthcare of Florida were Dr. Valerie Maguire, Medical Director; Rebecca Quintana, Grievance and Appeals Specialist; Carlos Cantillo, Manager of Grievance and Appeals; and Yani Veliz, Supervisor of Grievance and Appeals.

Respondent submitted a 29-page document which was entered into evidence and marked Respondent Exhibit 1.

Petitioner submitted an 11-page document which was entered into evidence and marked Petitioner Exhibit 1.

FINDINGS OF FACT

1. Petitioner is a 56 year-old recipient of the Medicaid program who became a member of Molina Healthcare of Florida (Molina) managed care plan effective June 1, 2015.

2. Petitioner is diagnosed with [redacted] According to a final MRI report from [redacted] dated April 21, 2015, Petitioner's neck has lesions, nodules and a benign tumor.

3. On October 10, 2015, Molina received a request from Petitioner's primary care physician for procedure 17999-facial reconstruction (hanging skin off of face).

4. On October 20, 2015, Molina denied the request and sent a Notice of Action to the Petitioner. The notice provided the following explanation for the denial:

> [B]ased on the medical records which were given to us, this surgery is not medically necessary. You have loose facial and neck skin which is within

> normal limits for your age, …. The pictures submitted do not demonstrate any significant skin problems. To have this covered you must meet the rules in the guidelines. The information sent id does not show that you have pain that has not responded to treatment. The information sent in does not show that you have infection that has not responded to adequate treatment. The information sent in does not show that you have a biopsy that shows extensive deep cancer changes in the skin area involved. This surgery is not medically necessary because you do not have any of these findings, and therefore, it would be a cosmetic procedure which is not covered….

5. The Petitioner submitted a timely request for a fair hearing on November 2, 2015.

6. Petitioner asserted he had the requested surgery three time before, the first in 2003 and the last in 2009, to prevent a cancerous condition developing in his neck.

7. No documentation or medical records were provided to substantiate Petitioner's surgeries in 2003 and 2009. Respondent was unable to verify procedure code 17999 was ever approved by Medicaid for the Petitioner.

8. Petitioner referred to his doctor's April 4, 2016 letter that states in relevant part:

> …the patient carries a diagnosis of medication-induced deformation of his facial features. This deformation of facial features is causing recurrent issues with infection in the skin folds and difficulty in activities of daily living For example, when the patient moves his head to the right or to the left, he has difficulty driving or walking. …
>
> This is a critical and sensitive procedure and is medically necessary in accordance with recognized guidelines.
>
> A procedure is considered cosmetic when it is to repair a deformity which is a variation of normal (for example, aging face). However, when a procedure is considered reconstructive (medically necessary) when it is to repair a consequence of a medical condition or trauma. [Petitioner] is in that category.

9. A July 8, 2015 Patient Note includes the following relevant comments by regarding a peer-to-peer with Dr. Blanco, Chief Medical Officer for Molina:

> Dr. Blanco agreed it was borderline and asked that we send photographs of the neck showing the fungus in the folds.
>
> If they can see these photographs of the neck, which they have not seen, the Chief Medical Officer may or may not overturn the decision.
>
> ….
>
> Approximately 18 minutes was spent with Dr. Blanco explaining the patient's necessity and how it interferes with his activities of daily living and how he is disabled from the condition.

10. Petitioner did not discuss any limitations regarding his activities of daily living at hearing.

11. On page 2 of Respondent's Exhibit 1 it is noted that:

> The pictures and clinical notes received with the request do not demonstrate that the enrollee has a significant skin problem, infection that has not responded to treatment, or indication of deep [redacted] changes in the skin.

12. Petitioner asserts the surgery is medically necessary and not cosmetic. He asserts the fat cells, if not removed, will feed the cysts and nodules in his thyroid which could lead them to become [redacted] He noted his family has a history of [redacted] Petitioner's goal is to prevent the [redacted] growing by feeding on the fat cells in his neck.

13. Respondent's doctor determined that removal of the fat cells was cosmetic and not related to his [redacted]

CONCLUSIONS OF LAW

14. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80 Fla. Stat.

15. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code § 65-2.056.

16. 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).

17. 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.

18. Fla. Admin. Code 59G-1.010 states in part:

> (166) “Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

> (b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service…

19. In Petitioner's letter of April 4, 2016 from his doctor, it mentions recurrent issues with infection in the skin folds but there was no statement or documentation regarding treatment efforts to address the infection. The doctor's determination of medical necessity is not compelling without sufficient documentation of non-surgical efforts to address the Petitioner's condition.

20. Respondent's medical witness testified that the facial reconstruction requested is cosmetic and not related to Petitioner's [redacted]. Petitioner's concern that cancer may develop if the fat is not removed from his neck does not establish medical necessity for the procedure.

21. After considering the evidence and all of the appropriate authorities set forth above, the hearing officer concludes that the Petitioner has not met his burden of proof.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED and the Agency action is AFFIRMED.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the Petitioner disagrees with this decision, the Petitioner may seek a judicial review. To begin the judicial review, the Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The Petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 13 day of June, 2016,

in Tallahassee, Florida.

Warren Hunter
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager

Jun 14, 2016

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 16N-00023

PETITIONER,

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on May 10, 2016, at 10:36 a.m., Center, Boynton Beach, Florida.

APPEARANCES

For the Petitioner:

For the Respondent:

ISSUE

At issue is whether or not the nursing facility's action to discharge the petitioner is an appropriate action based on the federal regulations at 42 C. F. R. § 483.12. The nursing home is seeking to transfer and discharge the petitioner because her "needs cannot be met at this facility".

The facility has the burden of proof to establish by clear and convincing evidence that the discharge is appropriate under federal regulations found in 42 C.F.R. § 483.12 (a) and Section 400.0255, Fla. Stat.

PRELIMINARY STATEMENT

By Nursing Home Transfer and Discharge Notice, dated March 17, 2016, the respondent informed the petitioner that she was to be discharged from the facility effective March 17, 2016. The facility's physician signed the notice. The reason cited was "Your needs cannot be met in this facility." On March 18, 2016, the petitioner timely requested an appeal to challenge the respondent's action.

The petitioner's representative presented one exhibit which was accepted 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.

AHCA completed a survey at the respondent's facility on March 31, 2016. The survey determined that there were no violations. The survey result was entered as Hearing Officer 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 has been living at the respondent's facility since [redacted]

2. From October 2015 through March 2016, the petitioner had an [redacted] On February 12, 2016, she had a Urinary Tract infection (UTI). As part of her medical treatment she was prescribed several strong medications that had major side effects. The petitioner's daughter argues that it was the medications prescribed to her mother which caused her to have [redacted]

3 On July 8, 2015, the petitioner's doctor recommended that a Wander Guard be placed on the petitioner due to unspecified [redacted] The petitioner's wheelchair was fitted with the recommended Wander Guard and was to be checked every shift.

4. In January 2016, the petitioner was given a new wheelchair. The Wander Guard was not transferred to the new wheelchair.

5. On February 7, 2016, at approximately 7:00 p.m., the petitioner became confused and wandered to the door. A visitor opened the door and allowed the petitioner to get out of the facility. The petitioner's daughter asserts that if the Wander Guard was transferred from the old wheelchair to the new wheelchair, it would have triggered an alarm alerting staff that her mother was out of the facility.

6. On March 17, 2016, the petitioner's doctor recommended the petitioner to be transferred to a safer nursing facility that was better equipped to manage her [redacted]

7. On March 17, 2016, the nursing facility issued a Nursing Home Transfer and Discharge Notice, the reason listed on the discharge notice was, "Your needs cannot be met in this facility." The Nursing Home Transfer and Discharge Notice indicates the discharge location as [redacted] The discharge notice was signed by a nursing facility physician. The explanation given to support reason for discharge was, "psychiatry recommendation and for the patient's safety." The physician recommended the petitioner be transfer to a secure [redacted] unit.

8. The petitioner's daughter argues the medication prescribed to her mother had altered her mother's behavior. She asserts that the discharge of her mother can be avoided if the facility would take the proper safety steps by (1) fitting her mother's wheelchair with a working Wander Guard and (2) treat her mother with medication that would not have as many side effects as the ones prescribed to her mother in the past.

9. The respondent believes the petitioner's needs would be better met elsewhere, at a facility which will allow the petitioner to move around. The respondent argues its facility is not equipped to handle patients with [redacted] or [redacted] The respondent also argues the nursing facility has many doors and is not a locked facility. The respondent asserts the petitioner has attempted to leave the facility 25 times and continues to demonstrate exit-seeking behaviors, one as recent as May 8, 2016.

10. The petitioner wants to remain at this facility as she has made many friends and has difficulty adjusting to new places/institutions. The petitioner's daughter argues the petitioner does not have the physical strength to open doors by herself or to stand by herself; therefore, she is not an exit risk without help. Her daughter asserts the

medication prescribed to her mother is the cause of her confusion, agitation and irritability.

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. Section 400.0255(15), Fla. Stat addresses Resident transfer or discharge; requirements and procedures; hearings and states in 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. Any notice indicating a medical reason for transfer or discharge must either be signed by the resident's attending physician or the medical director of the facility, or include an attached written order for the discharge or transfer. The notice or the order must be signed by the resident's physician, medical director, treating physician, nurse practitioner, or physician assistant.

13. In this case, the petitioner is being discharged because the respondent believes her needs cannot be met at its facility. The facility's medical doctors approved the discharge but the petitioner does not wish to leave the facility.

14. Federal Regulations appearing 42 C.F.R. § 483.12, sets forth the reasons a facility may involuntary discharge a Medicaid or Medicare patient as follows:

> (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;**
> (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…

15. In this case, the petitioner's daughter was given a notice on March 17, 2016, indicating that she would be discharged from the facility because her needs could not be met in this facility. The above-cited authorities set forth the conditions which must exist for a nursing home to involuntarily discharge a resident.

16. Based on the evidence presented, the nursing facility has established that petitioner's needs cannot be met at its 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.

17. The undersigned's decision is limited to whether the discharge meets the requirement at 42 C.F.R. § 483.12(a)(2)(i). These rules are directed to coincide with doctors' notes and documentation is required. The undersigned took note that the

medication may alter the petitioner's behavior. However, the undersigned must determine if the petitioner's needs can be met at the nursing facility.

18. Based on the evidence presented, the nursing facility has met its burden establishing that the petitioner's need cannot be met at this facility under federal regulation for which a nursing facility may voluntarily discharge a resident.

19. 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.

20. 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

The appeal is denied as facility's action to discharge the petitioner is in accordance with Federal Regulations. The facility may proceed with the discharge, as determined by the physician, and in accordance with applicable Agency for Health Care Administration requirements.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 14 day of June, 2016,

in Tallahassee, Florida.

Christiana Gopaul-Narine
Hearing Officer
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